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

CLAIMS CLUES

A Publication of the AHCCCS DFSM Claims Department

August 2026

Claims Must Be Submitted First Before Submitting Clinical Documentation Through the EDI Solution 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.

TrainingResource: www.azahcccs.gov/Resources/Downloads/DFSMTraining/2025/EDIPortalWebUploadAttachmentProcess.pdf

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: 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

Prepayment Review Notification

AHCCCS Prepayment Review Notification Effective July 24, 2026
Code Impact: H2038
Description: Skills Training and Development, Per Diem

Effective August 24, 2026, AHCCCS will conduct prepayment reviews for claims submitted with HCPCS code H2038 (Skills Training and Development, per diem) when billed without a group modifier.

Prepayment review will apply to claims for HCPCS Code H2038 received on or after August 24, 2026, including:

- Original claim submissions,
- Resubmissions,
- Reconsideration requests,
- Third Party Liability / Secondary claims.

The review will verify the following requirements are met.

- Services documented must match the services billed.
- Documentation supports the member's condition, treatment needs, services rendered and includes a thorough description of the specific individual member's response to services delivered.
- Modifiers are appropriately applied as needed, including but not limited to the appropriate usage of the HQ modifier when services take place in a group setting. Two or more individuals define a group.
- H2014 is billed when life skills services take place for fewer than 5 hours.
- The person who delivered the service is appropriately listed as either the rendering provider or participating provider on the claim.
- Compliance with basic requirements for all medical records is compliant with AMPM 940 Medical Records and Communication of Clinical Information.
- Compliance with basic requirements for behavioral health assessment, service, and treatment planning as described in AMPM 310-B.

Documentation Requirements:

For claims received on or after 8/24/2026, providers must submit supporting medical documentation with the initial claim and any/all subsequent replacement claims. Claims submitted without attached medical records will be denied. Providers should attach the required documentation through AHCCCS Solutions Center .

The minimum types of supportive documentation that are required to be submitted for each billed claim are listed below.

Comprehensive assessment:

- A comprehensive assessment completed before the date of service.

Treatment care plan:

- The treatment plan for the services billed, and

Progress Notes

- Medical record documentation for each claim line billed on the service date(s).

Medical records must be electronically or manually signed and dated. Progress notes, treatment plans, and assessments must be unique to the individual being served.

Claim Submission

Providers must continue to submit timely and accurate claims during the prepayment review period.

Prepayment Review Notification Continued

- Documentation cloning, on paper format or electronic format, is strictly prohibited.
- Clean claims must be received by the Administration within (6) months of the date of service.
- Multiple dates of services may be billed on a claim form, but each date of service (DOS) must be billed on its own claim line.
- Supporting documentation must be received with the initial claim, including but not limited to the following:
- Comprehensive assessment
- Treatment plan
- Progress Notes
- Claims are reviewed in the order in which they are received.

Resources:

AMPM Policy 940 Medical Records and Communication of Clinical Information

AHCCCS Covered BH Services Manual

AMPM Policy 320-O Behavioral Health Assessment, Service and Treatment Planning

Medical Coding Resources Guide

Skilled Nursing Facility Claims Denying with Remarks Code H189.1

AHCCCS has identified an issue affecting Skilled Nursing Facility claims that has resulted in claims incorrectly denying with the denial remark code H189.1, **"Recipient Has Medicare; Medicare Must be Indicated, is Missing"**.

AHCCCS is actively working to implement a resolution and will reprocess all claims affected by this issue. **Providers do not need to resubmit affected claims**. AHCCCS will automatically reprocess impacted claims until the issue has been resolved.

Additional communication regarding claim reprocessing timelines and schedules will be provided as more information becomes available.

AHCCCS appreciates your patience and cooperation as we work to resolve this issue.

EDI Solutions Portal Update – Multiple NPI Provider Selection

AHCCCS is actively working to resolve an issue within the EDI Solutions Portal affecting providers with multiple National Provider Identifier (NPI) numbers.

The NPI selection functionality has been updated, and most providers should now be able to select their NPI number within the portal.

However, providers with multiple NPIs may not yet see all associated NPI numbers available in the drop-down menu.

If the appropriate NPI number is not available, please continue using your AHCCCS-assigned six-digit provider ID until the enhanced multiple-NPI functionality is implemented.

AHCCCS will provide additional updates as they become available.

AHCCCS New Claim Edits

On June 29, 2026, the Arizona Health Care Cost Containment System (AHCCCS) launched Alivia 360, an advanced analytics solution designed to improve claims accuracy, strengthen program integrity, and support providers through enhanced claim review processes

https://www.azahcccs.gov/shared/News/GeneralNews/AHCCCSLaunchesNewAnalyticsTool.html

Effective September 4, 2026, Alivia will begin systematically reviewing all trip tickets submitted to support Non-Emergency Medical Transportation (NEMT) claims.

