7 General Billing Rules

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General Information

This chapter contains general information related to Health Choice Arizona's billing rules and requirements.

In addition to AHCCCS requirements, Health Choice Arizona follows the coding standards described in the current editions of the *Uniform Billing (UB-04)Manual*; *International Classification of Diseases (ICD) Clinical Modification (CM) and Procedure Classification System (PCS) Manuals; Physicians' Current Procedural Terminology (CPT) Manual; Healthcare Common Procedure Coding System (HCPCS) Guidelines*; the *First Data Bank Blue Book*; Centers for Medicaid and Medicare Services (CMS), and the *Current Dental Terminology (CDT) Manual*.

AHCCCS REGISTRATION ID NUMBER

Health Choice Arizona will not pay claims to a provider who is not registered with AHCCCS. Please ensure that the provider of services has current registration with AHCCCS before submission of the claim.

NATIONAL PRACTIONER IDENTIFICATION (NPI)

AHCCCS and Health Choice Arizona also require each provider to be registered with an active National Provider Identification (NPI) number as well as an active AHCCCS provider ID number in order to coordinate benefits and process claims. The NPI number is to be used as the healthcare provider identifier for all claim submissions.

Contracted providers can submit their NPI number to the Health Choice Arizona Network Services Department. To submit the NPI number, providers can mail or fax a copy of their NPI notification to:

Health Choice Arizona
Attention: Network Services
410 N. 44th Ave., Ste 900
Phoenix, AZ 85008
Fax: (480) 303-4433

The documentation must include the provider's name and AHCCCS ID number and provider's signature. NPI numbers will also be accepted via written notification mailed or faxed to the address or fax number listed above.

All claims must be submitted with the NPI as applicable.

CLAIM SUBMISSION REQUIREMENTS

Claims for services must be legible and submitted on the correct form for the type of service billed. Claims that are not legible or not submitted on the correct form will be returned to the provider without processing. If your claim is not accepted, this submission does not count as a clean claim submission. If you receive a returned claim, the provider must re-file a legible copy of the claim on the correct claim form type and it must be refilled within the appropriate time frame detailed in an upcoming section. ***Please note**: *Faxed claims are not accepted for processing*.

MAILING ADDRESS FOR PAPER CLAIMS

HEALTH CHOICE ARIZONA CLAIMS DEPARTMENT
410 N. 44TH ST., STE 500
PHOENIX, AZ 85008

ELECTRONIC BILLING

All providers are recommended to submit claims electronically. This accelerates receipt and processing of claims. Health Choice Arizona offers the ability to submit claims electronically through our clearinghouse Change Healthcare (formerly Emdeon)

☐ **The Health Choice Arizona payer ID number for clearinghouse submissions is 62179.**

In some instances (described throughout this manual), medical records may be required to support payment. If medical records are required to support electronic claim submissions, records may be mailed to the following address:

HEALTH CHOICE ARIZONA CLAIMS DEPARTMENT
410 N. 44TH ST., STE 500
PHOENIX, AZ 85008

CLAIM SUBMISSION TIME FRAMES

Generally, Health Choice Arizona adjudicates claims that include all information necessary for processing (i.e., a "clean claim") within thirty (30) days of receipt. AHCCCS defines a clean claim as one that may be processed without obtaining additional information from the provider of service or from a third party.

Claims that are under review for medical necessity or claims that are under investigation for fraud and abuse, are not considered clean claims.

- ☐ Initial claims must be submitted within six (6) months of the date of service (or date of discharge in the case of an inpatient stay) or six (6) months from the date of AHCCCS eligibility posting whichever is later. Claims received outside these time limits will be denied.
- ☐ Resubmission of a claim denied for any reason other than timeliness of submission must be received within twelve (12) months from the last date of service, or the date of eligibility posting for prior period coverage, with the appropriate corrections or documentation. Claims that do not achieve a clean claim status within 12 months from the date of service will be denied.

RETRO-ELIGIBILITY CLAIMS

A retro-eligibility claim is identified as a claim for services where the eligibility was posted retroactively to cover the date(s) of service by AHCCCS.

