PMMIS Training

Introduction to Encounter Processing

AHCCCS
Arizona Health Care Cost Containment System

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Contractor User Guide

Introduction

This User Guide is designed as a reference tool when utilizing the Arizona Health Care Cost Containment System (AHCCCS) information system called Prepaid Medical Management Information System (PMMIS).

This user guide includes information on:

- Registering with AHCCCS to be PMMIS user
- Password and Log on processes
- Screen navigation tools
- Commonly used screens
- How to perform basic tasks

The PMMIS system can be utilized by Contractors to find AHCCCS information regarding member enrollment and eligibility; registered providers; Medical, dental and pharmacy claims coding requirements; encounter status and the online encounter pend correction process.

Contact Information

For additional information, assistance, or training, please contact AHCCCS;

Questions regarding the validator or Technical Interface Portal (TIP) should be submitted to the AHCCCSTIEncounters@azahcccs.gov e-mail address.

All other encounter questions, including those concerning PMMIS mainframe access or utilization, should be sent to the AHCCCSEncounters@azahcccs.gov e-mail address.

Objectives

By the end of this session you will be able to:

- Understand the login process for PMMIS
- Describe the three methods to navigate through PMMIS Menus
- Locate Provider specific information
- Investigate Recipient data
- Validate information/coding utilizing the Reference screens
- Research an encounter to resolve pend errors

Accessing PMMIS

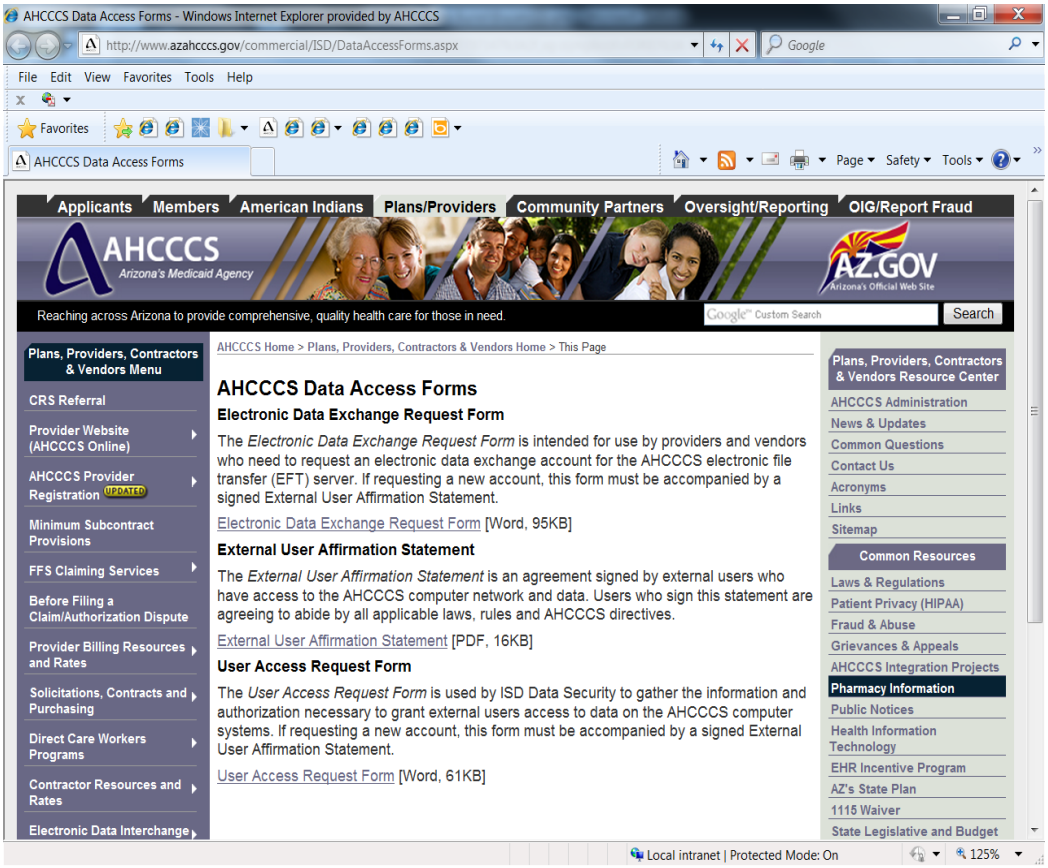
Section Introduction

This section describes the PMMIS login process, the main screen, how to navigate through PMMIS and understanding PMMIS.

Gaining Access

A user identification and password are necessary to login to PMMIS. To obtain both, email a copy of the required "User Access Request" form and "External User Affirmation Statement" to the AHCCCS Encounters mailbox. AHCCCSEncounters@azahcccs.gov.

The forms can be found at:
http://www.azahcccs.gov/commercial/ISD/DataAccessForms.aspx



Accessing PMMIS

Passwords

After the first logon to PMMIS, there will be a prompt to change the password.

A new password must meet the following security criteria:

- Must be 6 - 8 characters in length
- Must begin with an alpha character
- Must contain at least one numeric character
- Is not case sensitive

An example of a password that meets the security criteria is: **pmmis01**

Note: A best practice is to ***NOT*** use the names of family members or important dates, as these can more easily be compromised.

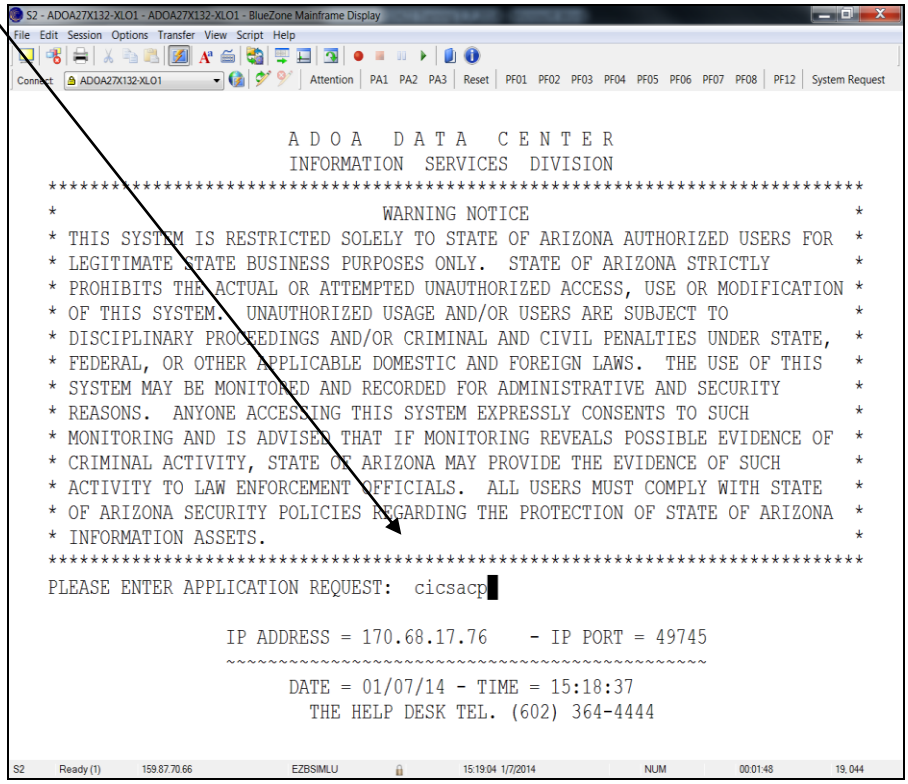
Changing the Password

Passwords must be changed every 30 days.

- There will be a system prompt to change the password 5 days prior to the required change date
- Each new password must be unique from the previous 31 passwords
- Three invalid login attempts in a row or not logging on for 30 days will inactivate the ID
- AHCCCS ISD Customer Support Desk at (602) 417-4451 completes all business hours password resets. AHCCCS ISD Computer Operations at (602) 417-4804 & 4705 completes after hours password resets.
- ***No login for 90 days will revoke the ID and a new user request form will be required to receive a new login.***

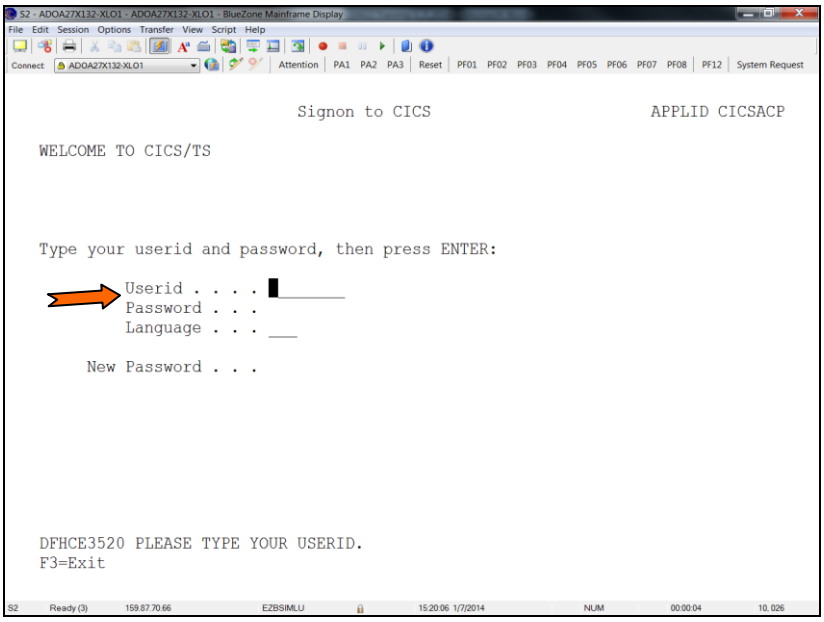
Signing On PMMIS

Complete the procedures to access PMMIS. After connecting, the following screen will be displayed. At this point, enter the application request sign on “cicsacp” and press <Enter>.

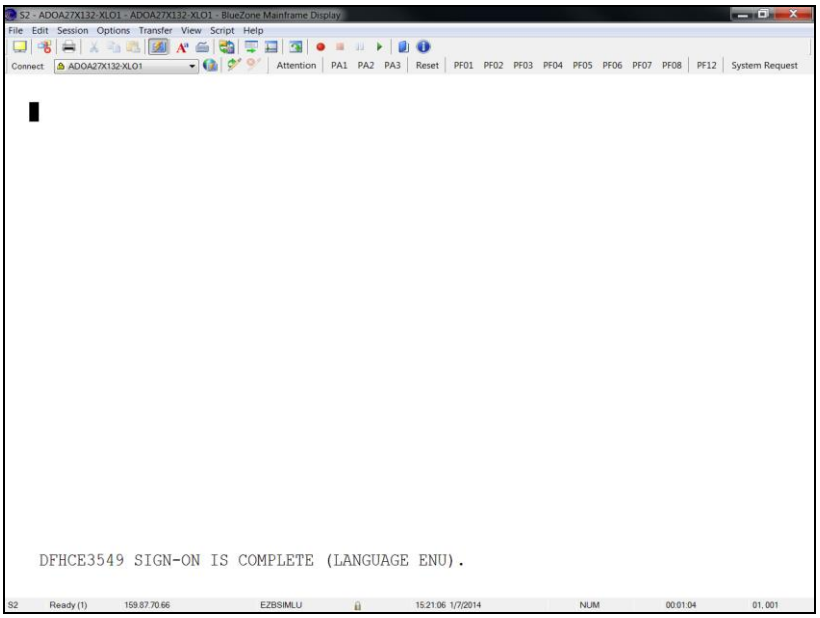


Signing On,
Continued

Next, the login screen will appear asking for a User ID and Password. Neither is case sensitive.



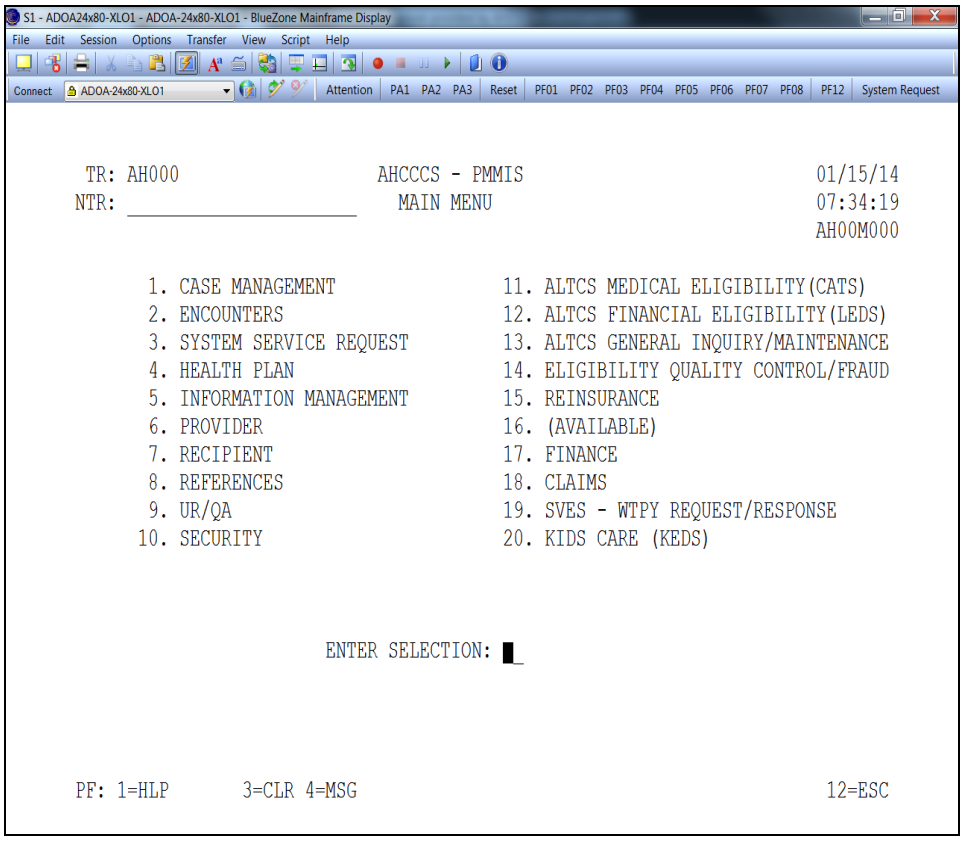
After entering the user name/password and pressing <Enter>, a blank screen will appear with the following message, “DFHCE3549 SIGN-ON IS COMPLETE (LANGUAGE ENU).” Type in “ADMN” and press <Enter>. Not case sensitive.



DFHCE3549 SIGN-ON IS COMPLETE (LANGUAGE ENU).

MAIN MENU

From this menu, you can navigate through PMMIS.



For Reference- NTR key code to main sybsystems: (2) digit alpha followed by (3) zeros

1. Case Management (CM000)
2. Encounters (EC000)
4. Health Plan (HP000)
6. Provider (PR000)
7. Recipient (RP000)
8. References (RF000)
11. ALTCS Medical Eligibility (CATS) (CA000)
12. ALTCS Financial Eligibility (LEDS) (LE000)
13. ALTCS General Inquiry/Maintenance (LT000)
15. Reinsurance (RI000)

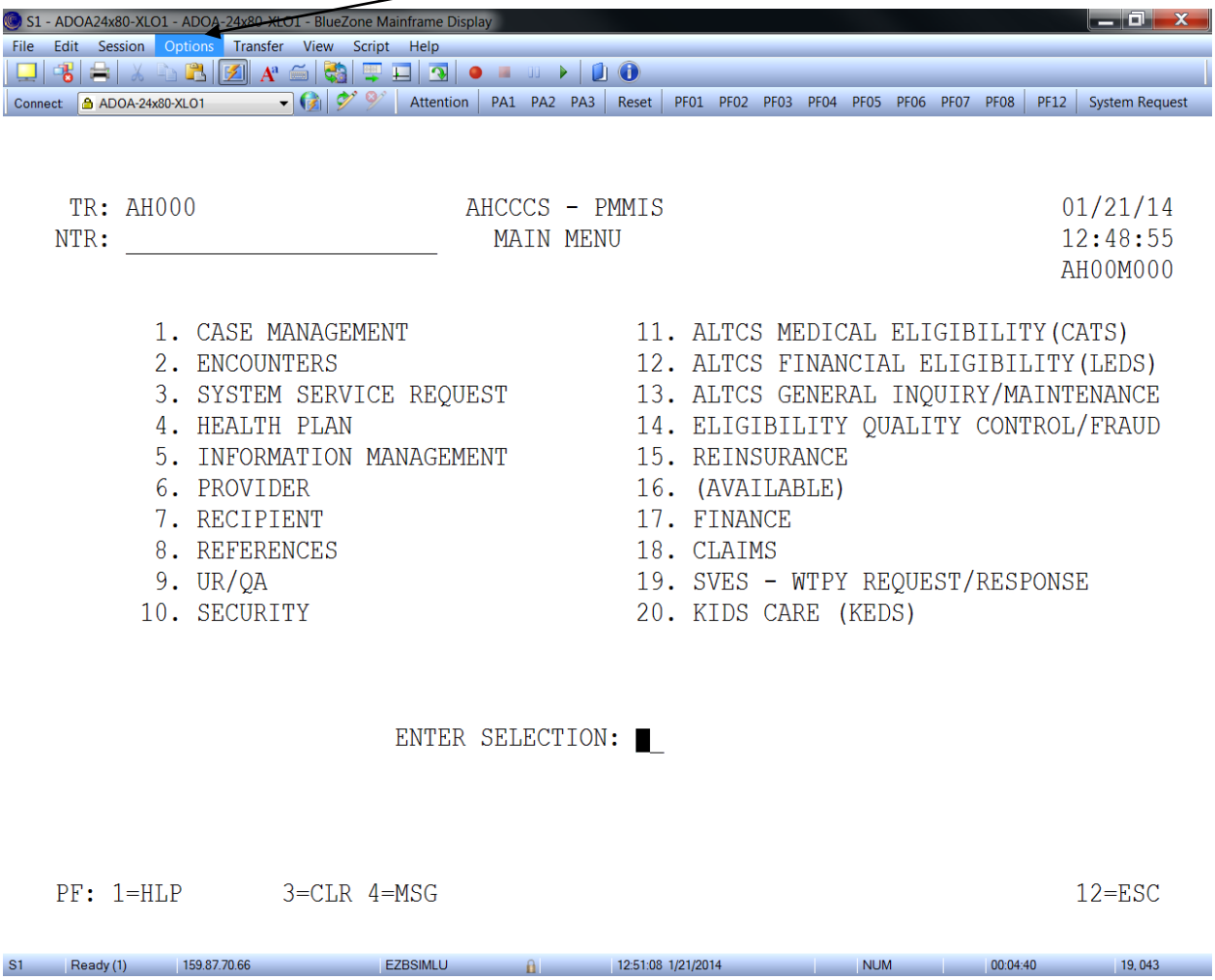
Menus and toolbar instructions differ with the various Windows releases/versions.

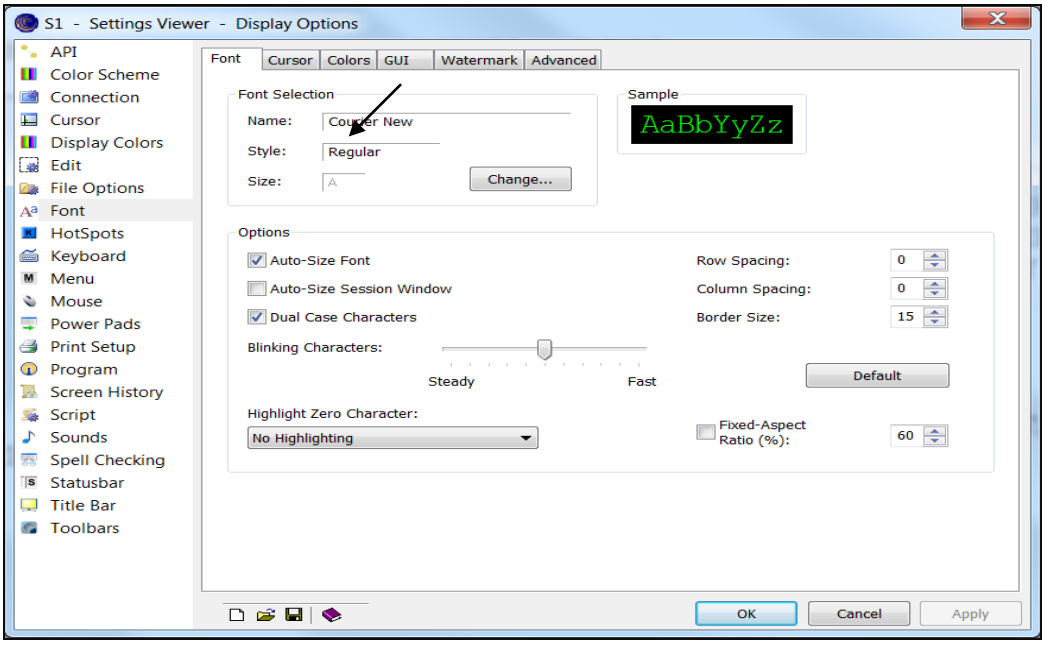
PMMIS routinely uses PF function keys 1-12 and in some instances 13-24. You will need to be sure at least 1-12 are mapped for your machine.

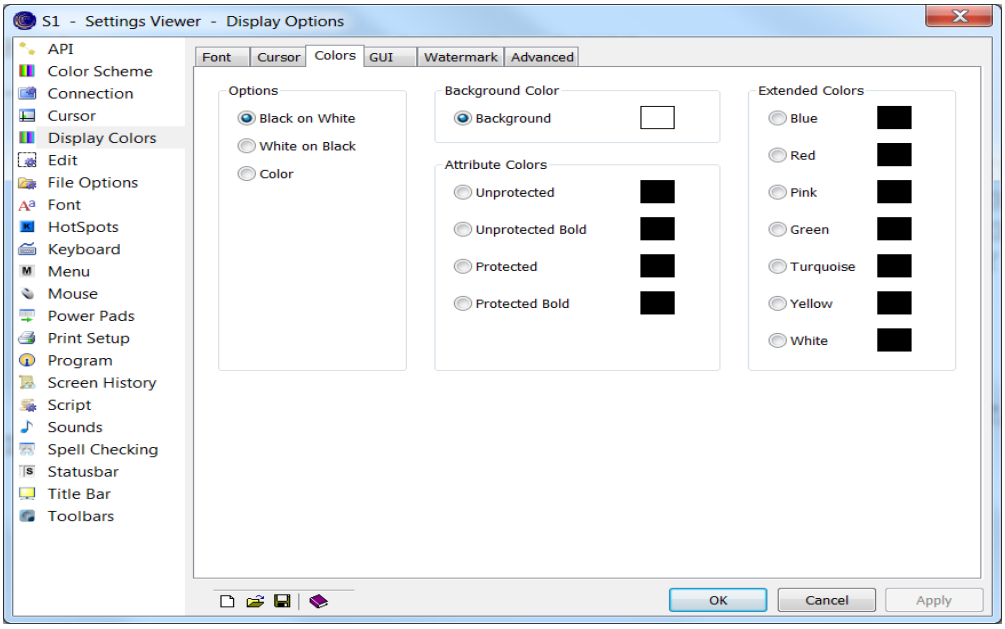
At the top of the PMMIS window is a menu bar and a toolbar.

Changing Colors:

To change background and foreground click on the “Options” menu and select “Colors”. The foreground color is the color of the text.




S1 - Settings Viewer - Display Options
API
Color Scheme
Connection
Cursor
Display Colors
Edit
File Options
Font
HotSpots
Keyboard
Menu
Mouse
Power Pads
Print Setup
Program
Screen History
Script
Sounds
Spell Checking
Statusbar
Title Bar
Toolbars
Font
Cursor
Colors
GUI
Watermark
Advanced
Font Selection
Name:
Courier New
Style:
Regular
Size:
Change...
Sample
AaBbYyZz
Options
Auto-Size Font
Auto-Size Session Window
Dual Case Characters
Blinking Characters:
Steady
Fast
Row Spacing:
Column Spacing:
Border Size:
Default
Highlight Zero Character:
No Highlighting
Fixed-Aspect Ratio (%):
OK
Cancel
Apply


S1 - Settings Viewer - Display Options
API
Color Scheme
Connection
Cursor
Display Colors
Edit
File Options
Font
HotSpots
Keyboard
Menu
Mouse
Power Pads
Print Setup
Program
Screen History
Script
Sounds
Spell Checking
Statusbar
Title Bar
Toolbars
Font
Cursor
Colors
GUI
Watermark
Advanced
Options
Black on White
White on Black
Color
Background Color
Background
Attribute Colors
Unprotected
Unprotected Bold
Protected
Protected Bold
Extended Colors
Blue
Red
Pink
Green
Turquoise
Yellow
White
OK
Cancel
Apply

Navigating PMMIS

There are two ways to navigate through PMMIS.

The First way is to enter the desired selection number in the “Enter Selection” field located near the bottom of each menu.

The Second method to navigate PMMIS is to utilize the “NTR” field at the top left of the screen. “NTR” (Next Transaction). This allows the user to enter a Transaction Number to directly travel to a specific screen rather than having to navigate through the menu structure, this is called transaction traveling.

The Home key will take you to the NTR field from anywhere on the screen. In the NTR field, key in the screen number (ex. “PR005” provider search screen) and press <Enter>.

Function Keys

Additional information may be available for each screen by using Function Keys. These function keys vary by screen.

Common Function Keys

Common PF Keys	Description
PF1=HLP	Contextual help. Returns one of two types of information. • Specific values allowed for one screen field from the Reference tables. • General information about a screen. Current help screen information is not always present or accurate. This manual should be used instead.
PF2=RTN	Return to the previous screen. Returns to one of two places: • If the current screen displayed was called from another program or menu, the user is returned to the calling program or menu. • Returns the user to the Tracking Main Menu
PF3=CLR	Clear Screen – Resets the entire screen back to the initial information shown when the user first entered the screen.
PF4=MSG	View the descriptions for each of the error message codes displayed
PF5=PREV PF6=NXT	Previous page in list Next page in list

PF7=UP PF8=DWN	Scroll up and down through the list
PF10=TOP PF11=DWN	Scroll to the top or bottom of the list
PF12=ESC	Escape – Return to the PMMIS Main Menu.

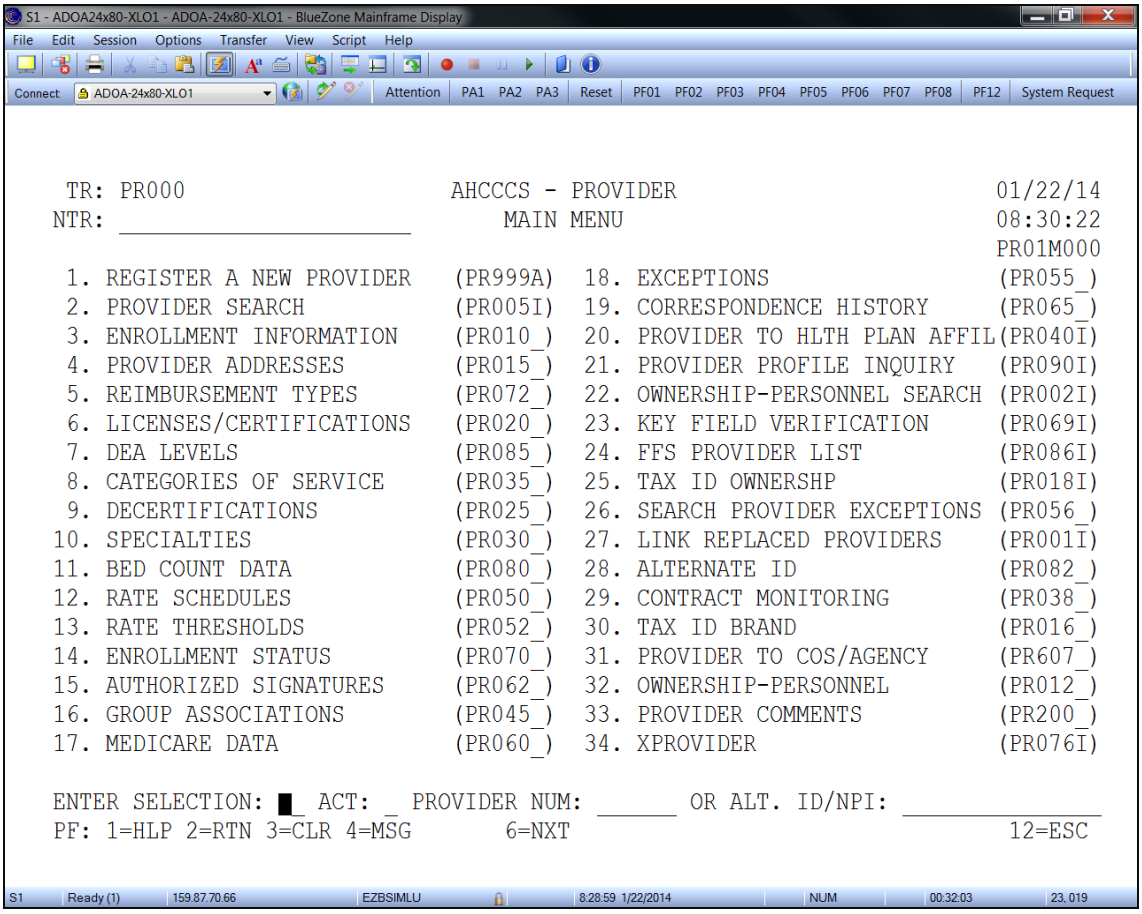
Provider Menu (PR000)

Introduction

This section documents some of the most frequently used Provider screens.

To access the Provider Menu from the Main Menu, either type a “6” into the “Enter Selection” field or type “PR000” into the “NTR” field and press <ENTER>.

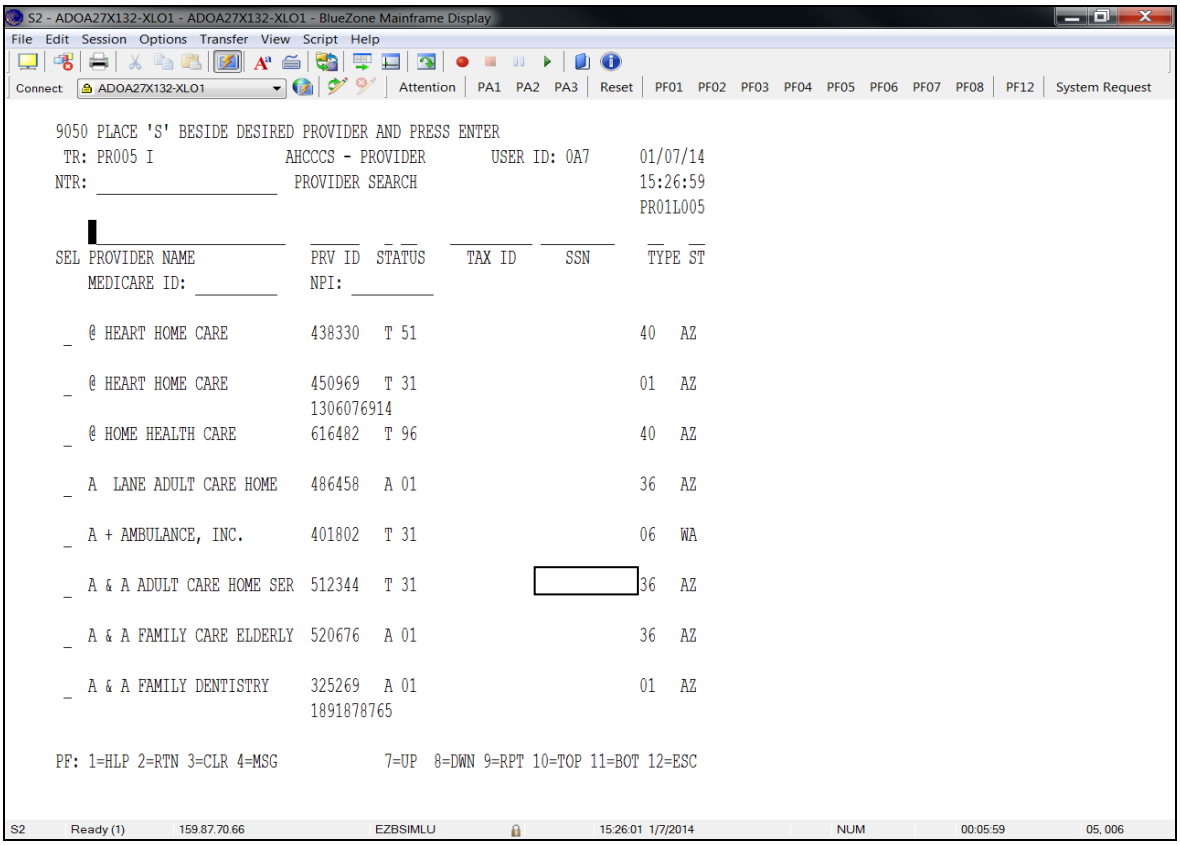
All provider subsystem screens begin with “PR” use PF6 to see additional screens listed.



Note: if you do not have access to a particular subsystem screen then you will get a return message like “ACCESS TO THE REQUESTED TRANSACTION IS DENIED”.

Provider Search (PR005I, or Selection #2)

The Provider Search screen is used to find a provider's AHCCCS identification number. This number will be used for all other transactions in the Provider subsystem.



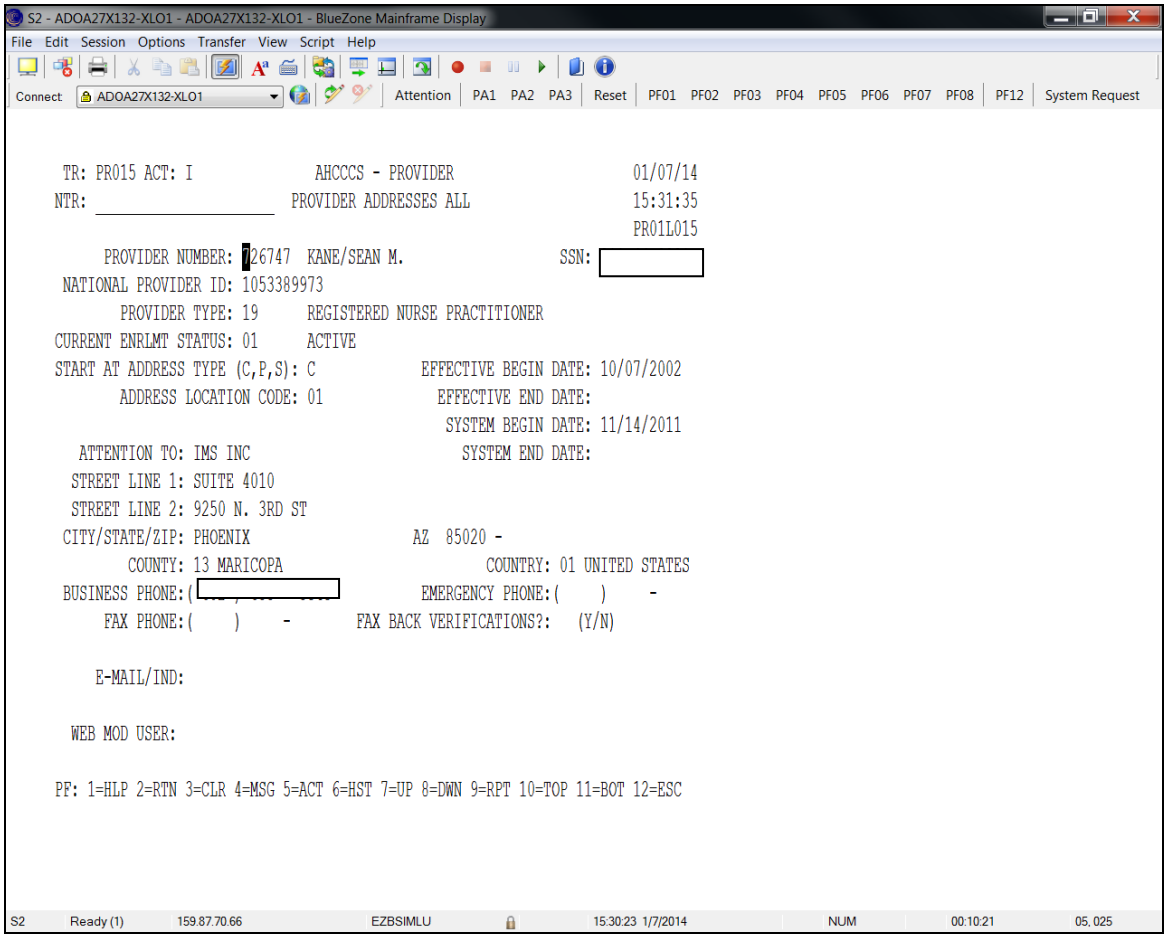
To perform a provider search, enter the provider's name, the beginning of the provider's name, NPI, and/or AHCCCS "legacy" ID.

In addition to searching using the provider's full or partial name, you can filter the results further by adding the provider type. If the provider type is unknown, move the cursor to the "TYPE" field and press <F1>. All of the provider types will then be listed for you to select one. Find the type that you want and enter an "S" into the "SEL" field and press <ENTER>. The Provider Search screen is now populated with the Provider Type selection. Complete the desired search criteria and press <Enter> for the results to be displayed.

To select the provider, put an "S" in the "SEL" Column and press <Enter>, which routes to the Provider Addresses screen.