Errors in any of the following trip ticket fields may result in denial of the associated claim:

- No prior authorization on file (for trips over 100 miles)
- TN Modifier used improperly (used in urban areas)

Effective September 4, 2026, Alivia will also begin reviewing claims for the errors listed below. Claims containing these errors will be denied.

1) Allergen Serum Prep Without Injection

- If any of the following allergen serum preparation CPT codes are billed: (95145- 95170) and the CPT for the Injection (95115-95117) isn't included.

2) CPAP Without Sleep Study

- This edit is looking for medical claims that have CPT codes 94660 or E0601) without a sleep study (95810, 95800, 95782, 95783, 95801, 95805, 95806, 95807, 95808, 95811, G0398, G0399, or G0400)

3) Multiple Urine Drug Tests on the Same Day

- This edit looks for multiple urine drug tests (CPT 80305, 80306, 80307, 80159, 80171, 80173, 83789, 83992, G0480, G0481, G0482, G0483, 80183, 80184, or 80320-80377) billed on the same day for a single patient.

4) Respiratory Panel + COVID Test Overlap

- Multiplex codes (87633, 0098U–0100U) are included in SARS-CoV-2, making Standalone COVID-19 (87635) or single-step antibody test for COVID (CPT 86328), and multiple-step lab antibody test for virus that causes COVID-19 (SARS-CoV-2) (CPT 86769) test redundant. Flu/COVID multiplex codes, Large multiplex respiratory viral panel CPT 87633, and 0098U–0100U proprietary laboratory analyses codes used to identify multiple types of respiratory pathogens. CPT codes 87633, 0098U–0100U billed with 87635 or 86328/86769.

5) Office Visit + EPSDT Overlap

- This edit is looking for medical claims that bill CPT 9921X/9920X and 96110 for the same patient on the single day of service.

6) >2 Pieces of Orthotic Equipment Same Day

- If a provider bills for more than one piece of orthotic equipment, on the same date of service, the claim will be denied.

7) Critical Care Unbundling

- This edit looks for critical care codes (CPTs (99291-99292) billed with 93561, 93662, 71045, 71046, 94760, 94761, 94762, 43752, 43753, 92953, 94002, 94003, 94004, 94660, 94662, 36000, 36410, 36415, 36591, 36600).

8) Trauma activation with Critical Care without Critical Care

- This edit looks for when a trauma activation with critical care (HCPCS G0390) is billed without a critical care CPT (CPT 99291) for the same member, same date of service, same provider (billing and servicing).

AHCCCS New Claim Edits Continued

9) Neulasta – Service Never Rendered

- This edit assesses claims with multiple Neulasta (J2506) injections in a specific period.

10) Implant w/o Surgery

- This edit looks for implants (Rev codes 0272, 0275, 0276, 0278-0280, 0289 or 0624) are billed without a surgery code.

11) Observation > 23 hours

- This edits reviews claims that have overlapping services for T1019 and T2020 on a single date of service.

Helpful resources:

Denial Resolution Guide: https://www.azahcccs.gov/PlansProviders/Downloads/ClaimsClues/AHCCCS_FFS_ClaimsDenialResolutionGuide.pdf

Exhibit 11-2 Fee-for-Service Outlier Exclusion List- Repeat from July

The Arizona Health Care Cost Containment Program (AHCCCS) would like to inform you of some important updates to the Fee-for-Service Outlier Exclusion List effective July 20, 2026.

AHCCCS has updated the Fee-for-Service Outlier Exclusion List for clarity. Providers are encouraged to review the list in its entirety to ensure awareness of the applicable exclusions.

For more information on outlier pricing please see the Inpatient APR DRG Reimbursement Values in the

AHCCCS APR-DRG Payment System Design Payment Policies

Resource links:

AHCCCS Archive

AHCCCS Fee-for-Service Provider Billing Manual

AHCCCS Medical Policy Manual (AMPM)

Participating Provider Reporting Details Description of Service Is Not Required- Repeat July

When reporting Participating Provider details in the “Additional Information” field, providers should not include a description of the behavioral health service code.

Following the required participating provider and claim submission process helps support timely reimbursement and can assist with reducing claim denials.

- The CPT/HCPCS code submitted on the claim identifies the behavioral health service provided.
- Only include information that is required to support accurate claim processing.

Example: Description of Service Included but Not Required

9999999999Jones, Tom
Skills Training and Development, Per Diem

We have provided the link to the AHCCCS training web page.

AHCCCS Provider Education and Training Web Page

Best Practices for Pending Prior Authorizations and Meeting Initial Claim Submission Time Frames-Repeat from July

If the Prior Authorization Request is in a pend status and the claim filing deadline is approaching, providers should submit the claim to ensure the **initial six-month timely filing period is met.**

This process does not replace or supersede the requirement to submit a timely prior authorization request. Prior authorizations must be submitted via the AHCCCS Online Provider Portal.