Retro-eligibility claims are considered timely submissions if the initial claim is received no later than 6 months from the date of the eligibility posting. Retro-eligibility claims must attain clean claim status no later than 12 months from the date of eligibility posting.

BILLING MEMBERS

Arizona Revised Statute §36-2903.01(K) prohibits providers from billing AHCCCS eligible recipients, including QMB Only recipients, for AHCCCS-covered services:

Upon oral or written notice from the patient that the patient believes the claims to be covered by the system [AHCCCS], a provider or non-provider of health and medical services prescribed in §36-2907 shall not do either of the following unless the provider or non-provider has verified through the administration that the person has been determined ineligible, has not yet been determined eligible or was not, at the time services were rendered, eligible or enrolled:

1. Charge, submit a claim to, or demand or otherwise collect payment from a member or person who has been determined eligible unless specifically authorized by this article or rules adopted pursuant to this article.
2. Refer or report a member or person who has been determined eligible to a collection agency or credit reporting agency for the failure of the member or person who has been determined eligible to pay charges for system covered care or services unless specifically authorized by this article or rules adopted pursuant to this article.

GENERAL BILLING RULES

Billing must follow completion of service delivery

☐ A claim may cover a time span over which service was provided, but the last date of service billed must be prior to or the same date that the claim is signed.

Referring/Ordering provider information

☐ Referring/ordering provider information is a claim submission requirement for all services rendered as a result of a referral/order. The claim must contain the name and individual NPI of the provider who referred/ordered the service(s)/item(s).If the referring provider information is not reported on the claim or if the provider is not enrolled in Health Choice Arizona the claim cannot be paid. On CMS-1500 form, referring/ordering physician information is required in box 17a when ordering provider is any of the following:

o Laboratory o Radiology o Medical and Surgical Supplies o Respiratory DME	o Enteral and Parenteral Therapy o Durable medical Equipment o Drugs (J-Codes) o Temporary K codes	o Orthotics o Prosthetics o Temporary Q Codes o Vision Codes (V-Codes) o 97001-97546

National Drug Code (NDC) Requirements

☐ These requirements are in accordance with and support of the Federal Deficit Reduction Act of 2005, which mandates that all providers submit National Drug Codes (NDC) on all claims with procedure codes for physician-administered drugs in outpatient clinical settings. These services are currently represented on submitted claims by use of the Healthcare Common Procedure Coding System (HCPCS) codes.

NDC Definition

The NDC is the number which identifies a drug. The NDC number consists of 11 digits in a 5-4-2 format. The first 5 digits identify the labeler code representing the manufacturer of the drug and are assigned by the FDA. The next 4 digits identify the specific drug product and are assigned by the manufacturer. The last 2 digits define the product package size and are also assigned by the manufacturer.

Providers of “physician-administered” drugs include any AHCCCS registered provider whose license and scope of practice permits the administration of drugs, such as a medical doctor (MD), doctor of osteopathic medicine (DO), nurse practitioner (NP), physician assistant (PA), ambulatory surgery centers (ASCs), hospital outpatient clinic/services and skilled nursing facilities (SNFs).

- ☐ In order to ensure compliance with AHCCCS guidelines for NDC codes, Health Choice has adopted the Noridian NDC crosswalk for reference. The NDC/HCPCS crosswalk provides a listing of each National Drug Code that is assigned to a HCPCS. Please refer to the NDC crosswalk located at https://www.dmepdac.com/crosswalk/2017.html

*****HCPCS codes that will require the NDC information on the claim submission***

Drugs billed using HCPCS codes include:
• A, C, J, Q and S codes as applicable.
• “Not otherwise classified” (NOC) and “Not otherwise specified” (NOS) drug codes (e.g., J3490, J9999, and
C9399).
• CPT codes, 90281-90399 for immune globulins
• CPT Codes 90476-90749 for vaccines and toxoids
• Providers **must** submit a valid 11-digit NDC when billing a HCPCS drug or CPT procedure code as defined above.
• The qualifier "N4" must be entered in front of the 11-digit NDC. The NDC will be submitted on the same detail line as the CPT/HCPCS drug procedure code in the pink shaded area.