Provider Addresses (PR015 or selection #4)

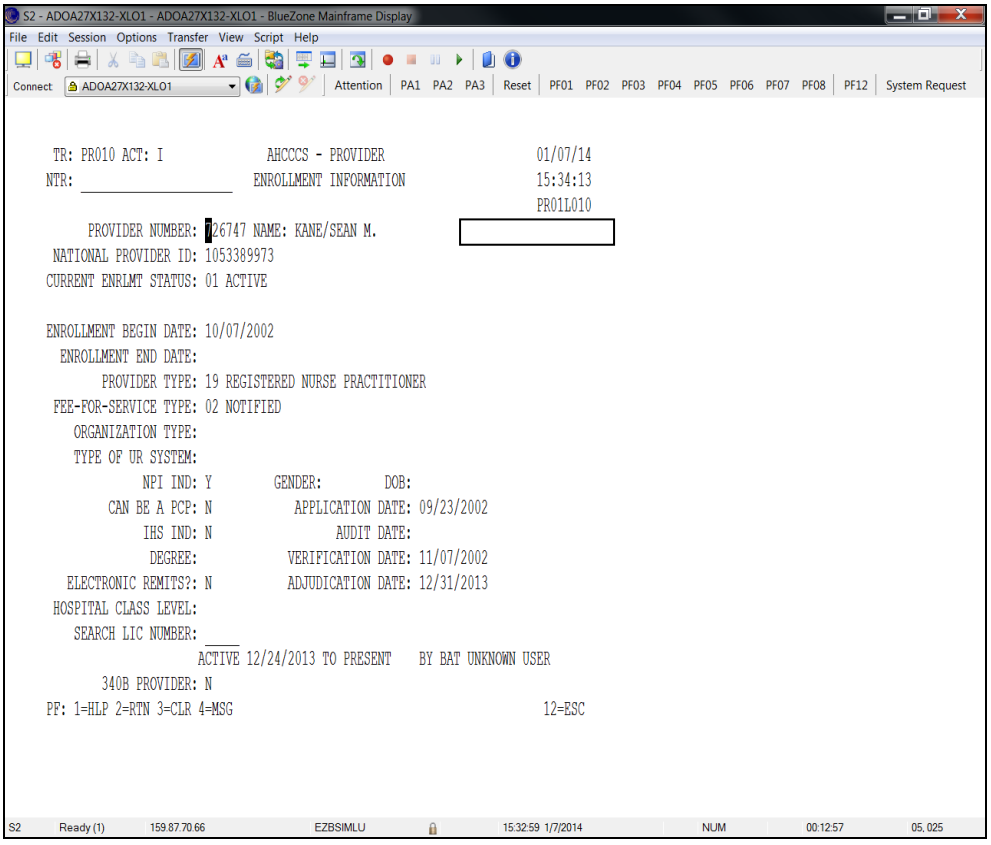
The Provider Addresses screen will indicate the three different provider address types: C=Correspondence, P=Pay to, and S=Servicing. The different addresses can be accessed by pressing <F8> and <F7> to scroll through the list. In addition, this screen can be used to view the NPI number used by the provider.



Provider Enrollment Information (PR010 or selection #3)

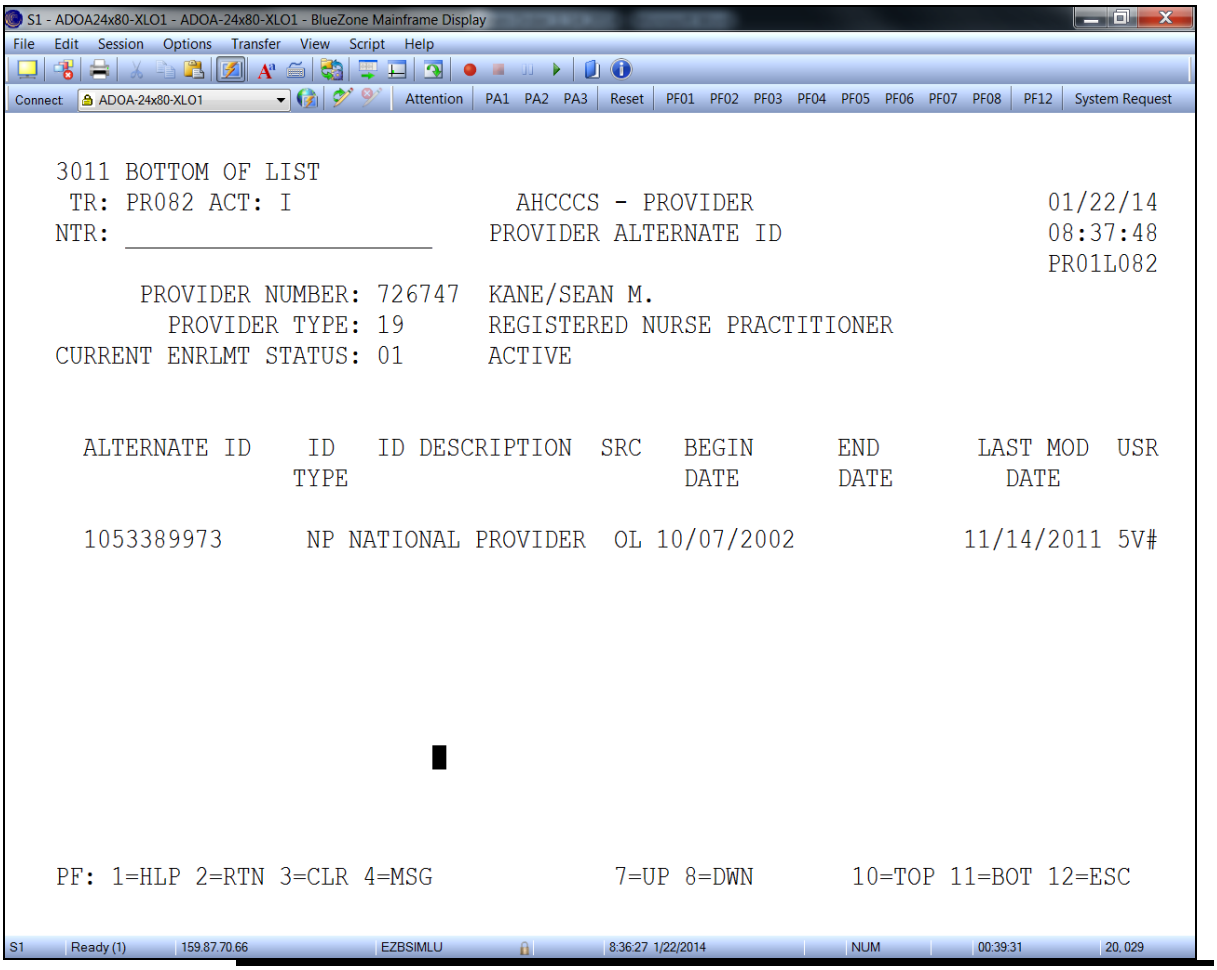
This screen will be the resource for detailed provider enrollment information such as:

- Enrollment begin and end date
- Provider type
- Current enrollment status



Provider Alternate ID. (PR082 or selection #28)

This screen provides other ID numbers associated with this provider including NPI and end dated AHCCCS provider ID numbers.

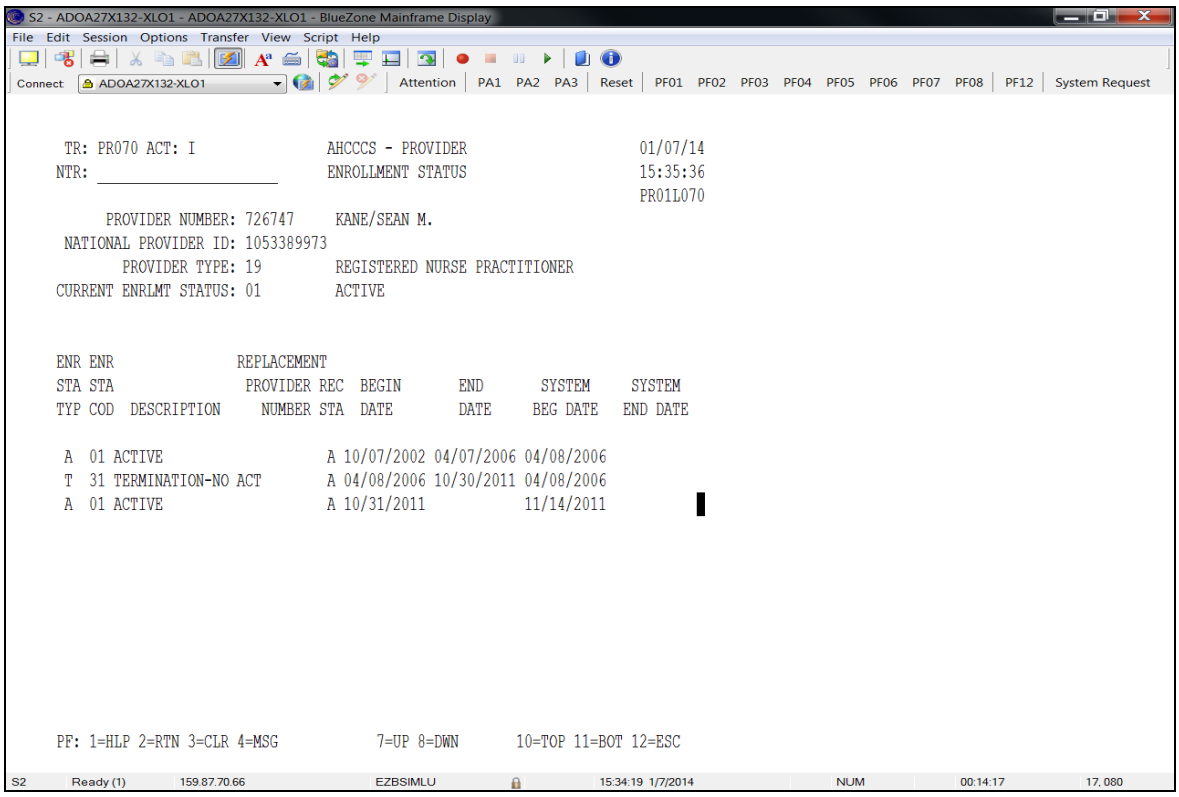


Contractors might use these previous screen's information to address Encounter Pend Error Codes associated with Provider including:

H030 – Referring provider NPI is Invalid
P295 - Service Provider Terminated
Z165 - Service Provider ID Not on File

Enrollment Status (PR070 or selection #14)

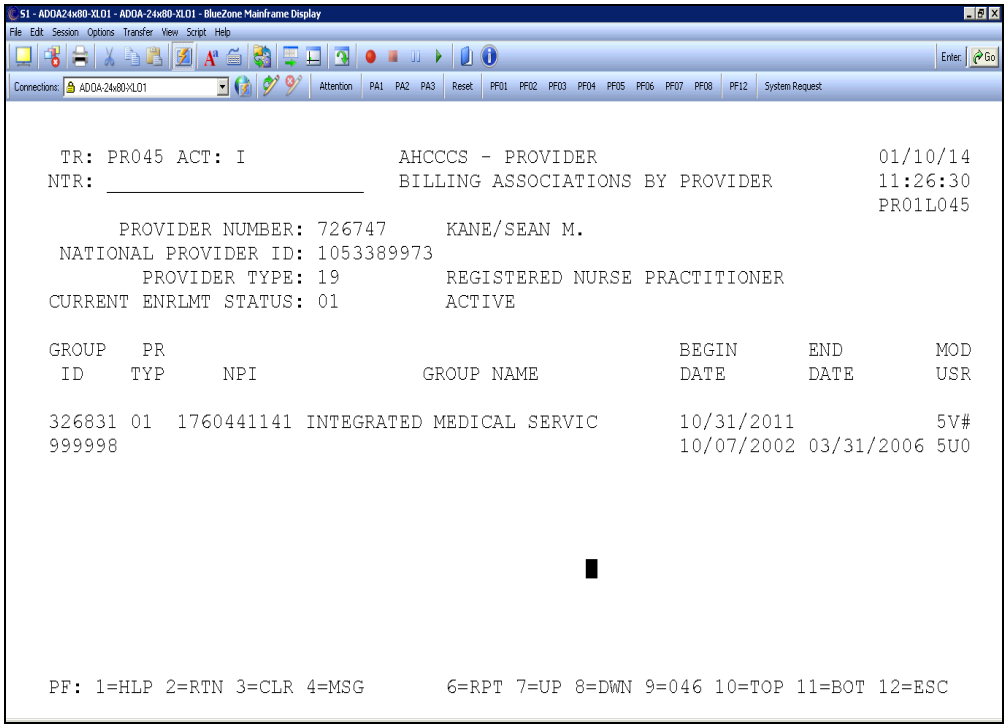
This status screen contains tracks changes in a provider's enrollment status. The enrollment status code and enrollment status segment begin and end dates below are illustrative of a provider who had a gap in AHCCCS enrollment.



This screen is useful for pends related to provider not enrolled on DOS.

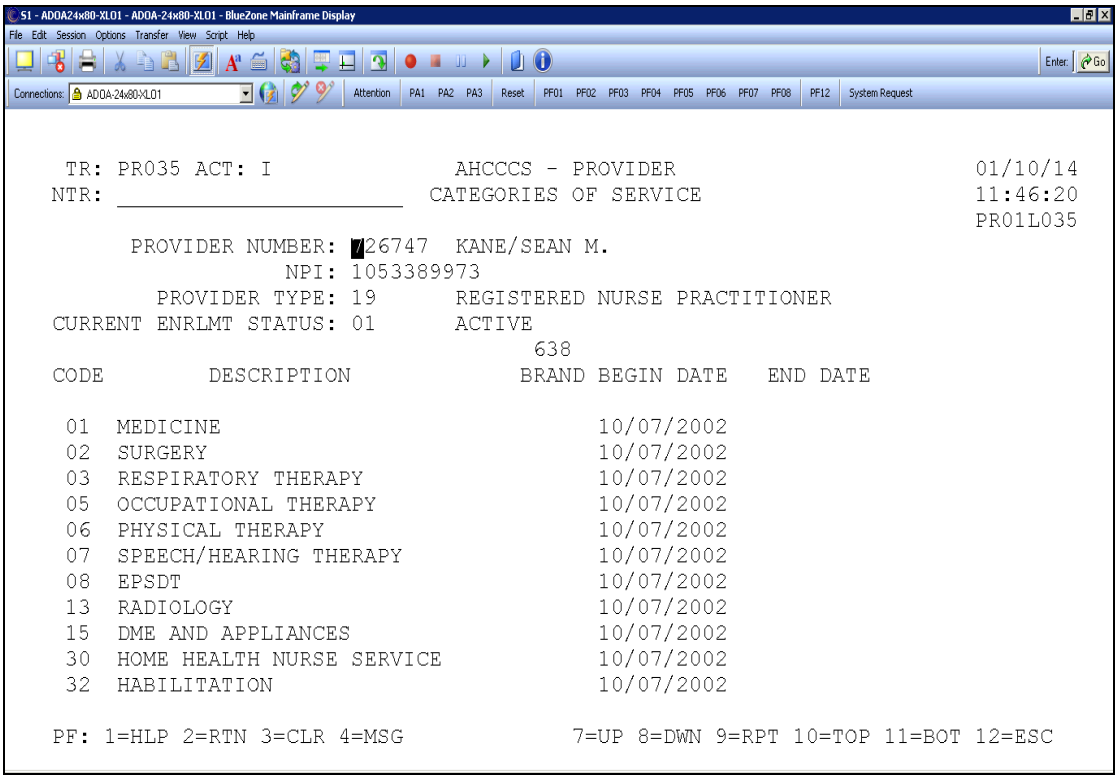
Group Association (PR045 or selection #16)

The Group Associations screen displays all affiliations listed for a specific provider and the date ranges of those affiliations. Possible affiliations include groups, hospitals, clinics, etc. that are permitted to bill and be reimbursed for the service provider.



Category of Service (COS) (PR035 or selection #8)

All procedure codes billable to AHCCCS are classified into a specific Category of Service. A provider must have the corresponding Category of Service code(s) on his/her file to bill for the service. This screen will list all the Categories of Service available to the provider.



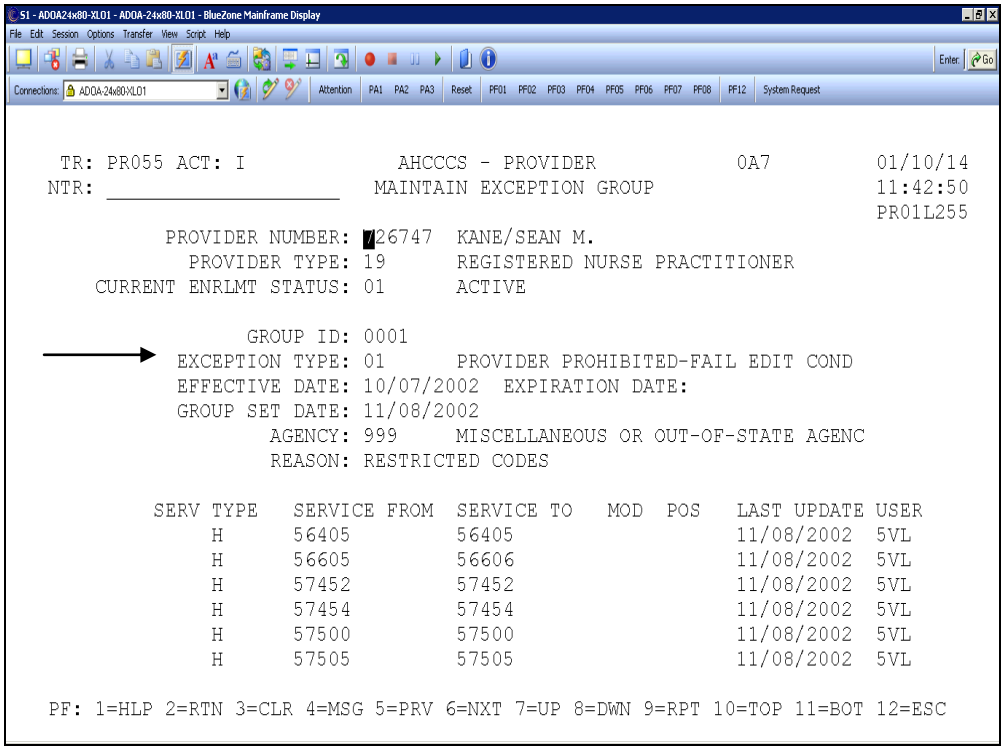
Exceptions (PR055 or selection #18)

From time-to-time, restrictions (on a procedure by procedure basis) can be placed on a provider. For example, Exception type: 01, “Provider Prohibited” – this could be due to the providers education level or the Medical Board of Examiners could place restrictions on a provider due to complaints, etc.

There are also instances when exceptions can be added for a particular provider rather than add to an entire provider type. Exception Type: 04. This screen will be the resource to find that information:

Exception Type: 01

If the provider is on review
If specific codes cannot be billed

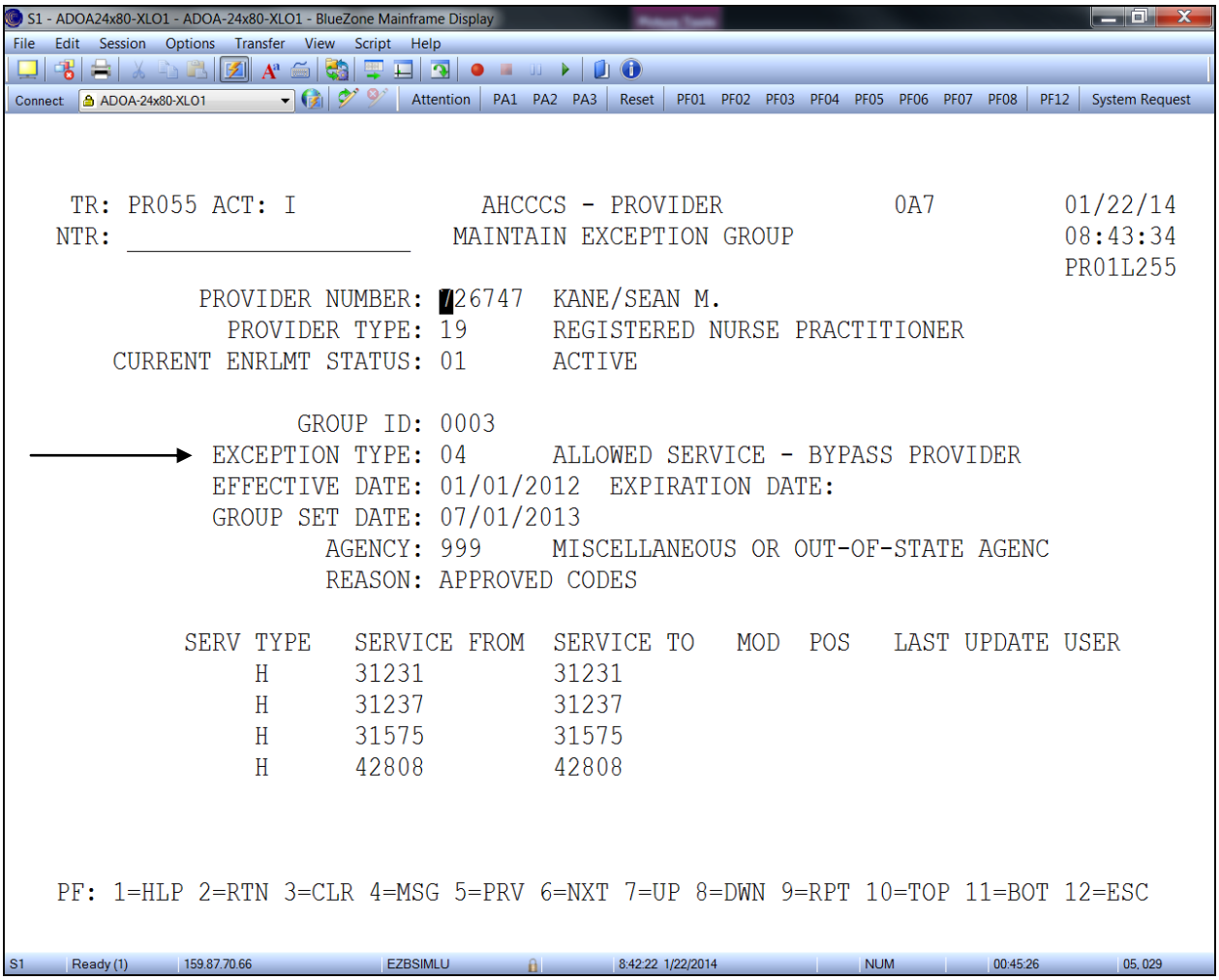


Researching for restrictions can assist in resolving encounter pends like Provider not eligible for COS on date of service P330 and the various P47X pended encounters.

Exceptions (PR055) continued

Exception Type: 04

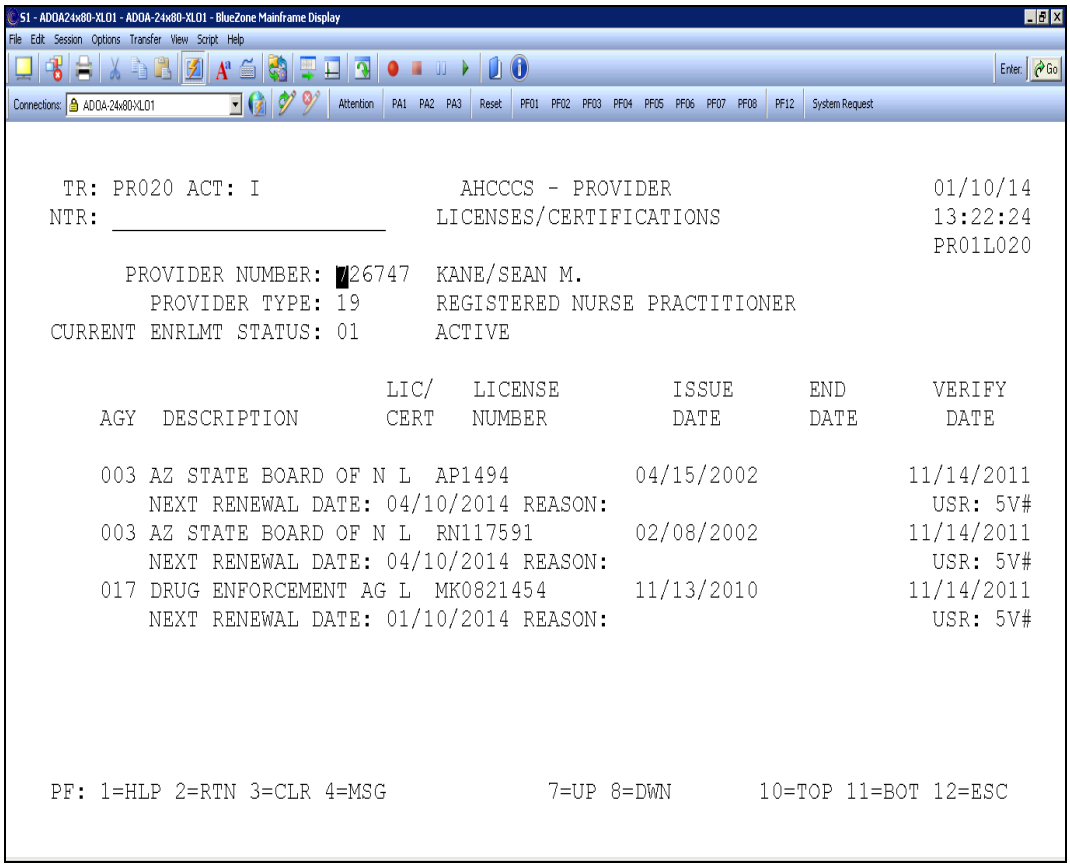
This is used when an individual provider is allowed to provide and bill for services that are typically not permitted for their Provider Type.



Contractors have to provide AHCCCS with documentation for review by AHCCCS Medical Management justifying additional codes.

Licenses & Certifications (PR020 or selection #6)

This screen identifies any licenses/certifications held by the provider to include the issue and end dates. It also provides a description of the license and the date it was verified by AHCCCS.



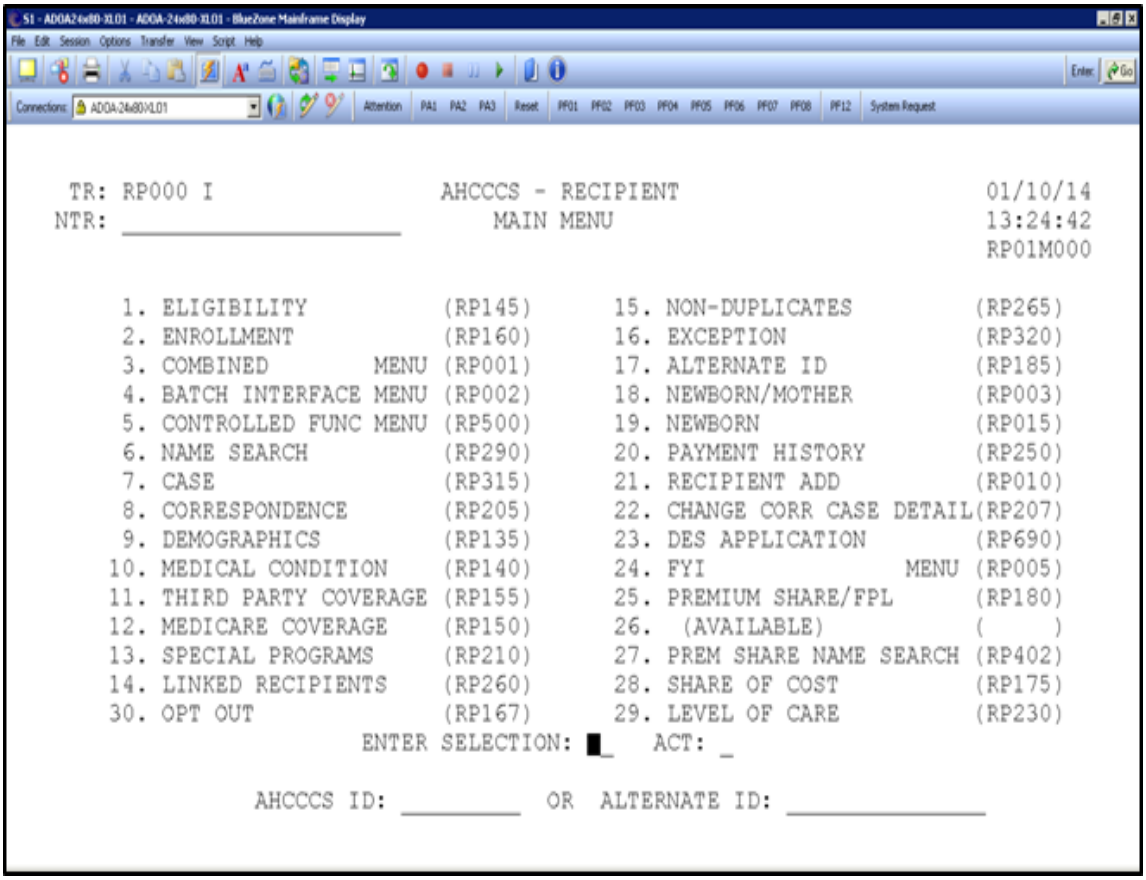
Recipient Section

Introduction

Recipient is the term used in PMMIS for those individuals who have been enrolled or are currently Title XIX/XXI AHCCCS eligible. Recipients may also be known as members.

To access the Recipient Menu from the Main Menu, either type a “7” into the “Enter Selection” field or type “RP000” into the “NTR” field and press <ENTER>.

Recipient Menu



The Recipient section includes all AHCCCS recipients – past and present. These screens provide additional details regarding the recipient.

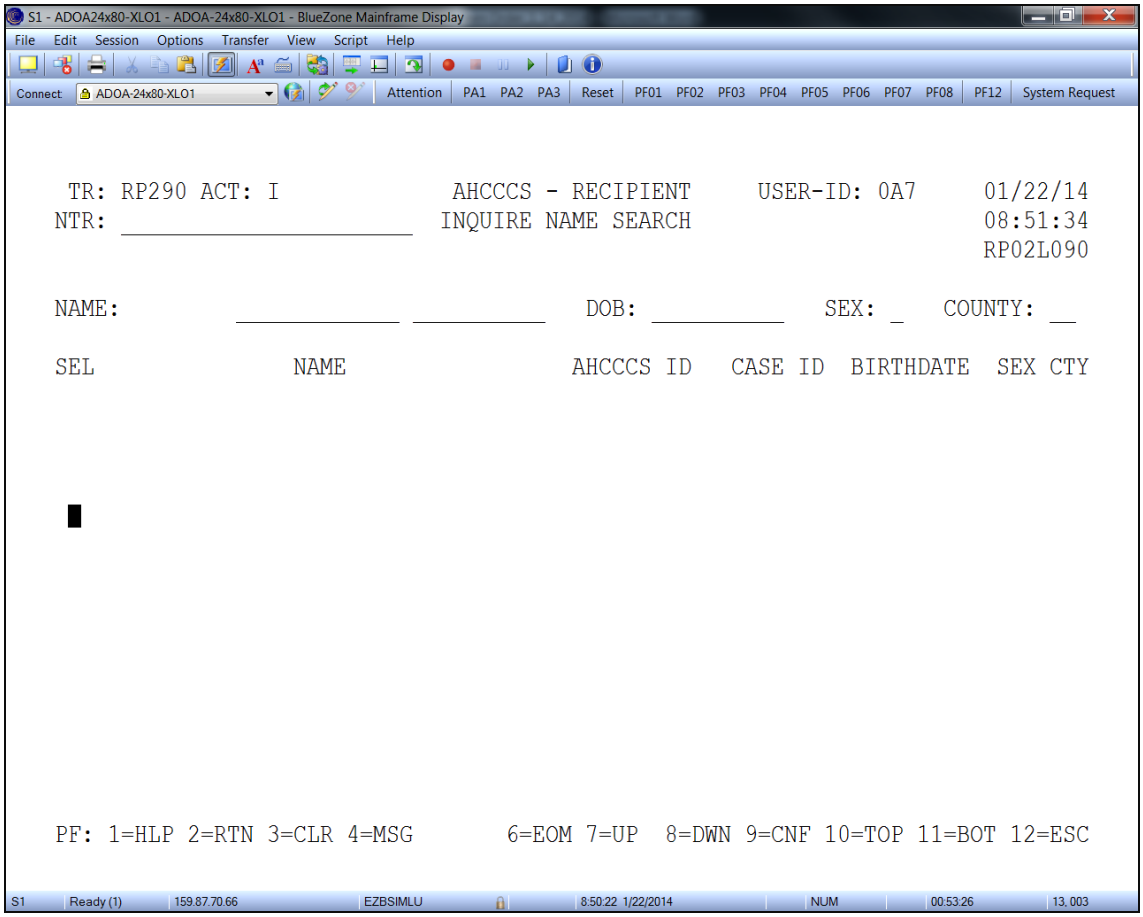
The most commonly used recipient screens are:

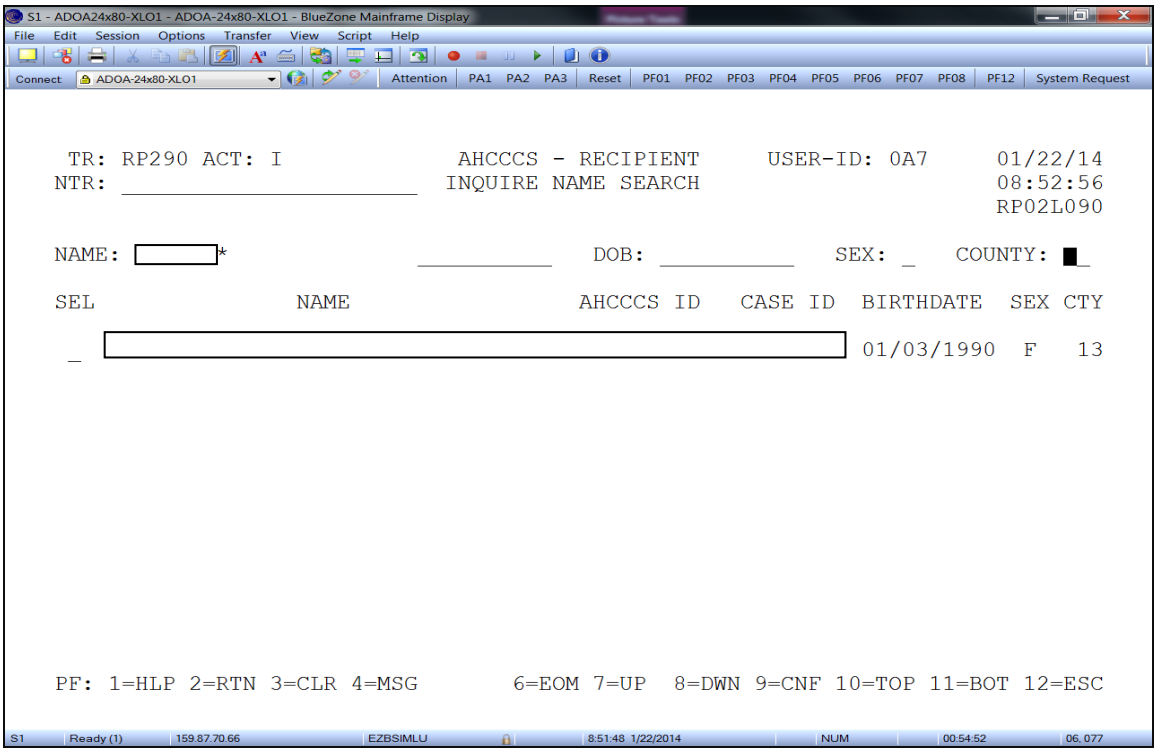
- Name Search (RP290)
- Demographics (RP135)
- Combined Eligibility/Enrollment (RP285)
- Eligibility (RP145)
- Enrollment (RP160)
- CRS Enrollment (RP215)
- BHS Enrollment (RP216)
- Third Party Coverage (RP155)
- Medicare Coverage (RP150)

Data in the following sections will be presented to specific plans in training and represent their enrolled members.

Name Search (RP290 or selection #6)

On this screen, a recipient's name can be entered in order to obtain the AHCCCS ID number. The AHCCCS ID number will be used throughout the rest of the recipient PMMIS screens to access information.





Enter the recipient's last name, press <Tab>, and then enter the recipient's first name (or first initial if the full name is not known). To decrease the number of search results, enter a date of birth, gender, and/or county of residence.

A partial last name may be entered with a wildcard (*) if you are unsure of the spelling. For example, if unsure if the name is Frankenstein or Frankenstien, enter Frankenst*, and the system will list all recipients whose last names begin with Frankenst, and will include either spelling. The wildcard (*) may not be used on the first name.

