AHCCCS PMMIS MAINFRAME QUESTIONS & ANSWERS

QUESTION:	When the provider is capitated for services how are the plan financial fields populated?
ANSWER:	AHCCCS assigns a value to each encounter submitted. The value helps us determine impacts on changes to fee-for-service rate schedules, capitation rates, reinsurance and other supplemental payments to plans. The AHCCCS value is based on the health plan paid amount, health plan approved/allowed amount (what the plan would have paid if you were paying the service as a fee-for-service claim) and the CN1 value. When the plan fully capitates provider services, CN1 = '05', AHCCCS expects the health plan paid amount to be $0.00 and the health plan approved/allowed amount to be greater than $0.00. AHCCCS relies on the accuracy of these fields for valuation. To receive appropriate AHCCCS valuation, it is important for plans to correctly populate the health plan allowed amount on all encounters. For additional information please refer to the 837 Encounter Companion Guide and the March/April 2008 Encounter Keys.
QUESTION:	If a service is paid due to a grievance and the encounter is pending for the error code D045 (Recipient Sex Is Invalid For Primary Diagnosis), what can be done to accept the encounter?
ANSWER:	For prior authorized or grievance related services plans should submit prior authorization or grievance numbers in the 837 Prior Authorization or Referral Segment REF02 field when REF01 = 'G1' qualifier; and referral numbers in the REF02 field when REF01 = '9F' qualifier of that segment. Please submit the two characters PA in front your prior authorization numbers and GR in front of your grievance numbers. In the NCPDP transaction the field ID for these numbers is 462-EV; be certain to use the appropriate qualifier in field 461-EU. Submitting these numbers will automatically bypass select clinical encounter edits found on RF7A6. AHCCCS may conduct post-adjudication reviews and request supporting documentation for encounters submitted with PA, grievance or referral numbers.
QUESTION:	I have a claim that Medicare paid as primary but the encounter will probably pend for S370 (Recipient's Age Is Greater Than The Maximum For The Procedure). When the encounter is submitted to AHCCCS can this error be overridden?
ANSWER:	When Medicare paid as primary and Medicare payment is reported on encounters an automatic edit bypass will occur on select encounter edits found on RF799. There will not be any need to override the pend errors listed on the Medicare primary payer bypass table. AHCCCS may perform post-adjudication reviews on encounters where Medicare paid as primary and edits were bypassed.
QUESTION:	Why is an encounter pended for lack of Medicare coinsurance when the CAS segment balanced?
ANSWER:	AHCCCS uses qualifier and claim adjustment reason codes to populate the corresponding fields on encounters. If these values are incorrect, wrong fields are populated.

	For example, When an encounter has Medicare Paid less than the Medicare Allowed/Approved and the coinsurance and/or deductible claim adjustment reason codes are missing, the Medicare Coinsurance and/or Deductible fields will be blank. The Medicare financial data on encounters must mirror the Medicare EOB and it is very important to use correct claim adjustment reason codes. **FOR EXAMPLE:** ♦ Suppose a professional service had a billed charge of $100 (loop 2400 SV102), ♦ Medicare Allowed/approved of $80 ♦ Medicare Paid of $24 (when Medicare loop – loop 2430 SVD02) ♦ Medicare Deductible of $50 (when Medicare loop – loop 2430 CAS03 [assuming deductible is the first adjustment reported—deductible could be in other CAS trio positions] = '1' [deductible]) ♦ Medicare Coinsurance of $6 (when Medicare loop – loop 2430 CAS06 [assuming coinsurance is the second adjustment reported—coinsurance could be in other CAS trio positions] = '2' [coinsurance]), ♦ and $20 exceeded the Medicare fee schedule for a participating provider (when Medicare loop – loop 2430 CAS09 [assuming fee schedule excess is the third adjustment reported – fee schedule excess could be in other CAS trio positions] = '45' [charge exceeds fee schedule]). AHCCCS has revised adjudication edits to evaluate correct qualifier and reason code usage. Incorrect reason codes will result in pends and require plans to correctly replace encounters.