ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
DIVISION OF FEE FOR SERVICE MANAGEMENT

CLAIMS CLUES

A Publication of the AHCCCS DFSM Claims Department

June/July 2025

July is National Ultraviolet (UV) Safety Awareness Month

July is National UV Safety Month. As the summertime weather starts to reach higher than average temperatures, heat related illnesses can happen when the body is not able to properly cool itself. Remember to stay cool during the summer weather by staying hydrated, wearing weather-appropriate clothing, and protecting your eyes from UV rays during the summer.

Billing Details for the CMS 1500 Claim Form Only One Rendering Provider NPI Is Accepted

AHCCCS FFS does not recognize multiple rendering providers on a single claim form. If the line level rendering provider (Form locator 24J) is different from the claim level rendering provider (Form locator 31), **separate** claims must be submitted. Claims submitted with multiple rendering providers will ***but denied within the AHCCCS claim adjudication system. It will be the responsibility of the biller to submit a correction claim for consideration.***

It is best practice to review all AHCCCS Payor policies and/or Billing manuals.

AHCCCS FFS Provider Billing Manual, Chapter 3 Provider Records and Registration

Recurrent Document Upload Issues EDI Solutions Portal

Solutions Upload Attachment Process When using the AHCCCS Claim Reference Number (CRN) as your document attachment number or Payer Claim Control Number, enter only the first 12 digits of the CRN. It is important to exclude the service line number, such as 001 or 002, as this information is not part of the claim number and will result in documents not linked to the associated claim.

The DFSM Claims Clues is a monthly newsletter that provides information about changes to the program, system changes/updates, billing and FFS policies.

Claims, Prior Authorization and Provider Enrollment inquires: The Division of Member and Provider Services (DMPS) manages the service calls for AHCCCS Fee-for-Service. DMPS can assist providers with prior authorizations, claim inquires and status and provider registration (APEP) questions and processes.

The hours of operation are Monday – Friday, 8:00am-5:00pm (602-417-7670).

AHCCCS Provider Enrollment Portal (APEP): Questions regarding provider-related enrollment, policy, or APEP user issues email APEPTrainingQuestions@azahcccs.gov . Your email will automatically create a service ticket to Provider Enrollment for assistance.

AHCCCS Warrents - For questions about Warrants, paper EOBs or Electronic Fund Transfers (EFT), contact the Division of Business & Finance (DBF) at (602) 417-5500.

835 Electronic Remittance Payment Sign Up (Remittance Advice Sign Up/835) Contact: ServiceDesk@azahcccs.gov or call (602) 417-4451

To upload documents to the new EDI Solutions portal ServiceNow, users will need to have access. If you do not have an account, please follow the instructions outlined in the EDI Portal Provider Signup and Login Guide.

Training materials for FFS Providers and upcoming Provider Training Sessions can be found on the DFSM Provider Training Web Page .

For provider training questions please outreach the Provider Training Team via email at ServiceDesk@azahcccs.gov

COVID FAQ: FAQ COVID Fact Sheet

Common Non-Emergency Medical Transportation (PT28) Prior Authorization Denials

AHCCCS provides non-emergency medical transportation that is medically necessary, to and from an AHCCCS covered service for eligible recipients when no other transportation source is available. NEMT (Non-Emergency Medical Transportation) prior authorization denials can occur for various reasons, mainly involving incomplete or inaccurate information, lack of justification, and failing to adhere to payer-specific rules and deadlines.

- PD900 Medical Documentation Not Received
- PD800 Deny/No IHS Referral Received
- PD005 Authorization Request Not Within Timeframe
- PD014 Deny/Not a Covered Service
- PD017 Medical Information Does Not Support Request

Important Denial Error Code MD093 "Medical Documents Encrypted, Resubmit the Documents Only"

Password protected or encrypted documents cannot be uploaded for any claim that requires clinical, medical, or behavioral health review to include documents submitted for prior authorization requests.

When documents are received and cannot be examined, this delays the review and adjudication of the claim. The denial code MD093 "Medical documents encrypted, resubmit the documents only" will be listed on your remittance advice and viewable on the AHCCCS Online Portal.

What can you do to avoid delays?

