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

CLAIMS CLUES

A Publication of the AHCCCS DFSM Claims Department

March 2026

DFSM Provider Training Schedule January - March 2026

AHCCCS offers various Fee-for-Service provider training opportunities, which covers the AHCCCS Online Provider portal, general processes to include claim submissions and corrections, Fee-for-Service prior authorization, and the EDI Solutions portal for documentation uploads. Training dates and times for February and March have been posted on the provider training webpage. AHCCCS Provider Training Schedule First Quarter 2026

AHCCCS Quality Management (QM) Portal

All AHCCCS-registered providers must register an account in the AHCCCS Quality Management (QM) Portal within 30 days of becoming an AHCCCS provider, as required by AMPM Policy 961, AMPM 830 and the AHCCCS Provider Participation Agreement (PPA).

This registration supports timely and consistent reporting of Incidents, Accidents, and Deaths (IADs) across the AHCCCS delivery system. Providers serving Fee-For-Service (FFS) members must enter all reportable IADs directly into the QM Portal.

In addition, providers are responsible for reporting Quality of Care (QOC) concerns in accordance with AMPM Policy 830, which outlines the procedures and expectations for identifying and reporting QOC issues.

Please ensure compliance with:

- AMPM 961 – Incident, Accident, and Death Reporting
- AMPM 830- Quality of Care Concerns

Register or access your account here: AHCCCS QM Portal

- Review the QM Portal User Guidance on How to Report an IAD.

Your compliance is essential to maintaining the integrity and safety of care provided to AHCCCS members. If you have not yet registered, please do so promptly to avoid delays in reporting and ensure adherence to AHCCCS standard.

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

EDI 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.

Prior Authorization Documentation Behavioral Health Residential Facility (B8

The Certification of Need (CON) covers the first 30 calendar days of approved admission. After this time frame, a Recertification of Need (RON) is needed and should be submitted upon expiration of the CON or previous RON.

- Recertification of Need (RON) for BHRF services is due at a minimum of 60 days. For example, if a RON is due January 2026, include the January treatment plan. The treatment plan should include all treatment notes from the most recent 7 consecutive days preceding RON date.
- Treatment notes should include Group/Progress/Assessment notes/ evidence of coordination with the outpatient care team, and targeted discharge date.

This example shows common documentation upload identifiers; alternate formats are acceptable, keep in mind documents must be clearly identifiable.

File Name
Tom J. Admission Form 02-01-2026.pdf
Tom J. CON signed 02-01-2026.pdf
Tom J. Initial Assessment / Intake 02-01-2026.pdf
Tom J. Psych Evaluation 02-02-2026.pdf
Tom J. Treatment Notes 2.2.2026 through 2.9.2026
Tom J. Treatment Plan 02-01-2026.pdf
Tom J. RON signed 2-28-2026.pdf
Tom J. RON Treatment Plan 2-28-2026.pdf
Tom J. Discharge Summary

The BHP Signature, Date Signed, BHP AHCCCS Provider ID Number (six digits) and BHP phone number must be completed on the CON/RON.

- BHRF treatment is expected to be inclusive of all services specified in the member's behavioral health treatment plan.
- Members in a BHRF shall not receive consecutive Intensive Outpatient (IOP) treatment or other treatment from outside providers that is duplicative of the services the BHRF is expected to provide.
- Claims and prior authorization requests may be delayed or denied if submitted documentation does not include the client/member's name and AHCCCS ID on every page.

Providers are strongly encouraged to include the date of birth on each page to support identification and processing.

Tips For Checking Claim Status

Providers are encouraged to access AHCCCS Online Provider Portal for real-time claim and prior authorization updates, and information, including eligibility verification, claims status, prior authorization status, and more.

Provider Claim Research Tips To research a claim denial online, navigate to the "claims" inquiry section, and then filter to view only the claims for the member and date span.

Review Claim Denial Details: Once you select a claim, the portal should display the reason for the action taken on the claim. This will usually provide details about the reason for the denial, including specific policy codes and explanations for why the claim was not approved.

Identify the Claim Issue:

1. **Exceeded timely filing limit** – This occurs when claims are filed outside the initial 6- months from the date of service period and or if the provider failed to include the original or subsequent claim reference number from the prior claim submission as proof of timely filing.

2. **Prior authorization**: In the event that prior authorization is not obtained prior to the service being performed, a claim may be denied. Mismatch in service details will cause a claim to be denied.

3. **Submitting Unnecessary Prior Authorization requests:** When providers submit prior authorizations for services that do not require prior authorization creates unnecessary burdens for both the provider and the prior authorization staff.