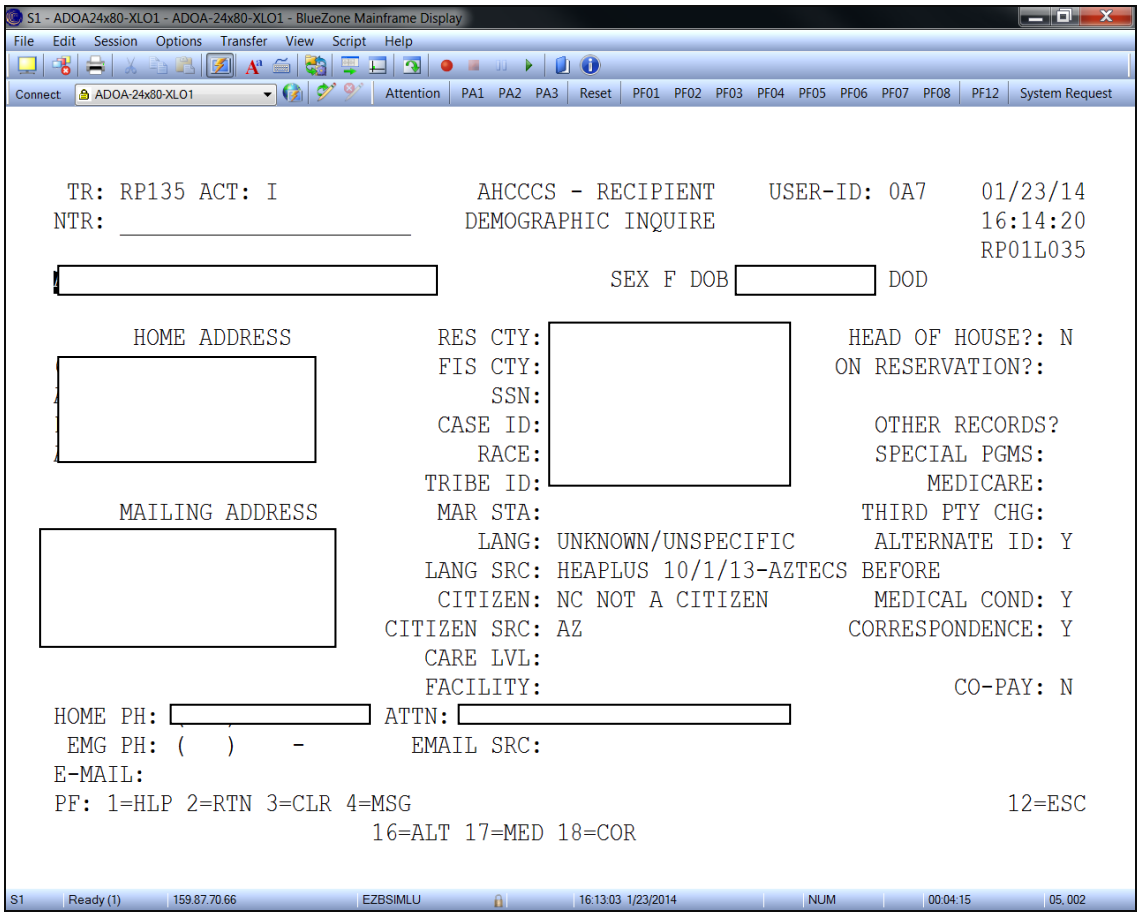
A search can be conducted only by using the first, last name, or date of birth (DOB).

If the search returns several recipients that meet the search criteria, enter an "S" into the "SEL" field and press <F9> to view the selected recipient's demographics. Press <F2> to go back to the RP290 screen. If F9 is not available then hit enter and go to RP135.

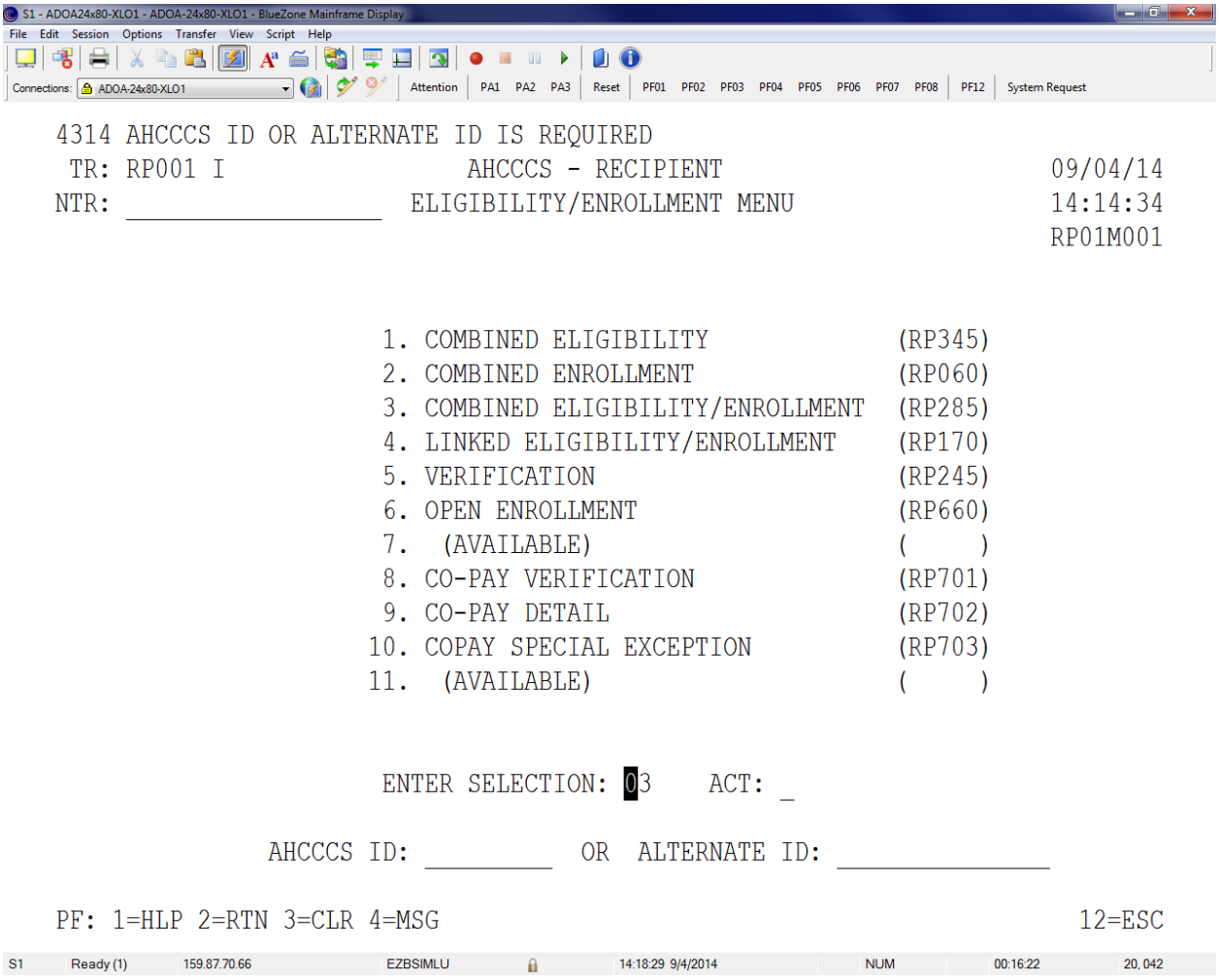
Demographics (RP135 or selection #9)

Included in the basic demographic information:

- Recipient Address
- Household information
- Background

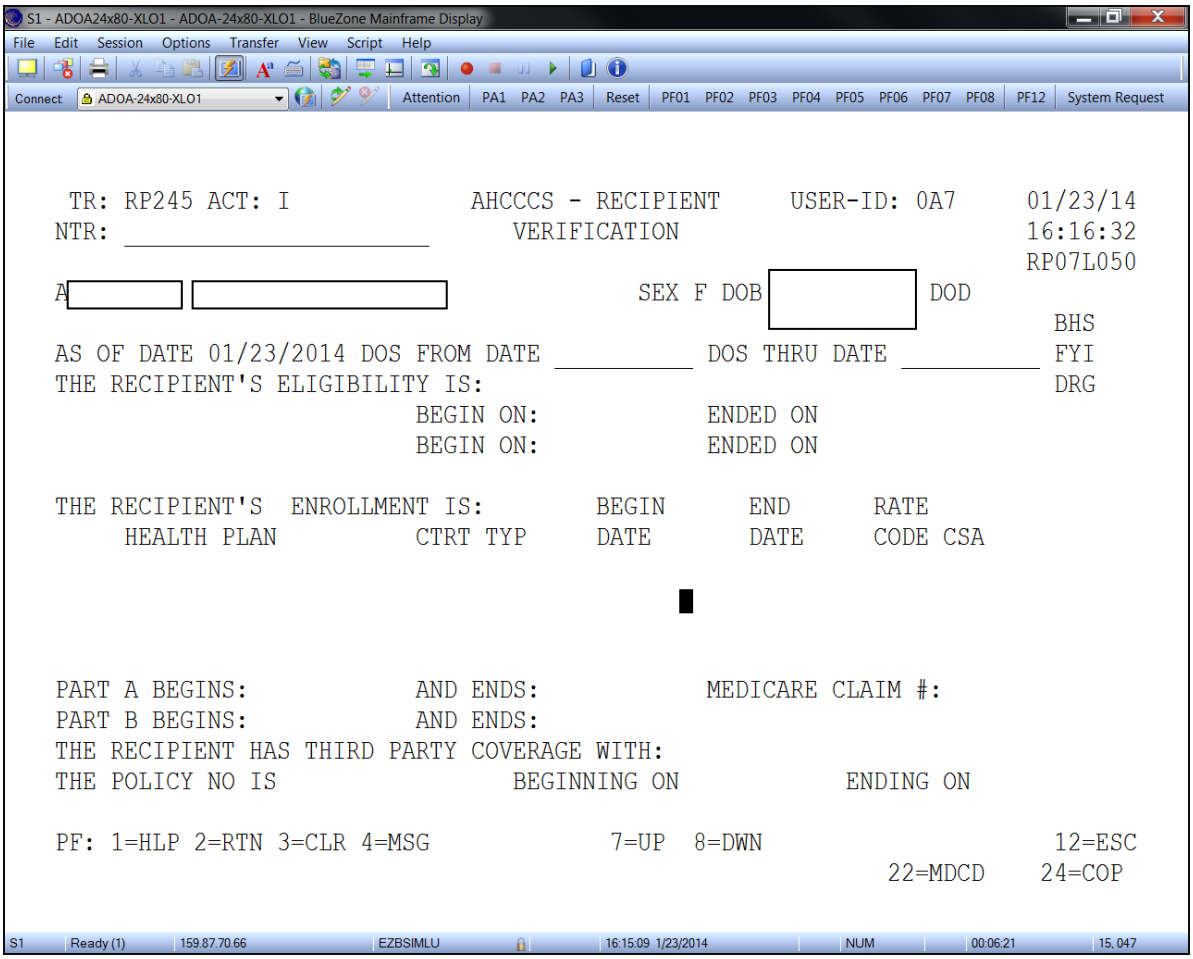


Combined Eligibility/Enrollment (RP001 or selection #3)



AHCCCS Recipient Verification (RP245 or selection RP001 #5)

This screen enables a fast verification of eligibility, enrollment, Medicare, and third party coverage after entering the recipient's AHCCCS ID. Enter the DOS in question and press <ENTER> for the information to populate.

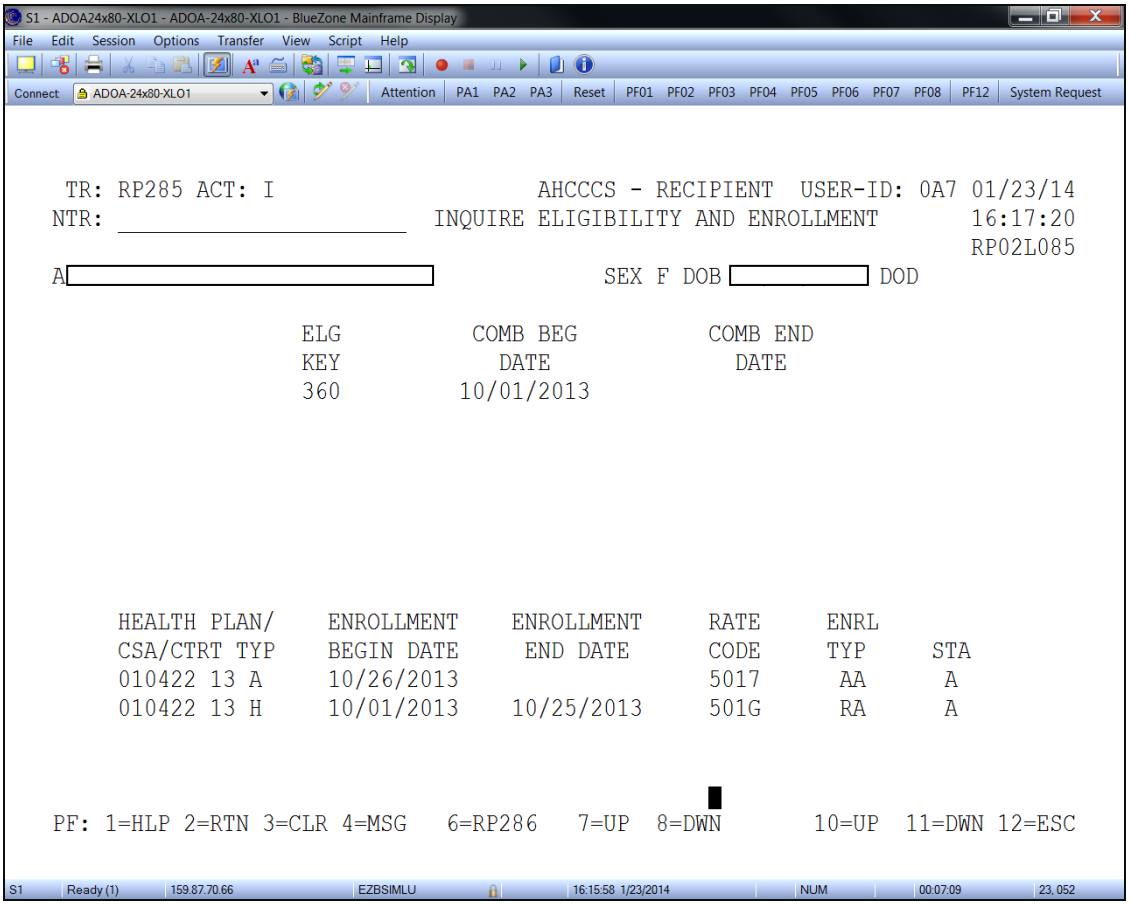


The same information can be obtained but with different layouts on the following screens: RP245 & RP160; RP145 and RP285.

Error Codes – RXX Recipient ineligible/not eligible on DOS pend edit errors

Combined Eligibility/Enrollment (RP285 or RP001 #3)

This screen will display both the AHCCCS eligibility and enrollment for the specified recipient. Function keys <F7> and <F8> will scroll forward and backward through eligibility segments. <F10> and <F11> will scroll forward and backward through the enrollment segments.



Eligibility information available on this screen includes:

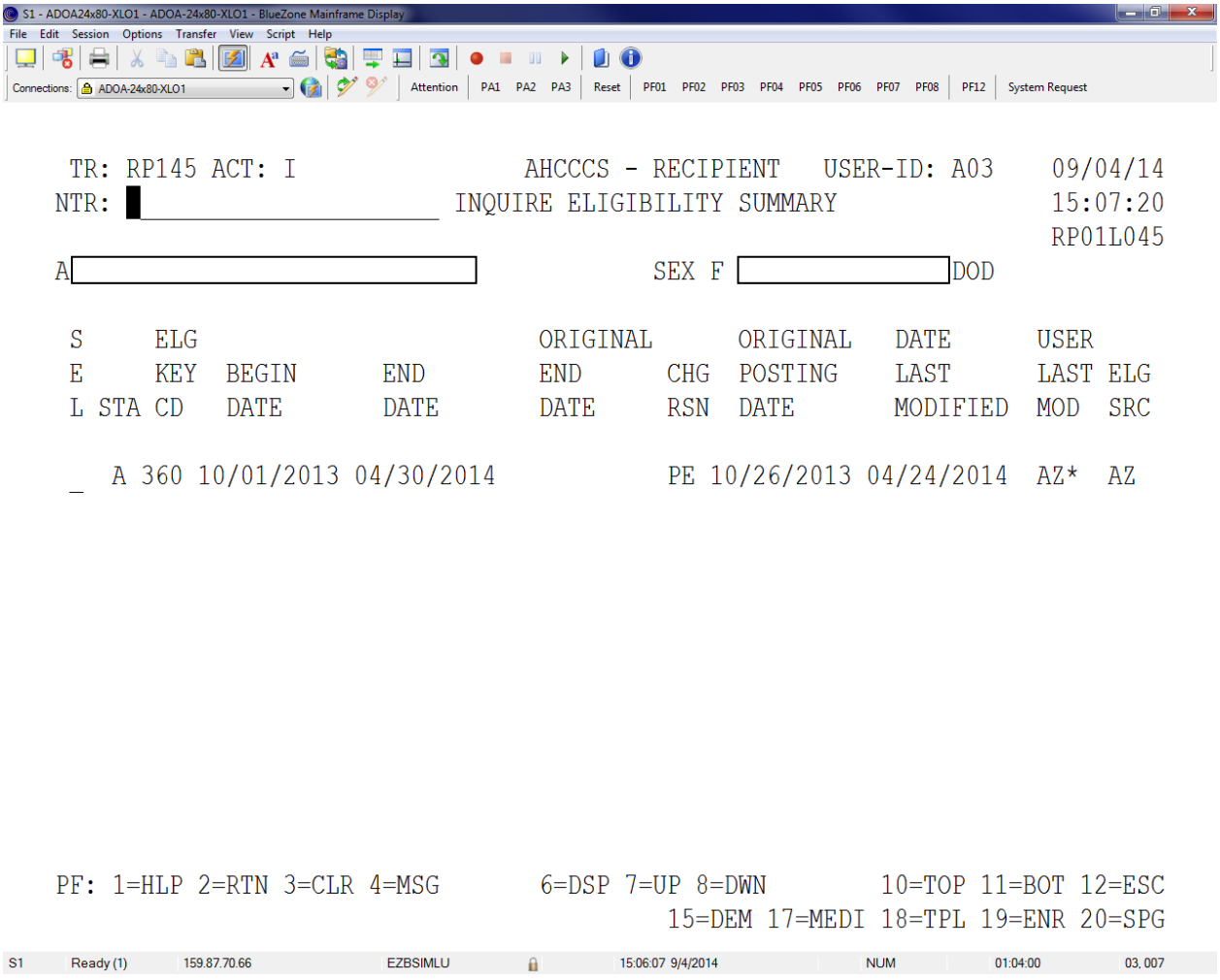
- Eligibility Key Code (RF534)
- AHCCCS Eligible Begin Date
- AHCCCS Eligible End Date

Enrollment information includes:

- Health Plan Number (RF770)
- Contract Service Area (CSA) AKA GSA Geographic Service Area (RF019)
- Contract Type (RF410)
- Health Plan Enrollment Begin Date
- Health Plan Enrollment End Date
- Rate Code (RF412)
- Enrollment Type (RF513)

Eligibility (RP145), continued

This screen will display all eligibility segments for a selected recipient. Type in the AHCCCS ID and press <Enter>. Pressing the <F6> key will remove the inactive segments and only display the active segments. To scroll through segment press <F8> to go down and <F7> to go back up.



Additional Information:

- Status A=Active, T=Terminated
- Eligibility Key Code (RF538)
- AHCCCS Eligibility Begin Date
- AHCCCS Eligibility End Date
- Change Reason (RF525)

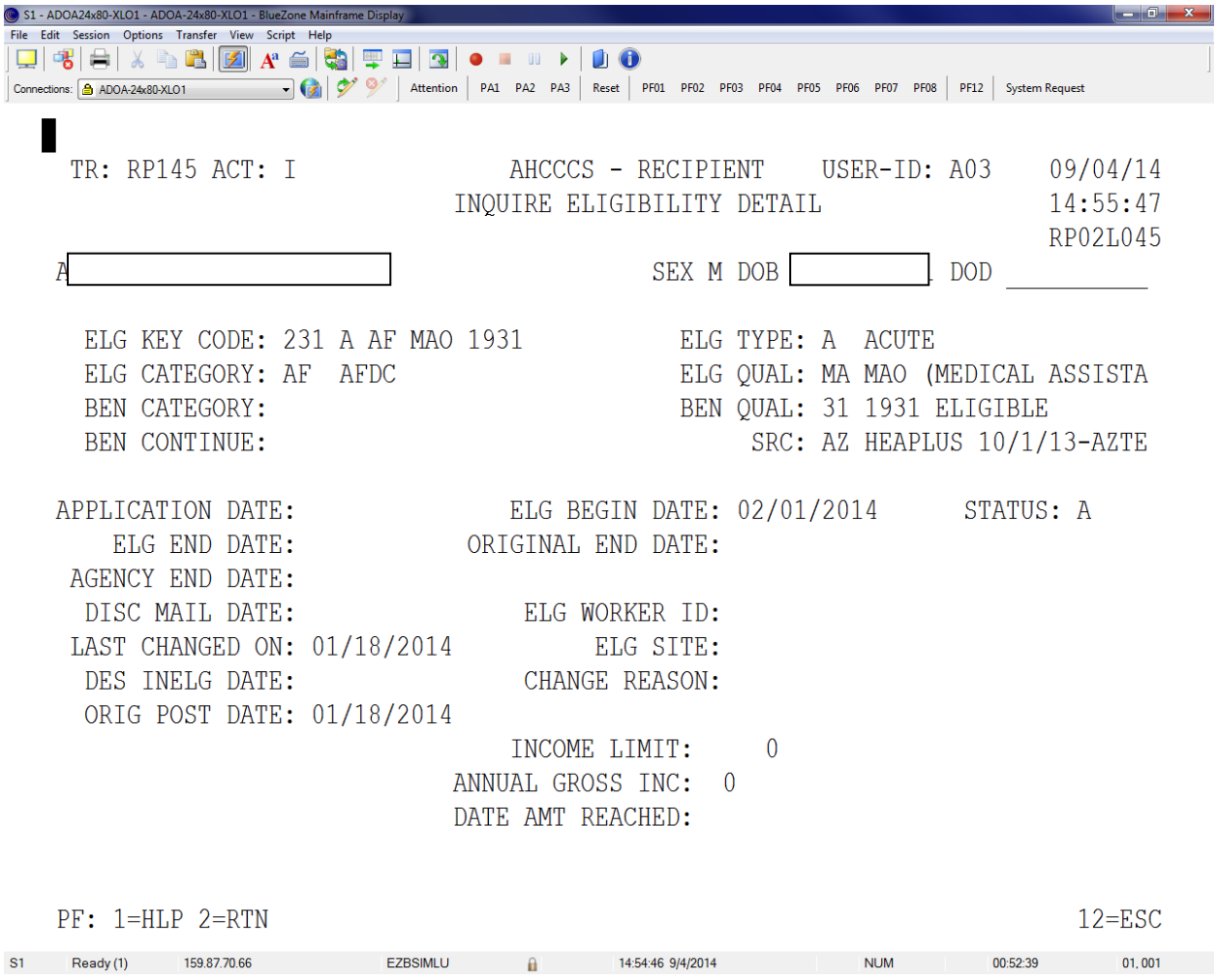
Two active segments may cover the same dates and have two different eligibility key codes. When this occurs, the reference screen (RP285) will indicate which key code takes precedence.

To view detailed information about a selected segment of eligibility, type an ”S” into the “SEL” field and press <Enter>, then press <F2> to return to the RP145 screen.

Included in the detailed information:

- Eligibility Key Code/Description (RF538)
- Eligibility Category (RF509)
- Eligibility Type (RF537)
- Eligibility Qualifier (RF510)

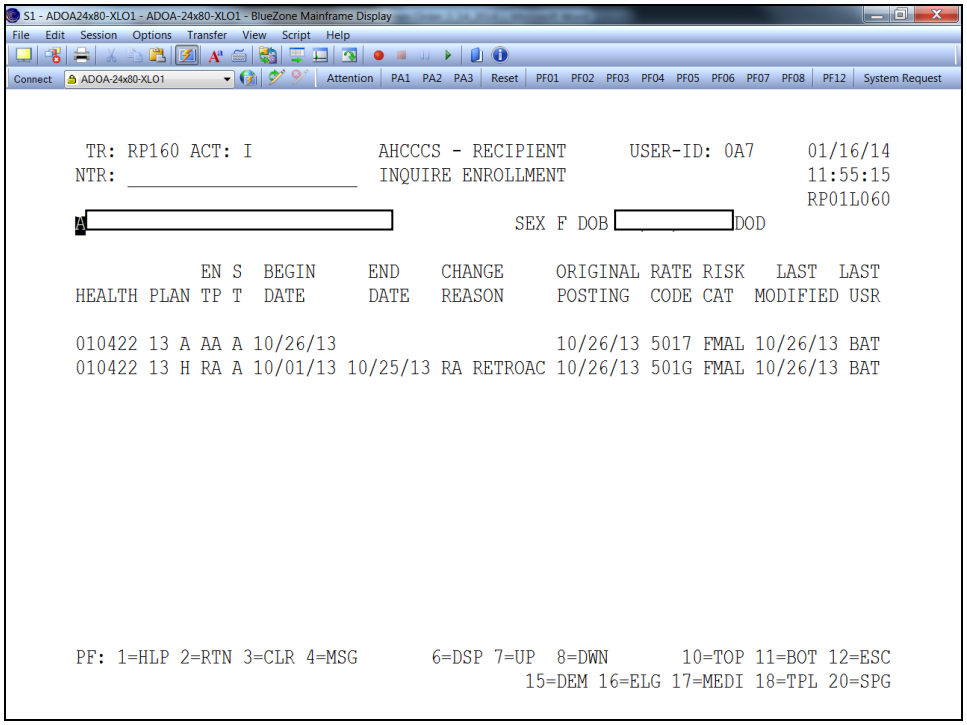
Status A=Active, T=Terminated



Enrollment (RP160 or selection #2)

The enrollment screen shows what health plan the recipient is/was enrolled in. The health plan information shown is:

- Health Plan (RF770)
- Enrollment Type (RF513)
- Status (ST)
    - A=Active, T=Terminated
- Health Plan Enrollment Begin Date
- Health Plan Enrollment End Date
- Change Reason (RF525)
- Original Posting Date
- Rate Code (RF412)
- Last Modified Date



This screen is used to research a recipient's enrollment status. The two most important fields to look at when researching enrollment is Change Reason (RF525) and Last Modified.

This screen (RP160) is used in conjunction with RP215 to determine CRS eligibility.

Error Code: R350 – Date of Death Prior to DOS

Medicare Coverage (RP150 or selection #12)

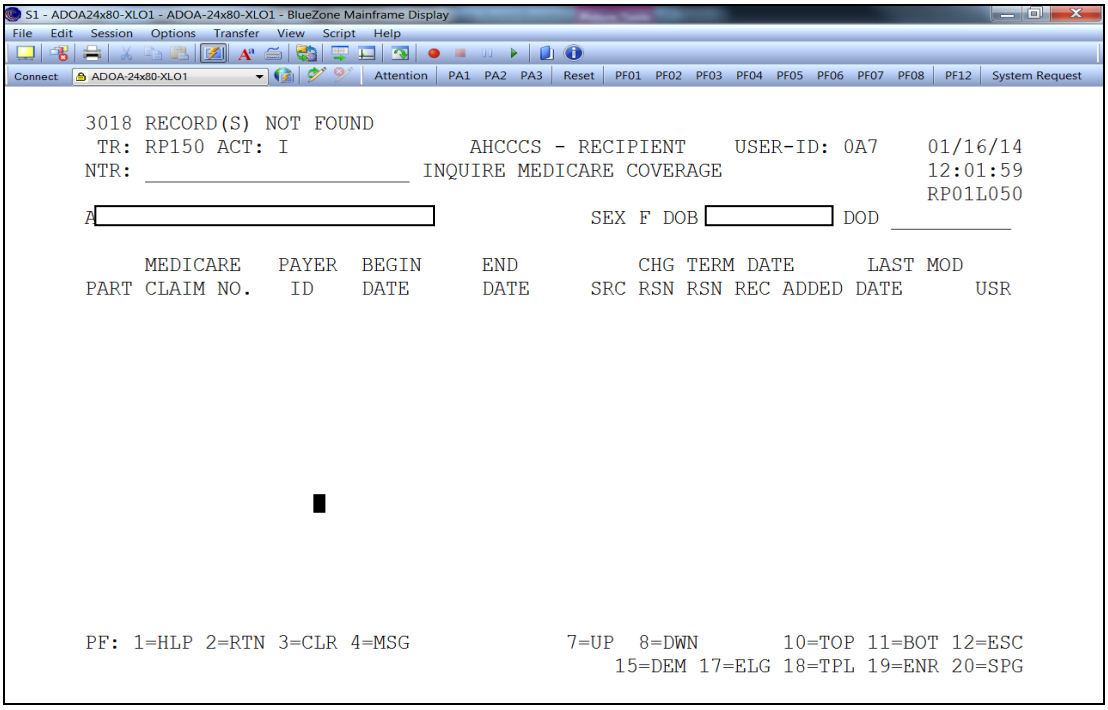
Coverage through AHCCCS is secondary to Medicare coverage. This means if a recipient has Medicare the claims must be submitted to Medicare first. After Medicare has done its part, the encounter can be submitted to AHCCCS along with the Medicare payment information. The parts of Medicare you should be aware of are:

Medicare Part A – (Hospital insurance) if the recipient has Medicare Part A, Professional and Outpatient Hospital encounters/claims submitted to AHCCCS for dates of service covered must include Medicare payment information. Part A covers Inpatient - IP services (IP Hospital, SNF, Home Health and Hospice) only.

Medicare Part B – (Medical insurance) If the recipient has Medicare Part B, Outpatient-OP Hospital encounters/claims submitted to AHCCCS for dates of service covered must include Medicare payment information. Part B covers doctors, OP Hospital, preventive care, DME, lab, radiology, ambulance, etc.

Medicare Part C – (Medicare Advantage Plan)-MAP-D is available in many areas. People with Medicare Parts A and B can choose to receive all of their health care services through a Medicare licensed provider organization. This includes the Medicare Drug benefit

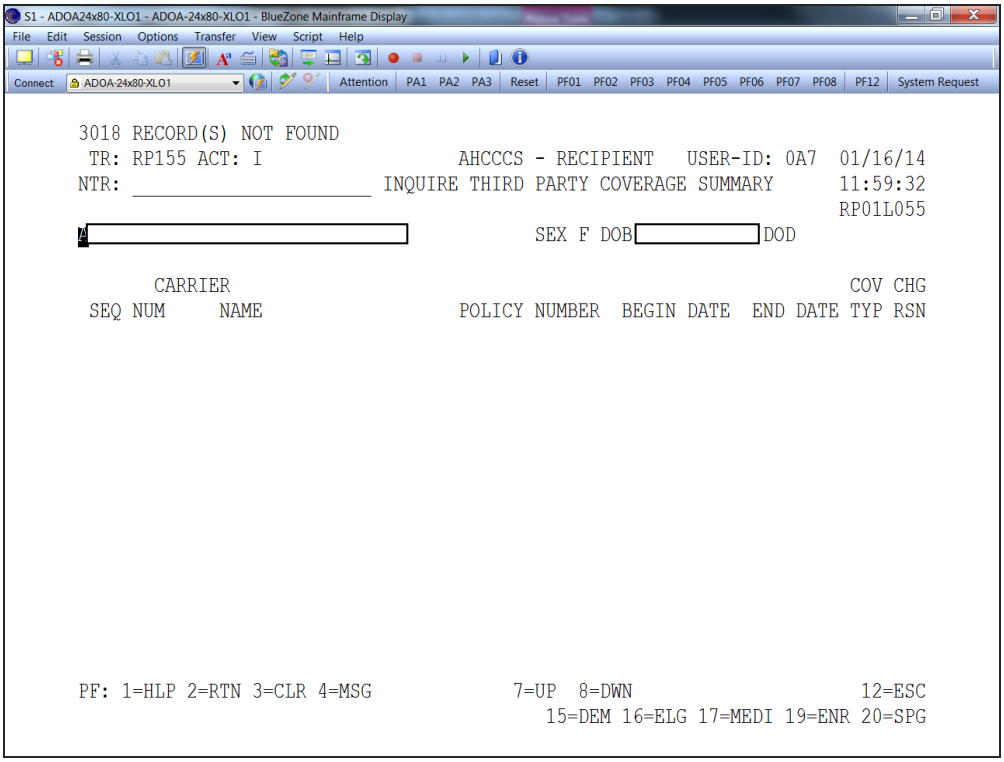
Medicare Part D – (Prescription drug coverage only) if the recipient has Medicare Part D, Pharmacy encounters/claims submitted to AHCCCS for dates of service covered must include Medicare payment information.



Error Code R600 – Medicare coverage indicated But Not Billed

Third Party Coverage (RP155 or selection #11)

This screen will indicate if the recipient has any other coverage from a third party (i.e. commercial insurance (including commercial Medicare Supplemental policies). If there is a carrier listed on this screen, encounters/claims submitted to AHCCCS for dates of service covered must include third party payment information.



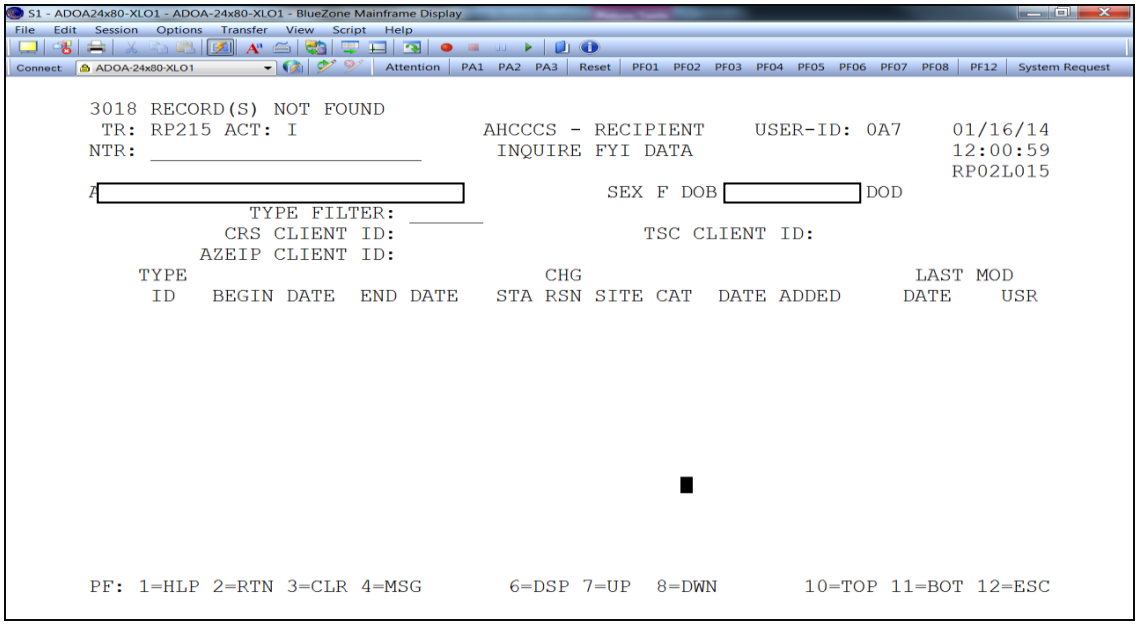
If the recipient has third party insurance this screen will display:

- Carrier Name
- Policy Number
- Coverage Begin Date
- Coverage End Date

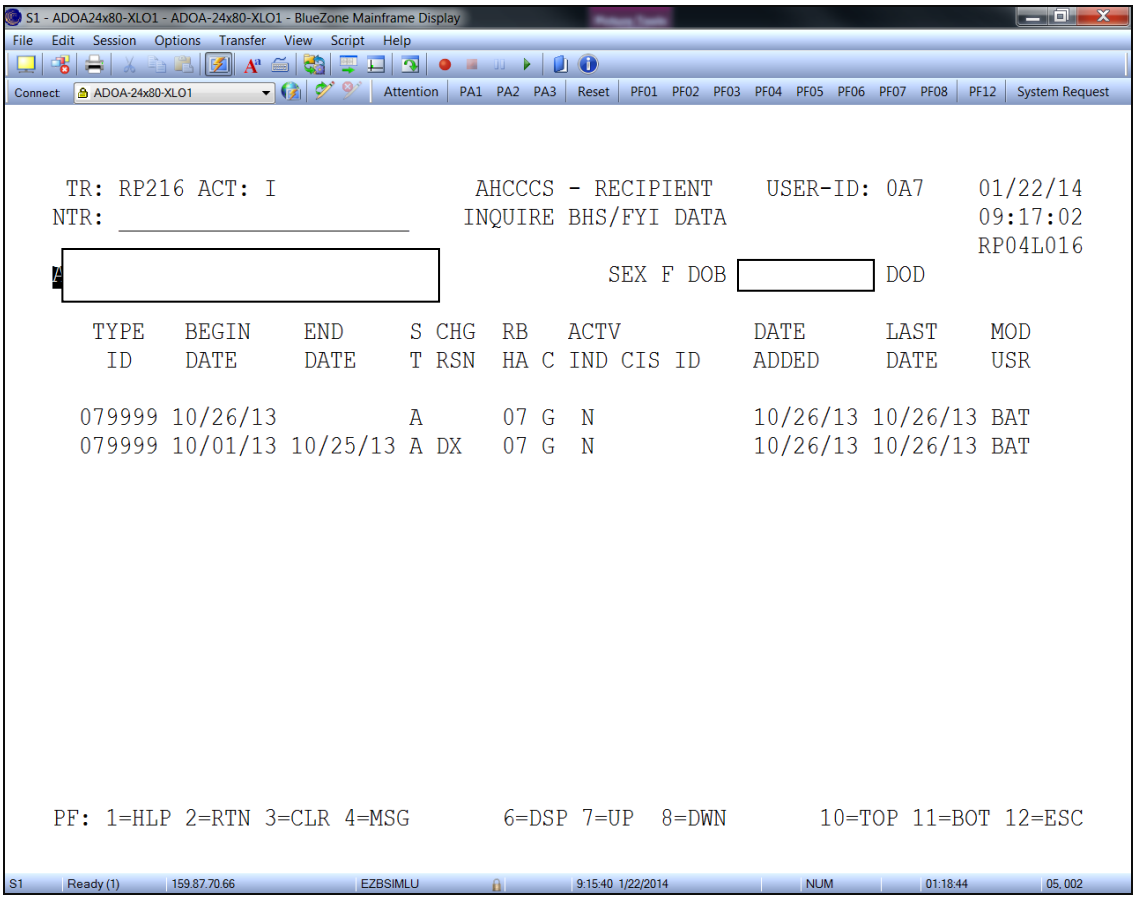
Error Code A580 – Recipient Has Other Coverage That Must Be Billed First

CRS Enrollment (RP215)

This screen will indicate if the recipient has CRS enrollment.



