CHAPTER 7:

General Billing Rules

Reviewed/Revised: 10/01/18, 09/25/19, 1/1/20, 9/1/20, 1/1/21

7.0 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.

Health Choice Arizona subcontracted providers are required to submit claims or encounters in conformance with the AHCCCS Office of Program Support Operations and Procedures Manual, AHCCCS FFS Provider Manual, AHCCCS AMPM, AHCCCS Behavioral Health Services Matrix, the AHCCCS Financial Reporting Guide the Client Information System (CIS) File Layouts and Specifications Manual requirements, AHCCCS Rules and Regulations, the AHCCCS Companion Guides, and in accordance with HIPAA for each covered service delivered to a member.

The Health Choice Arizona Claims Department is responsible for claim/encounter adjudication; resubmissions, claim/encounter inquiry/research and provider claim/encounter submissions to AHCCCS.

Health Choice Arizona Provider Notices can be found on our website at:
www.HealthChoiceAZ.com - 'Providers' -> 'Provider Notices'.

7.1 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.

All providers who participate with Health Choice Arizona must first register with AHCCCS to obtain an AHCCCS Provider Identification Number. AHCCCS requires all providers providing and billing for AHCCCS covered services to have an NPI number. Please contact AHCCCS directly for this number (**AHCCCS Provider registration link**). Once you have obtained your 6 digit AHCCCS provider ID, notify Health Choice Arizona's Provider Network Department at (800) 322-8670.

Effective January 1, 2021 claims which include referring, ordering, prescribing or attending (ROPA) providers who are not enrolled with AHCCCS will not be reimbursed. If a prescribing, ordering, referring or attending provider is reported on a claim or encounter they must be a valid and active AHCCCS registered provider, or the rendering/service providers claim should not be paid.

To ensure payment of claims when submitting for items and/or services attended, ordered, referred, or prescribed by another provider, the rendering provider must ensure that the ordering/referring/prescribing provider is actively registered with AHCCCS.

ROPA providers will need to register with AHCCCS by visiting the AHCCCS Provider Enrollment Portal (APEP) at: https://www.azahcccs.gov/PlansProviders/APEP/ProviderEnrollment.html

7.2 NATIONAL PRACTITIONER 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/encounters. The NPI number is to be used as the healthcare provider identifier for all claim/encounter 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 Street, Suite 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/encounters must be submitted with the NPI as applicable. In accordance with AHCCCS's guidelines, all rendering providers must bill under their own NPI number. As a result, incident-to billing is not permissible for mid-level practitioners. (A rendering provider is defined as the individual who provided care to the client and needs to be reported as such in box 24J of the CMS 1500 claim form.)

Per the AHCCCS participating Provider Agreement General Terms and Conditions: "No provider may bill with another provider's ID number, except in locum tenens situations. Locum Tenens provider must submit claims using the AHCCCS provider ID number of the physician for whom the Locum Tenens provider is substituting or temporarily assisting." Locum Tenens arrangements will be recognized and restricted to the length of the Locum Tenens registration with the American Medical Association.

7.3 ELECTRONIC SUBMISSIONS

All providers are recommended to submit claims/encounters electronically. Electronic billing ensures faster processing and payment of claims, eliminates the cost of sending paper claims, allows tracking of each claim/encounter sent, and minimizes clerical data entry errors. Health Choice Arizona offers the ability to submit claims/encounters electronically through our clearinghouse Change Healthcare or direct submission as documented below.

Methods:

a. **Clearinghouse**: The EDI Clearinghouse Vendor that Health Choice Arizona utilizes is Change Healthcare.
b. **Direct Submission**: **Upon approval,** qualified Providers have the option of submitting electronic files directly to Health Choice Arizona.

All electronic submissions shall be submitted in compliance with applicable law including HIPAA regulations, AHCCCS policies and procedures, and Health Choice Arizona policies and procedures. For contracted providers, please contact your software vendor, visit Change Healthcare directly www.changehealthcare.com/enrollment, or your Health Choice Arizona Provider Performance Representative can provide more information about electronic billing. For non-contracted providers, please contact your software vendor for more information about electronic billing.

EDI Claim/Encounter Submission

	Electronic Submission*
All HCA Form Types	Through Electronic Clearinghouse, Payer ID 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/encounter submissions, records may be mailed to the Health Choice Arizona Claims Department. Refer to Section 7.14 *Documentation Requirements* for additional guidance.