Claim Submission Timeframe: If a claim is originally received within the 6-month time frame, the provider has up to 12 months from the date of service to correctly resubmit the claim in order to achieve clean claim status or to adjust a previously processed claim, unless the claim involves retro-eligibility. If a claim does not achieve clean claim status or is not adjusted correctly within 12 months, AHCCCS is not liable for payment.

Reference: Fee-for-Service Provider Billing Manual Chapter 04 General Billing Rule

Prior Authorization Requirements

Nothing has changed regarding the requirement for FFS providers to submit prior authorization requests for medical and behavioral services that require prior authorization.

Receiving authorization approval does not guarantee payment. The service must be supported by medical documentation establishing medical necessity, and the claim must meet all AHCCCS criteria including clean claim and timely filing criteria.

Identify Services That Require Prior Authorization

Providers are responsible for identifying which services require prior authorization before submitting a PA request. Providers should avoid submitting PA requests for services that do not require prior authorization, such as office visits, laboratory services, x-rays, and evaluation and management codes.

Reference: Fee For Service Prior Authorization Guidelines.xlsx

Prepare and Submit Complete Prior Auth Requests

Complete and accurate prior authorization submissions help reduce processing delays. Providers should:

- Include all necessary documentation such as clinical notes, lab results, and diagnostic codes if required.
- Make sure to verify the member and patient information is accurate.
- Regularly check the status of the prior authorization request and respond promptly to requests for additional information.

How Providers Can Complete the Revalidation Process

To complete the revalidation process you must:

1. Log into APEP.
2. Under the Provider Tab, click on the “Manage Provider Information” link to find your application.
3. Respond to all steps that are marked as “Incomplete” before submitting application.
4. Upload any required documentation such as current license/certification and W-9 signed in the last 12 months.
5. Sign the electronic Provider Participation Agreement; and
6. Submit the revalidation application for State approval.

How Providers Can Complete the Revalidation Process Continued

NOTE: You must complete ALL application steps through step 12 to fully submit the revalidation application. When the revalidation is submitted, you will see a red message at the top of the screen that says the application has been submitted for review.

You may also be required to submit an enrollment fee, be subject to a site visit, or perform a fingerprint criminal background check in accordance with Section 6401 of the Affordable Care Act and 42 CFR 455, Subpart E. Separate notification will be sent if your provider type requires one of these actions.

For additional questions regarding how to troubleshoot through APEP to complete the revalidation application, submit an inquiry through the AHCCCS Solutions Center or Provider Services **(602) 417-7670**. Include the provider's name, NPI, and a brief description of the issue.

Prescribing Notification-Repeat from June

Referring, Ordering, Attending, Prescribing (ROPA) Providers Required to Register with AHCCCS

Effective September 01, 2026, claims submitted by fee-for-service providers that include a referring, ordering, attending or **prescribing** provider who is NOT registered with AHCCCS will be denied.

To begin the enrollment process, visit AHCCCS Provider Enrollment.

The Patient Protection and Affordable Care Act (ACA) and the 21st Century Cures Act (Cures) require that all health care providers who refer AHCCCS members for an item or service, who order non-physician services for members, who prescribe medications to members, and who attend/certify medical necessity for services and/or who take primary responsibility for members' medical care must be registered as AHCCCS providers. AHCCCS calls this initiative, and these providers, "ROPA."

Prior to the passage of these Acts, referring, ordering, prescribing, and attending providers were required to obtain and maintain a National Provider Identifier (NPI), but were not required to be registered as an AHCCCS provider. With the implementation of ROPA requirements, any registrable healthcare provider who is not already registered as an active AHCCCS provider must register or be identified as an Exception non-registerable provider, if applicable.

To make the ROPA registration process as simple as possible, AHCCCS developed a streamlined application for ROPA providers who meet all of the following criteria:

- Have a National Provider Identifier (NPI) from the National Plan and Provider Enumeration System (NPPES),
- Already fully enrolled in Medicare or another state's Medicaid program, and
- Do not intend to bill AHCCCS for services.

Steps To Comply with ROPA

If you are a provider or work with a provider who refers, orders, or acts as an attending provider for AHCCCS members, and you or the provider you work with are not registered with AHCCCS, you must begin the registration or exception provider designation process.

More information around this process can be found here: AHCCCS ROPA

The Arizona Health Care Cost Containment System (AHCCCS) is committed to promoting payment integrity and accurate claim reimbursement. To support this effort, AHCCCS conducts Prepayment Reviews (PPR), which involve reviewing medical documentation before payment is issued for a Fee-for-Service (FFS) claim.