BHS Enrollment (RP216) This screen will indicate the recipient's BHS enrollment.



Reference
Section Introduction

The reference subsystem provides coding information e.g. procedure and diagnosis pharmacy NDC, and provider specific. These code reference tables contain values, indicators and descriptions that are used to validate accurate coding as well as verify coding relationships. There are 3 kinds of tables:

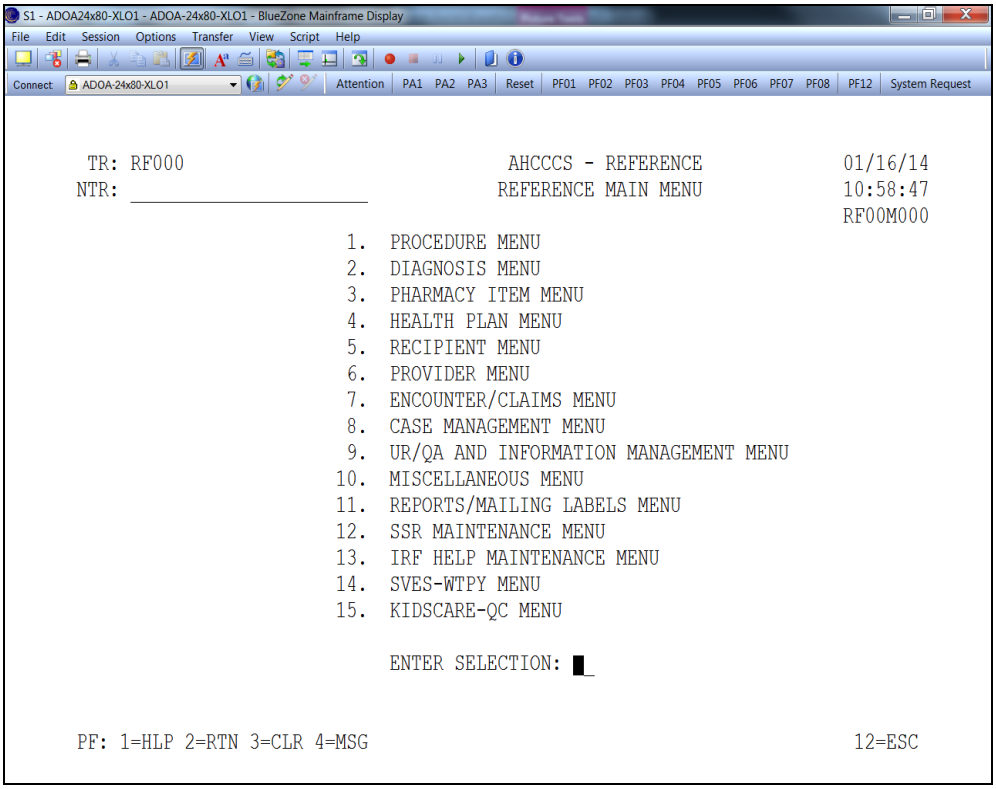
- Point in Time - If a change is made it effects all dates retroactively.
- Date of service – Information is maintained for date ranges.
- Interrelated – Different tables on different screens have a connection.

This section will go through some of the most commonly used reference screens and their applicable information.

To get into the reference menu from the main menu, you can either type an “8” into the “Enter Selection” field or type “RF000” into the “NTR” field.

Reference Main Menu

This is the Main Menu for Reference:

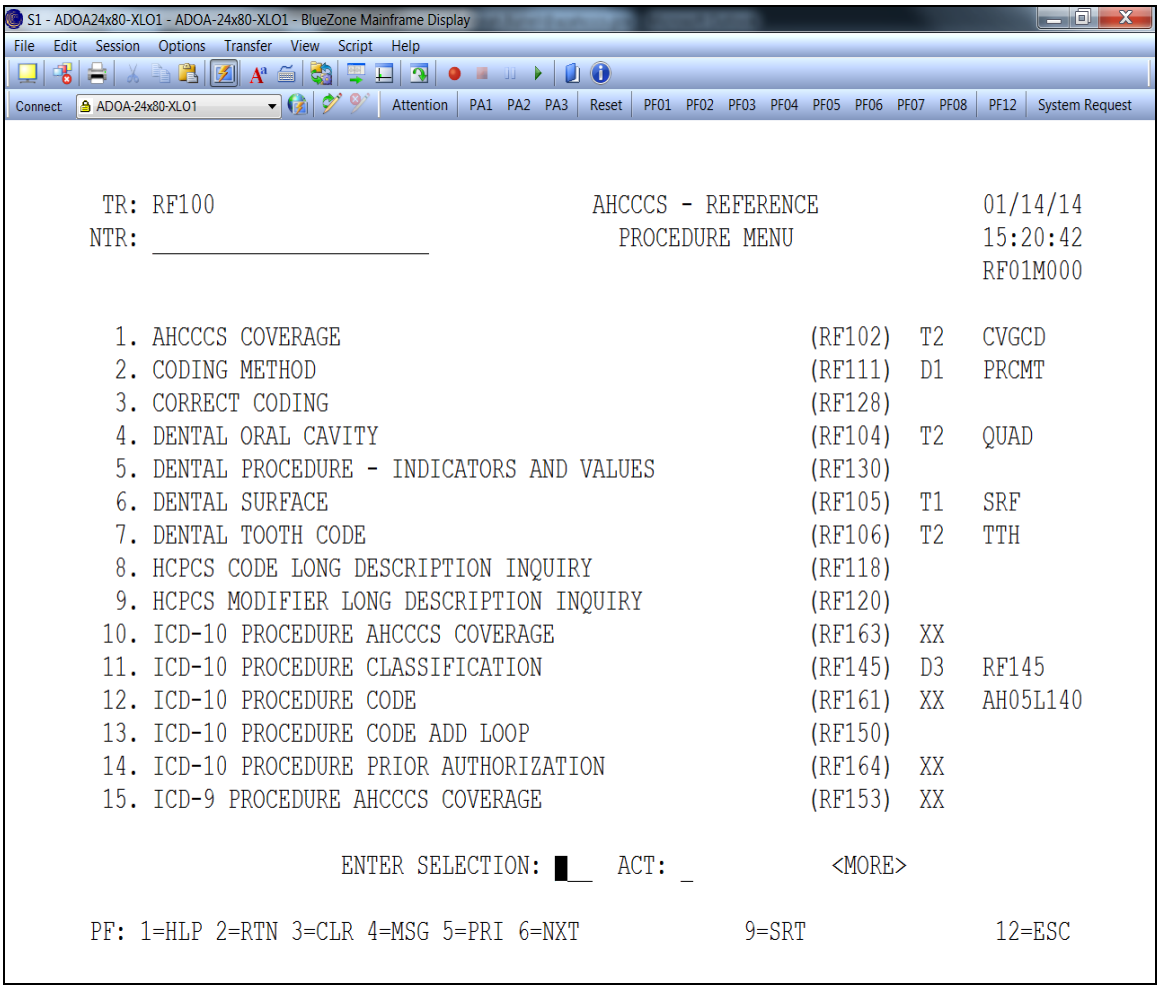


The most commonly used reference menus are:

1. Procedure menu
2. Diagnosis menu
6. Provider
3. Pharmacy Item menu
7. Encounter Claims menu

Procedure Menu (RF100)

From the Procedure menu, there are 49 selections available. Select the <F6> key to scroll through the screen to see all of the options.



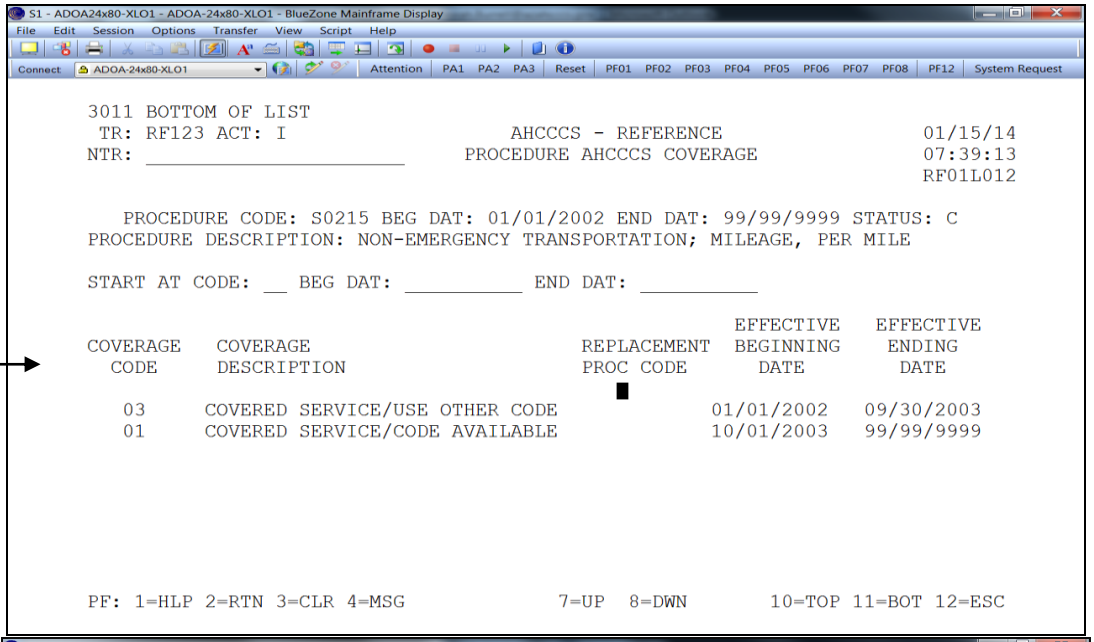
The most commonly used procedure code screens are:

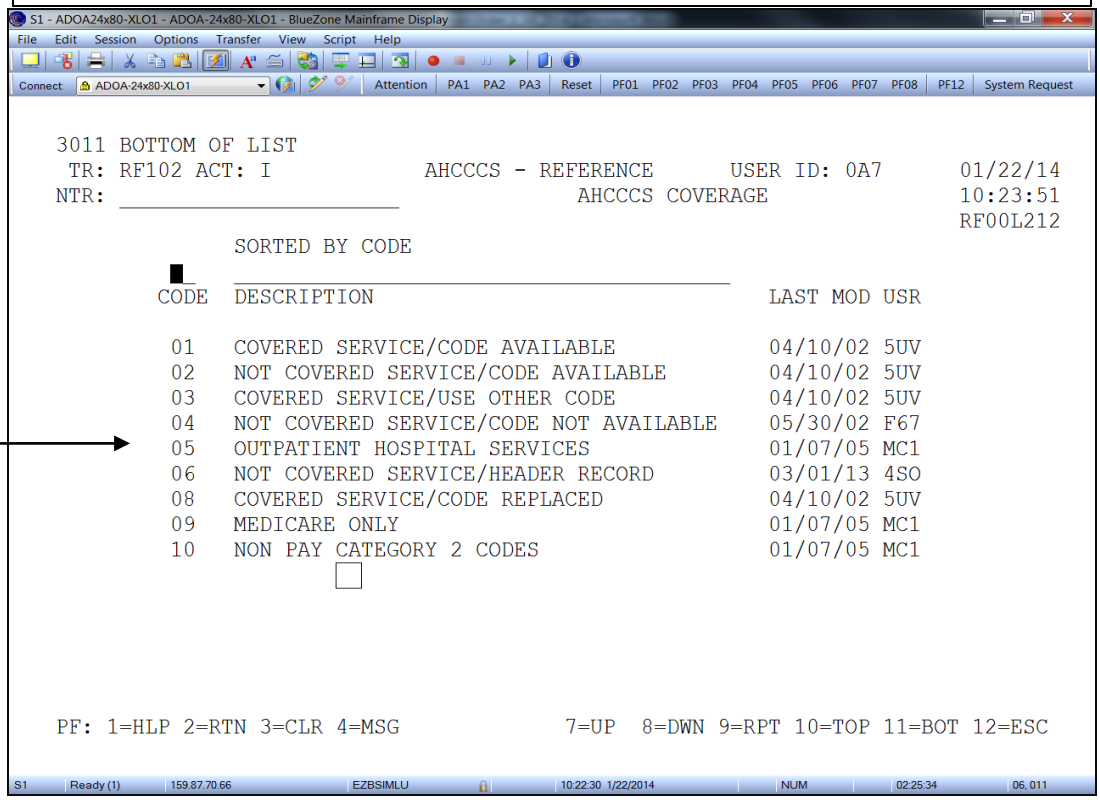
- Procedure Code Indicators and Values (RF113)
- Procedure AHCCCS Coverage (RF123)
- Procedure Prior Authorization (RF124)
- Valid Procedure Modifiers (RF122)
- Procedure Modifiers (RF114)
- Procedure Modifier Amount/Percent (RF119)
- Procedure Place of Service (RF115)
- Place of Service (RF107)
- Procedure Maximum Allowable Charge (RF112)
- Valid OPFS Procedure codes (RF127)
- Valid OPFS Procedure Modifiers (RF121)
- Procedure OPFS Price (RF126)
- ICD9 Procedure Code (RF151) and ICD10 (RF161)
- ICD9 AHCCCS Procedure Coverage (RF153) and ICD10 (RF163)
- CCI Edits (RF128)

Procedure AHCCCS Coverage (RF123)

This screen will indicate how a particular HCPCS/CPT code entered into the procedure code field is covered by AHCCCS.

Coverage Code (RF102) (see coverage code values below). Codes 1-4 have two parts: 1- coverage as AHCCCS service / 2- availability for encounter reporting. Codes 5-10 indicate special code purpose.





AHCCCS Coverage Codes

The AHCCCS Coverage Code describes the coverage parameters determined by AHCCCS for each procedure code.

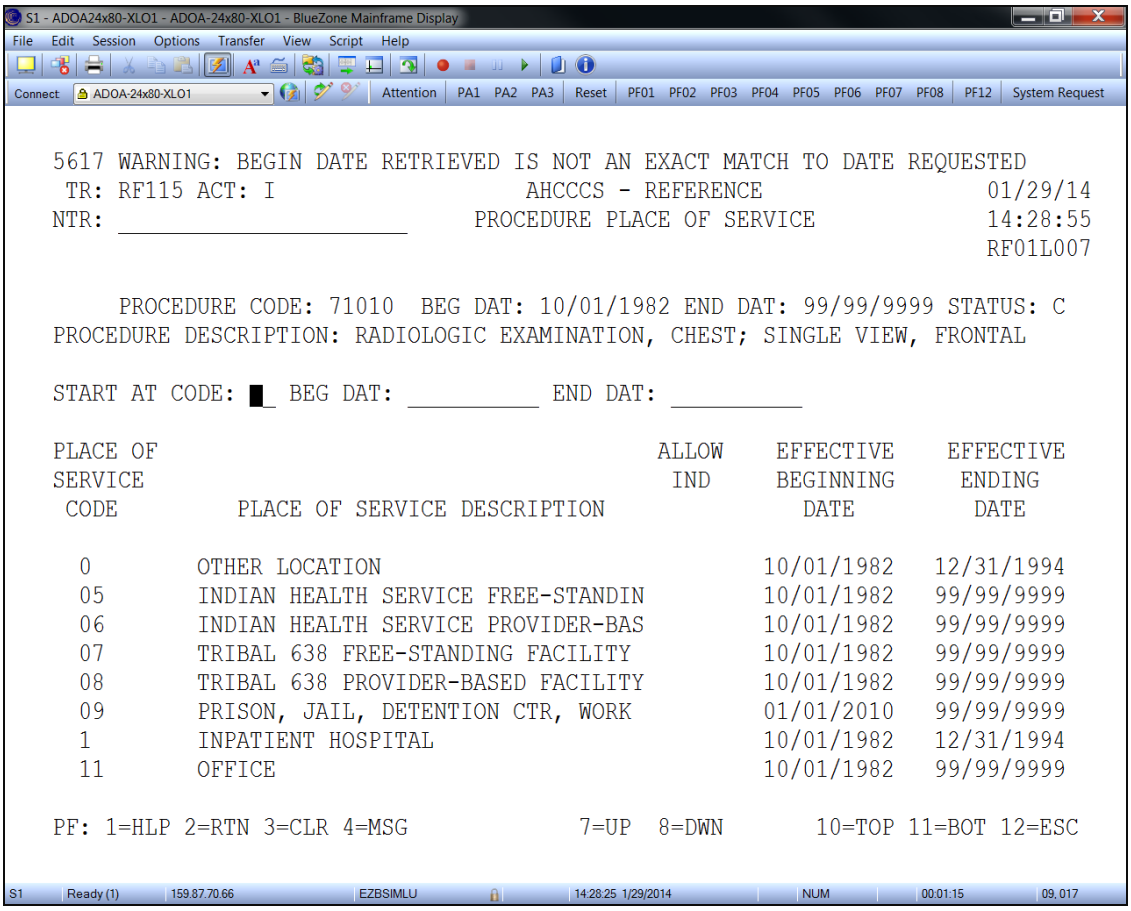
01	Covered service/Code available	Service as described by code is covered and appropriate for reporting.
02	Not covered service/Code available	Service as described by code is not covered or used by AHCCCS, but may be allowed on an exception/contract basis by MCO's (related encounters will deny for this reason, but be captured for utilization purposes).
03	Covered service/Use other code	Service as described by code is covered, however another code is more appropriate for reporting.
04	Not covered service/Code not available	Service as described by code is neither covered nor appropriate for reporting.
05	Outpatient hospital services	Service as described by code is covered and appropriate for outpatient hospital reporting.
08	Covered service/Code replaced	Service as described by code is covered; however it has been replaced by another code.
09	Medicare only	Service as described by code is not covered, but it is appropriate for reporting when Medicare is primary.
10	Non pay Category II Codes	Regardless of coverage determination, allows plans to report performance measurement codes.

Related encounter edits S345 (procedure is not available on DOS), S350 (procedure is not covered by AHCCCS on DOS), S354 (procedure is Medicare only)

Procedure Place of Service Code (RF115)

This screen will identify the valid places of service for a specific CPT/HCPCS procedure code. Additional fields displayed on the screen are:

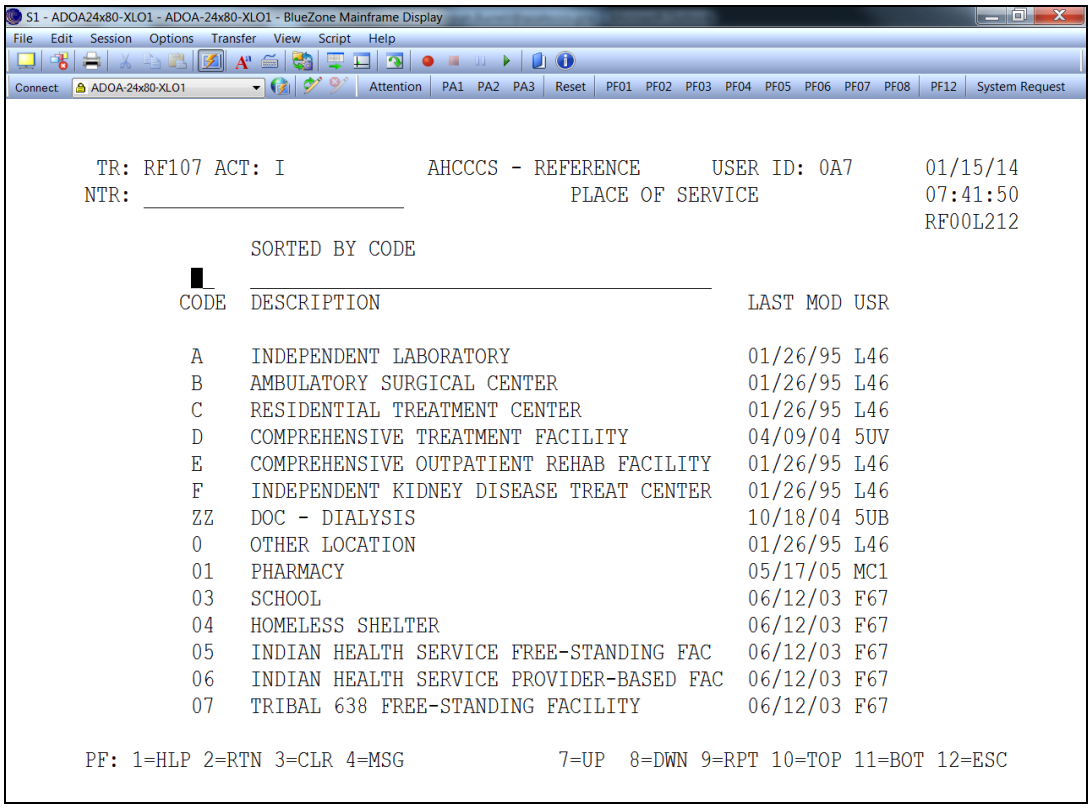
- Place of Service Description
- Effective Beginning Date
- Effective Ending Date



Error Code S430 – Place of Service Is Invalid for specified Procedure

Place of Service (POS) (RF107)

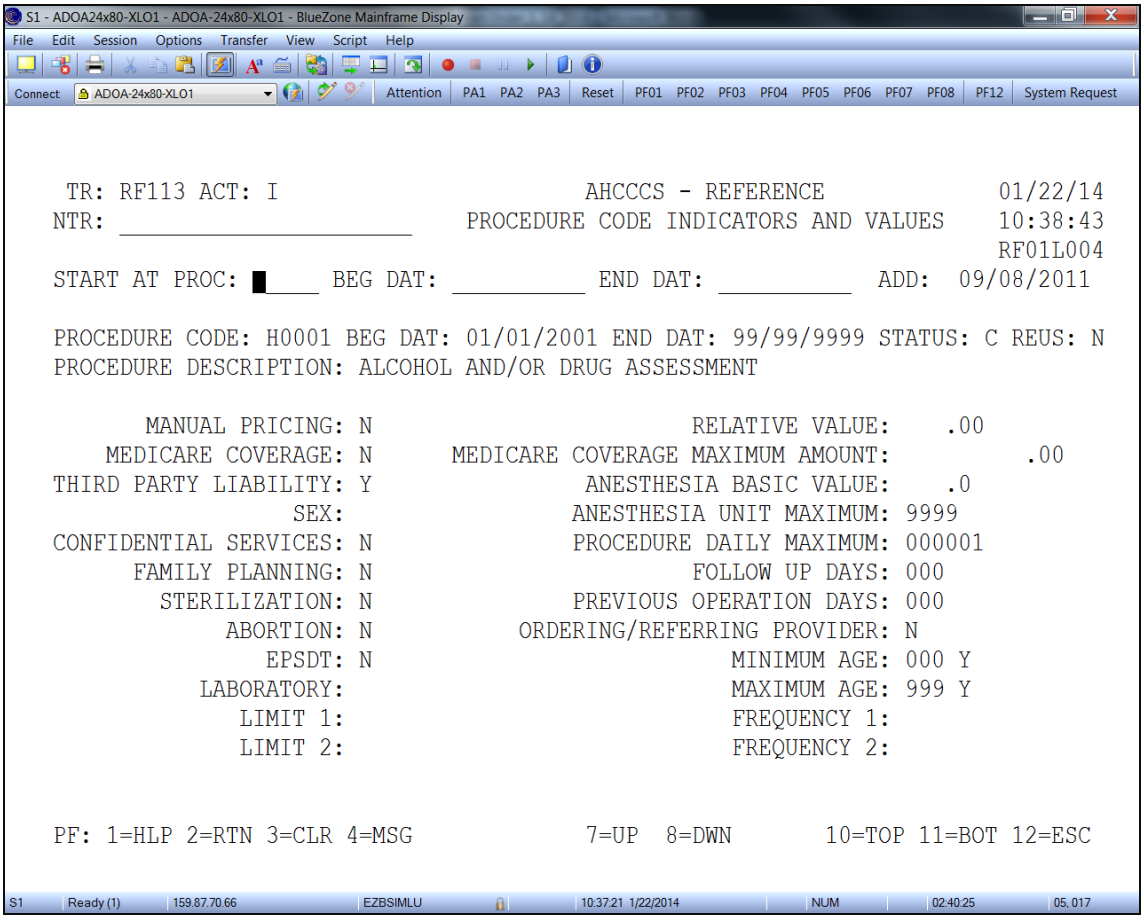
This screen will give descriptions for the place of service (POS) codes that are currently valid at AHCCCS. To see if a specific place of service code is valid for a specific procedure code, access the Procedure Place of Service Table (RF115).



Procedure Code Indicators and Values (RF113)

This screen will display detailed information about a specified procedure code. The most important information is:

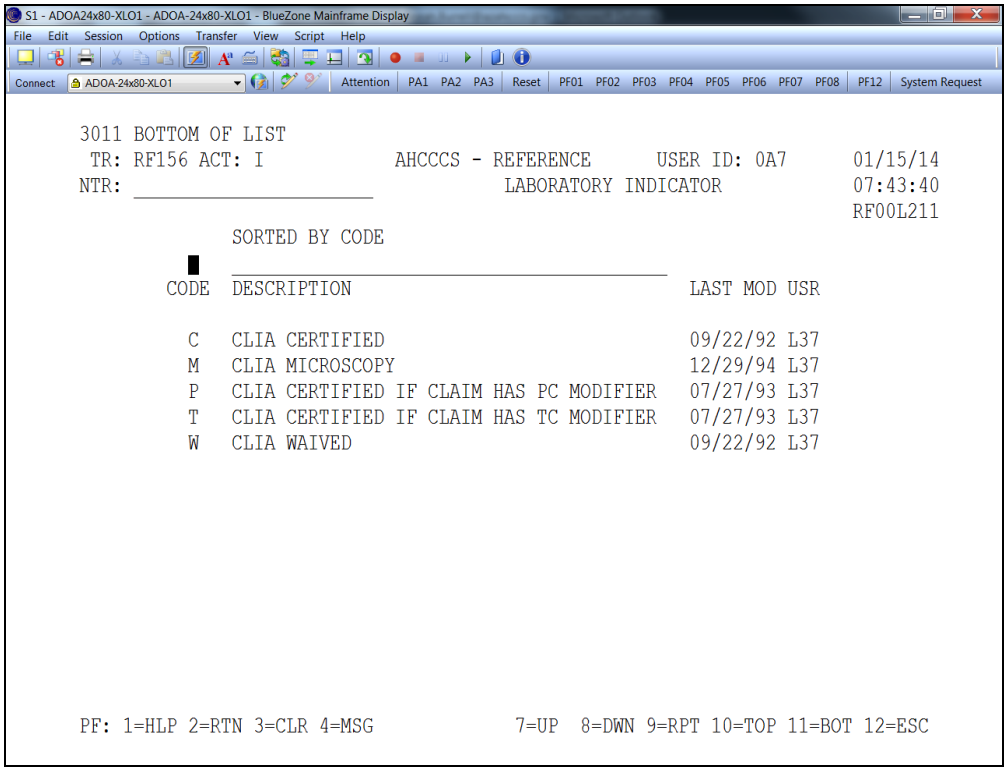
- Procedure Daily Maximum
- Minimum Age/Maximum Age
- Frequency Limits
- Medicare Coverage



RF113 has a corresponding screen RF127 (Procedure OPFS Indicators & Values)

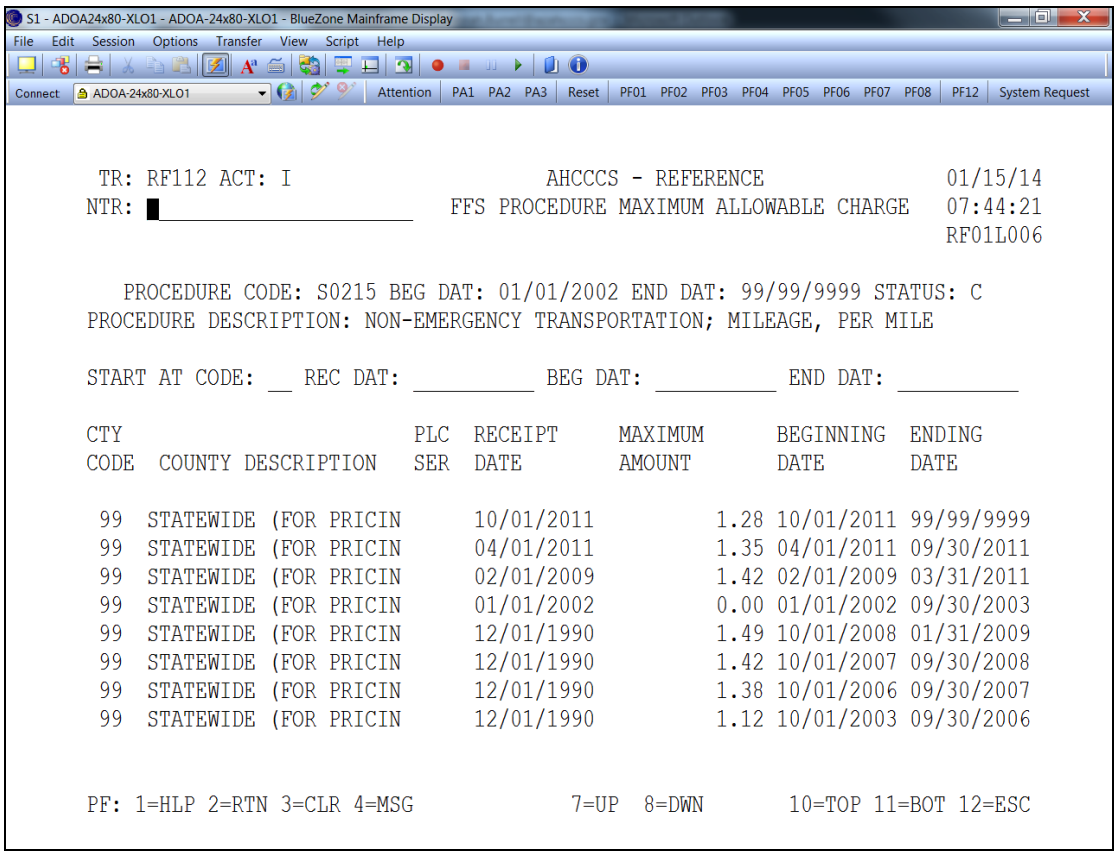
Laboratory Indicator (RF156)

This screen will display detailed information about a specified CLIA code for laboratory tests.



Procedure Maximum Allowable Charge (RF112)

Entering a specific CPT/HCPCS code into the procedure Code field will display the AHCCCS allowable charge.

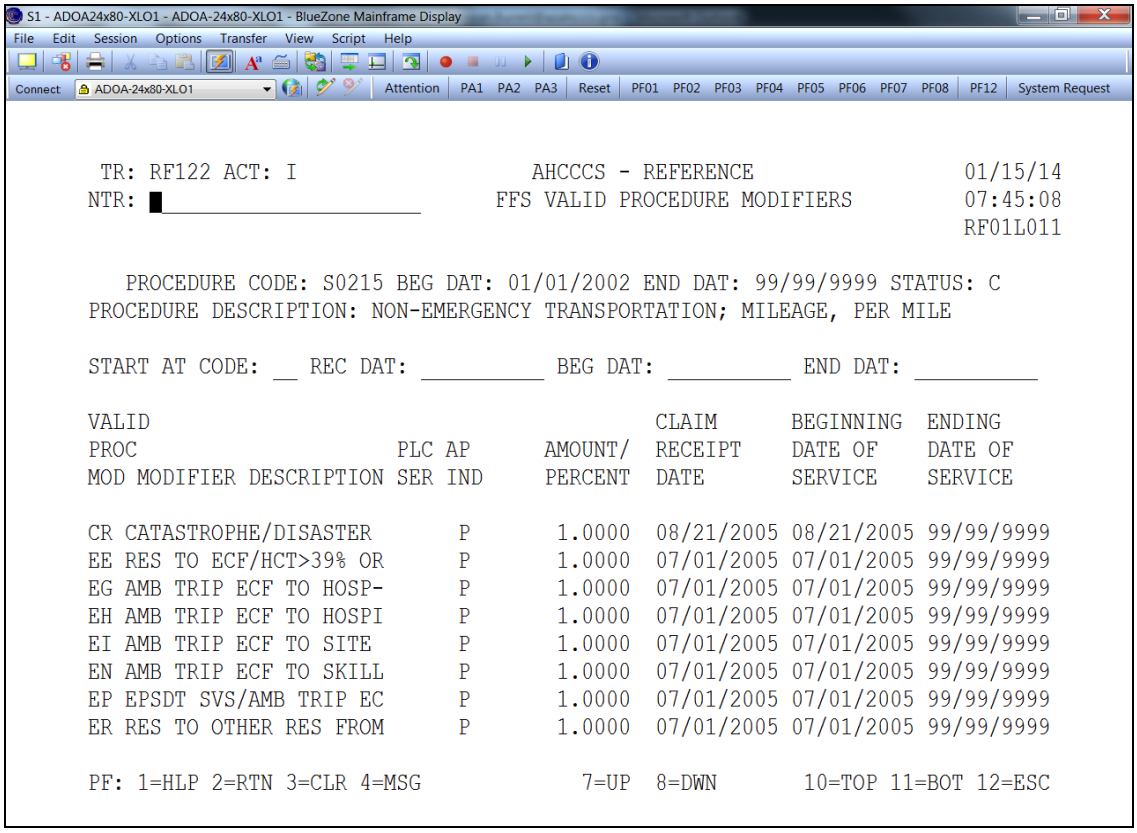


RF112 has a corresponding seen RF126 (Procedure OPFS Price)

Valid Procedure Modifiers (RF122)

This screen identifies the valid modifiers for a specific CPT/HCPCS procedure. Additional fields displayed on the screen are:

- Modifier Description
- Amount/Percentage
- Claim Receipt Date
- Date Range

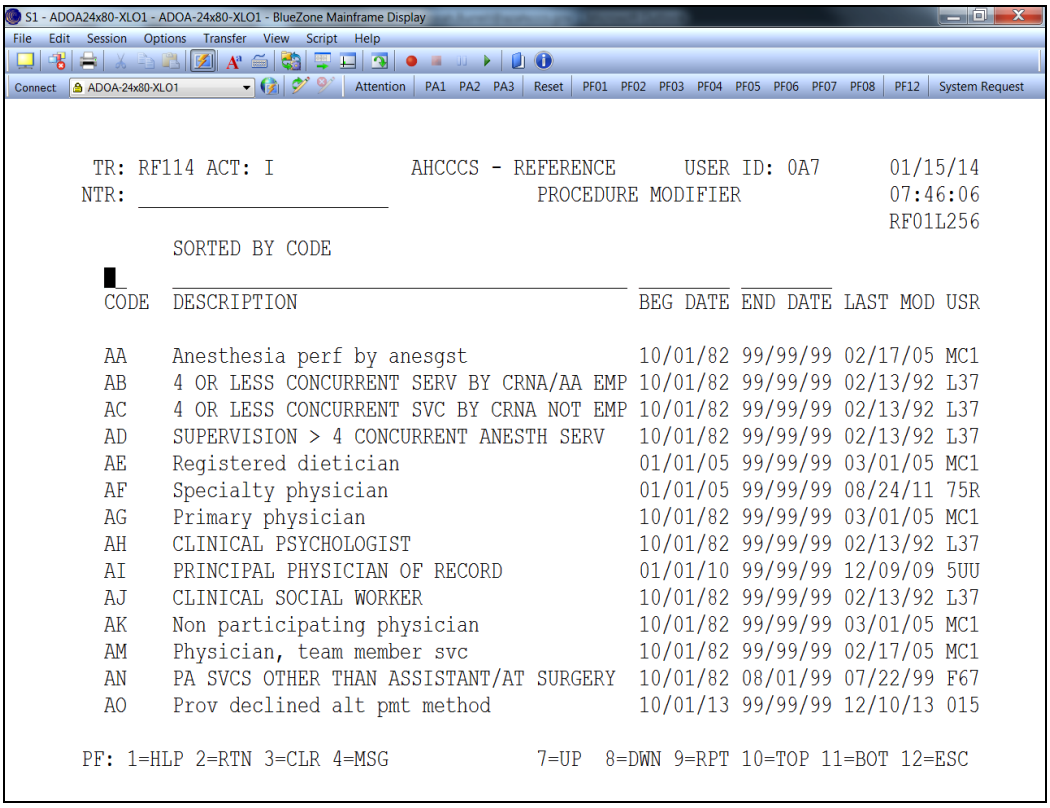


Corresponding screens are RF121 (Valid OPFS Procedure Modifiers) and RF 132 (MCO Valid Procedure Modifiers)

Error Code S445 – Procedure Modifier Invalid for Procedure on Date of Service

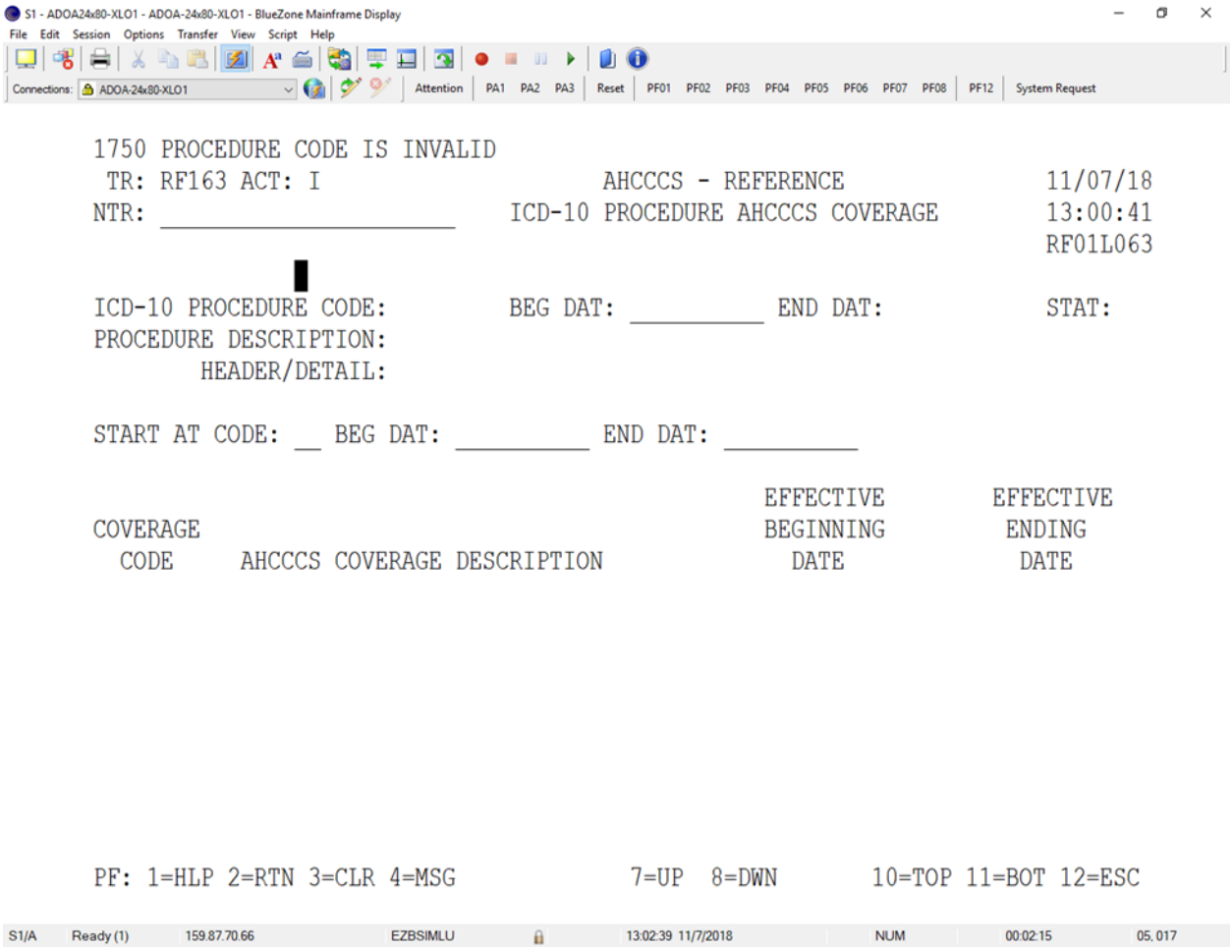
Procedure Modifier (RF114)

This screen provides a list of all the valid modifiers, their description, and effective dates. Remember all modifiers are not valid for every CPT/HCPCS code. To determine if a specific modifier is valid for an identified CPT/HCPCS code, access the Valid Procedure Modifier screen RF122.



