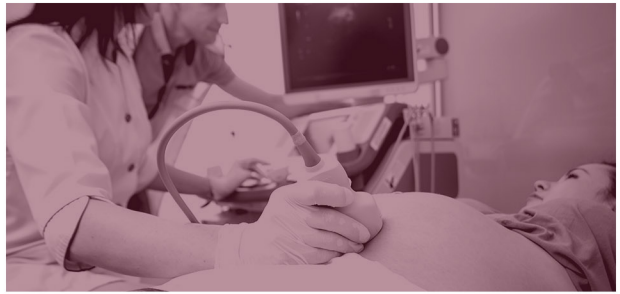





Voids and Replacements

October 1, 2021

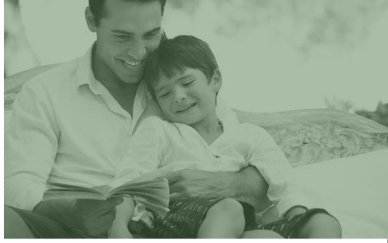
AHCCCS
Arizona Health Care Cost Containment System

About this Course

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

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

If you have any questions about this training presentation, please email the Provider Training Unit: **ProviderTrainingffs@azahcccs.gov**

AHCCCS Online Provider Portal

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AHCCCS Online Provider Portal

Submitting claims electronically is the fastest way to submit claims to any health plan payer. To help expedite this process providers can use the AHCCCS Online Provider Portal which is a free application to submit your claims directly to the Fee-for-Service (FFS) program.

Providers must have a valid Username and Password and providers must keep your login information safe and secure. Sharing your account information is prohibited.

- To Register for an AHCCCS online account for the Online Provider Portal
  https://azweb.statemedicaid.us/Account/Register.aspx
- To login to the AHCCCS Online Provider Portal
  URL: https://azweb.statemedicaid.us/Account/Login.aspx?ReturnUrl=%2f




Replacement Claim

What is a Replacement Claim?

A replacement claim is a claim that has previously been adjudicated but may contain errors. The provider can submit a replacement claim if the original claim requires correction.

For example, to correct one of the following (this is not an all-inclusive list):

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

Replacement Claims

- The AHCCCS Claims Processing system will deny claims with errors that are identified during the editing process. These errors will be reported to you on the AHCCCS Remittance Advice. You should correct claim errors and resubmit claims to AHCCCS for processing within the 12 month clean claim time frame.
- A Replacement claim can be used to adjust a paid or denied claim, and it can also be used to recoup previously paid lines. A replacement will allow individual lines to be recouped, rather than the entire claim / monies to be recouped.
- A Void is a straight recoupment of a claim, with the entire claim being recouped (monies).

Submitting a Replacement Claim

When a provider submits a replacement claim, the (CRN) must be included on the replacement claim. This will enable the AHCCCS system to identify the claim that you want to replace. The Claim Reference Number is a 12-digit number that is assigned to each claim *received by AHCCCS.*

The AHCCCS claims system is programmed to link the replacement claim to the claim reference number that you enter in the ***"original reference number"*** field when you are completing the Service Lines tab.

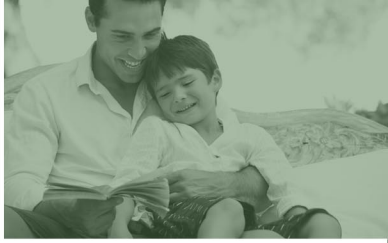
Important Note: If the CRN number is not included, the processing system will read the replacement as a "New" claim and the replacement of the claim will ***not*** be completed.




AHCCCS Claim Status Codes

AHCCCS Claim Status Codes

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

Timely Filing and Claim Replacement

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Timely Filing and Replacement Claims

Timely Filing Requirements for Fee for Service (FFS) Providers

- If the initial claim was received within six (6) months from the date of service, or 6 months form the eligibility posting date, or 6 months from the date of discharge for an inpatient claim.
- If all of the time frames listed above are met, then the provider will have up to 12 months from the date of service to submit a replacement claim.

Timely Filing and Replacement Claims

Timely Filing Requirements for IHS/638 Providers

- If the initial claim was received within twelve (12) months from the date of service, or 12 months form the eligibility posting date, or 12 months from the date of discharge for an inpatient claim.
- If all of the time frames listed above are met, then the provider will have up to 12 months from the date of service to submit a replacement claim.