7.4 PAPER CLAIM SUBMISSION REQUIREMENTS

All providers are recommended to submit claims/encounters electronically. Electronic billing ensures faster processing and payment of claims, eliminates the cost of sending paper claims, allows tracking of each claim/encounter sent, and minimizes clerical data entry errors.

We understand that at times you may need to submit a claim through the mail, here's some reminders:

- When a claim is submitted please ensure that the printed information is aligned correctly with the appropriate section/box on the form.

- 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.

- Paper claims or copies that contain highlighter or color marks, copy overexposure marks, or dark edges are not legible on the imaging system. Liquid paper correction fluid ("White Out") **may not** be used. Correction tape **may not** be used.

- Do not submit double-sided, multiple-page claims. Each claim page must be submitted on a separate piece of paper, with the pages numbered (e.g., 1 of 3, 2 of 3, 3 of 3, etc.). To ensure that all pages of a multiple-page, UB-04 claim are processed as a single claim the pages **must** be numbered. Totals should not be carried forward onto each page, and each page can be treated as a single page. **The total should be entered on the last page only.**

- Please do not staple documents or claims. If there is a document being submitted with the claim, the document should lay directly behind the claim.

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
P.O. BOX 52033
PHOENIX, AZ 85072-2033

7.5 CLAIM/ENCOUNTER SUBMISSION TIME FRAMES

As defined by ARS §36-2904 (G)(1) a "clean claim" is:
A claim that may be processed without obtaining additional information from the subcontracted provider of care, from a non-contracting provider, or from a third party, but does not include claims under investigation for fraud or abuse or claims under review for medical necessity.

In accordance with ARS §36-2904 (G),

- An initial claim for services provided to an AHCCCS member must be received no later than 6 months after the date of service, unless the claim involves retro-eligibility. Claims initially received beyond the 6-month time frame, except claims involving retro-eligibility, will be denied.

- Resubmission of a claim/encounter 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/encounters that do not achieve a clean claim status within 12 months from the date of service will be denied.

7.6 RETRO-ELIGIBILITY CLAIMS/ENCOUNTERS

A retro-eligibility claim/encounter is identified as a claim/encounter for services where the eligibility was posted retroactively to cover the date(s) of service by AHCCCS. Retro-eligibility claims/encounters are considered timely submissions if the initial claim/encounter is received no later than 6 months from the date of the eligibility posting. Retro-eligibility claims/encounters must attain clean claim status no later than 12 months from the date of eligibility posting. For hospital inpatient claims, "date of service" means the date of discharge of the patient.

7.7 PRIOR PERIOD COVERAGE

On occasion AHCCCS eligible members are enrolled retrospectively into Health Choice Arizona. The retrospective enrollment is referred to as Prior Period of Coverage (PPC).
Members may have received services during PPC and Health Choice Arizona is responsible for payment of covered services that were received.

For services rendered to the member during PPC, the provider must submit PPC claims/encounters to Health Choice Arizona for payment of covered benefits. The provider must promptly refund, in full, any payments made by the member for covered services during the PPC period.

While prior authorization is not required for PPC services, Health Choice Arizona, at its discretion, retroactively review medical records to determine medical necessity. If such services are deemed not medically necessary, Health Choice Arizona reserves the right to recoup payment, in full, from the provider. The provider may not bill the member.

7.8 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/encounters to be covered by the system [AHCCCS], a provider or non-provider of health and medical services prescribed in A.R.S. §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/encounter 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.

Providers may **NOT** collect copayments, coinsurance or deductibles from members with other insurance, whether it is Medicare, a Medicare HMO or a commercial carrier (except for AHCCCS mandated co-pay members). Providers must bill Health Choice Arizona for these amounts and Health Choice Arizona will coordinate benefits. Unless otherwise stated in contract, Health Choice Arizona adjudicates payment using the lesser of methodology and members may not be billed for any remaining balances due to the lesser of methodology calculation.

Note: "QMB Only" is a Qualified Medicare Beneficiary under the federal program, but does not qualify for Medicaid. Under A.A.C. R9-29-301 AHCCCS shall only reimburse the provider for the Medicare deductible and coinsurance amount when Medicare pays first. For further information on QMB Only please refer to Chapter 14, *Medicare and Other Insurance Liability*.

7.9 GENERAL BILLING RULES

Billing must follow completion of service delivery

- A claim/encounter 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 the 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 and Q codes	o Orthotics o Prosthetics o "V"codes – (including, but not limited to codes pertaining to vision and hearing) o 97001-97150 or 97159-97546

For Electronic claim/encounter submissions, please refer to the ASCX12 HIPAA Guidelines for the appropriate loop/segment to utilize for reporting the referring/ordering physician information. A copy of the HIPAA Guidelines can be purchased from the Washington Publishing Company at http://www.wpc-edi.com/.