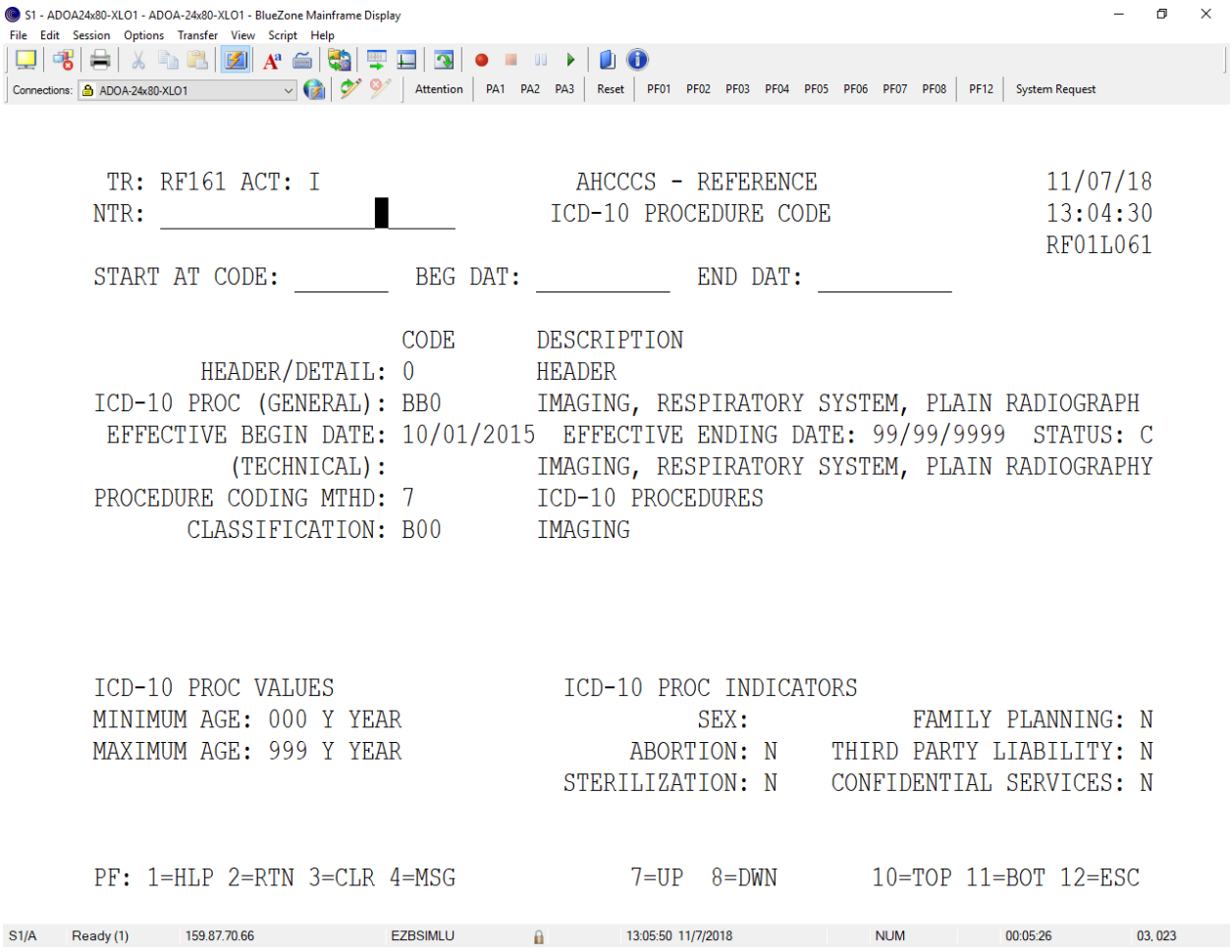
ICD – 10 Procedure AHCCCS Coverage (RF163)

Use this screen to verify if a particular ICD-10 Procedure code is covered by AHCCCS.



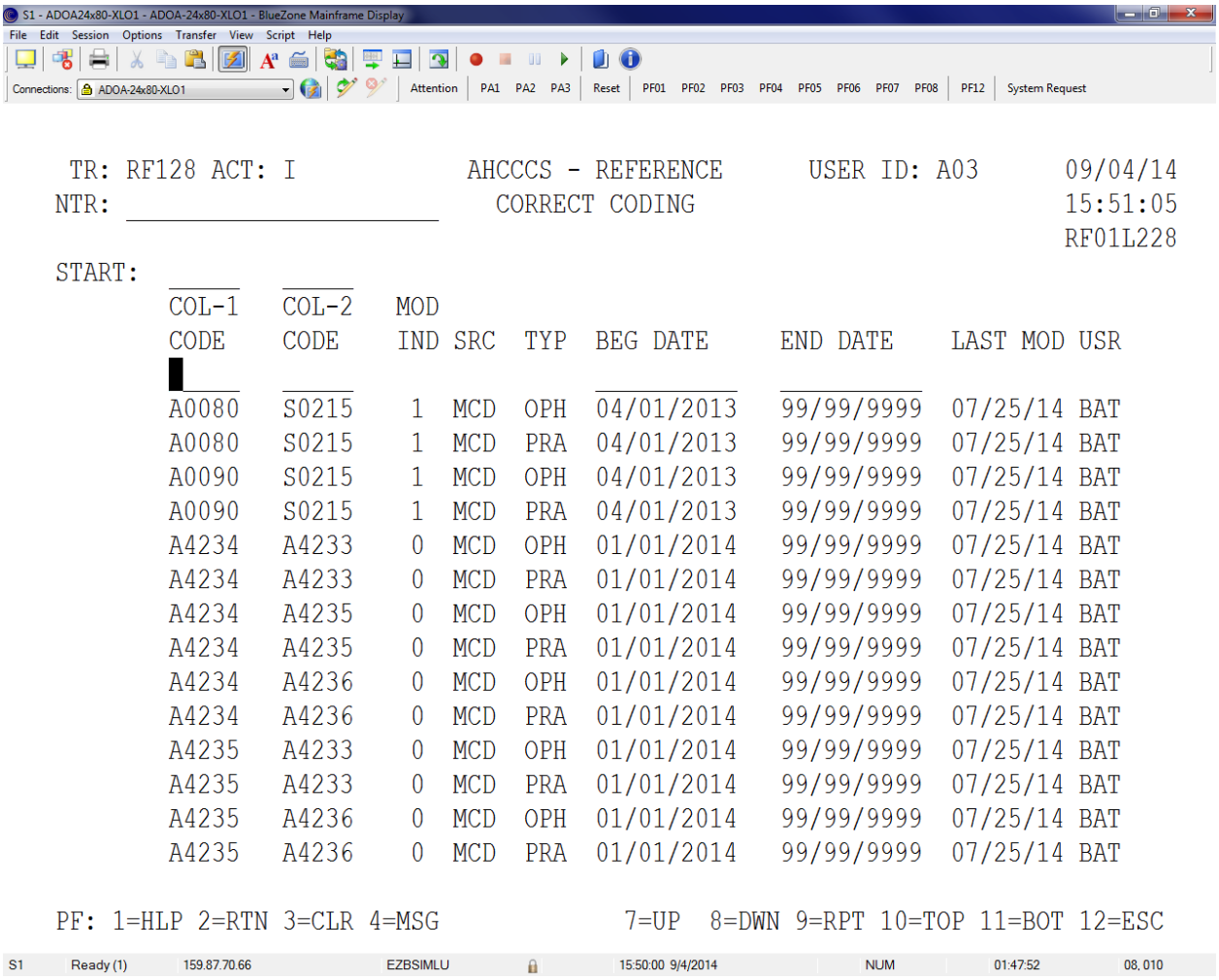
Procedure codes ICD -10 (RF161)

ICD-9 Procedure codes are codes used to bill inpatient services that a reimbursed using Diagnosis Related Groups (DRG). This screen provides descriptions, indicators, and values for ICD- 10 Procedure codes.



CCI Edits (RF128)

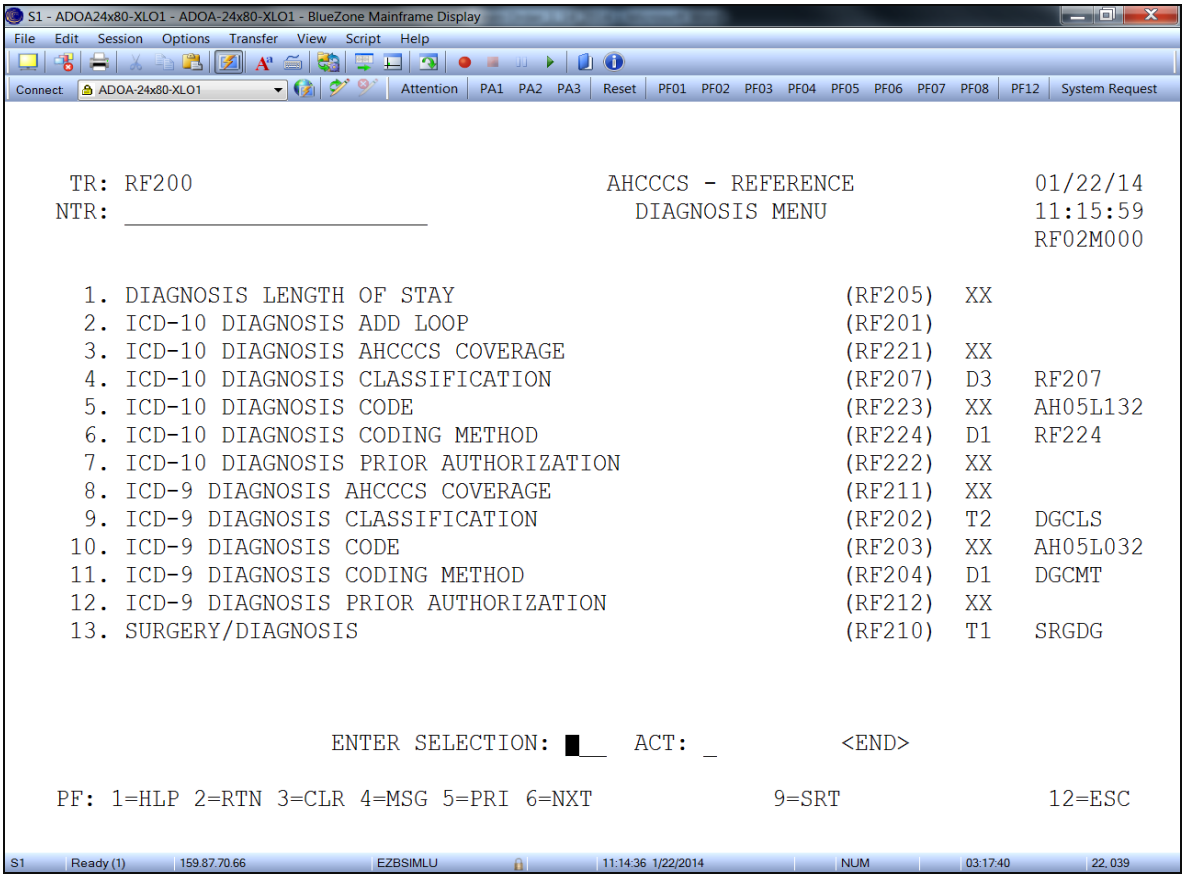
Correct Coding Initiative (CCI) edits are used to verify that multiple procedure codes on a single claim are permitted. And if so, is a modifier is required for them to be on the same claim.



Modifier Indicator: 1= allowed if modifiers are needed and submitted
0 = not allowed

Diagnosis Menu (RF200)

The Diagnosis section provides information about AHCCCS' valid and allowable diagnosis codes.

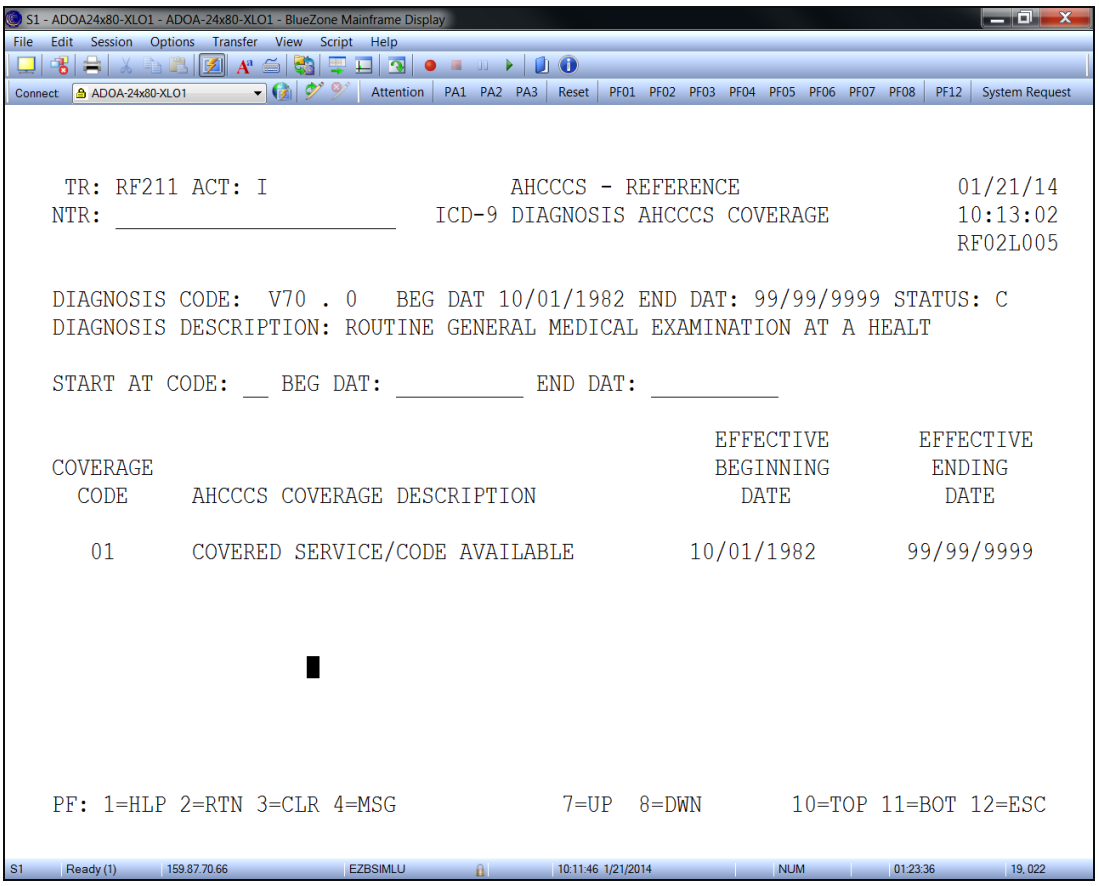


The most commonly used screens are:

- ICD-9 Diagnosis AHCCCS Coverage (RF211) and (RF221) ICD-10
- Diagnosis Code (RF203) and (RF 223) ICD-10

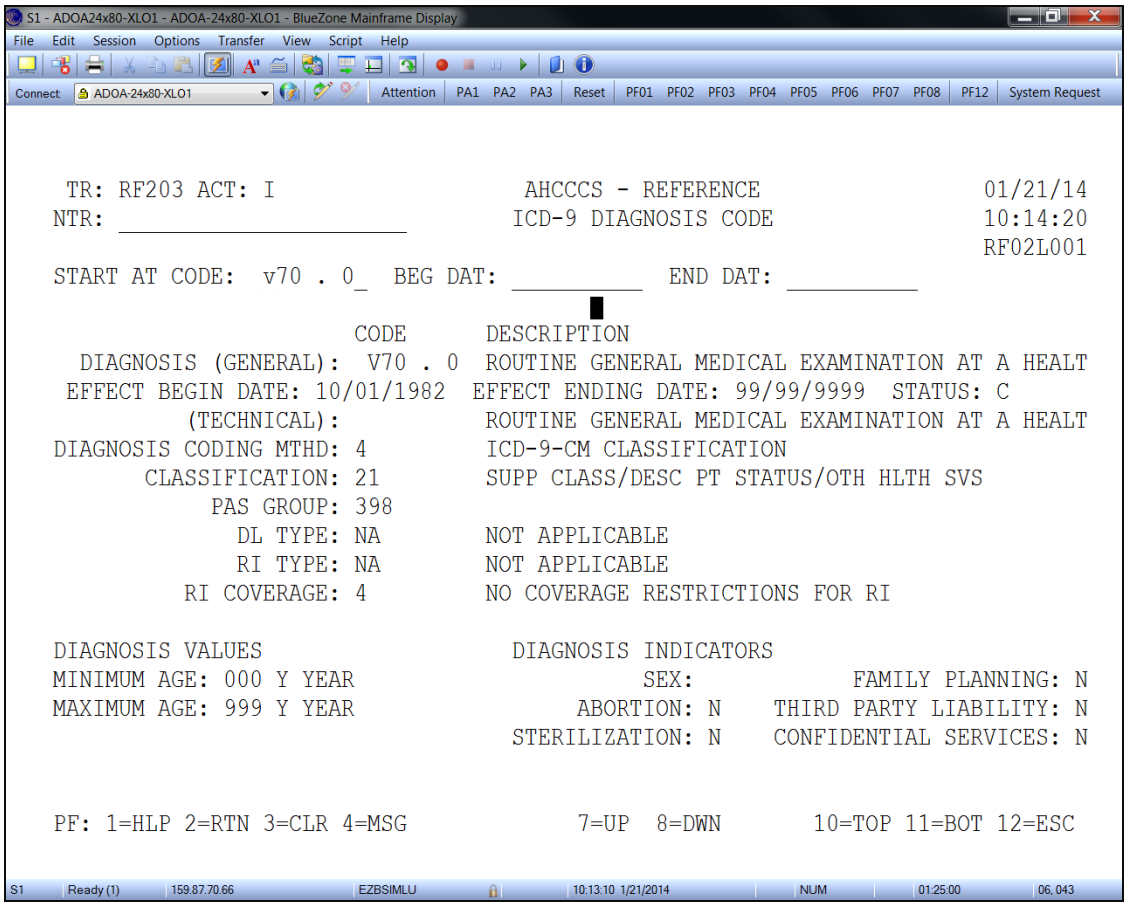
Diagnosis AHCCCS Coverage (RF211)

This screen will indicate whether the diagnosis code entered into the diagnosis code field is covered by AHCCCS along with its effective dates.



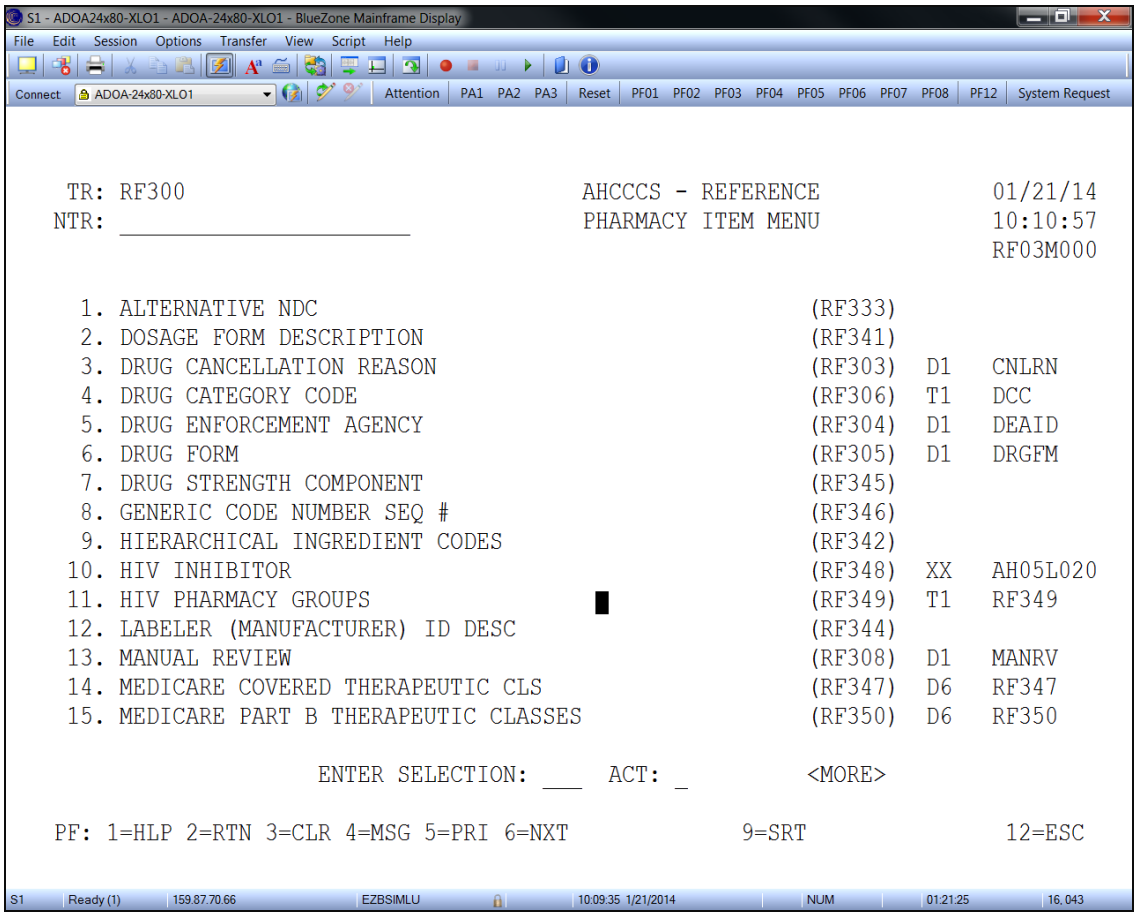
Diagnosis Code (RF203)

This screen will display miscellaneous information about a specified diagnosis code. The most important information displayed is the minimum and maximum age allowed. **(Note: add a space before you type the code).**



Pharmacy Item Menu (RF300)

From the Pharmacy code menu, there are 28 selections available Select the <F6> key to scroll through the screen to see all of the options.

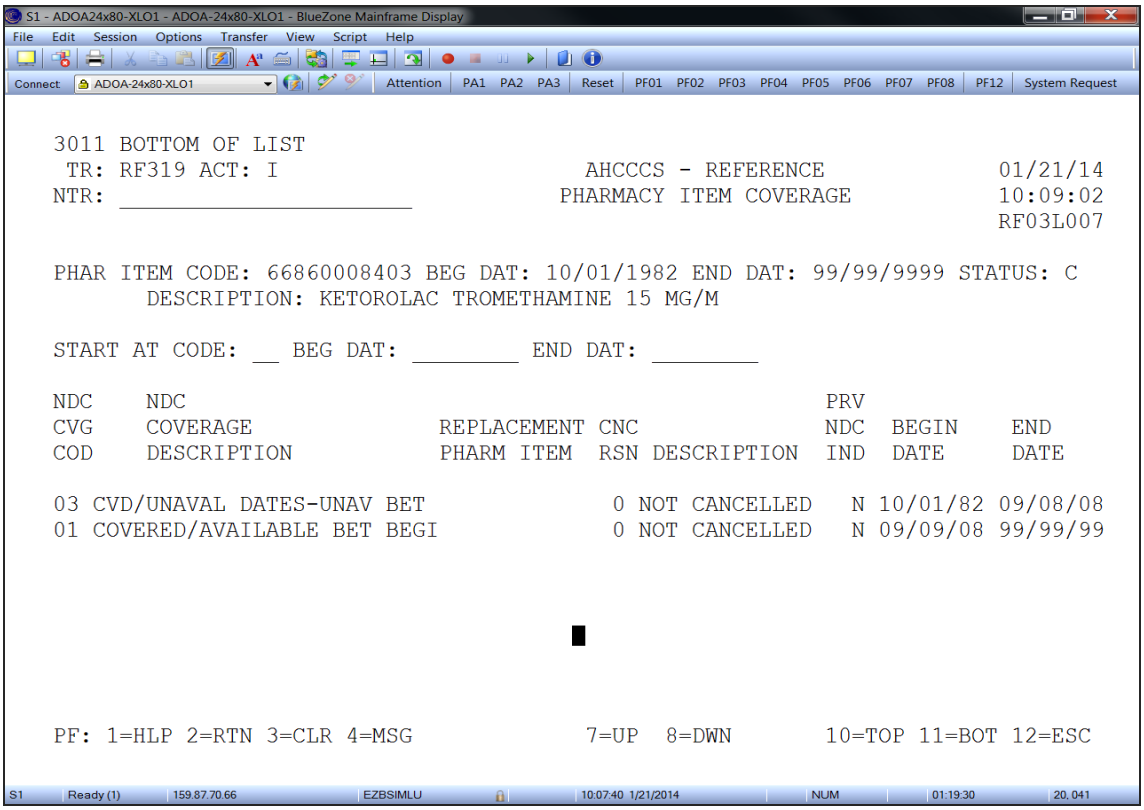


The most commonly used screens are:

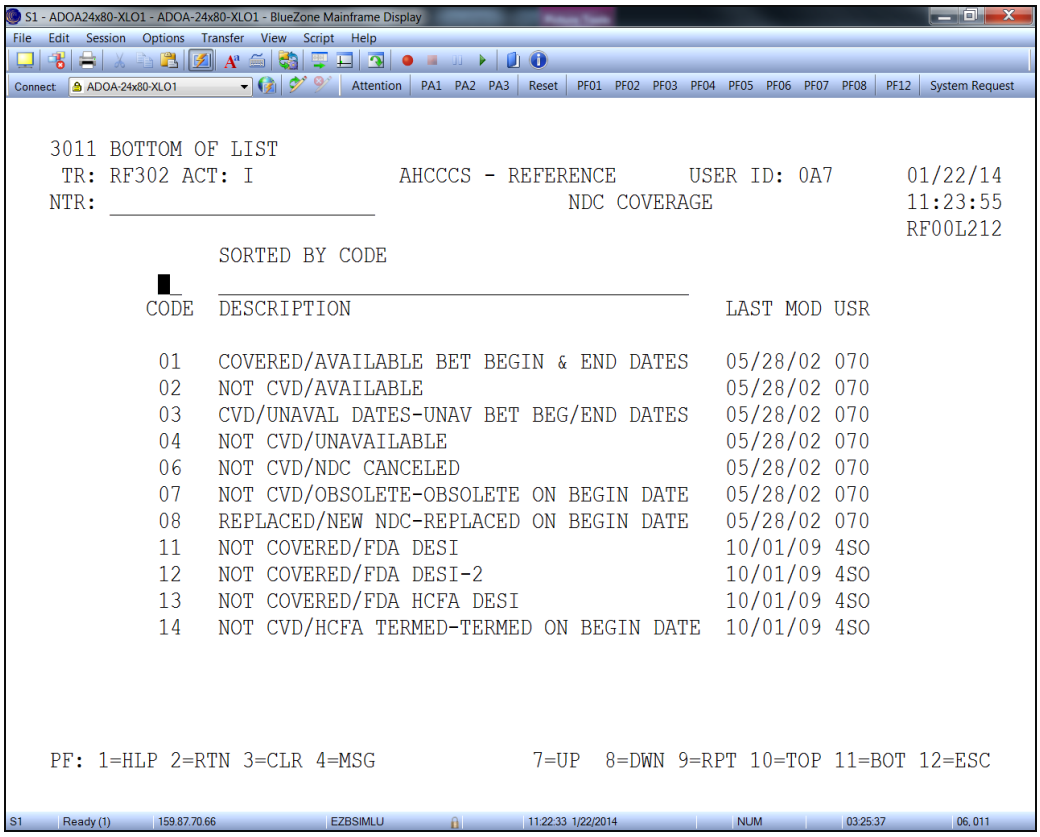
- Pharmacy Item Indicators and Values (RF312)
- Pharmacy Item Coverage (RF319)
- Alternate NDC List (RF333)

Pharmacy Item Coverage (RF319)

This screen will indicate whether the pharmacy code is covered by AHCCCS and its effective dates.

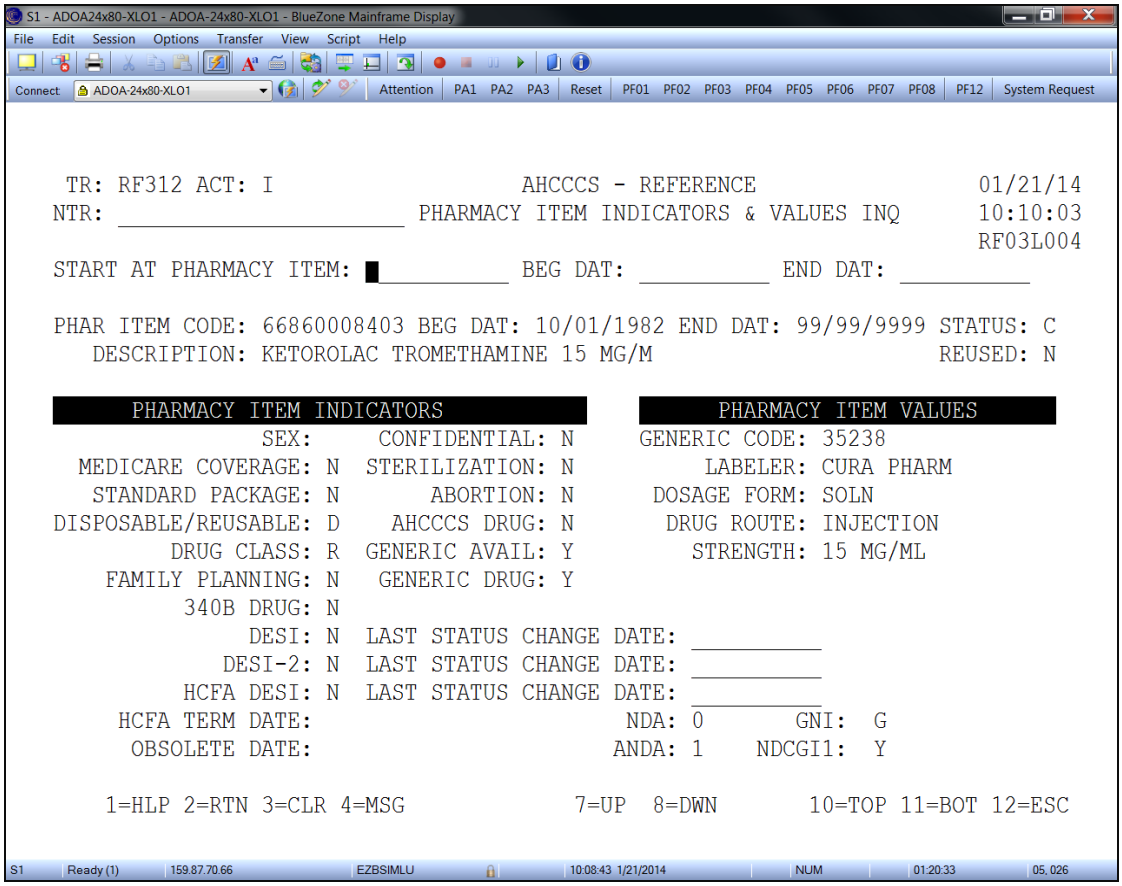


NDC Coverage (RF302) – Defines the “NDC CVG COD” found in RF319



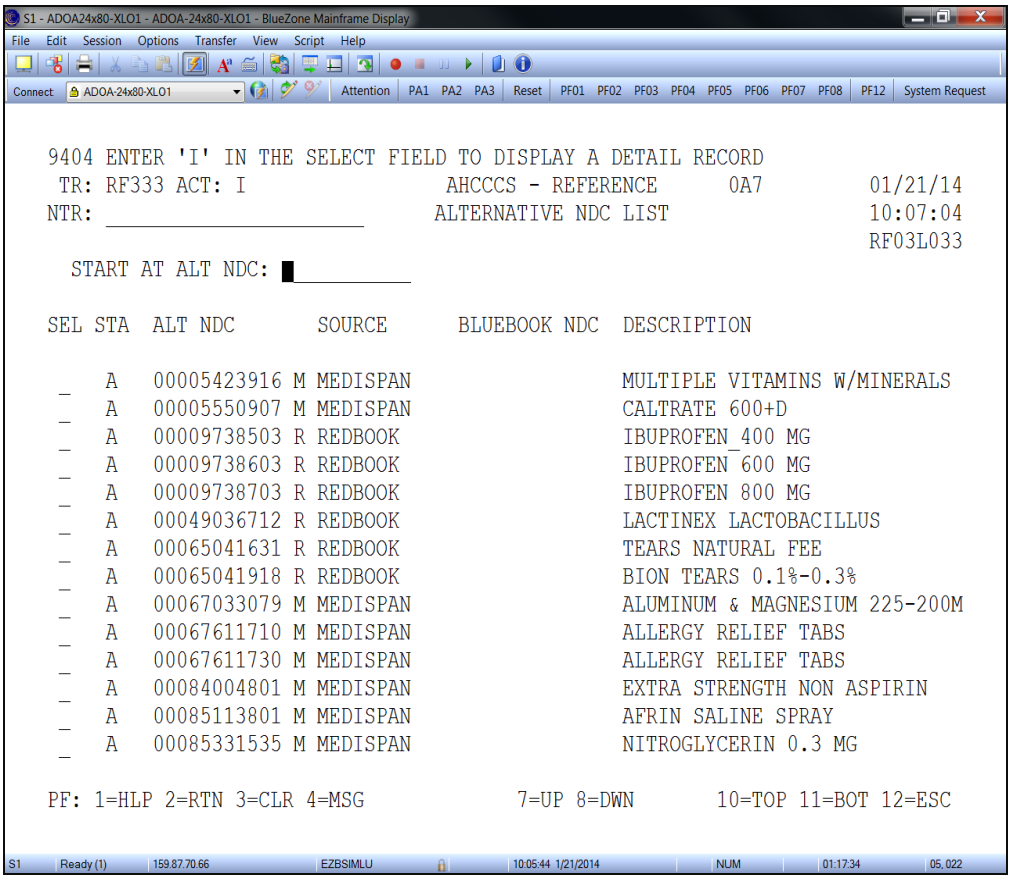
Pharmacy Item Indicators and Values (RF312)

This screen will display indicators and values for specific drugs. When locating a specific NDC, it is important to verify that the correct NDC is entered - if it is an invalid NDC code, PMMIS will display the next valid value and not notify that the code is invalid.