Billing multiple units

- ☐ If the same procedure is provided multiple times on the same date of service, the procedure code must be entered once on the claim form with the appropriate units.
- ☐ The units field is used to specify the number of times the procedure was performed on the date of service.
- ☐ The total billed charge is the unit charge multiplied by the number of units.
- ☐ Age, gender, and frequency based service limitations. Health Choice Arizona uses the limitations on services based on recipient age and/or gender as set forth by AHCCCS.
- ☐ Some procedures have a limit on the number of units that can be provided during a given time span. Health Choice Arizona uses these limitations as set by AHCCCS.
- ☐ By law, AHCCCS has liability for payment of benefits after all other third party payers, including Medicare.
- ☐ Providers must determine the extent of third party coverage and bill all third party payers prior to billing AHCCCS.

Emergency services claims

- ☐ All claims are considered non-emergent and subject to applicable prior authorization unless the provider clearly identifies the service billed on the claim form as an emergency.
- ☐ On the UB claim form, the Admit Type must be “1” (emergency) or “4” (newborn) on all emergency inpatient and outpatient claims.
- ☐ All other Admit Types, including a “2” for urgent, designate the claim as non-emergent.
- ☐ On the CMS 1500 claim form, Field 24C must be marked to indicate that the service billed on a particular claim line was an emergency or the place of service that the procedure was billed with must be “23” for emergency room or “20” for urgent care facility.

- ☐ Medical review is a function of Health Choice and is performed to determine medical necessity and coding appropriateness. Health Choice Arizona reserves the right to review claims for emergency services to determine medical necessity and appropriate billing and coding. Physicians and facilities must bill the level of service as documented in medical record and as identified in the CPT coding descriptions to ensure proper reimbursement.

Evaluation and Management Services (E&M)

When determining the level of "established patient" Evaluation and Management (E&M) services (i.e., 99211-99215), Medical Decision Making must be one of the components (history, exam, medical decision making) required. *Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted*. *The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported*. [CMS, Chapter 12, Section 30.6.1 A.]

Medical decision making (MDM) is defined by the complexity of a physician's work that is necessary to establish a diagnosis and/or to select a healthcare management option.

Evaluation and Management services are assigned based on the medical appropriateness and/or necessity of the physician patient encounter. E&M services must meet the specific requirements of the Current Procedural Terminology (CPT) code billed on the claim with the caveat that 1 of the determining components must include medical decision making. A physician should not submit a CPT code for a high level E&M service (i.e., 99214 or 99215), when the circumstances surrounding the physician patient encounter do not **support medical decision making of moderate to high complexity**.

Health Choice requires that a provider who bills a high level E&M code is either treating a very ill patient or the physician was required to review an extensive amount of clinical data to determine the best health management option. To help ensure proper reimbursement when billing high level E&M codes, providers must show documentation that supports medical necessity which could include:

1. An extensive number of diagnoses or management options were reviewed
2. An extensive amount and/or complexity of data was reviewed
3. Baseline condition is at high risk of complications and/or morbidity or mortality
4. Medical Decision Making of moderate or high complexity
5. Documentation of total time; and counseling dominates (more than 50%) of the encounter

Related Content for Reference to identify MDM:
https://ngsmedicare.com/ngs/wcm/connect/830c7ee7-59b0-48f1-bbe1-d25d31f5d595/1074_0617_EM_Documentation_Training_Tool_508.pdf?MOD=AJPERES

Recoupment

- ☐ Under certain circumstances, Health Choice Arizona may find it necessary to *recoup* or take back money previously paid to a provider.
- ☐ Overpayments and erroneous payments are identified through reports, medical review, grievance and appeal decisions, internal audit review, and provider-initiated recoupments.
- ☐ Upon completion of the recoupment, Health Choice Arizona will send a remittance advice explaining the action, date of the action, recipient, date of service, date of original remittance advice, and reason for the recoupment.

Resubmissions, Adjustments, and Voids

Resubmitting a denied CMS 1500 claim or requesting adjustment to a previously adjudicated claim:

- ☐ Write or stamp the word “resubmission” and enter the CRN (claim reference number which is found on the remittance advice) of the claim in the field labeled "Original Ref. No."
- ☐ Resubmit the claim in its entirety, including all original lines if the claim contained more than one line. Failure to include all lines of a multiple-line claim will result in recoupment of any paid lines that are not accounted for on the resubmitted claim.
  Example: Provider submits a three-line claim. Lines 1 and 3 are paid, but Line 2 is denied. When resubmitting the claim, the provider should resubmit all three lines. If only Line 2 is resubmitted, it will be determined lines one and three were submitted in error and will be recouped.