If applicable, enter the Qualifier:
DN Referring Provider **DK** Ordering Provider* **DQ** Supervising Provider

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 Arizona 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 as applicable for your Jurisdiction located at https://med.noridianmedicare.com/ .

***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 for Electronic claims/encounters, the drug information is reported in Loop 2410

Billing multiple units

- If the same service is provided multiple times on the same date, and the service is not required to be reported with a modifier to indicate an additional procedure was performed, then services for the same provider/member/location/modifier(s), are required to have the service code entered once on the claim form with the appropriate units rolled up.
- The unit field is used to specify the number of times the procedure was performed on the date of service.
    - For time/unit based services, units should first be calculated for each instance of the service, then the total units reported should be a combination of all units for that particular service/day/provider/member/location/modifiers(s) added together.
        - For example: for a T1016 the unit duration is 15min so for a service that lasted an hour, the units would be 4 (60/15). If an additional T1016 for the same day/provider/ member/location/modifier(s) was provided for 30 minutes, the units for that instance would be 2 (30/15), the total units reported on the one T1016 claim line would be 6.
- 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.

Medicare and Third Party Payments

- 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.

Correct Coding Initiative

Health Choice follows Medicare's Correct Coding Initiative (CCI) policy and performs CCI edits and audits on Fee-For-Service claims for the same provider, same member, and same date of service.

Correct coding means billing for procedures with the appropriate comprehensive code. "Unbundling" is the billing of multiple procedure codes for services that are covered by a single comprehensive code. Some examples of **incorrect** coding include:

- Fragmenting one service into components and coding each as if it were a separate service.
- Billing separate codes for related services when one code includes all related services.
- Breaking out bilateral procedures when one code is appropriate.
- Down-coding a service in order to use an additional code when one higher level, more comprehensive code is appropriate.

All services that are integral to a procedure are considered bundled into that procedure as components of the comprehensive code when those services:

- Represent the standard of care for the overall procedure, or
- Are necessary to accomplish the comprehensive procedure, or
- Do not represent a separately identifiable procedure unrelated to the comprehensive procedure.

Modifier 59 must be attached to a component code to indicate that the procedure was distinct or separate from other services performed on the same day and was not part of the comprehensive service and clinically justified as demonstrated in the medical record. Claims submitted to Health Choice utilizing modifier 59 will be subject to Medical Review. **Documentation in the medical record must satisfy the criteria required for appropriate use of the modifier.** Modifier 59 cannot be billed with evaluation and management codes (99201-99499) or radiation therapy codes (77261 -77499).

To align with Medicare billing rule, bilateral procedures are to be billed on one line with the "50" modifier and the appropriate number of units. The rate valuation is 150% of the capped fee schedule.

Separate services during the post-operative period may be billed with modifier 58 or 78.

Other modifiers may be appropriately attached to comprehensive codes (e.g., professional component (26), assistant surgeon (80), etc.).

Changes in Reimbursement Rate

- It is not necessary to split bill an inpatient hospital claim when the claim dates of service span a change in the inpatient hospital reimbursement rates.
- If a hospital outpatient claim is submitted with dates of service that span a change in the hospital outpatient reimbursement rates, then the claim must be split.

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), "2" (urgent), "5" (trauma) or "4" (newborn) on all emergency inpatient and outpatient claims.
- All other Admit Types, including "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.
- For electronic Professional claims/encounters, loop 2400 segment SV109 must indicate a 'Y' for emergency services. For electronic Institutional claims/encounters the admit type reported in loop 2300 segment CL101 must be included as indicated above.

Medical review is a function of Health Choice Arizona 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.

Pseudo Identification Numbers
Pseudo identification numbers are only applicable to behavioral health providers under contract with Health Choice Arizona. On very rare occasions, usually following a crisis episode, basic information about a behavioral health recipient may not be available. When the identity of a behavioral health recipient is unknown, a behavioral health provider may use a pseudo identification number to register an unidentified person. This allows a claim/encounter to be submitted to AHCCCS, allowing Health Choice Arizona and the provider to be reimbursed for delivering certain covered services. Covered services that can be encountered/billed using pseudo identification numbers are limited to:

- Crisis Intervention Services (Mobile);
- Case Management; and
- Transportation

Pseudo identification numbers must only be used as a **last option** when other means to obtain the needed information have been exhausted. Inappropriate use of a pseudo identification number may be considered a fraudulent act.

