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

CLAIMS CLUES

A Publication of the AHCCCS DFSM Claims Department

October/ November 2026

Maternity Care Unbundling Frequently Asked Questions



The American Medical Association (AMA) and American College of Obstetricians and Gynecologists (ACOG) have announced significant changes to maternity care billing and coding that will take effect January 1, 2027. In order to help providers, Managed Care Organizations (MCOs), and other stakeholders prepare for and stay informed about this transition, AHCCCS has compiled the Maternity Care Unbundling FAQ.pdf

Reminder Register for the Quality Management Portal

Fee-for-Service providers are required to report any Quality of Care (QOC) Concerns and Incidents, Accidents, and Deaths (IADs) as soon as they are aware, and no later than 24 hours after discovering the issue. Reports should be submitted through the QM portal.

Per the Provider Participation Agreement (PPA), providers must be registered in the AHCCCS Quality Management Portal

- Providers are responsible for keeping their portal logins current,
- Login at least once every 30 days to stay in active status

Correct Billing Multiple Units of the Same CPT/HCPCS Code

Billing Multiple Units: When the same CPT/HCPCS procedure is performed multiple times on the same date of service, report the procedure code once on the claim and enter the total number of times the service was performed in the Units field. The total billed charge should equal the charge per unit multiplied by the number of units billed.

Important Note: Do not bill the same CPT/HCPCS procedure code on multiple lines for the same date of service; the first line may be approved for payment, while sequent lines will deny as a duplicate service.

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

Report an Incident, Accident, and/or Death in the AHCCCS QM Portal FFS providers are required to report any Quality of Care (QOC) Concerns and Incidents, Accidents, and Deaths (IADs) as soon as they are aware, and no later than 24 hours after discovering the issue. Reports should be submitted through the QM portal.

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: ServiceNow@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 Service Now Solution center at ServiceNow.azahcccs.gov/gsp

Prior Authorizations Rate Changes and Creating a New PA Case for BHRF and IOP Services

Effective October 1, 2026, new Fee-for-Service (FFS) rates apply to dates of service on and after October 1, 2026. Providers should be aware that these rate changes may affect prior authorizations that span multiple rate periods.

Provider Required Action: Providers with authorized services that continue into the new FFS rate period are required to submit a **new prior authorization case with a begin date of October 1, 2026**. This requirement applies to services including but not limited to Behavioral Health Residential Facility (BHRF) and Intensive Outpatient Programs (IOP).

Submit all required supporting documentation with the new prior authorization request to support accurate processing and reimbursement. Failure to submit a new prior authorization may result in an incorrect rate being applied and may affect reimbursement.

Submit prior authorization requests electronically through the AHCCCS Online Provider Portal. Providers are responsible for periodically checking the case status for updates or requests for additional information.

Best Practices for Tracking Status Of the Prior Authorization Case Request

To stay up to date with your prior authorization request, use these tracking and follow-up strategies:

Best Practices for Tracking Prior Authorization Status:

- **Utilize the AHCCCS Online Provider portal** for real-time status updates.
- **Follow up routinely;** this may be every 48 to 72 hours or more frequently if needed.
- **Open the case** to view any notes added to the case.
- **Keep a record of any requests** for additional information requested by the prior authorization team and respond immediately**.**
- **Provide Complete Documentation** – Incomplete, missing or insufficient supporting information is a leading reason for denials. Always ensure that patient details, clinical notes, test results, and other supporting documentation are included.
- **Avoid** claim denials and delays due to lack of or untimely follow up.

Authorization Requirement Check List

Determine whether prior authorization is required for a specific service, test, or procedure **Before** the prior authorization is submitted Fee-for-Services Prior Authorization Guidelines.xlsx

Best Practices Documentation Upload for Claims Review

When you know supporting documents are required for claims review, following the correct submission steps from the beginning can help reduce processing delays. During the initial claim submission, creates a unique **Paperwork (PWK) numbe**r in the attachment section to notify the AHCCCS Claims Processing System (PMMIS) that supporting documentation will be submitted. The same **PWK number** must be used when uploading the documentation through the EDI Solutions portal to ensure it is properly linked to the claim.

Providers should never upload the documents before submitting the claim. During this, the documents will fail to be associated with a claim.

- The PWK number must be unique to each claim and must match exactly on the claim (Web/EDI clam) and the attachment submission in the EDI Solutions Portal to ensure successful document linkage.
- Keep the formatting simple. The suggested format is to use the AHCCCS member ID and date of service, omitting all slashes (Example: A1234567809052026).

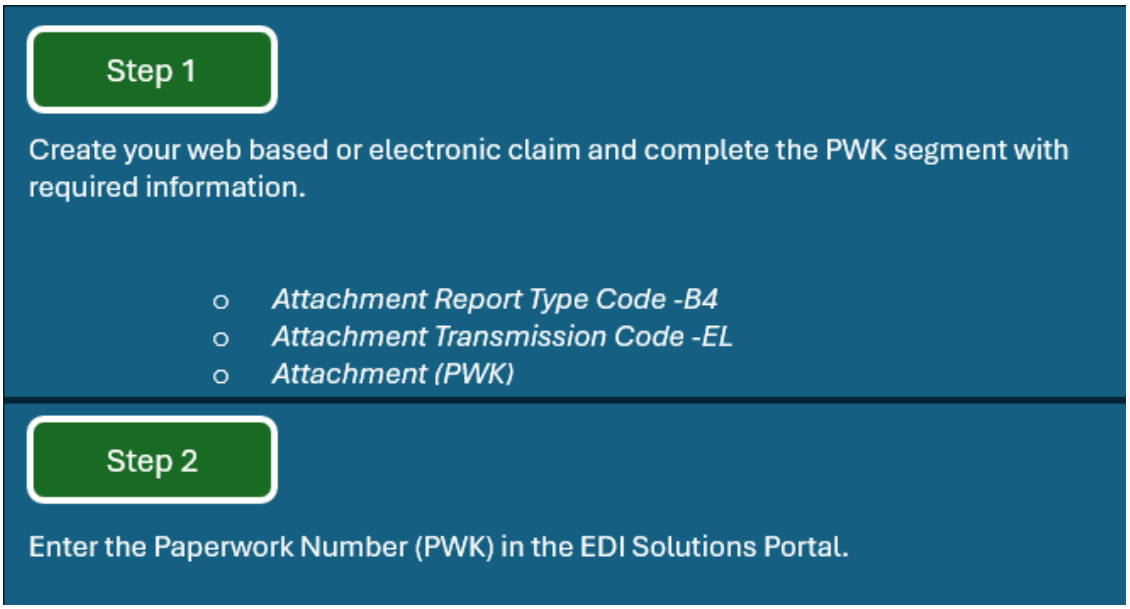
Best Practices for Tracking Status Of the Prior Authorization Case Request Continued

