Chapter 57 Third Party Liability

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CHAPTER 57-A INTRODUCTION

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This chapter applies to the following Division-specific service codes: Therapy Service Codes OTA, OEA, PTA, PEA, STA, SEA, PTI, OTI, and STI; Nursing Service Codes HN1, HNR, HNV, HN9, ICM, NF 1, NF 2, and NF 3.

"Other Payors/Third Party Liability (TPL)" refers to the resources available from a person or entity that is, or may be, by agreement, circumstance or otherwise, liable to pay all or part of the medical expenses incurred by a member eligible for Arizona Health Care Cost Containment System (AHCCCS) benefits. AHCCCS and the Department of Economic Security (DES)/Division of Developmental Disabilities (DDD), as an AHCCCS program contractor, are the payor(s) of last resort. Excluded: Medical Savings Account (MSA), Health Flex Spending Arrangement (FTA), Health Savings Account (HSA).

"Coordination of benefits" refers to the activities involved in determining Medicaid benefits when a member has coverage through an individual, entity, insurance, or program that is liable to pay for health care services.

"Cost avoidance" refers to the process of denying a claim and returning it to the provider for a determination of the amount of third-party liability.

CHAPTER 57-B STATUTORY REQUIREMENTS FOR OTHER PAYOR (THIRD PARTY LIABILITY) CLAIMS

EFFECTIVE DATE: August 5, 2016
REFERENCES: 42 CFR 433.138, 42 CFR 433.139, Deficit Reduction Act ("DRA") of 2005, A.R.S. § 36-2923, A.A.C. R9-22-1002, A.A.C. R9-22-1003, A.A.C. R9-22-1001, A.R.S. § 36-596, A.A.C. R6-6-1303, A.R.S. § 36 Chapter 5.1

A. The Arizona Health Care Cost Containment System (AHCCCS) is, by Federal law, the "payor of last resort" in most instances. "Payor of last resort" means that AHCCCS only pays claims after all other forms of payment have been exhausted. According to 42 CFR 433.138, 42 CFR 433.139, and the Deficit Reduction Act (DRA) of 2005, AHCCCS is required to take measures to identify third party payers who are responsible for paying for services provided through AHCCCS and its program contractors.

B. Arizona Revised Statutes (A.R.S.) § 36-2923 requires that private health insurers provide AHCCCS with the enrollment information and respond to AHCCCS requests for claims data necessary to ensure the time period in which the AHCCCS-eligible person or his/her spouse or dependents may or may not have been covered by the health care insurer and the nature of that coverage.

C. Arizona Administrative Code (A.A.C.) R9-22-1002 requires AHCCCS to be the payor of last resort.

D. A.A.C. R9-22-1003 requires AHCCCS to apply the principles of cost avoidance and coordination of benefits.

E. According to A.A.C. R9-22-1001, "cost avoidance" is defined as "to deny a claim and return the claim to the provider for a determination of the amounts of first and third party liability."

F. Pursuant to A.A.C. R9-22-1003(C), the responsibility to take reasonable measures to identify potentially legally liable first and third-party sources is bestowed upon AHCCCS or its program contractor, a provider, a non-contracting provider, and a member.

G. A.R.S. § 36-596 requires ADES/DDD to act as the payor of last resort unless specifically prohibited by law, and to establish a benefit recovery program for state-funded services for individuals who receive services pursuant to Title 36, Chapter 5.1 of the Arizona Revised Statutes which are covered wholly or partly by a first party health insurance medical benefit.

H. A.A.C. R6-6-1303 governs DD/non-Arizona Long Term Care System (ALTCS) Division-covered services and requires DDD to be the payor of last resort. It also requires service providers to submit Explanation of Benefits (EOB) for claim and payment processing in situations where a DDD member may have other medical benefits.

CHAPTER 57-C PAYMENTS AND DENIALS

EFFECTIVE DATE: August 5, 2016
REFERENCES: A.R.S. § 36-2904

Claims submitted on behalf of the Qualified Vendor can either be paid or denied. When submitting a claim to the Division, the Qualified Vendor must provide acceptable information, verifying the rejection or non-payment of the claim.

An Explanation of Benefits (EOB) is considered an acceptable document when the other payor/third party is an insurance company whose potential liability for the claim arises out of a contract of insurance. An EOB indicates how the payment was calculated and any reasons for non-payment. If there is more than one insurance company involved, the same process must be repeated for each insurance company.

The Qualified Vendor may submit a *COBV Waiver Request (DDD-1651A)* to the Division to indicate the member's Third Party Liability (TPL) payor was billed. Prior to submitting a *COBV Waiver Request*, the Qualified Vendor must receive a clean denial from the primary insurance company or companies (more information regarding waiver processing is available in Chapter 57-E DES/DDD Waiver Request). A request for additional or corrected information on behalf of the insurance company is not a clean denial.

