



AHCCCS Office of Administrative Legal Services

Claims Dispute Overview

Third Quarter 2019

OALS Claims Dispute Process

Effective August 16, 2018 the Office of Administrative Legal Services (OALS) implemented an online process for submission of claim disputes.

The claim dispute process however should not be used for claim denials that are a result of a provider billing or coding error, untimely submission of a claim, not submitting the appropriate documents to support the facts of the case, or a prior authorization that may require a corrective action by the provider (e.g. change in CPT code, date of service, units, etc).

A claim dispute must state in detail the factual and legal basis for the claim dispute and the relief requested (e.g. payment, specific claim denial reason(s), quick pay discount). The dispute must include any / all documents which support the facts of the case. Claim disputes that lack specificity will be denied.

The claims dispute process cannot be used to submit claims corrections, provide documentation requested by the Prior Authorization or Medical Review teams or to file a claim Resubmission or Reconsideration request.

Providers should refer to the AHCCCS Fee for Service Provider Manual, Chapter 28 Claims Dispute, and the AHCCCS IHS/Tribal Provider Billing Manual, Chapter 19 Claims Disputes, for additional information regarding the claim dispute process.

Constant Contact Release Mar 22, 2019

Claim Dispute Process

- The claim dispute process is used to resolve disputes regarding post-service payment denials and payment disputes.
- If a claim is pending in the AHCCCS claims processing system, a claim dispute will not be investigated until the claim is paid or denied.
- A delay in processing a claim by the AHCCCS Administration may be cause for OALS to consider a claim dispute on a Pended claim, provided all claim dispute deadlines are met.

Your Remittance Notice

Claim Denials - The explanation of benefits (EOB) or remittance advice details the reason a claim is approved or denied.

The EOB will also provide “remark codes” to provide further detail in regards to the denial reason and what additional information may be required for review.

Time Limits for Filing a Dispute

The initial claim must be received by AHCCCS

- ✓ 6 months of the date of service.
- ✓ 6 months from the retro-eligibility posting date.
- ✓ 6 months from the date of discharge for an Inpatient hospital claim.
- ✓ The date that a dispute is received by OALS is considered the date the claim dispute is filed.

Time Limits for Filing a Dispute

The timeline for filing a claim dispute is:
the greater of:

- 12 months from the date of service.
- 12 months from the posting of eligibility.
- 60 days from the denial of a timely submitted claim.

Invalid Appeal/Dispute Requests

- ✓ Requests for an authorization or an update to an existing authorization.
- ✓ Submission of corrected claims.
- ✓ Submission of missing documents
- ✓ Documents requested by DFSM
- ✓ Requests to reprocess claims (provider updates (Group biller affiliation, Tax ID, etc)

Invalid Appeal / Dispute Requests

- ✓ Services not covered under the plan.
- ✓ Incorrect code for the service.
- ✓ Incomplete information for review.
- ✓ Wrong member ID

Important: A corrected claim submission including medical documentation should be submitted to the AHCCCS Claims department for reconsideration.

Resolving Claim Disputes

If the provider has exhausted all authorized processing procedures and still has a disputed claim, the provider has the right to file a claim dispute with the Office of Administrative Services.

Emergency Medical Treatment & Labor Act (EMTALA)

In 1986, Congress enacted the Emergency Medical Treatment & Labor Act (EMTALA) to ensure public access to emergency services regardless of ability to pay.

Citing EMTALA as the reason for the dispute does not override AHCCCS requirements for coverage, medical review or approval of a claim.

Services that may be deemed “**Medically Necessary**” may not meet the Federal definition for “emergency” care.

Federal Emergency Service Plan

AHCCCS provides emergency health care services through the Federal Emergency Services Program (FESP) for qualified and nonqualified aliens, as specified in 8 USC 1611 et seq., who meet all requirements for Title XIX eligibility as specified in the State Plan except for citizenship.