Timely Filing and Replacement Claims

Important Notes on Replacement Claims

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

Overpayments

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

How to Submit a Replacement Claim

- Make any necessary changes and/or add lines to the replacement claim.
- ***Resubmit all lines from the original claim even if the lines contained no changes or do not require correction.***
- If any previously paid lines are omitted, the AHCCCS system will assume that those lines should not be considered for reimbursement and payment will be recouped.
- All fields cannot be changed on a replacement claim. There may be instances when the claim will have to be Voided and a New claim submitted. This will be discussed in more detail on slide #24 “How to Void a Claim”.




How to Replace a Denied Claim

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When is it Appropriate to Replace a Denied Claim?

Claims may deny for multiple reasons, such as:

- Service excluded
- Incorrect coding
- Units exceed maximum
- Missing claim information

Providers are responsible for reviewing the Remittance Advice.

- The AHCCCS Fee-for-Service Remittance Advice provides information about claims adjudicated by the AHCCCS Division of Fee For Service Management (DFSM) , including claims paid or voided, claims which were denied, and in process and adjusted claims.

You can also status the claim details using the AHCCCS Online Provider Portal to review the reason for the denial and to determine what corrective action is required.

Fields that Cannot be Changed on a Replacement Claim

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

- Service Provider field (6 digit or NPI number)
- Billing Provider field (6 digit or NPI number)
- Tax Identification Number (TIN)

Important Note: If these fields must be changed, the provider must "Void" the original claim and submit the correction as a "New" claim submission.

The biller will not indicate the original claim reference number on the "New" claim submission when either of the above fields are to be corrected.

Fields that Cannot be Changed on a Replacement Claim

Please note that if you void a claim and submit a new “replacement” claim outside of the timely filing deadlines for *initial claim submission* then the newly submitted claim will deny.

For example:

- A FFS Provider submits an initial claim on 1/1/2022.
- The claim denies due to an error on a field that cannot be corrected/changed on a replacement claim.
- The provider then voids the claim and submits a “new” replacement claim on 7/15/2022.
- ***However,*** this is now outside the timely filing guidelines for the submission of an initial (new) claim, so the claim will **deny.**

Replacing a Denied or Paid Claim

How to replace a claim:

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



How to Void a Claim

How to Void a Claim

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

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




How to submit a Replacement

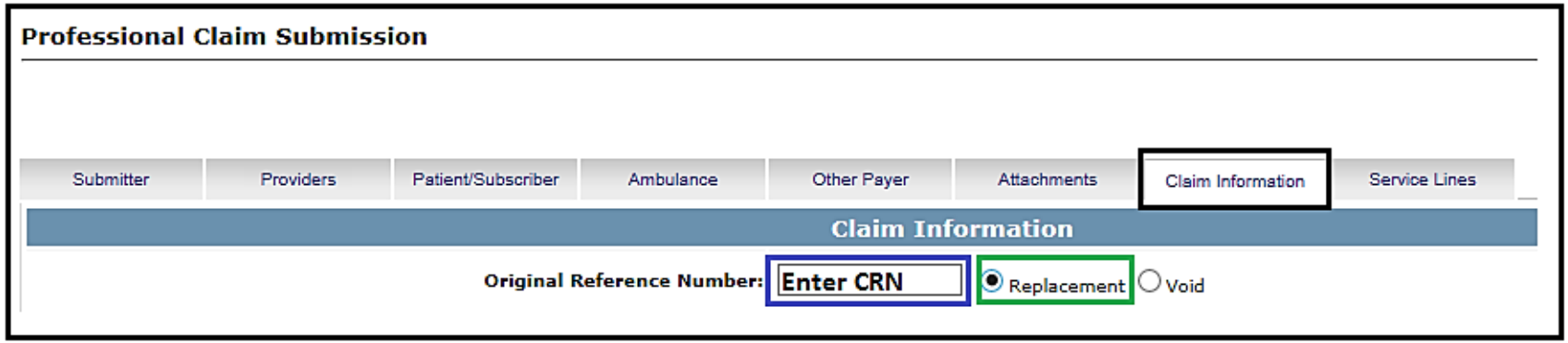
CMS 1500 Professional Claim Form

Replacement of a CMS 1500 / Professional Claim

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

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

Replacement - CMS 1500 / Professional Claim



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




How to Void

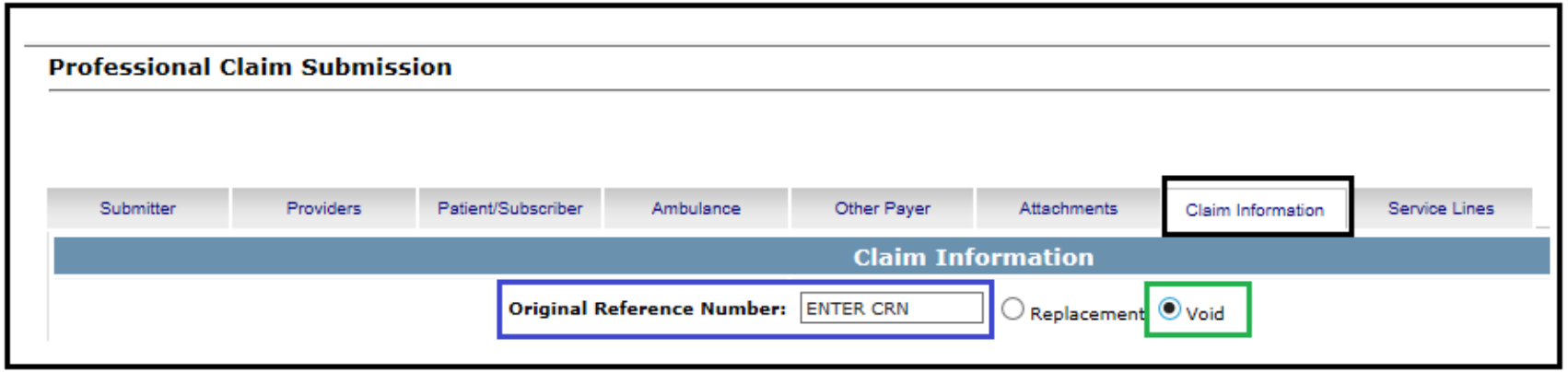
CMS 1500 Professional Claim Form

Voiding a CMS 1500 / Professional Claim

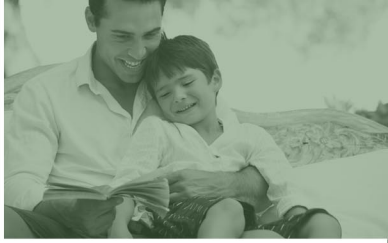
If you identify an overpayment, such as when the claim was submitted in error or a primary payer paid the claim in full, providers can submit a refund request to AHCCCS using the Void option.

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

Void CMS 1500 / Professional Claim



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

How to do a Replacement Claim

ADA Dental Claim Form

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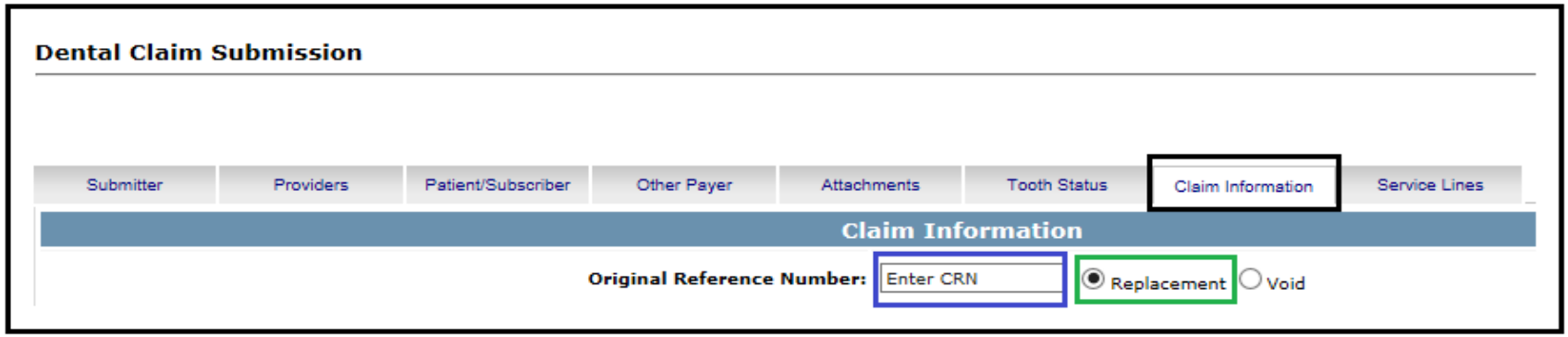
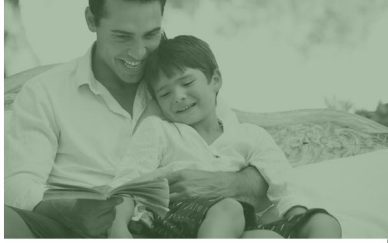
Replacement of an ADA 2012 / Dental Claim