7.10 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 100-04, Chapter 12, Section 30.6.1]

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**.

7.11 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.

In the case of recoupments, the time frame for submission of a clean claim differs from the time frames described earlier in this chapter. In the case of recoupments, the time span allowed for resubmission of a clean claim will be the *greatest* of:

- Twelve months from the date of service, or
- Twelve months from the date of eligibility posting for a retro-eligibility claim, or
- Sixty days from the date of the adverse action.

7.12 RESUBMISSIONS, ADJUSTMENTS, AND VOIDS

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

- Enter an "A" or "7" in Field 22 (Medicaid Resubmission Code) and the CRN (claim reference number which is found on the remittance advice) of the claim in the field labeled "Original Ref. No." *Failure to replace a 1500 claim without Field 22 completed can cause the claim to be considered a "new" claim and then not link to the original denial/paid claim. The "new" claim may be denied for timely filing limits exceeded.*
- **Resubmit the claim in its entirety,** including all original lines if the claim contained more than one line. Hand written information or corrections on 1500 forms are not accepted and will be denied. 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.

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

- Replace UB with the appropriate Bill Type and **resubmit the claim in its entirety**, including all original lines.
    - Bill type - xx7 for a replacement and corrected claim

  Failure to replace a UB-04 without the appropriate Bill Type can cause the claim to be considered a "new" claim and it will not link to the original denial. The "new" claim may be denied as timely filing exceeded.
- Enter the CRN of the denied claim in the "Document Control Number" (Field 64) and/ "Remarks" field (Field 84).
- Hand written information or corrections on the UB form is not accepted and will be

denied.

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) on the ADA form.
    - Enter a note in Box 35 ("Remarks") indicating the claim as "resubmission" or "corrected claim" and provide explanation.
- **Resubmit the claim in its entirety,** including all original lines if the claim contained more than one line. Hand written information or corrections on ADA forms are not accepted and will be denied. 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.

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.

***Please Note:** **Behavioral Health claims** billed with a primary behavioral health diagnosis (claims identified with both numeric and alpha characters i.e. 12345E67890) require the most recently processed claim number in the claim series (e.g.A1, A2, etc.), be used for claim resubmissions/replacements/reversals (when applicable), not simply the first claim processed. Please refer to your most recent EOB for the most recently processed claim number.

Claim/Encounter voids and replacements can be submitted electronically, however, we are unable to accept electronic attachments at this time. To include required or requested supporting documentation, such as members' medical records, clearly label, **include the corrected paper claim**, and send to the Claims department at the correct address.

- To submit an electronic void, the *original claim/encounter with a frequency type code of 8 should be sent in Loop 2300 CLM05-03 and the original CRN included in Loop 2300 REF02.
- To submit an electronic replacement, the corrected claim/encounter with a frequency type code of 7 should be sent in Loop 2300 CLM05-03 and the original CRN included in Loop 2300 REF02.
- Please note: When reporting the Loop 2300 REF*F8, Payer Claim Control Number for Replacement/Reversal claims (Frequency type 7 or 8). **Behavioral Health claims** billed with a primary behavioral health diagnosis (claims identified with both numeric and alpha characters i.e. 12345E67890) require the most recently processed claim number in the claim series (e.g.A1, A2, etc.), be used for claim resubmissions/replacements/reversals (when applicable), not simply the first claim processed. Please refer to your most recent EOB for the most recently processed claim number.

Voids

When **voiding a claim**, you should submit documentation stating the reason for the void. Only the provider who submitted the original claim may void the claim. When a claim is voided, all payment is recouped. This process should only be used when there is no other alternative.
To **void** a paid CMS 1500 claim

- Enter “V” or “8” in Field 22 (Medicaid Resubmission Code) and the *CRN of the claim to be voided in the "Original Ref. No." field.

To **void** a paid UB-04 claim:

- Use bill type xx8
- Enter the CRN of the claim to be voided in the “Remarks” field (Field 80).
- If Field 80 is used for other purposes, type the CRN at the top of the claim form.

To **void** a paid ADA claim

- Enter “VOID” and enter the CRN of the paid claim to be voided in Field 2 (Predetermination/Preauthorization Number).