- Providers with a valid NPI number must use the NPI when billing the claim and when uploading attachments in the EDI Solutions portal.
- The 6-digit AHCCCS provider ID may be used only if the claim was submitted with that ID.
- In the EDI Solutions portal, the PWK number must be entered in the Payer Claim Control Number or Provider Attachment Control Number field.

Important Reminder

To ensure successful linkage, the PWK number must:

- Be unique to each claim submission.
- Match exactly on both the claim and the uploaded documentation in EDI.
- Be entered in the appropriate attachment control field when uploading supporting documents.



Medical Coding Resources - Important Coding Updates

AHCCCS Medical Coding Resources The team periodically updates the resources listed below. We encourage providers to review for recent changes/updates effective October 1, 2026:

The AHCCCS Behavioral Health Services Matrix (B2 Matrix) is updated and published monthly, with the current month's information. Refer to the 'as of' date in the header of the Matrix document below: B2 Matrix *(updated 10/01/2026)*

The AHCCCS Same Day Disallow Table includes the most commonly used per diem, single day, counseling, treatment, and assessment/screening/evaluation code combinations. This is not an exhaustive list of all available codes. Refer to the AHCCCS Same Day Disallow Table below:

- AHCCCS Same Day Disallow Table (Updated 10/01/2026)
- Disallow Table Summary (Added 10/01/2026)

The AHCCCS Covered Behavioral Health Services Guide (CBHSG) is updated and published as needed. Refer to this chart: AHCCCS Covered Behavioral Health Services Guide

AHCCCS Provider Edit Resolution Guide

Providers can use the Provider Denial Edit Resolution Guide to identify claim denials edits, understand their descriptions and determine the appropriate corrective action. Providers are encouraged to review the guide periodically, as new denial edits will be added as they become available. Providers remain responsible for accurate and compliant billing. Provider Denial Resolution Guide

Claims Must Be Submitted First Before Submitting Clinical Documentation Through the EDI Solutions Portal

Attachments should never be submitted before the claim is submitted. Documentation submitted before the claim cannot be matched to the claim, which will result in delays and denials.

The Attachment Control Number **(PWK) field** must be created during the initial submission of the claim. This requirement applies to claims submitted through the AHCCCS Online Provider Portal, billing software or a clearing house.

1. Determine whether supporting documents is required prior to the submission of the claim, for i.e.; NEMT, behavioral health, secondary claim.
2. Generate a unique Attachment Control Number (PWK) during the initial claim submission process.
3. If a PWK number was not created during the initial submission, the AHCCCS 12-digit claim number can be used to attach the document to the claim.
4. If the PWK number was created during the initial submission of the claim, enter the PWK number in the Attachment Control Number (PWK) field in the EDI Solutions portal.
5. Submitters must verify all identifiers match exactly between the claim and the attachment.

Examples:
Correct:
During the initial claim submission, the provider created the (PWK) number (A1234567808052026).

After the claim was submitter, the provider uploaded the supporting documentation through the EDI Solutions Portal. The provider entered the exact Attachment Control Number (PWK), (A1234567808052026), in the Payer Claim Control Number field.

Incorrect: An example of mismatch of this information may be (a12345678_080526), this does not meet the matching criteria and may prevent the documentation from being successfully associated and linked to the appropriate claim.

Training Resource www.azahcccs.gov/Resources/ Downloads/DFSMTraining/2025/ EDIPortalWebUploadAttachmentProcess.pdf

Medicare and Third-Party Liability Claims Correction

Providers are responsible for correcting errors that are a result of the direct claim submission. This applies to claims submitted on the AHCCCS Online Provider portal and direct EDI claim submissions.

Providers must submit a replacement/correction claim with any previously entered fields submitted with the correct information.

AHCCCS cannot edit/change or alter details entered by the provider.

This includes instances where Third Party Liability (TPL) and/or Medicare cost-sharing amounts were entered in the incorrect fields. If you are uncertain which fields should be used for Other (OTH) or Medicare amounts, leave these fields blank and submit a copy of the Explanation of Benefits (EOB) to ensure accurate processing.

Submitting a Correction/Replacement Claim

AHCCCS Claims Replacement: The initial claim must be received by AHCCCS within 6 months from the date of service to meet the timely filing period.

Step 1. Check the date(s) of service (DOS).

- Confirm the earliest DOS on the claim and verify the claim was received within 6 months of the DOS.

Step 2. Confirm that the resubmission/adjustment is still **within 12 months of the DOS** (unless retro-eligibility applies).

- If the DOS is past the 12-month timely filing period and the provider submits a replacement claim, any payments issued **will be automatically recouped and the identified claim will be placed in Void status. No action will be taken on the replacement claim.**