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

Replacement
ADA (Dental) Claim Form



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

How to initiate a Void

ADA Dental Claim Form

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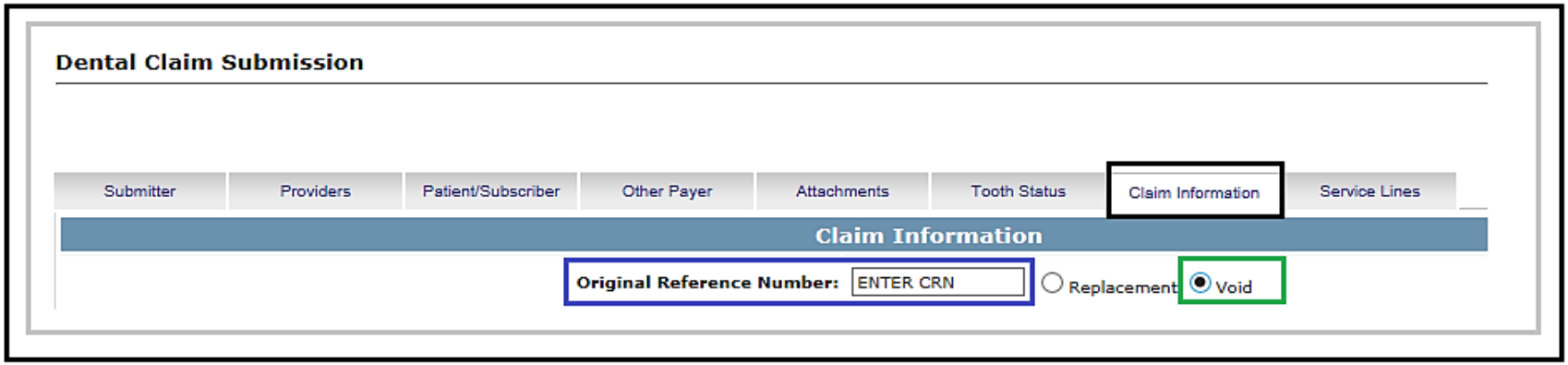
Void
ADA (Dental) Claim Form



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



Replacement and Void

Institutional (UB-04) Claim Form

Institutional UB-04 Bill Type Codes

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

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

Bill Type Code Assignment

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

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

Examples of Common Bill Type Codes

Inpatient Hospital Claim

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

Hospital Outpatient (Including Emergency Department)

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

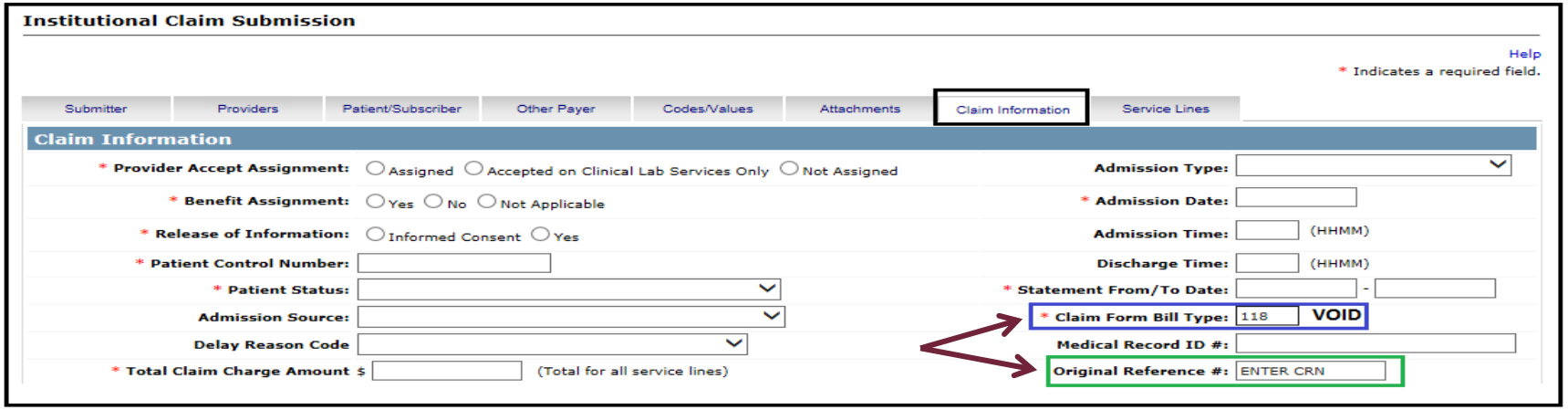
Skilled Nursing Facility

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

Replacement of an UB-04 / Institutional Claim

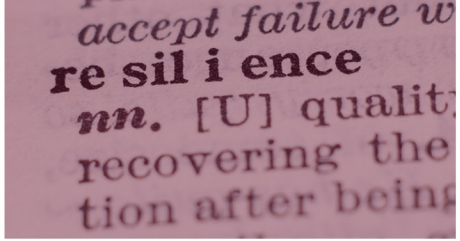
1. Complete the following tabs Submitter, Providers, Patient/Subscriber, Other Payer (if applicable), Attachments (if applicable) tabs. Once this is completed move on to the Claim Information tab.
2. On the Claim information tab enter the Bill Type Code to indicate that you are submitting a Replacement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