According to A.R.S. § 36-2904, a "clean claim" means a claim that may be processed without obtaining additional information from the provider of service or from a third party. Clean claims do not include claims under investigation for fraud and abuse or claims under review for medical necessity. In order to be considered a clean claim, the EOB must contain, at minimum, the items listed under "Key Components of EOB" specified in Chapter 57-D Explanation of Benefits.

CHAPTER 57-D EXPLANATION OF BENEFITS

EFFECTIVE DATE: August 5, 2016

An Explanation of Benefits (EOB) is a statement provided by a health insurance company to covered individuals explaining what medical treatments and/or services were processed on their behalf.

Key Components of EOB

It is important to note that not all EOBs are the same. The format and content of the EOB depends on the benefit plan and the services provided by insurance companies. Deductible and copayment amounts may also vary.

The following are the most common and important parts of the EOB which, at a minimum, are needed for the Division's waiver review. If the EOB is missing the required information, the Qualified Vendor should contact the insurance company to obtain a corrected EOB and resubmit the corrected EOB to the Division.

A. **Provider's Name:** Name of the Qualified Vendor.

B. **Claim Information:** Includes the member/patient name, the member's group and identification numbers, and the claim number.

C. **Service Information:** Identifies the health care facility or physician, dates of service and charges, and service or bill code for each specific service.

D. **Coverage Information:** Shows what was paid to whom, what discounts and deductions were applied, and what part of the total expense was not covered.

E. **Information About Amounts Not Covered:** Shows what benefit limitations or exclusions apply.

F. **Information About Out-Of-Pocket Expenses**: Shows an amount when a claim applies toward the deductible or counts toward out-of-pocket expenses.

G. **Summary:** Highlights the financial information and identifies the amount billed, total benefits approved, and the amount owed to the provider.

H. **Reason Denial Codes/Remarks/Comments:** Most insurance companies generally use a numbering-based system to reflect the denial reason followed by comments or number-based explanation. Explanation of the denial codes is required for the Division's waiver process.

Important Considerations

A. The billed service code reflected on the EOB must correspond to an AHCCCS-approved Current Procedural Terminology codes (CPT)/Healthcare Common Procedure Coding System (HCPCS) code. Usage of unapproved codes could be grounds for denial of the waiver. If the EOB does not contain the CPT/HCPCS codes, the CMS 1500 claim form must be included for the Division's review.

B. If the EOB states "prior to the coverage effective date" or "termination of coverage," the Qualified Vendor must verify the eligibility information with the insurance company. All insurance updates must be provided to the Division TPL Benefits Coordinators at TPLBenefits@azdes.gov.

CHAPTER 57-E DES/DDD WAIVER REQUESTS

REVISION DATE: April 25, 2018
EFFECTIVE DATE: August 5, 2016

REFERENCES: *COBV Waiver Request (DDD-1651A)*, CMS 1500

Coordination of Benefits and Verification Waiver Request Form (COBV Waiver Request)

The waiver request form, *COBV Waiver Request (DDD-1651A),* is initiated by the Qualified Vendor and used by the Division to meet the coordination of benefits requirement.

Location of the Waiver Request Form

The *COBV Waiver Request (DDD-1651A)* is available via the following link: https://des.az.gov/services/disabilities/developmental-child-and-adult/help-providers. In the resulting screen, under the "Billing" header, click on "Waiver Request Form."

The Division will not accept any older versions of the form.

Required Documents

The Qualified Vendor must submit waiver requests by e-mail to TPLWaiver@azdes.gov; requests must include:

A. *COBV Waiver Request (DDD-1651A)* properly filled out (see below for more information), and

B. Each corresponding Explanation of Benefits (EOB).

If the EOB does not contain the procedure codes (CPT/ HCPCS), include the CMS 1500 form (if applicable).

Key Components of the COBV Waiver Request Form

The following is information regarding the required fields.

	Field	Explanation
1	Provider Name	Name of the billing agency
2	Provider ID Number	Tax ID or FEI Number, 9 digits
3	Four Digit Code	Four-letter alpha code assigned to the provider agency bythe Division
4	Fax Number	Fax number of the agency
5	E-Mail Address	E-mail address of the assigned individual on behalf of the agency
6	Signature	Signature of the assigned individual on behalf of the agency
7	Date	Date of completion of the Waiver form
8	Member's Name	Legal name of the member
9	ASSIST ID	Unique 10 digit number
10	Insurance name/ MCID	Name of the Insurance Company in reference to EOB along with the Master Carrier ID (MCID)
11	Service Code	The Division-assigned service code for the approved services based on the ISP
12	Start Date	Start date of the service
13	End Date	End date of the service
14	Comments	Any comments that might be helpful in understanding the submitted documentation

When to Apply for DES/DDD Waiver

The Division may grant a waiver to the Qualified Vendor, based on the following conditions:

A. When a Qualified Vendor obtains a denied EOB listing an approved service code and appropriate remarks codes and explanation from the primary insurance or third party payor.