4. **Verify patient information:** Many denial codes for claims sent to the wrong payer will show the name of the health plan responsible for the claim and the member, based on the service date. For instance, "L050.1" indicates that the recipient was enrolled in the Mercy Care Plan for the entire service date, while" L050.3" means the recipient was enrolled in a plan that does not permit payment, like AHCCCS SLMB-Part B Buy-In. The health plan enrollment can be easily verified using the online provider portal.

5. Missing or incorrect information: This may include various elements such as a member identification number, a place of service code, a missing modifier, a provider who was not active on the date of service or the National Provider Identifier (NPI). NPI was approved after receipt of the claim.

6. **Frequency of service denials:** Service denials can occur for various reasons. For instance, the code "V002.1" means that the service has a lifetime limit of one and has already been paid. Another example is "V004.2," which relates to pricing issues; this may occur when the service dates fall into two different rate periods. In this case, the first date of service is 9/25/2024, and the service ends on 10/5/2024, which marks the beginning of a new fee-for-service rate period (10/1) HCPCS - CPT Procedures Daily Limits

Provider Denial Resolution Guide *(01/26/2026)*

• The Edit Resolution Guide is a tool that was created to help providers understand the denial edits, descriptions, and actionable next steps. New denial edits will be added periodically to the guide. Providers maintain the responsibility to ensure all claims are billed appropriately.

7. **Duplicate Claims** – Claims submitted for a single encounter on the same day by the same provider for the same patient. Before submitting a new claim, check the remittance advice or the online portal for the previously processed claim. Verify the reason the initial claim did not allow payment. Review the actual copy of the claim submission. Providers must submit one claim to include all lines of services for the same date of service. Multiple Claims submitted for CPT services on the same date of service may be denied as duplicate.

8. **Check For Accuracy of Claim Coding Details**: Verify that all information on the denial notice is correct, including patient details, procedure codes, and dates of service.

Outpatient Behavioral Health Claims Documentation

Unnecessary claim resubmissions to include missing documents can be addressed by ensuring all necessary supporting documentation is included in the initial claim submission. Behavioral health providers should not void and replace a claim when documentation has been requested and when there is no change to the billing details.

> Corrected claims are required when the provider has found incorrect information was submitted on a claim or when charges need to be added or corrected.

Claims documentation is an essential process. It ensures that claims are processed accurately and efficiently. However, errors in documentation can lead to delays and claim denials. The correct process is to upload the requested documentation using the EDI Solutions portal. Documents should be associated with the claim within 48 hours of submission. Next submit a service ticket to have the claim reopened for review.

Steps to Take When a Claim is Denied

1. Review the Denial Notice: Carefully check the reason for the denial.
2. Identify the Errors: Determine if the issue was due to missing documents, incorrect data, or coding errors.
3. Submit the necessary documentation – remember do not submit a replacement claim if there is no change to the billing details.

Understanding the Basics of BH Claims Documentation Requirements Claims documentation refers to the collection and submission of necessary paperwork to support a claim request. Proper documentation ensures that all required details are correctly recorded.

Lack of Supporting Evidence

- Claims often require additional documents,
- Failure to attach these supporting documents can lead to denial.
- Incorrect or incomplete documentation is a leading cause of claim denials as evidenced by the claim denial edit codes.

Best Practices to Avoid Errors in Claims Documentation

- Double-Check All Documents Before Submission, check and make corrections in advance.

Train Your Staff on Proper BH Documentation Procedures

- Ensuring quality reviews and checks for accuracy of documentation requires continuous improvement and staff training. Organizations should adopt a proactive approach to minimize errors and enhance
- Conduct regular staff training in the latest documentation requirements, procedures and compliance standards.
- Proper training reduces errors.

Claim Resubmissions After the 12-Month Timely Filing Deadline

Submitting a replacement or correction claim for a date of service that is past the 12-month timely filing period *will result in an automatic denial and/ or recoup of previously paid funds.*

Providers should routinely check their remittance advice or use the AHCCCS Online Provider portal to reconcile payments and denial postings. A failed or returned claim submission is not considered valid proof of timely filing. If a claim does not achieve clean claim status or is not adjusted correctly within 12 months from the date of service, AHCCCS is not liable for payment.

Additionally, if a replacement claim includes new charges or services that were not billed on the original submission, those additional services must independently meet the same timely filing submission guidelines as the services on the original claim.

Secondary claims must also meet the initial 6-month timely filing requirement for consideration and must be accompanied by a copy of the primary payer's explanation of benefits.

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.