Alternate NDC List (RF333)

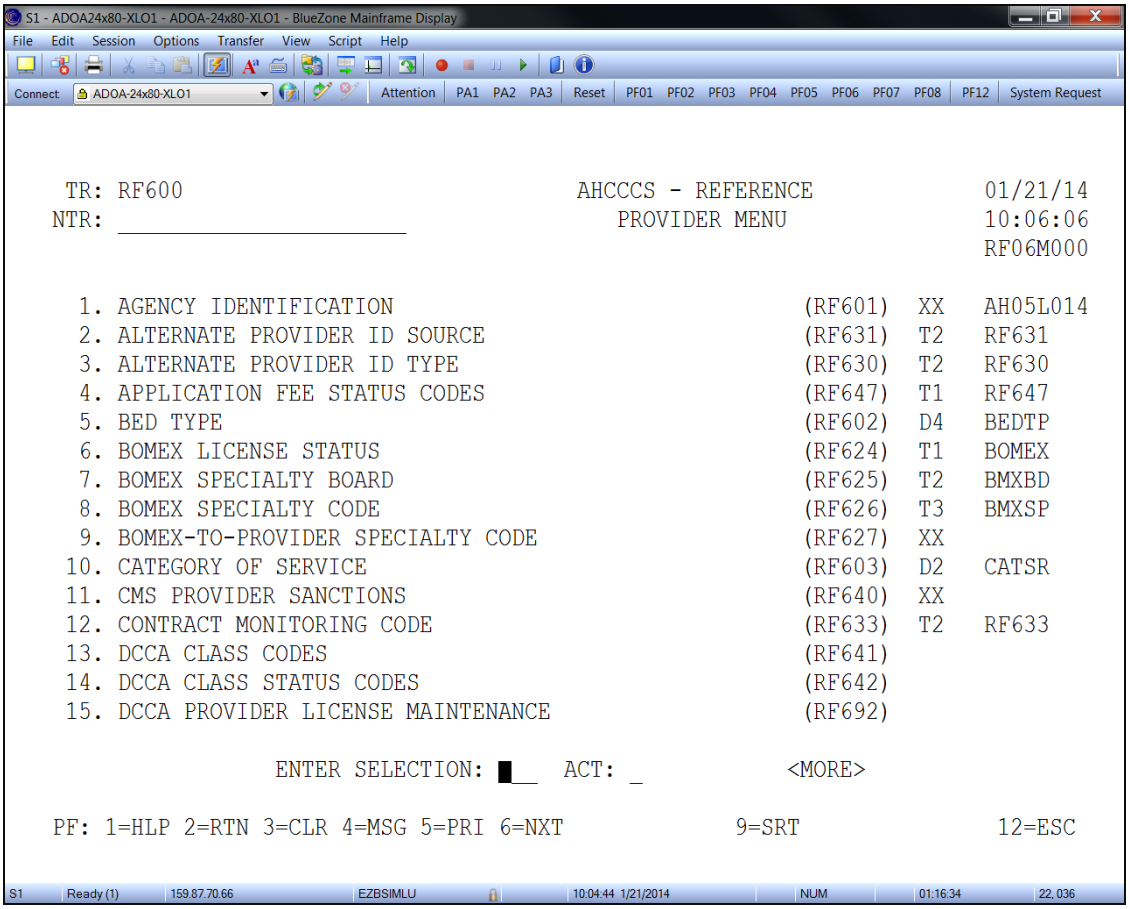
It is possible that there is an NDC for a medication that is not currently in the PMMIS system. If this is the case and the correct information (name, dosage, manufacture, dates, code and cost) is verified from a legitimate source (e.g., Redbook or Medispan), the information can be submitted to AHCCCS. Once it is verified, the drug will be added to this screen and the encounter will adjudicate.



Edit Error- N004 NCD Code Not of File

Provider Menu (RF600)

From the Provider Reference menu, there are 59 selections available. Select the <F6> key to scroll through the screen to see all of the options.

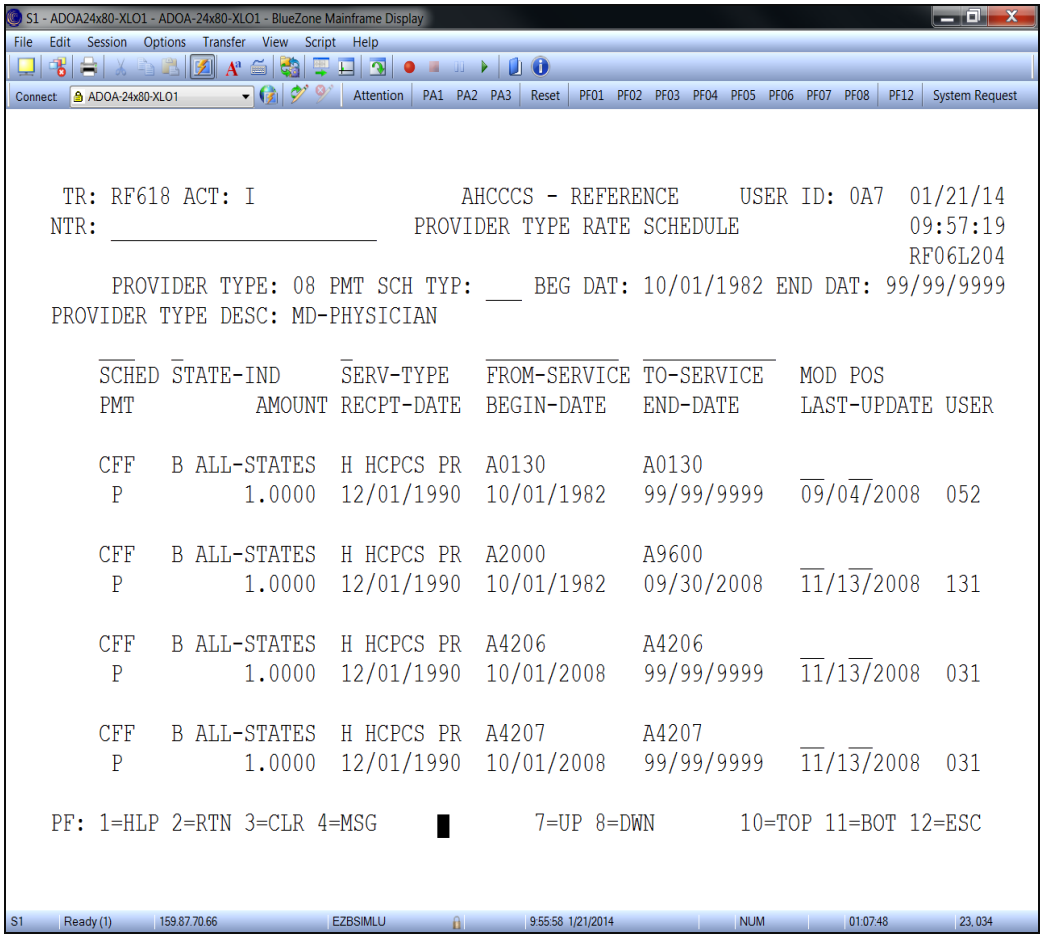


The most commonly used screens are:

- Category of Service (RF603)
- Provider Category of Service to Licensing Agency (RF607)
- Provider Type Rate Schedule (RF618)
- Provider Type Code (RF612)

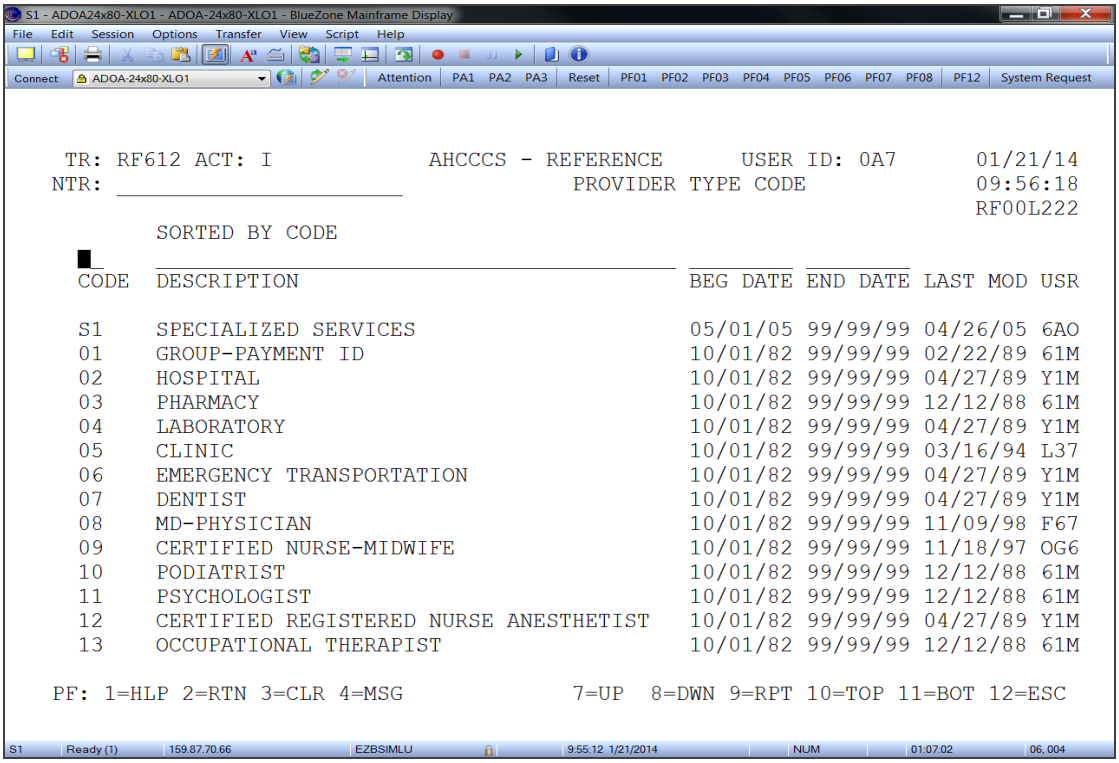
Provider Type Rate Schedule (RF618)

This screen displays procedure codes the provider type is authorized to bill.



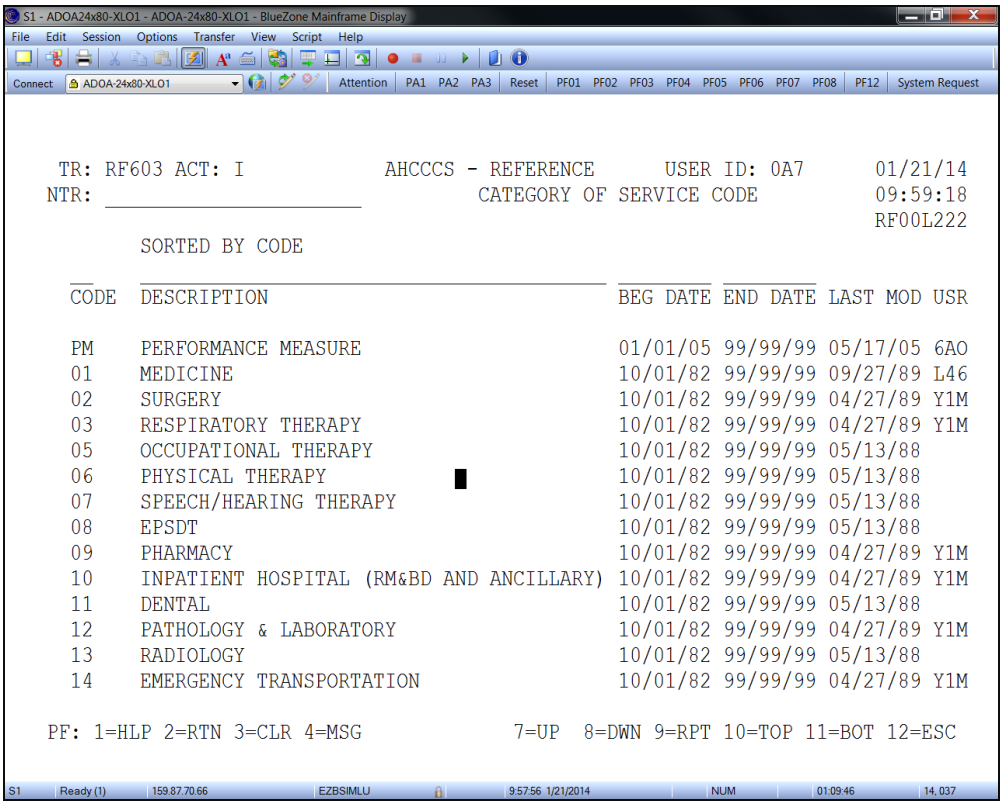
Provider Type Code (RF612)

Each provider is attached to a provider type. The provider type identifies the kinds of codes that the provider can submit. This screen provides descriptions for the various provider type codes.



Category of Service (RF603)

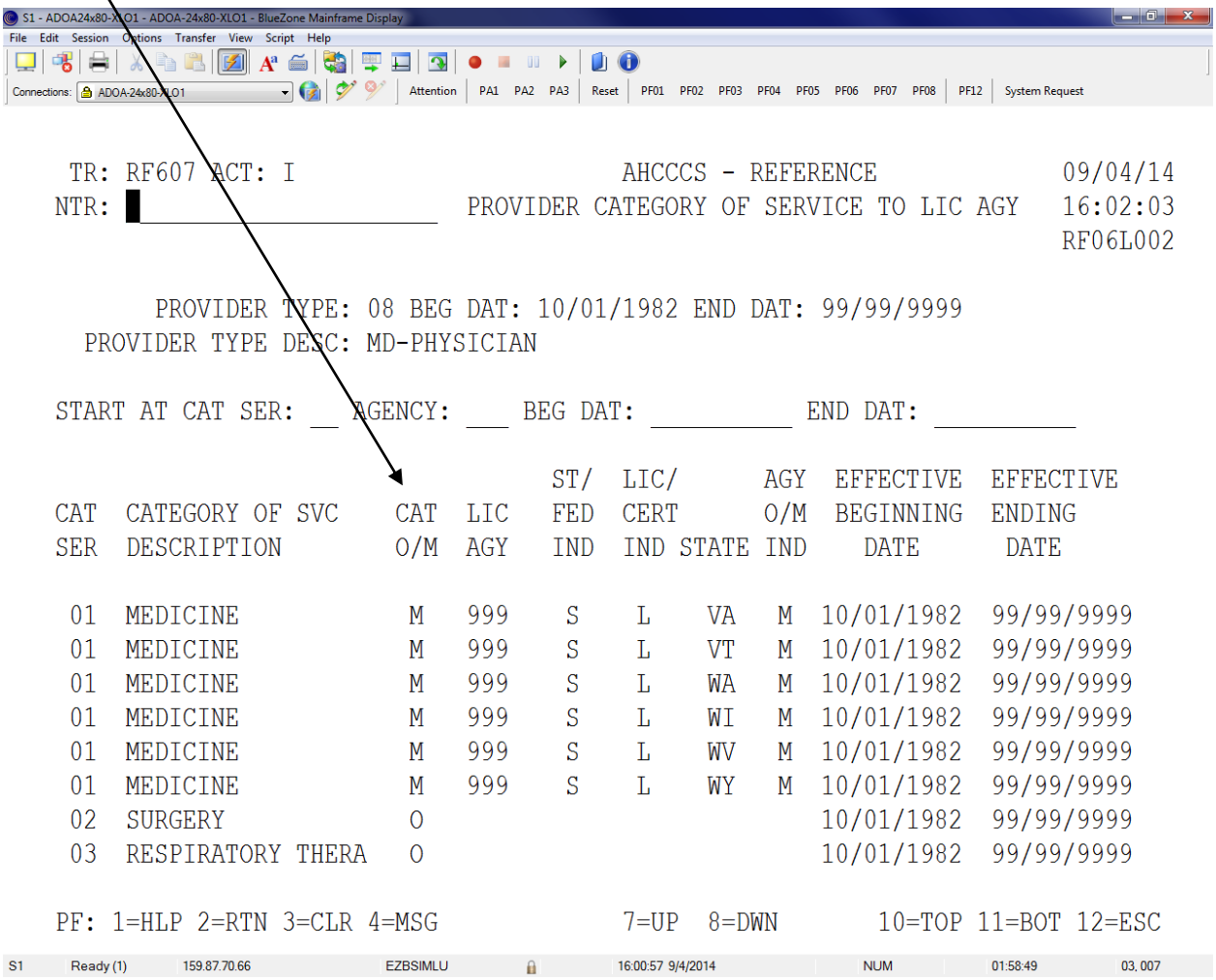
This screen provides a description of the category of service codes that apply to the providers.



Provider Category of Service to Licensing Agency (RF607)

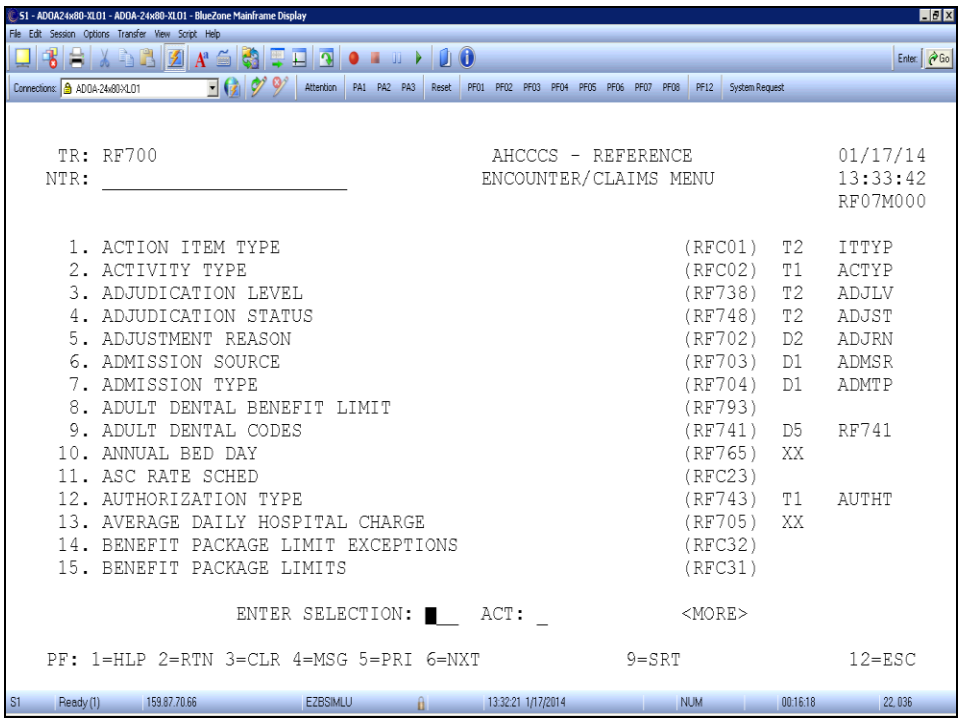
This screen identifies if a category of service is mandatory for the entered provider type and the type of license the provider is required to have.

Category values M=Mandatory and O=Optional



Encounter/ Claims Menu (RF700)

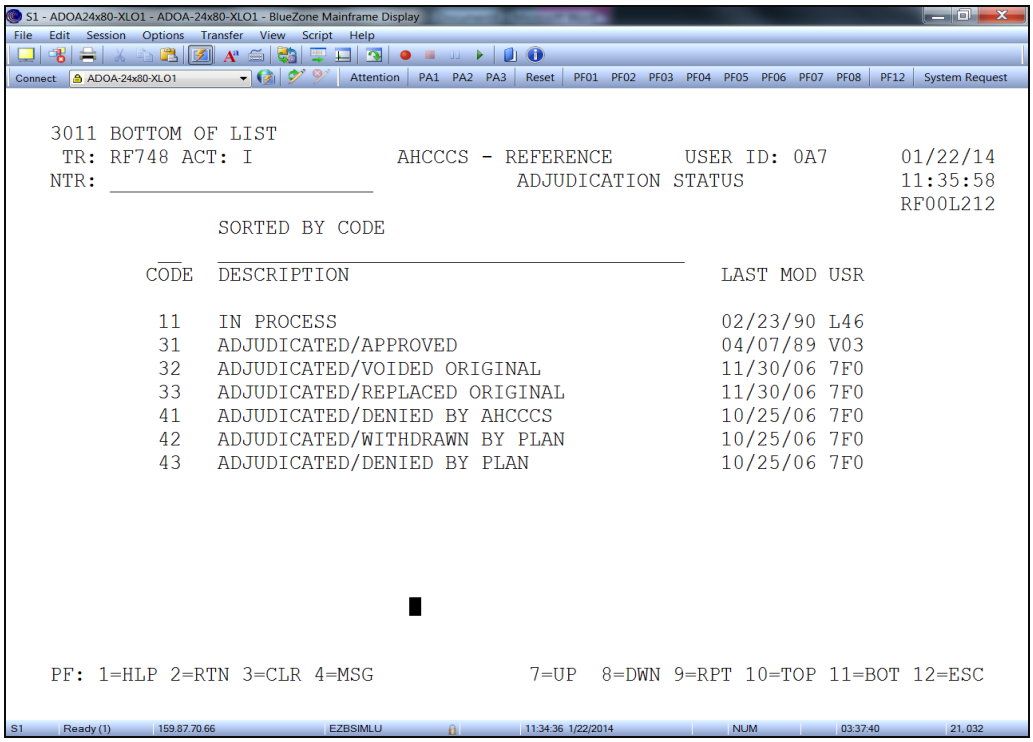
The Encounter/Claims menu has 140 selections available. Select the <F6> key to scroll through the menu to see all of the options.



The most commonly used screens are:

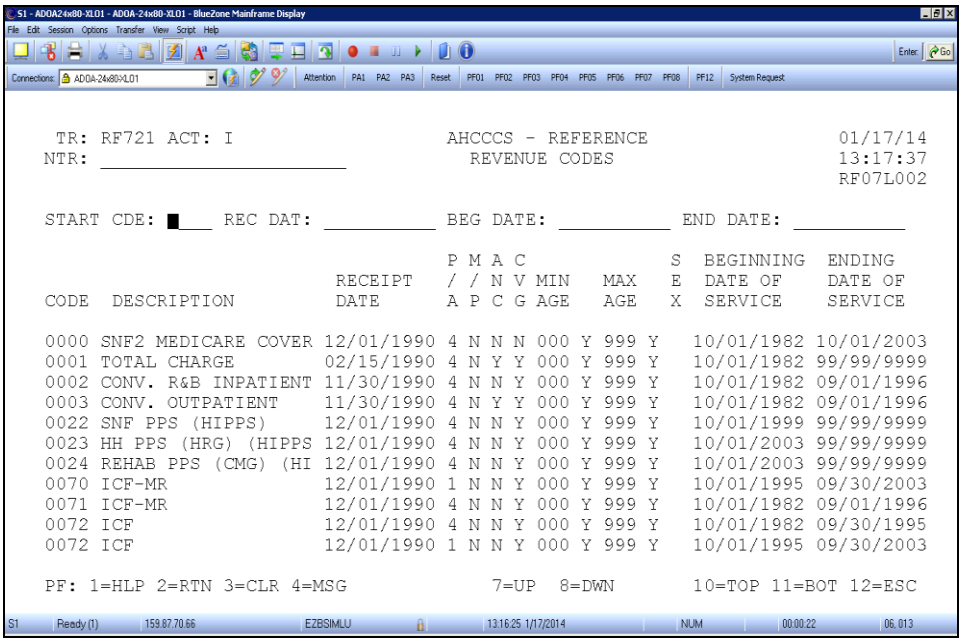
- Admission Type (RF704)
- Bill Type (RF706)
- Medical Categories of Service (RF769)
- Revenue Codes (RF721)
- Revenue Codes to Bill Types (RF774)
- Revenue Codes to Procedure Codes (RF773)
- UB Patient Status (RF717)
- Limit Override Modifiers (RF723)
- Condition Codes (RF708)

Adjudication Status (RF748)



Revenue Codes (RF721)

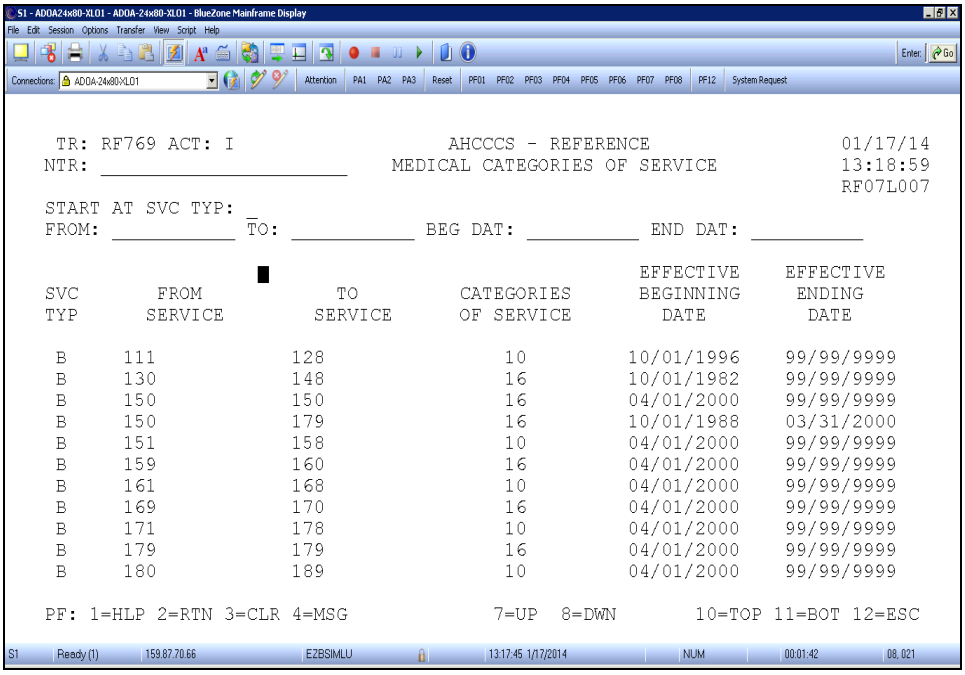
This screen displays all revenue codes, whether the code is an accommodation or ancillary, covered (“Y” or “N”) and the minimum and maximum age allowed.



Medical Categories of Service (RF769)

This screen displays the Category of Services assigned to the various codes based on the three code types:

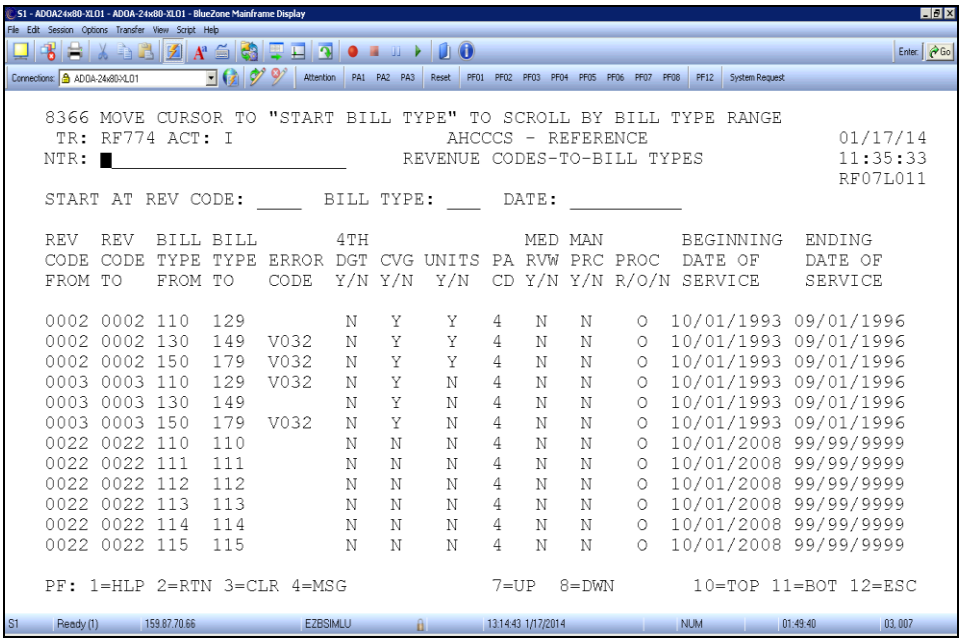
R – Revenue Code
B – Bill Type
H – CPT/HCPCS Code



Have the appropriate code type in the “START AT SVC TYP:” field.

Revenue Codes to Bill Types (RF774)

This screen identifies the valid bill type for each revenue code and whether a procedure code is required for a particular revenue code.

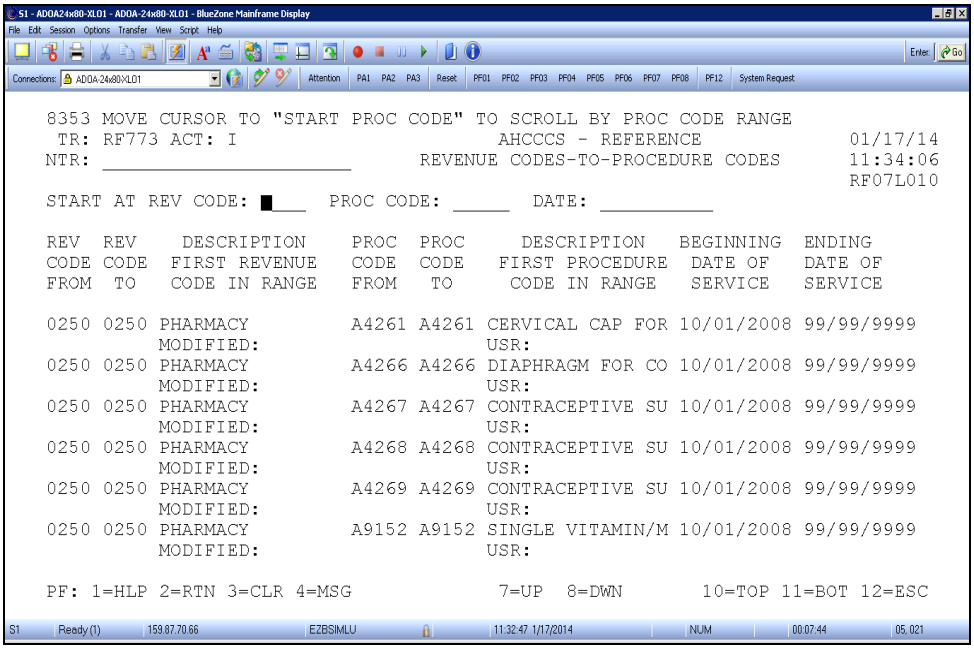


```
8366 MOVE CURSOR TO "START BILL TYPE" TO SCROLL BY BILL TYPE RANGE
 TR: RF774 ACT: I                    AHCCCS - REFERENCE                  01/17/14
NTR: ____________________        REVENUE CODES-TO-BILL TYPES            11:35:33
                                                                        RF07L011
START AT REV CODE: ____  BILL TYPE: ___  DATE: __________

REV  REV  BILL BILL       4TH              MED MAN       BEGINNING  ENDING
CODE CODE TYPE TYPE ERROR DGT CVG UNITS PA RVW PRC PROC  DATE OF    DATE OF
FROM TO   FROM TO   CODE  Y/N Y/N  Y/N  CD Y/N Y/N R/O/N SERVICE    SERVICE

0002 0002 110  129         N   Y    Y   4   N   N    O  10/01/1993 09/01/1996
0002 0002 130  149  V032   N   Y    Y   4   N   N    O  10/01/1993 09/01/1996
0002 0002 150  179  V032   N   Y    Y   4   N   N    O  10/01/1993 09/01/1996
0003 0003 110  129  V032   N   Y    N   4   N   N    O  10/01/1993 09/01/1996
0003 0003 130  149         N   Y    N   4   N   N    O  10/01/1993 09/01/1996
0003 0003 150  179  V032   N   Y    N   4   N   N    O  10/01/1993 09/01/1996
0022 0022 110  110         N   N    N   4   N   N    O  10/01/2008 99/99/9999
0022 0022 111  111         N   N    N   4   N   N    O  10/01/2008 99/99/9999
0022 0022 112  112         N   N    N   4   N   N    O  10/01/2008 99/99/9999
0022 0022 113  113         N   N    N   4   N   N    O  10/01/2008 99/99/9999
0022 0022 114  114         N   N    N   4   N   N    O  10/01/2008 99/99/9999
0022 0022 115  115         N   N    N   4   N   N    O  10/01/2008 99/99/9999

PF: 1=HLP 2=RTN 3=CLR 4=MSG            7=UP  8=DWN       10=TOP 11=BOT 12=ESC
```

The “PROC” is the indicator if a procedure code is needed when the revenue code is used with the bill type. ”R” means a procedure code is required, an “O” means a procedure code is optional, and an “N” means a procedure code is not required.

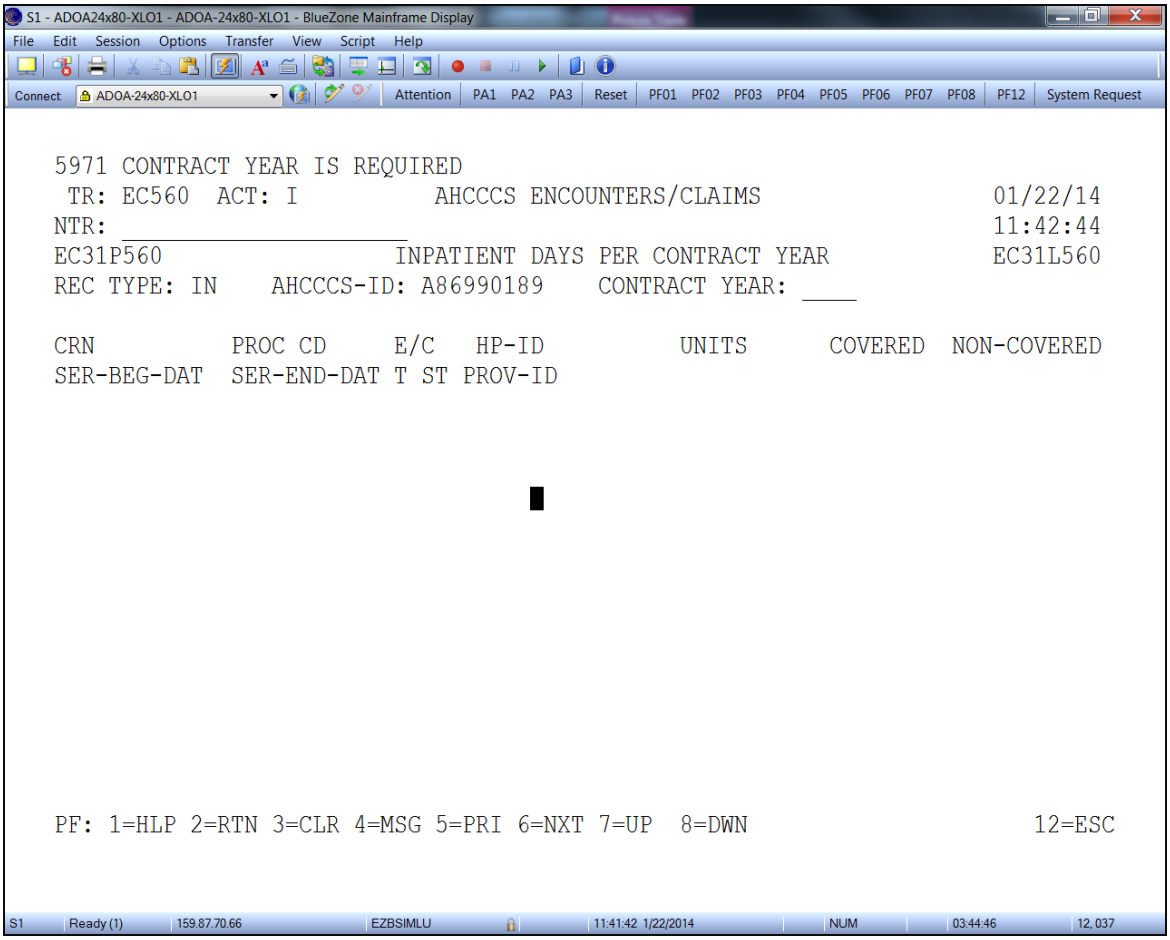
Revenue Codes to Procedure Code (RF773)

This screen identifies the valid procedure code for each revenue code.