***Please note:** **Behavioral Health claims** billed with a primary behavioral health diagnosis (claims identified with both numeric and alpha characters i.e. 12345E67890) require the most recently processed claim number in the claim series (e.g. A1, A2, etc.), be used for claim resubmissions/replacements/reversals (when applicable), not simply the first claim processed. Please refer to your most recent EOB for the most recently processed claim number.

7.13 OVERPAYMENTS

A provider must notify Health Choice Arizona of an overpayment on a claim by requesting an adjustment to the paid claim. The provider can notify by submitting a replacement claim, which will allow recoupment of the overpayment to occur. In the event that an adjustment is needed then providers should attach documentation substantiating the overpayment, such as an EOB if the overpayment was due to payment received from a third party payer.

7.14 DOCUMENTATION REQUIREMENTS (Medical Record 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 Arizona 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 P.O. Box 52033 Phoenix, AZ 85072-2033.

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 Reconsiderations: If you are sending medical records in response to a claim denial, please resubmit the claim in its entirety, include the original claim number on the claim resubmission along with the medical records.

Providers must include the name and/or department of the requestor in order to ensure the records are routed appropriately. Providers should include the member name, the member ID, the line-of-business, and reason for submission and claim number (if applicable). Records submitted without specifying the reason for submission along with the member ID information may not be routed to the intended recipient. Faxed records must be faxed directly to a specific person or department only after providers have verified the fax number and recipient.

Providers may also request a Medical Review which would require the submission of medical records when there are questions regarding coding, authorization, leveling of care, risk issues, etc. Contact us at (800) 322-8670.

7.15 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.

AHCCCS /Encounter Data Validation (Behavioral Health Providers / Sub-Capitated Providers)
AHCCCS performs periodic data validation studies. All AHCCCS contractors and subcontractors are contractually required to participate in this process. In addition, the data validation studies enable AHCCCS to monitor and improve the quality of claim/encounter data. Information regarding AHCCCS Claim/Encounter Data Validation Study procedures can be found in the **Office of Program Support Operations and Procedures Manual**.

7.16 CAPITATED SERVICES

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 (15^{th}) day of each month.

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.

7.17 QUICK PAY DISCOUNTS/INTEREST PAYMENTS

Quick Pay Discount:
Health Choice shall apply a quick pay discount of 1% on hospital claims paid within 30 days of the date the Clean Claim was received (A.R.S. §36-2903.01(G)). Quick pay discounts are applied to any acute hospital inpatient, outpatient and freestanding emergency department claims billed on a UB-04 claim form.

Interest Payments:

1. For hospital Clean Claims, Health Choice shall pay slow payment penalties (interest) on payments made after 60 day of receipt of the Clean Claim.

2. Health Choice shall pay interest on all claim disputes as appropriate based on the date of the receipt of the original Clean Claim submission (not the claim dispute).
    - In the event a claim is reprocessed as a result of an overturned claim dispute or State Fair Hearing, the claims shall be reprocessed within 15 days from the date of the decision, and interest shall be paid back to the date the clean claim was received.

Source: AHCCCS ACOM Policy 203 *Claims Processing* (https://azahcccs.gov/).

7.18 SOCIAL DETERMINANTS

Social determinants of health are the conditions in which a person is born, grows, lives, works and ages. ICD-10 codes have been created to correspond with these social determinants. Social determinants of health take into account factors like the member's education, employment, physical environment, socioeconomic status, and social support network.

The use of social determinants allows a provider to identify things such as illiteracy, unemployment, a lack of adequate food and safe drinking water, social exclusion and rejection, homelessness, alcoholism, and many other factors that could affect a member's overall health and wellbeing. Beginning with dates of service on and after **April 1st, 2018**, AHCCCS began to monitor all claims for the presence of social determinant ICD-10 codes. As appropriate within their scope of practice, providers should be routinely screening for, and documenting, the presence of social determinants. Information about the social determinant should be included in the member's chart.

Any social determinant ICD-10 diagnosis codes that are identified should be included on the submitted claims for AHCCCS members, in order to comply with state and federal coding requirements. Note: Social determinants are ***not*** the primary ICD-10 code. They are secondary ICD-10 codes. Dental providers will be **exempt** from the use of social determinants.

For a list of ICD-10 codes relevant to social determinants of health, please refer to the AHCCCS Fee-For-Service Provider Billing Manual Chapter 4, Exhibit 4-1, Social Determinants of Health ICD-10 Code List (https://azahcccs.gov/PlansProviders/RatesAndBilling/FFS/providermanual.html). The list of social determinants of health codes may be added to or updated on a quarterly basis. Providers should remain current in their use of these codes.