- Do not void and replace the claim, unless there is a change in the details,
- Resubmit the unencrypted documents only to the existing claim using the 12-digt claim number,
- Please allow 5 to 7 business days for the documents to be manually linked to the claim.
- If the claim status is denied, providers must submit a service ticket to the attention of DFSM Claims In the text box enter, "new unencrypted docs have been uploaded to the claim. Please reopen the claim for review.

Prior Authorization documentation upload:

- Resubmit the unencrypted documents only to the PA case using the AHCCCS prior authorization upload tool.

Reminders: Fee-For-Service (FFS) Claims Billing

- Submit claims as quickly as possible.
- Verify the coding details on the claim to avoid errors.
- If the claim or a specific line of service is denied, review the claim first with your coder to determine what is required for correction.
- Check the member's Medicaid enrollment prior to the submission of the claim.

Important: AHCCCS Registration is Required for all Behavioral Health Professionals Providing Clinical Oversight

Physicians, non-physician practitioners, and other health care practitioners who meet the criteria to be a behavioral health professional must be registered and in active status with AHCCCS prior to providing clinical oversight and directly supervising services rendered by a behavioral health technician, behavioral health paraprofessional, case manager, or other staff.

A Behavioral Health Professional, as specified in R9-10-101, is an individual licensed under A.R.S. Title 32, Chapter 33, whose scope of practice allows the individual to independently engage in the practice of behavioral health as defined in A.R.S. § 32-3251.

AHCCCS Medical Policy 310-B Title XIX/XXI Behavioral Health Service Benefit (section 4) guidance states: **Clinical oversight and supervision**: Behavioral Health Paraprofessionals (BHPPs) that provide services in the public behavioral health system, shall receive supervision by a Behavioral Health Professional (BHP). Behavioral Health Technicians (BHTs) that provide services in the public behavioral health system shall receive clinical oversight by a BHP.

In addition to possessing the requisite licenses and other qualifications, BHPs providing clinical oversight of BHTs shall have demonstrated competence in delivering the same or similar services to members of comparable acuity and intensity of service needs as the BHTs they supervise. BHPs providing clinical oversight of BHTs shall also demonstrate the following key competencies:

a. Demonstrated knowledge of the relevant best clinical practices and policies that guide the services being provided,

b. Demonstrated knowledge of the policies and principles governing ethical practice,

c. Demonstrated ability to develop individualized BHT competency development goals and action steps to accomplish these goals, and

d. Demonstrated ability to advise, coach, and directly model behavior to improve interpersonal and service delivery skills.

Importance of Reviewing the Behavioral Health Documentation Prior To Submission

Behavioral health documentation errors can include inconsistent documentation, incorrect diagnoses, treatments, and charting of services and duration. Creating and maintaining accurate records can reduce these types of errors.

It is critical for clinical and billing staff to review the documentation and claim specifics before submitting the claim to prevent any discrepancies in the information provided.

For example, the denial reason code MD418 “Claim Mismatch Units/Code Documented” indicates that there is a discrepancy between the CPT code, the recorded start and end times of the services, and the units reported on the claim.

Common Prior Authorization Submission Errors:

AHCCCS has identified several common PA submission errors that include but are not limited:

- PA request entered for CPT/HCPCS code that does not require a PA.
- Incorrect Date of Service(s).
- Incorrect Event type.
- Failure to complete the Event Tab.
- Failure to complete the Activity Tab.
- PA request entered under the incorrect provider NPI number.

To learn more about procedures that may or may not require a prior authorization view the AHCCCS Fee for Service Prior Authorization Guide.

Medical Review Denial Edit MD041

Accurately submitting medical claims is an important step in the claims review process. Additionally, making sure the appropriate documentation is also submitted with the claim is critical. Missing or incomplete documentation can significantly impact your claims, leading to delays and denials.

Why Proper Documentation Matters:

Medical documentation encompasses all the written records pertaining to a patient's services. It includes various elements such as:

- Diagnosis, physician notes and orders, progress notes, operative report, discharge summary and treatment plans and assessments.
- Complete and legible documentation is crucial for accurate claims processing.
- Streamlining your documentation process and ensuring complete information is key to minimizing denials and maximizing reimbursements.