Resubmitting a denied UB claim or requesting adjustment to a previously adjudicated claim:

- ☐ Write the word “Resubmission” and the CRN of the denied claim in the “Remarks” field (Field 84). However, any other hand written information or corrections on the UB form is not accepted and will be denied.
- ☐ Use the appropriate bill type to indicate a replacement claim.

Resubmitting a denied dental claim or requesting adjustment to a previously paid claim:

- ☐ Enter the CRN of the denied claim in Field 2 (Predetermination/Preauthorization Number) and write or stamp the word “resubmission” on the claim form.

After a claim has been paid by Health Choice Arizona, errors may be discovered in the amounts or services that were billed. These errors may require submission of an adjustment to the paid claim.

The original CRN must be included on the claim to identify the claim being adjusted. Otherwise, the claim will be entered as a new claim and may be denied for being received beyond the initial submission time frame or for being a duplicate of a previously paid claim.

OVERPAYMENTS

A provider must notify Health Choice of an overpayment on a claim by requesting an adjustment to the paid claim. Providers can also send a letter, copy of the claim and/or EOB to the plan indicating that an overpayment has occurred. Providers should attach documentation substantiating the overpayment.

DOCUMENTATION REQUIREMENTS (Medical Records Submission)

Health Choice Arizona reviews all submitted claims to ensure billed services are medically necessary, appropriate, and performed within AHCCCS and Health Choice Arizona guidelines. This review may require review of medical records, which can be conducted during the initial claim submission, or may be required in order to proceed with processing/adjudication. Medical records are required for Health Choice to process Prior Period Coverage (PPC) claims, level 4 and 5 emergency department claims as well as Level 4 APR-DRG and/or outlier claims. Additionally, itemized statements are required for PPC and Level 4 APR-DRG or outlier claims. Medical records and itemized statements to support electronic claim submissions may be mailed to the following address:

HEALTH CHOICE ARIZONA CLAIMS DEPARTMENT
410 N. 44TH ST., STE 500
PHOENIX, AZ 85008

If records or itemized statements are not submitted with a claim for a service that requires supporting documentation to establish medical necessity or appropriateness of services, the claim will be denied with all applicable denial reason/codes reflected on the claims remittance advice, indicating what supporting documentation needs to be submitted.

For Claim Resubmissions: If you are sending medical records in response to a claim denial, please include the original claim number on the claim resubmission. *Please note*: Providers may also request a Medical Review when there are questions regarding coding, authorization, leveling of care, risk issues, etc. Contact us at (800) 322-8670.

AHCCCS DATA VALIDATION REVIEWs

In compliance with federal reporting requirements, AHCCCS conducts an annual review data validation audit, which verifies reported services against corresponding medical records to ensure completeness, accuracy, and timeliness of encounters submissions. AHCCCS may request providers send medical records directly to their administration for this review. Specifically, the review is conducted with focus on the following:

- *Omission Errors*: a service reflected in medical records was not encountered to AHCCCS.
- *Correctness Errors*: inconsistencies between the medical record documentation and a submitted encounter with respect to procedure, diagnosis, and/or date of service.
- *Timeliness Errors*: an encounter is received at AHCCCS beyond the allowable time period after the end of the month in which the service was rendered or the effective date of enrollment with the health plan.

CAPITATED SERVICES

AHCCCS requires the reporting of all patient encounters for all services provided, including capitated services provided by Primary Care Providers (PCP), Specialty Providers, Ancillary Service Providers and Facilities. Correct reporting of all encounters and claims will assure both proper payment for capitated and non-capitated services. Failure to report capitated services may result in reductions to capitation for subsequent periods, or potential sanctions.

Capitation is a prospective payment for members assigned on the first day of the month and includes a payment for those members added after the first day of the previous month. Capitation is issued by the fifteenth (15th) day of each month.