Federal Emergency Service Plan

- Any services billed must meet the federal definition of emergency services as defined in federal law within section 1903(v)(3) of the Social Security Act and 42 CFR 440.255 in order for a claim to be considered for reimbursement.
- “Emergency medical or behavioral health condition” for a FESP member means a medical condition (including labor and delivery) or a behavioral health condition manifesting itself by acute symptoms of sufficient severity, including extreme pain, such that the absence of immediate medical attention could reasonably be expected to result

in:

Covered Services and Limitations

- 1. Placing the member's health in serious jeopardy;
- 2. Serious impairment to bodily functions;
- 3. Serious dysfunction of any bodily organ or part; or
- 4. Serious physical harm to self or another person (for behavioral health conditions).

IMPORTANT: Only services that fully meet the federal definition of an emergency medical condition will be covered. Services may be medically necessary, but may not meet this definition for FES Program.

FES PLAN GUIDELINES

In accordance with the Balanced Budget Act, prior authorization cannot be required for emergency services.

Each time emergency services are delivered to an FES Program member, “the Federal criteria for an emergency medical condition must be met in order for the claim to be considered for payment”.

FES PLAN GUIDELINES

Services rendered through the FESP are subject to all exclusions and limitations on services in [R9-22-217](#).

This includes, but is not limited to, the limitations on inpatient hospital services as described in R9-22-204 and AMPM Chapter 300, Policy 310-K, Hospital Inpatient Services.

FES PLAN GUIDELINES

All emergency services under the FESP, in any setting, *are subject to retrospective review* to determine if an emergency did exist at the time of service. If AHCCCS determines that the service did not meet the *definition of an emergency medical or behavioral health condition then the following actions may occur:*

- 1. Denial or recoupment of payments,
- 2. Feedback and education to the provider, and/or
- 3. Referral for investigation, if there appears to be a pattern of inappropriate billing.

Claims Submission & Documentation Requirements

FESP members are not enrolled in health plans and they have no primary care physician.

Claims for services are reimbursed by the AHCCCS Administration on a Fee-For-Service basis if services meet the Federal definition of emergency services.

Claims Submission & Documentation Requirements (continued)

All claims for services provided to members eligible under the FES and FFS program will be *reviewed by the AHCCCS Administration on a case-by-case basis.*

All claims must be submitted to AHCCCS with documentation that supports the emergent nature of the services provided or AHCCCS must have remote access to the medical records.

Important Billing Rules

The appropriate emergency indicator and Admission Type code must be included on each claim submission for an FESP/FFS member.

CMS 1500 /837P	Field 24C (EMG) must be completed with a 'Y' or 'X'.
UB-04 / 837	The Admit Type Field 14 identifies the type of visit. Per AHCCCS guidelines Admit Type "1" identifies the service as an "EMERGENCY" and must be included on the UB-04 for Inpatient and Outpatient services.

Important Billing Rules

If the Fields are not completed correctly, it will result in a denial of the claim and the biller must submit a corrected claim with the appropriate fields completed for consideration.

- ✓ **Important: Filing an appeal for an improperly completed claim form is not accepted.**

Edit Denial Reasons

Edit Code	Description	Action
MD034	Emergency Criteria Not Met	Medical review denial. Option to contact CS for reviewer comments.
H140.3	Primary Diagnosis not covered for contract type	Review claim data, make correction if appropriate.
L028.3	Diagnosis not covered for contract type	Review claim data, make correction if appropriate.
L076.4	Claim received past 6 month limit.	Did not meet the time frame for claim submission.
H218.4	Service not covered for ESP recipient must be emergency or PA.	Review the Admit type field. (UB-04)
L101.1	Service not covered for ESP recipient; must be emergency.	Review the EMG Field 24C on the CMS 1500.

Charges To Members R9-22-702

AHCCCS (Title 9, Health Services)

The state rules about AHCCCS are found in Title 9 of the Arizona Administrative Code, and include the following:

<https://www.azahcccs.gov/PlansProviders/CurrentProviders/State/AAC.html>

RECAP

- Review the denials on the EOB or AHCCCS Web portal.
- Make appropriate corrections and resubmit the claim (within timely) to the claims dept.
- Provide the requested documentation.
- Ensure the claim is coded correctly.
- EDI submissions reduce delay times.
- Upload Medical Records (EDI)

Questions?



Thank You