AHCCCS Encounters/Claims (EC560)

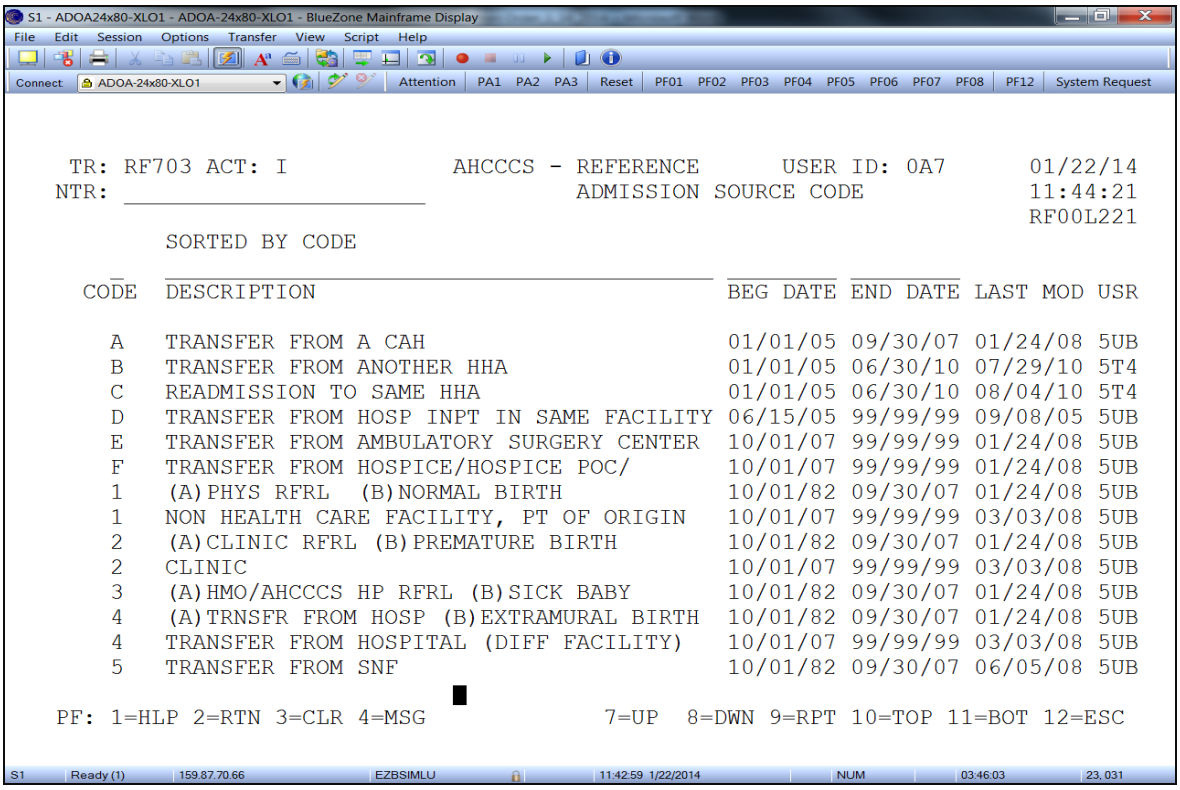
This screen provides member specific information and provides the used benefit information, for the contract year, such as inpatient days and therapy limits.



Edit Error – Z297 Inpatient Limit Exceeded, Z295 Allowed number of Physical Therapy Visits Exceeded.

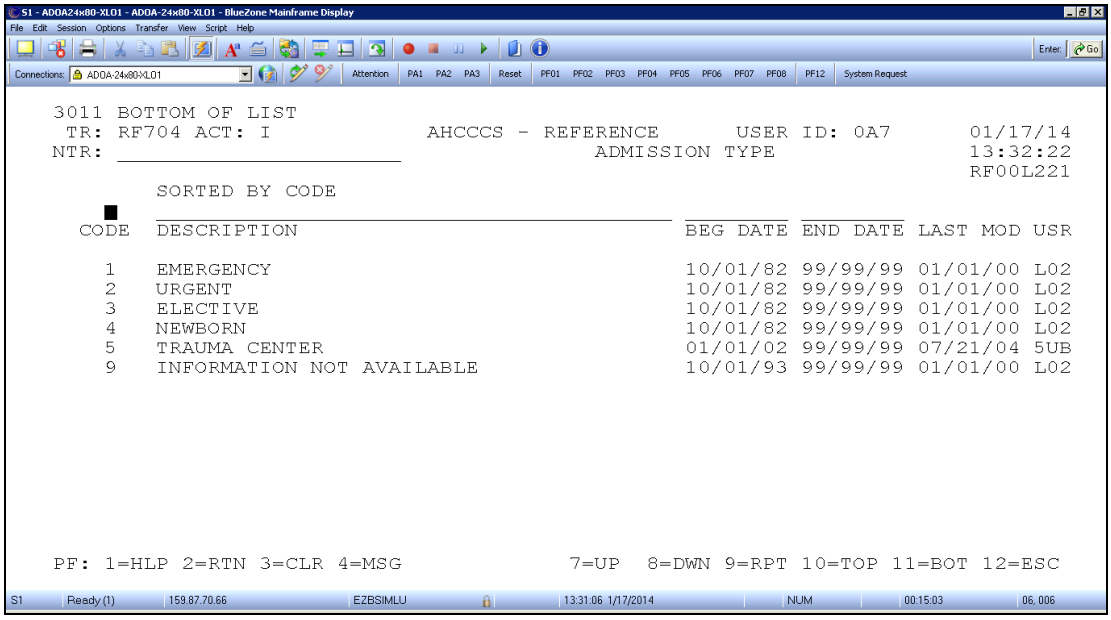
Admission Source Code (RF703)

This screen displays the valid admit source codes to be used when submitting inpatient encounters. Admit source is required on inpatient encounters.



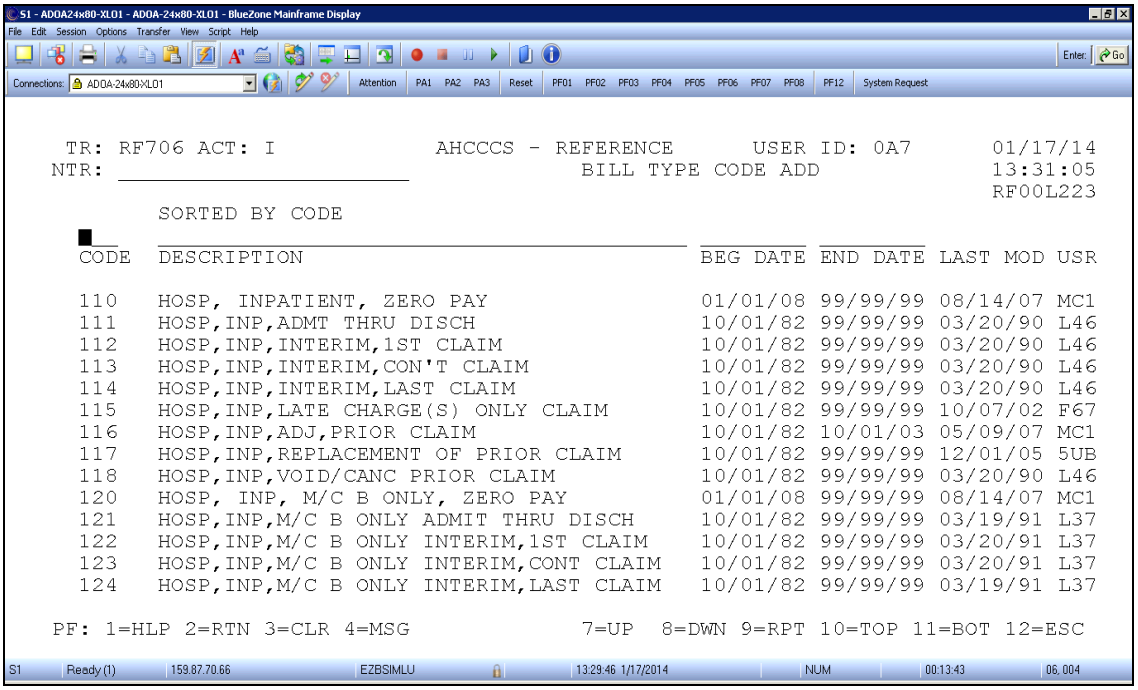
Admission Type (RF704)

This screen displays the valid admit type codes required when submitting inpatient encounters.



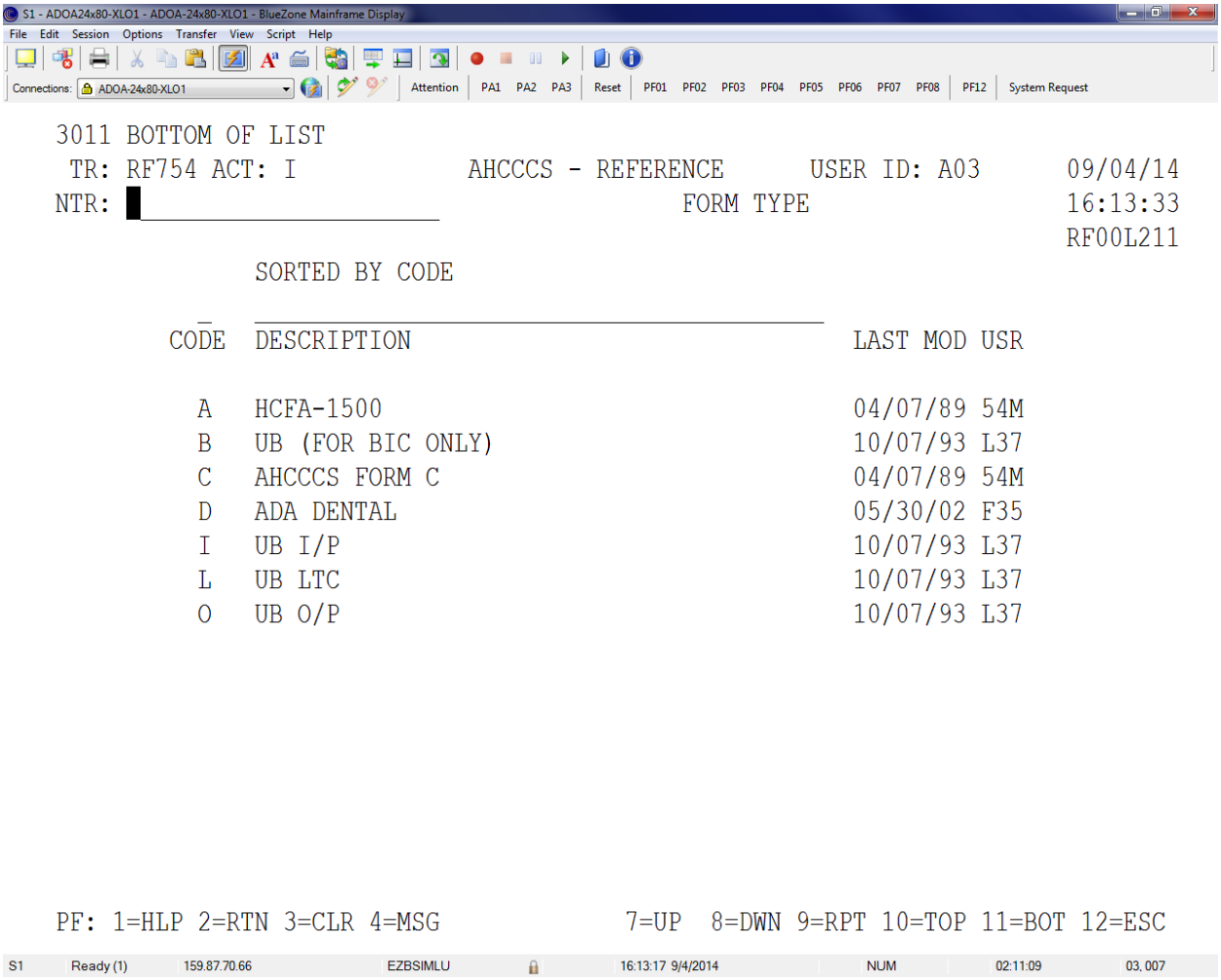
Bill Type (RF706)

This screen displays the valid bill type codes to be used when submitting inpatient/outpatient encounters.

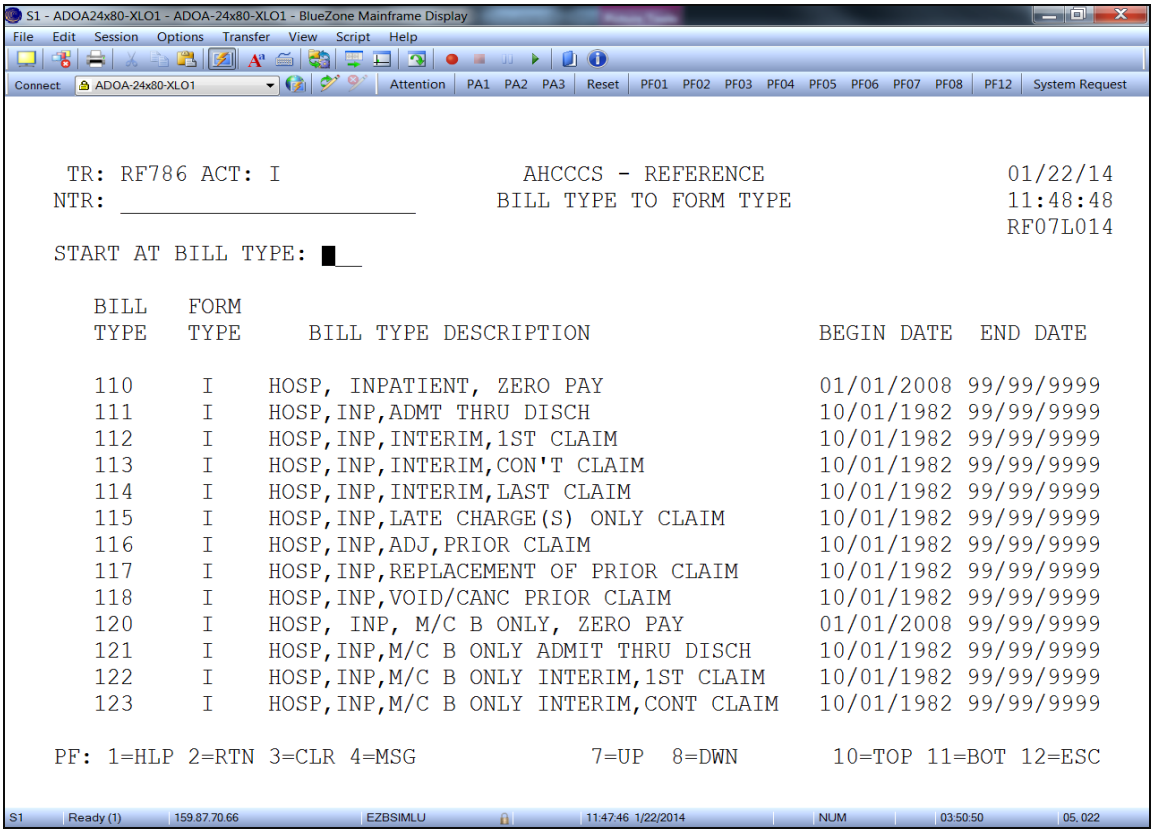


Form Type (RF754)

This screen displays the valid form type codes to be used when submitting inpatient/outpatient encounters.

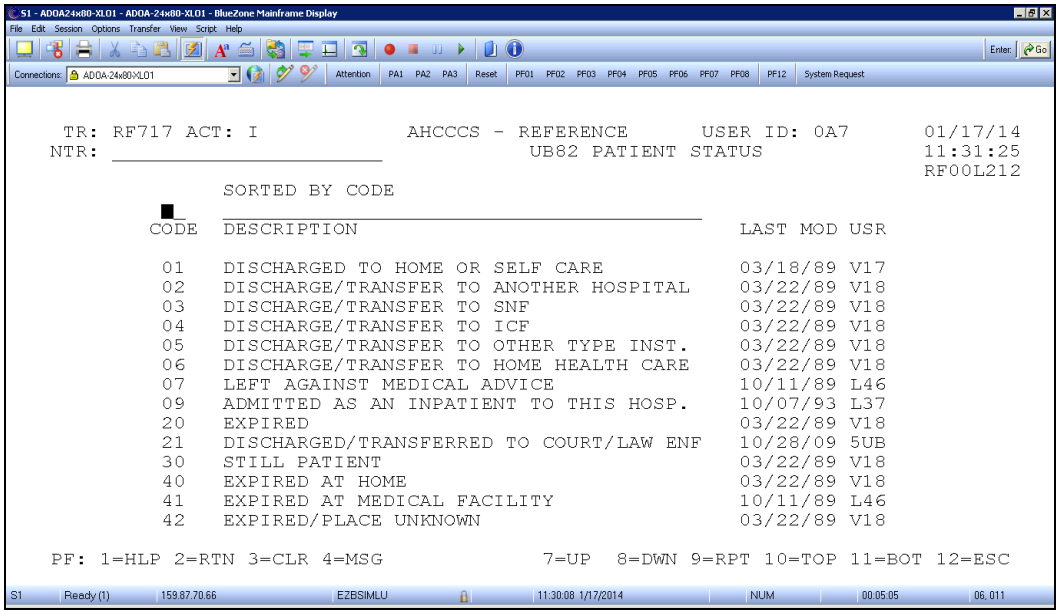


Bill Type to Form Type (RF786)



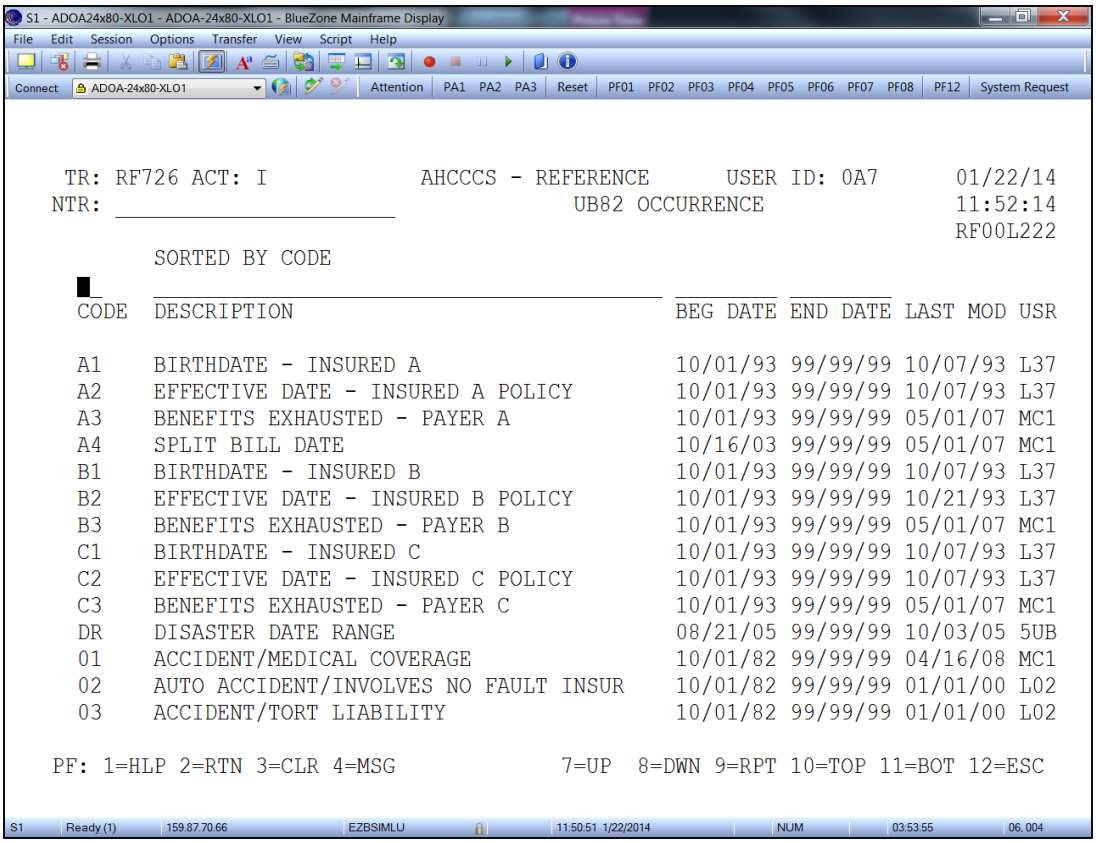
UB Patient Status (RF717)

This screen displays the valid patient status codes to be used when billing inpatient services. Note: patient status 30 should only be used with continued stay bill types.



```
TR: RF717 ACT: I            AHCCCS - REFERENCE      USER ID: 0A7      01/17/14
NTR: ____________________              UB82 PATIENT STATUS            11:31:25
                                                                      RF00L212
              SORTED BY CODE
          _____________________________________________
        CODE  DESCRIPTION                                LAST MOD USR

         01   DISCHARGED TO HOME OR SELF CARE             03/18/89 V17
         02   DISCHARGE/TRANSFER TO ANOTHER HOSPITAL      03/22/89 V18
         03   DISCHARGE/TRANSFER TO SNF                   03/22/89 V18
         04   DISCHARGE/TRANSFER TO ICF                   03/22/89 V18
         05   DISCHARGE/TRANSFER TO OTHER TYPE INST.      03/22/89 V18
         06   DISCHARGE/TRANSFER TO HOME HEALTH CARE      03/22/89 V18
         07   LEFT AGAINST MEDICAL ADVICE                 10/11/89 L46
         09   ADMITTED AS AN INPATIENT TO THIS HOSP.      10/07/93 L37
         20   EXPIRED                                     03/22/89 V18
         21   DISCHARGED/TRANSFERRED TO COURT/LAW ENF     10/28/09 5UB
         30   STILL PATIENT                               03/22/89 V18
         40   EXPIRED AT HOME                             03/22/89 V18
         41   EXPIRED AT MEDICAL FACILITY                 10/11/89 L46
         42   EXPIRED/PLACE UNKNOWN                       03/22/89 V18

PF: 1=HLP 2=RTN 3=CLR 4=MSG            7=UP  8=DWN 9=RPT 10=TOP 11=BOT 12=ESC
```

UB82 Occurrence (RF726)



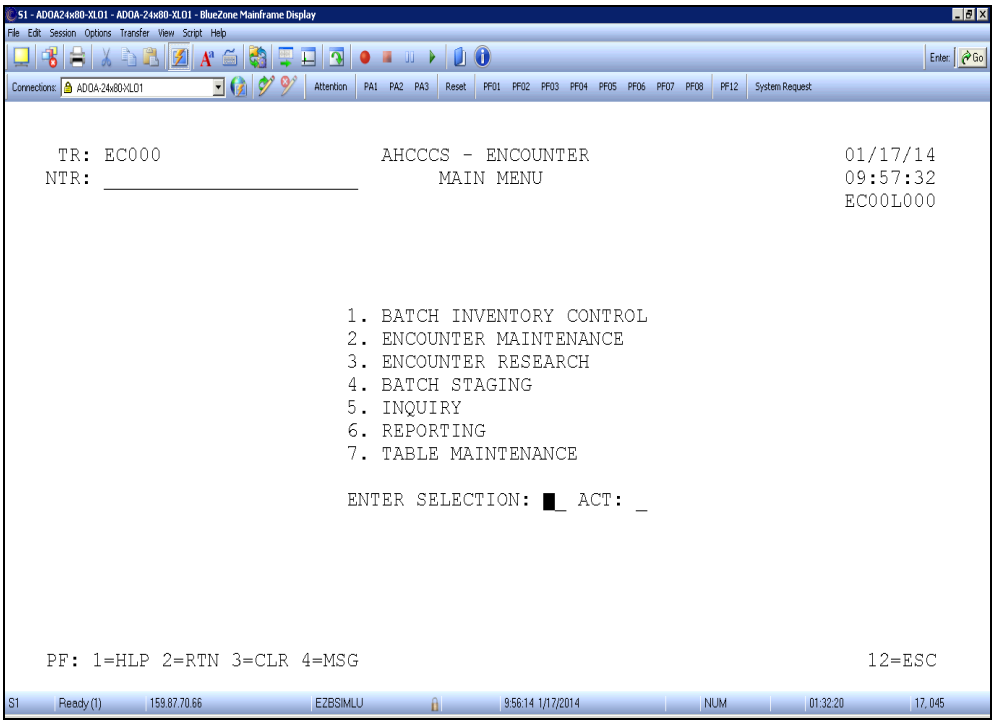
```
TR: RF726 ACT: I            AHCCCS - REFERENCE      USER ID: 0A7      01/22/14
NTR: ____________________              UB82 OCCURRENCE                11:52:14
                                                                      RF00L222
        SORTED BY CODE
          _____________________________________________ ________ ________
        CODE  DESCRIPTION                                BEG DATE END DATE LAST MOD USR

        A1    BIRTHDATE - INSURED A                      10/01/93 99/99/99 10/07/93 L37
        A2    EFFECTIVE DATE - INSURED A POLICY          10/01/93 99/99/99 10/07/93 L37
        A3    BENEFITS EXHAUSTED - PAYER A               10/01/93 99/99/99 05/01/07 MC1
        A4    SPLIT BILL DATE                            10/16/03 99/99/99 05/01/07 MC1
        B1    BIRTHDATE - INSURED B                      10/01/93 99/99/99 10/07/93 L37
        B2    EFFECTIVE DATE - INSURED B POLICY          10/01/93 99/99/99 10/21/93 L37
        B3    BENEFITS EXHAUSTED - PAYER B               10/01/93 99/99/99 05/01/07 MC1
        C1    BIRTHDATE - INSURED C                      10/01/93 99/99/99 10/07/93 L37
        C2    EFFECTIVE DATE - INSURED C POLICY          10/01/93 99/99/99 10/07/93 L37
        C3    BENEFITS EXHAUSTED - PAYER C               10/01/93 99/99/99 05/01/07 MC1
        DR    DISASTER DATE RANGE                        08/21/05 99/99/99 10/03/05 5UB
        01    ACCIDENT/MEDICAL COVERAGE                  10/01/82 99/99/99 04/16/08 MC1
        02    AUTO ACCIDENT/INVOLVES NO FAULT INSUR      10/01/82 99/99/99 01/01/00 L02
        03    ACCIDENT/TORT LIABILITY                    10/01/82 99/99/99 01/01/00 L02

PF: 1=HLP 2=RTN 3=CLR 4=MSG            7=UP  8=DWN 9=RPT 10=TOP 11=BOT 12=ESC
```

Encounters

Section Introduction

An encounter is a record of a medically related service rendered by a registered AHCCCS provider to an AHCCCS member enrolled with a capitated contractor on the date of service adjudicated by that contractor.

Encounter Main Menu (EC000)



Of the 7 options, only 2 will be addressed in this overview: **Encounter Maintenance (2)** and **Inquiry (5)**. These sections are used to view an encounter, discover why an encounter has pended, test a corrected pend, and track changes made to pends.

The most commonly used screens are:

- HCFA Inquiry (EC205)
- UB Inquiry (EC810)
- Drug Inquiry (EC215)
- Dental Inquiry (EC203)
- Error Correction Audit Trail (EC261)
- Error Override Audit Trail (EC262)
- Error Audit Trail (EC263)
- Duplicate Check (EC270C)

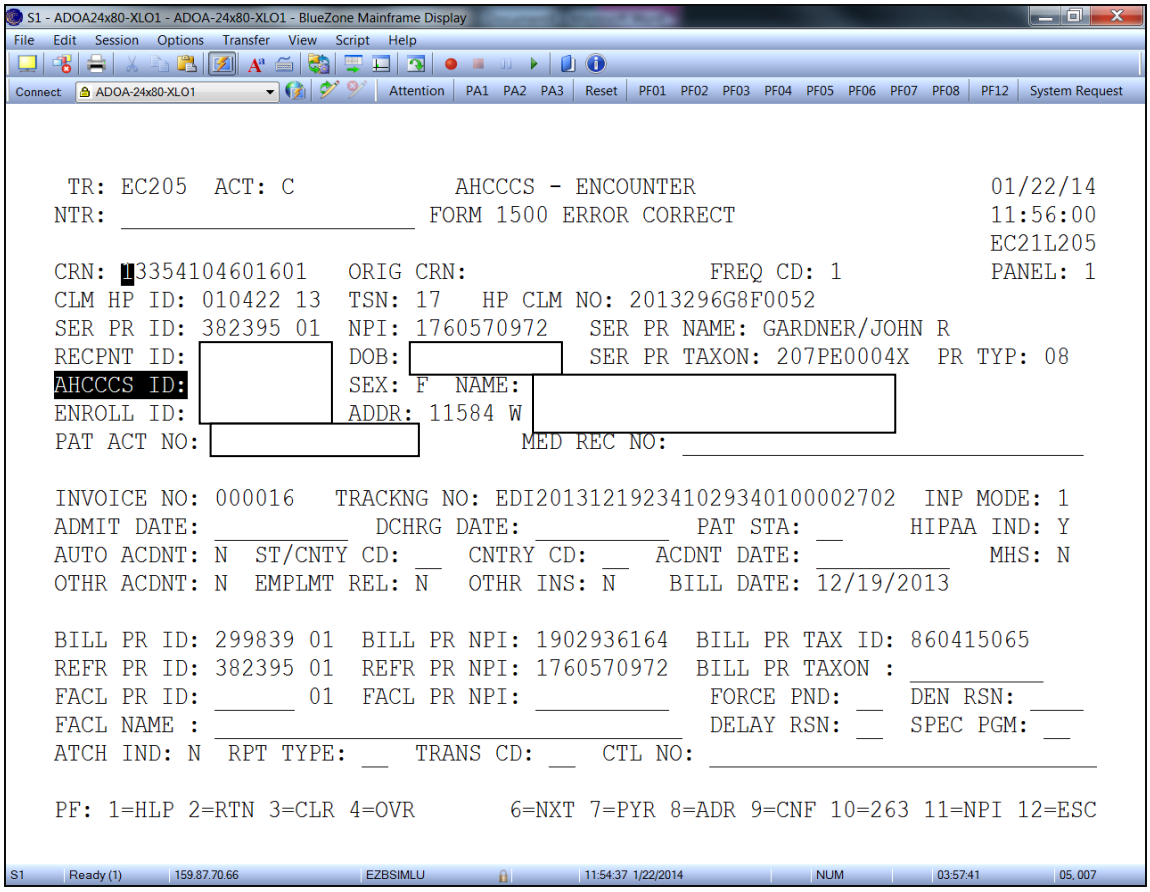
- Recipient Activity Inquiry (EC510)
- Error to Field Inquiry (EC735) found in 7 Table Maintenance

AHCCCS Claim Reference Number:

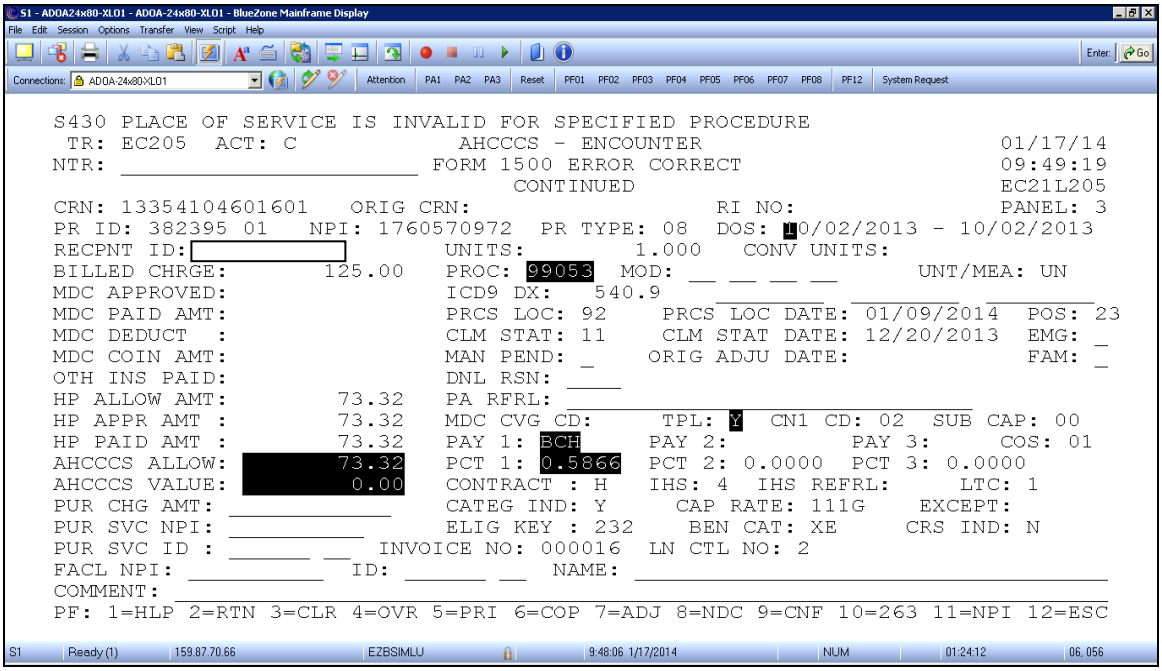
Bytes 1-5 equal Julina Calendar date encounter was processed
Bytes 6-12 unique encounter number assigned by AHCCCS
Bytes 13-14 to digit sequence number that indicates line number on the encounter

Form 1500 Inquiry (EC205)

This inquiry screen allows the viewing of Form 1500 encounters that have been submitted to AHCCCS. The encounter's information can be checked for accuracy, status, and where the encounter is located within PMMIS during the encounter processing cycle/s. One reason to pull up a Form 1500 encounter would be if it pended at AHCCCS.



To get to the Payment screen, press <F6> twice.



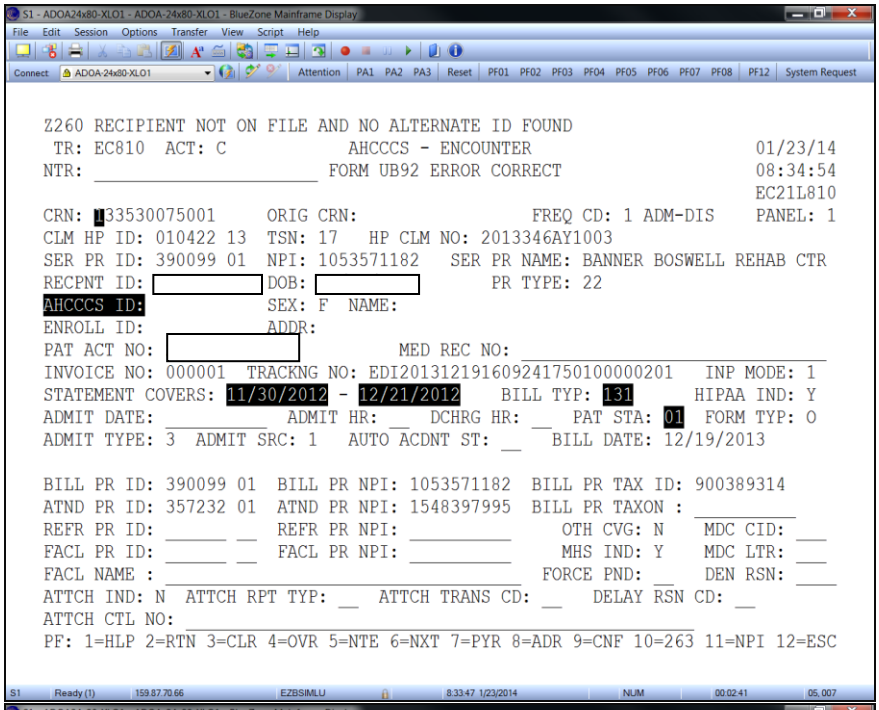
The function keys at the bottom of this screen have these unique functions:

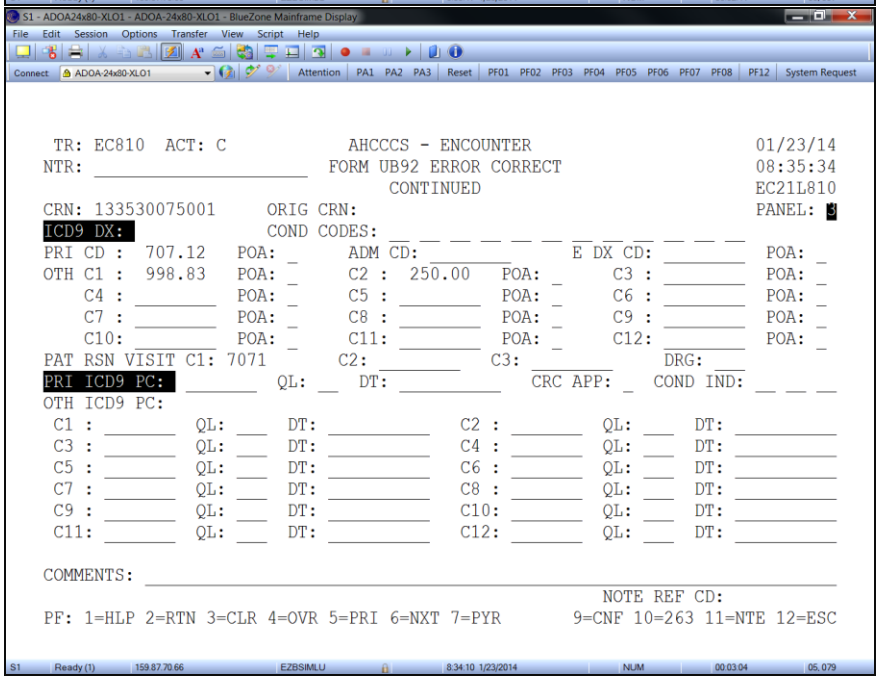
<F5> Change to previous screen
<F6> Copay Table
<F7> Line Adjudication information
<F8> Drug Information
<F10> Screen EC263 (Error Audit Trail)

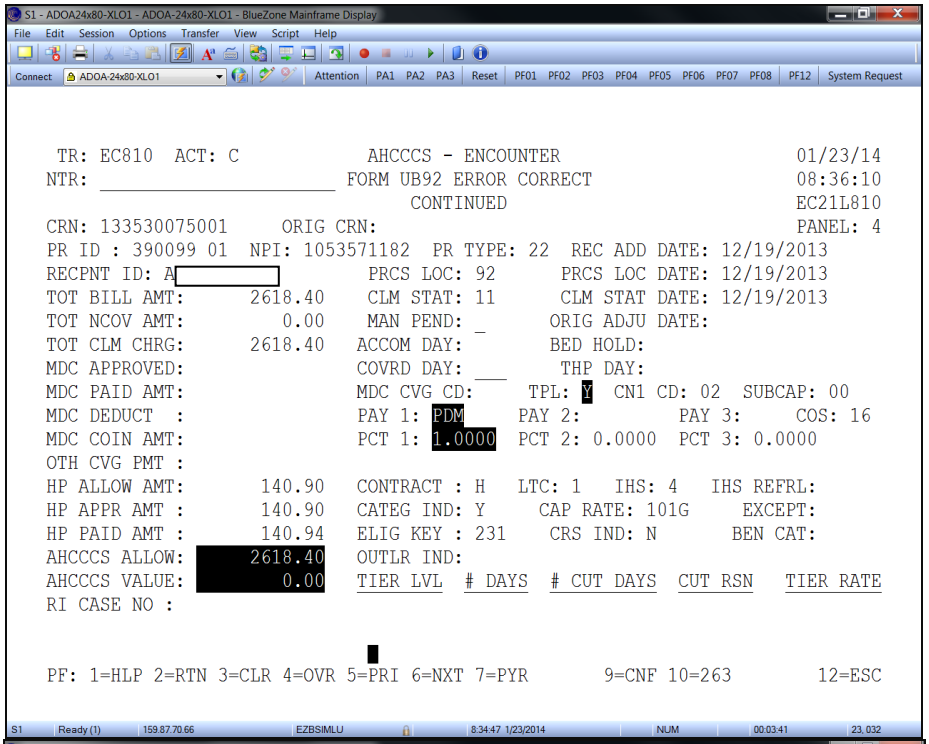
Note: To return from the Copay Table, use the <F5> key to go back to the payment screen.