Voiding of an UB-04 / Institutional Claim



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





Common Denial Reasons for Replacement Claims

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Claim Denial - Unmatched Key Fields (SD005)

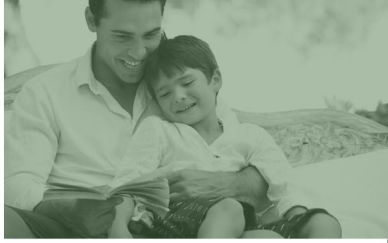
If the replacement claim denies with the reason code “Unmatched Key Field”, SD005 the replacement claim action failed, and the original claim has not been replaced.

Steps to take if the claim denies with the denial reason code SD005:

- Review the original claim to determine if all fields were entered correctly.
- Correct the errors and submit a new replacement claim and reference the original CRN number.
- If the replacement needs subsequent corrections, the replacement claim becomes the original claim. Use the CRN of the replacement claim.

Reminders

- For Replacements and Voids the provider must include the Claim Reference Number (CRN).
- If doing a replacement claim, fill out the rendering, billing and referring tabs on the AHCCCS Online Provider Portal.
- Service Provider field (6 digit or NPI number)
- Billing Provider field (6 digit or NPI number)
- Tax Identification Number (TIN)

DFSM Provider Education and Training Unit

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DFSM Provider Training

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).
- Submission of documentation using the Transaction Insight Portal (i.e. the AHCCCS Daily Trip report, requested medical records, etc.).

Additionally, the DFSM Provider 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.

The DFSM Provider Training Team can be reached at ProviderTrainingFFS@azahcccs.gov

Technical Questions?

For technical assistance with the AHCCCS Online Provider Portal, please call:

- AHCCCS ISD Customer Support Desk at 602-417-4451 or ISDCustomerSupport@azahcccs.gov

Claims Questions?

For claims questions that cannot be resolved on the portal, please outreach the Claims Customer Service team at:

- Phone: (602) 417-7670 – Select Option 4
- From: Monday – Friday from 7:30am – 4:00pm (Phoenix Time).

The Claims Customer Service team can assist with the following items:

- Details regarding a claim status that cannot be answered on the AHCCCS Online Provider Portal;
- Providing denial codes and general information regarding denied claims; and
- Providing general information about approved and pended claims.

NOTE: Providers should not call the Claims Customer Service team if they have questions on rates, CPT/HCPCS codes and modifiers, billing questions, the address a check was mailed to, and payment details for approved claims.

Prior Authorization Questions?

For prior authorization questions, please visit the AHCCCS Online Provider Portal or the AHCCCS website at:

- AHCCCS Online Provider Portal:
  - https://azweb.statemedicaid.us/Account/Login.aspx?ReturnUrl=/
- DFSM Prior Authorization Web Page:
  - https://www.azahcccs.gov/PlansProviders/FeeForServiceHealthPlans/PriorAuthorization/requirements.html

Providers can check the status of a submitted authorization request online and view messages from PA staff under the Prior Authorization Inquiry link.

Prior Authorization Questions?

For questions that cannot be resolved on the portal, please outreach the Fee-for-Service Authorization Phone Line at:

- Within Maricopa County: 602-417-4400, Select option 1 for transportation
- Statewide: 1-800-433-0425
- Outside Arizona: 1-800-523-0231
- FESP Dialysis: 602-417-7548

NOTE: Providers should not call the FFS Prior Authorization team if they have questions on rates, CPT/HCPCS codes and modifiers, billing questions, claims, or for status updates.

Policy Information

AHCCCS FFS Provider Billing Manual:

- https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/providermanual.html

AHCCCS IHS/Tribal Provider Billing Manual:

- https://www.azahcccs.gov/PlansProviders/RatesAndBilling/ProviderManuals/IHStribalbillingManual.html

AHCCCS Medical Policy Manual

- https://www.azahcccs.gov/shared/MedicalPolicyManual/

Questions?

Thank You.

This concludes the presentation.

Questions?