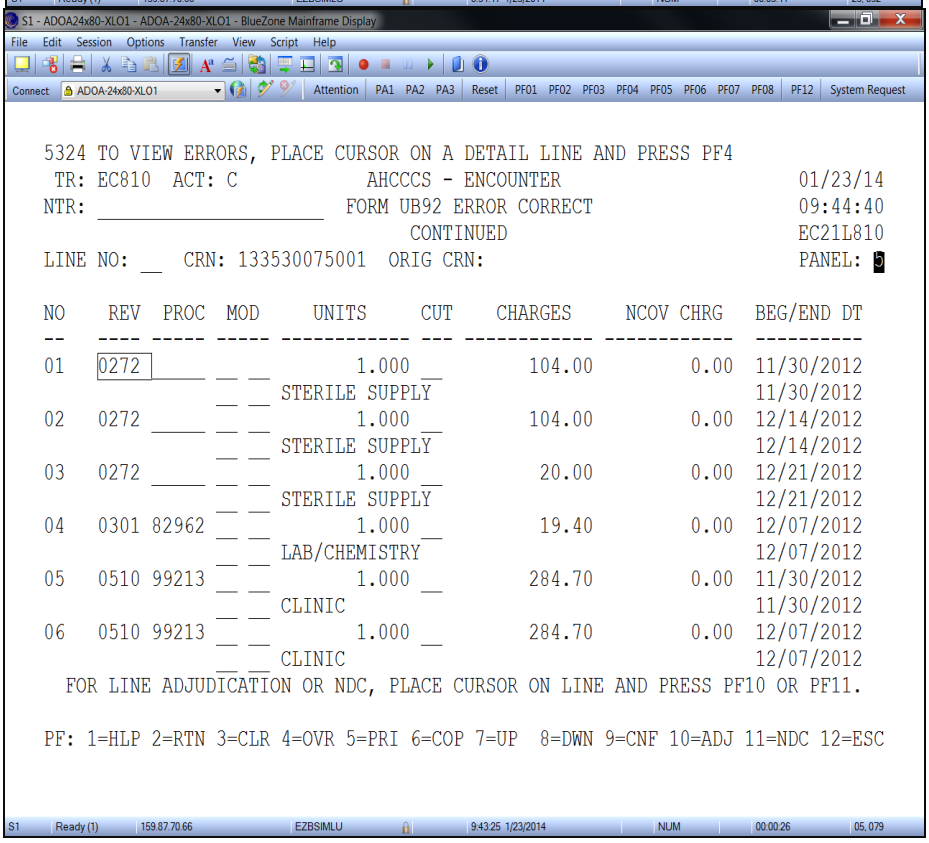
UB Inquiry (EC810)

This inquiry screen will allow the viewing of UB encounters that have been submitted to AHCCCS. The encounter's information can be checked for accuracy, status, and processing locations. One reason to pull up a UB encounter would be if it pended at AHCCCS.





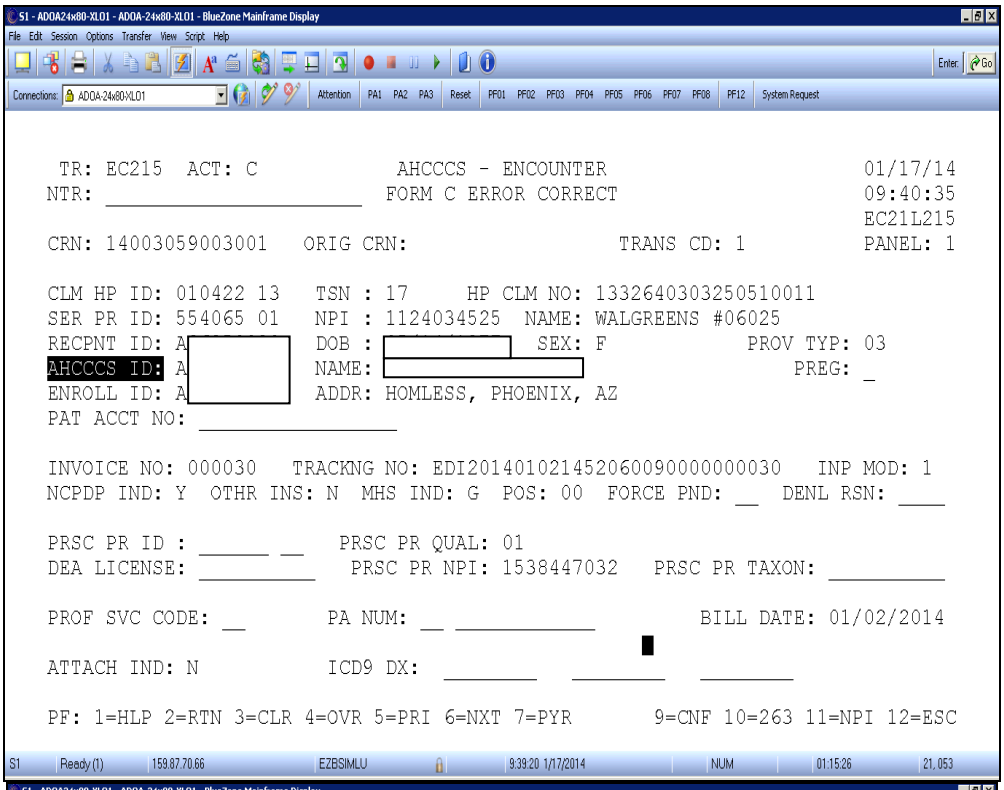


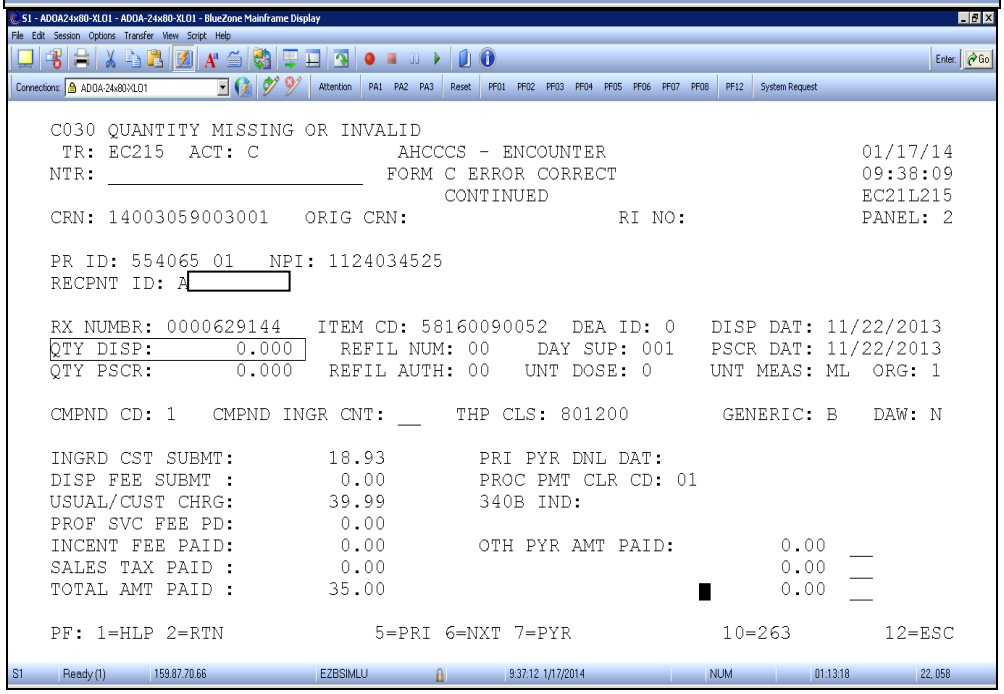


Encounter is pending for P340 - Provider Specific Rate Not On File For DOS

Pharmacy Inquiry (EC215)

This inquiry screen allows the viewing of Pharmacy encounters that have been submitted to AHCCCS. The encounter's information can be checked for accuracy, status, and processing locations. One reason to pull up a Pharmacy encounter would be if it pended at AHCCCS.

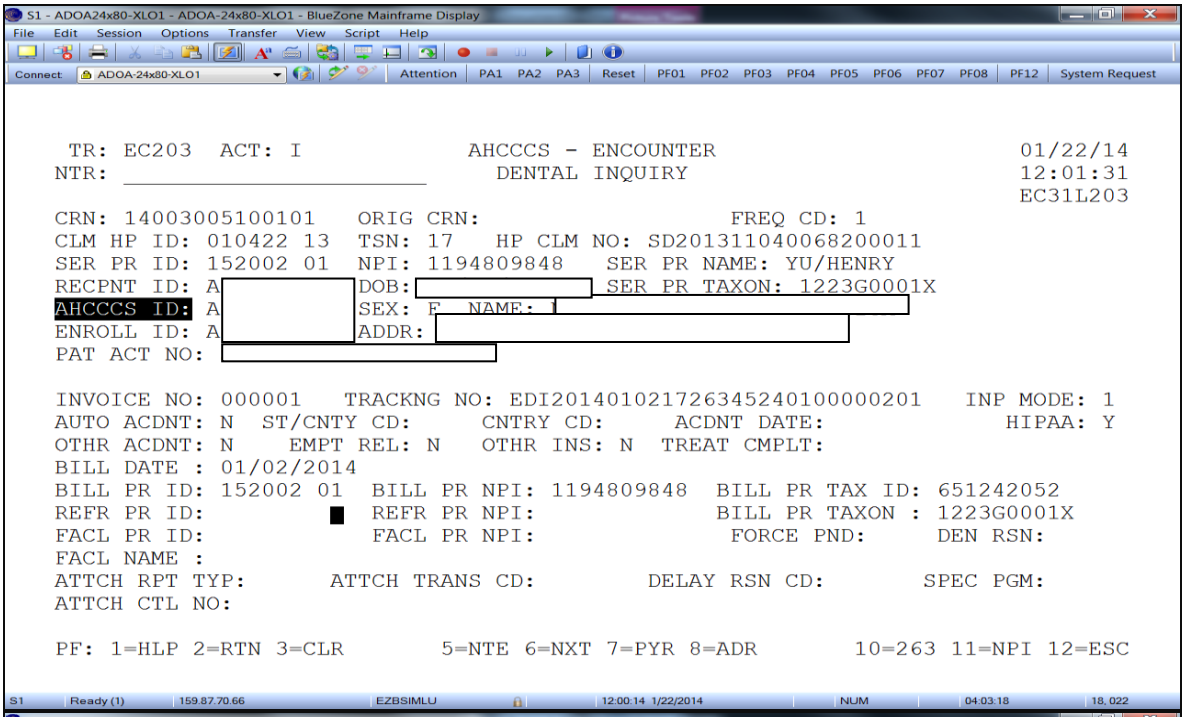


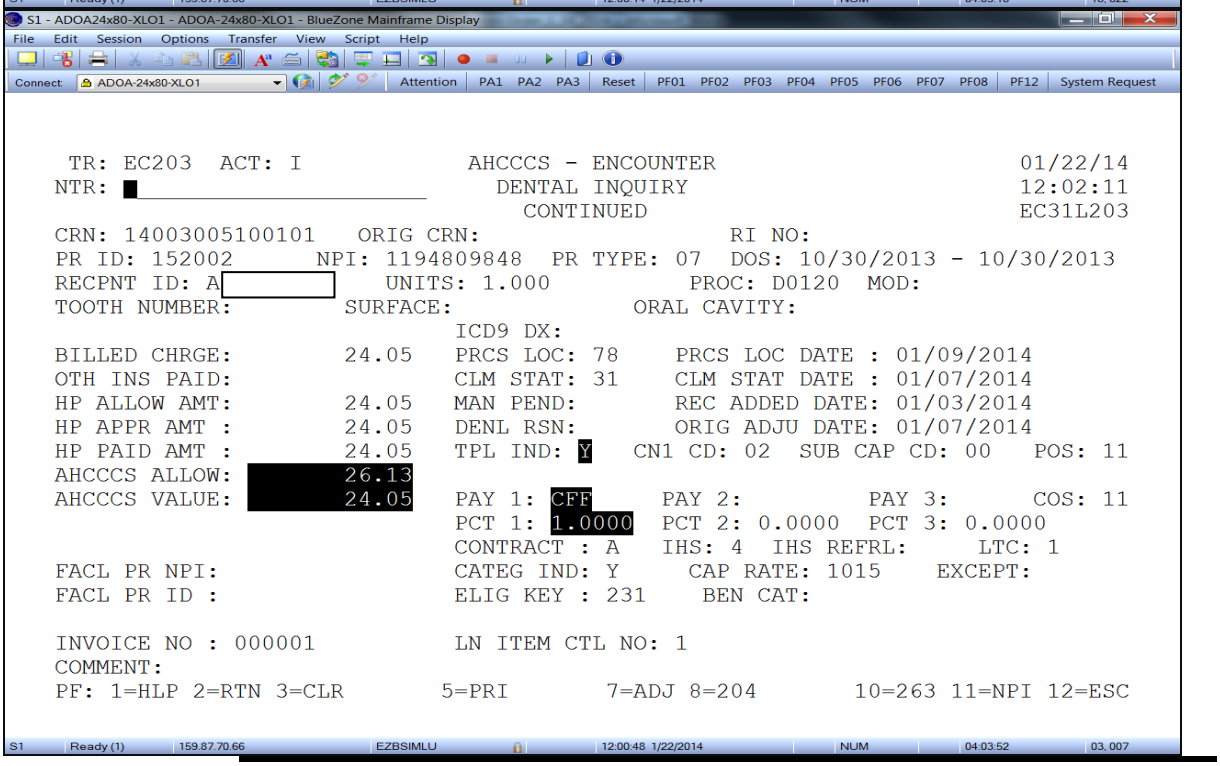


Error Code: C030 – Quantity Missing or Invalid

Dental Inquiry (EC203)

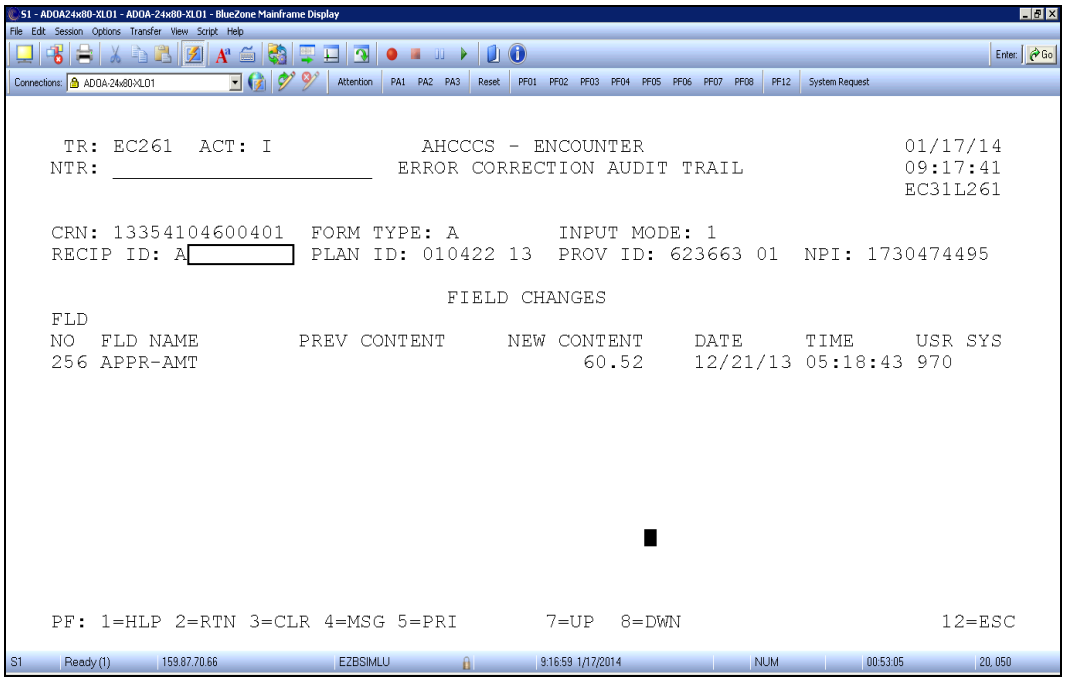
This inquiry screen allows the viewing of Dental encounters that have been submitted to AHCCCS. The encounter information can be checked for accuracy, status, and processing locations. One reason to pull up a Dental encounter would be if it pended at AHCCCS.





Error Correction Audit Trail (EC261)

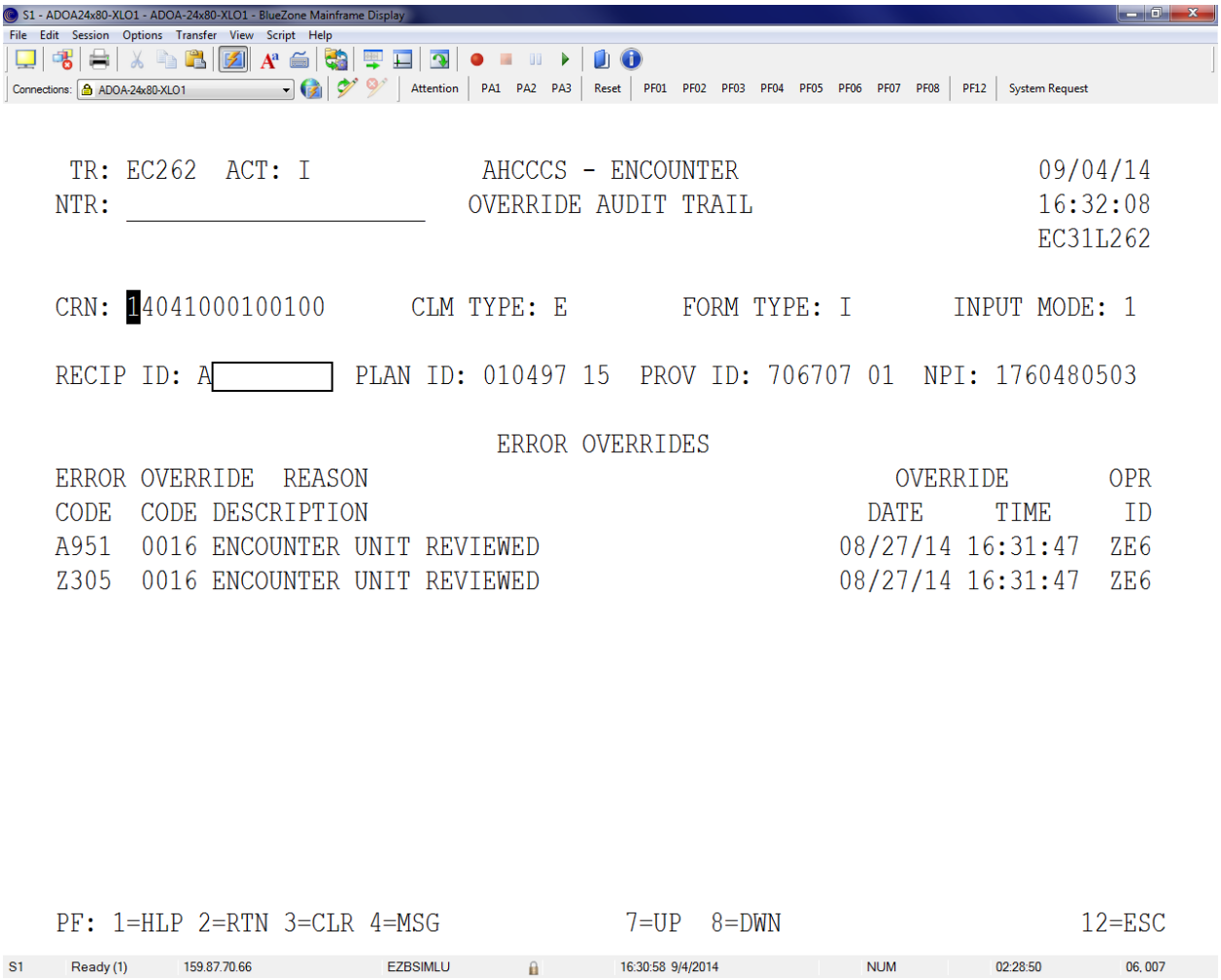
When corrections are made to fields within an encounter, the Error Correction Audit Trail screen keeps track of these changes.



The picture of the screen indicates that there was a correction to the Appr-Amt (Approved Amount) field. Previously there was no approved amount, and now they have added the amount of $60.52 field. This screen shows the date, time, and who made the change.

Error Override Audit Trail (EC262)

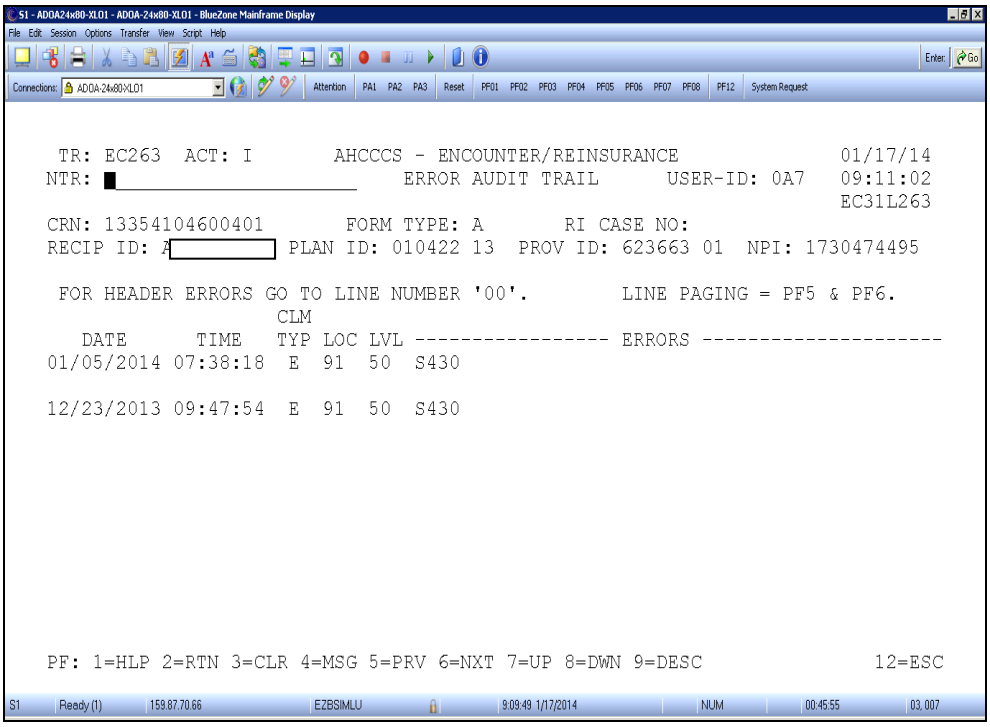
An Encounter might require an override if it has pended at AHCCCS but the encounter contains correct and acceptable information. This screen shows when an encounter's pend error was overridden by AHCCCS so the encounter could be accepted.



This screen lists the error code that the encounter was pended for, the override reason code (override reason code screen RF747), date, time, and who overrode the error.

Error Audit Trail (EC263)

The Error Audit Trail screen is a log of the encounter being submitted/ pended and the soft and hard edits associated with each line during each submission. To view the different line of the encounter, add the line number to the back of the CRN. For example, if you wanted to see line 2 of encounter with the CRN of 13354104600401 you would type in 13354104600402.

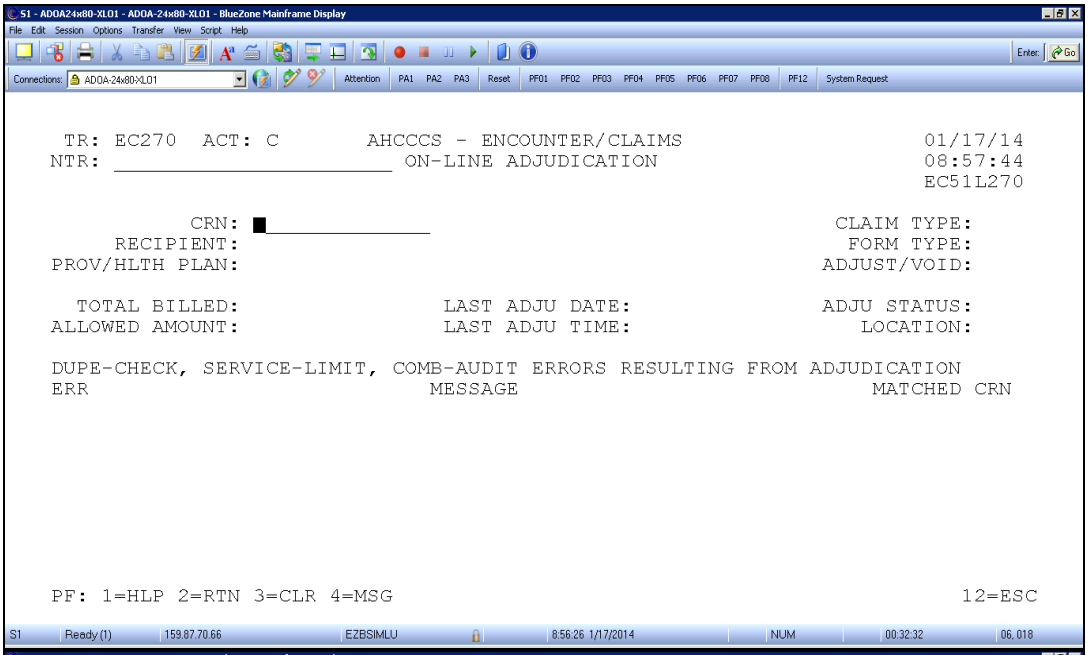


The location is identified by referencing (RF711), the level by referencing (RF738), and errors by referencing (EC710).

Each date represents when the encounter is introduced to an edit process. The error codes indicate the soft/hard edits encountered at the various steps in the process. If there are errors and no location or level codes, then the edit is soft which means the encounter will not be pended. To verify if an edit is soft or hard, utilize screen (EC710).

Duplicate Check (EC270C)

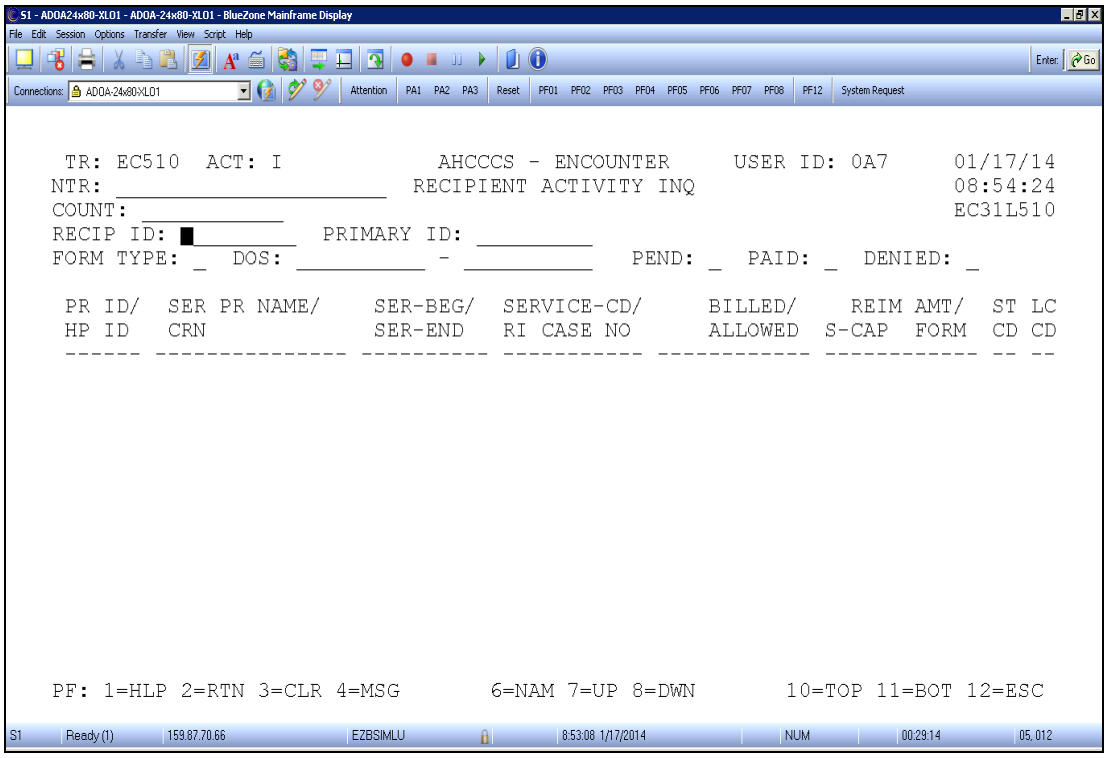
An encounter can be pended because it closely resembles another encounter. This is known as duplicating. This is signified with the pend errors stating either a near duplicate or an exact duplicate. To find the CRN that the encounter is duplicating against, access EC270C and type in the CRN of the encounter that received the duplicate error.

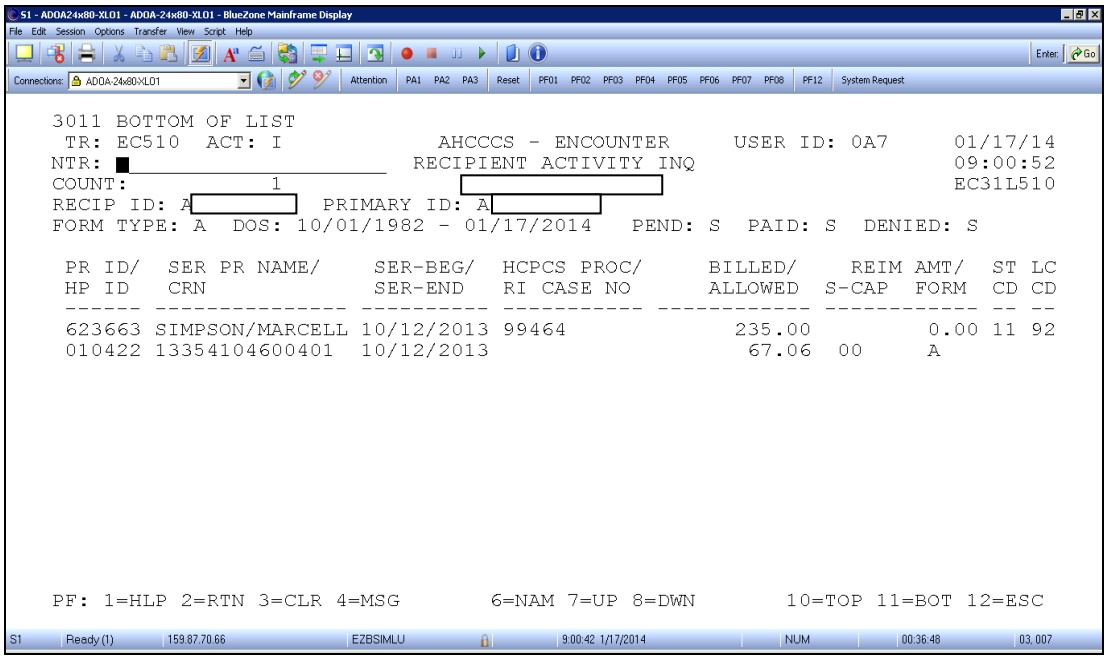


The CRN of the encounter that was found to be a near duplicate or an exact duplicate will be under the field matched CRN. You can then research the matched CRN.

Recipient Activity Inquiry (EC510)

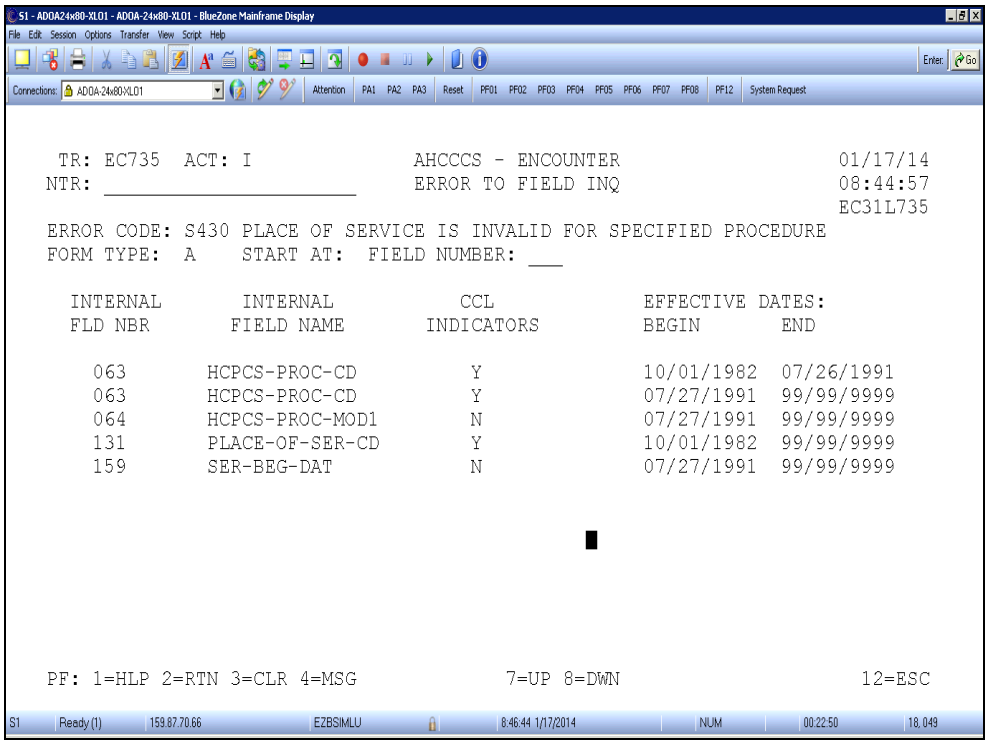
This screen provides a history of encounters/claims submitted for a particular recipient. The search can be performed or narrowed with entering of form type, date of service, and other information. The history of encounters/claims for a recipient can help identify why frequency limit errors are happening or to locate a CRN.





Error to Field Inquiry (EC735)

AHCCCS pend errors are activated due to questionable data in a field. This screen allows you to enter the pend error code and form type to see what fields are involved with that particular pend. YOU must enter B for UB edits on form types I, O and L.



Contractor Request to Override Pended Encounters

Override requests should be submitted to the AHCCCS Encounter Unit utilizing the '**Override Request Form**" below. Sufficient information must be submitted in order to approve and override the pend error. Overrides completed by the Contractor in PMMIS or the pend correction file must be submitted separately. If possible, the override request will be processed with 30 days. AHCCCS expedites override request related to reinsurance cases. Override requests involving reinsurance should be notated on the request.

https://www.azahcccs.gov/PlansProviders/HealthPlans/encounters.html

Edit Status Report Table

This report list all error codes, descriptions, form types. Can be found on the AHCCCS website:

https://www.azahcccs.gov/PlansProviders/HealthPlans/encounteradjudicationresources.html