B. If a Qualified Vendor bills for services covered under Medicare Part B, the Qualified Vendor must follow the criteria below to obtain a waiver:

1. Be a certified Medicare provider.

2. Submit a *COBV Waiver Request (DDD-1651A)* and a Medicare Part B EOB.

   Note: The waiver requirement is only applicable for Medicare Part B. Billing pertaining to Medicare Parts A, C, and D does not require a waiver.

The Division reviews all waiver requests. If a waiver request is denied, the Division notifies the Qualified Vendor via e-mail, including the reason for the denial.

Approved waivers can be viewed under "Waivers" in the Professional Billing System (PBS)."

Important Considerations

A. Each service requires a specific three-letter alpha code on *COBV Waiver Request (DDD-1651A)*.

B. Third Party Liability Exclusions

The following accounts are not considered as liable third party resources and providers will not be required to bill these types of accounts:

1. Medical Savings Account (MSA)

2. Health Flex Spending Arrangement (FTA)

3. Health Savings Account (HSA)

C. Health Reimbursement Arrangement (HRA), also known as Health Reimbursement Account or Personal Care Accounts, are a type of health insurance plan considered as a Third Party Liability resource, and providers shall bill this type of account.

CHAPTER 57-F DENIAL CODE EXPLANATION AND OTHER PAYOR / THIRD PARTY LIABILITY

EFFECTIVE DATE: August 5, 2016

The following are the most common messages that appear in the "Billing Detail Report" when there is other payor (third party liability):

	Error Description	What it Means	What Should the Qualified Vendor Do
1	*Waiver not found and reason code not supplied*	The claim submitted does not have a *COBV Waiver Request* form on file and/or a TPL payment or deductible reported within the claim line of the Uniform Billing document.	Review Focus and ensure a waiver is on file for each active policy. Submit *COBV Waiver Request* form to TPLWaiver@azdes.gov. Submit eligibility information to DDD Claims for an insurance update, if a policy is no longer active.
2	*Number of insurances does not match number of active insurances*	There is discrepancy between Focus records and the claim lines provided in the Uniform Billing Document (based on EOB submitted on behalf of the member). Claim lines provided in the Uniform Billing Document have different information (more or less) than what is available in Focus.	Review member's medical coverage and verify the insurances reported in Focus. If the insurance reported is not found in Focus, the Qualified Vendor should email TPLbenefits@azdes.gov for an insurance update. If there are two policies in Focus for the same insurance, the Qualified Vendor should email: TPLbenefits@azdes.gov for a review.

	Error Description	What it Means	What Should the Provider Do
3	*Invalid Insurance Company*	The Master Carrier ID (MCID) reported on the claim line of the Uniform Billing Document does not match Focus records.	The Qualified Vendor should review Focus and ensure the Master Carrier ID (MCID) reported in Focus matches the claim lines of the Uniform Billing Document. If the MCID on the claim line does not reflect the MCID in Focus; claim will need adjustment. If the insurance reported is not found in Focus, the Qualified Vendor should email TPLbenefits@azdes.gov for an insurance review/update.
4	*TPL amount greater than zero, no insurance on file*	The claim line reports a TPL payment; members record shows no insurance on file	The Qualified Vendor should review the member's medical coverage and verify the reported insurance found in Focus. If the insurance reported is verified, the Qualified Vendor should email TPLbenefits@azdes.gov for an insurance review/update.
5	*Pay amount plus TPL amount does not equal rate times unit*	This is an indication of the mathematical error. Rate times units minus TPL amount does not match the total amount due.	The Qualified Vendor should check the calculations of the rate times the units minus the TPL amount (if applicable) is equal to the total pay amount. ("Rate" x "Units" – "TPL amount" = "Total pay amount")

CHAPTER 57-G RESPONSIBILITIES

EFFECTIVE DATE: August 5, 2016

The following section provides additional information regarding different aspects of provider responsibility in relation to Other Payor (Third Party Liability [TPL]) processing. Due to the statutory Federal and State requirements of the Other Payor (TPL) billing process, the Qualified Vendor is responsible for creating appropriate methodologies and processes for obtaining required documentation and payment from third parties aligned with Division requirements. Qualified Vendors are required to follow specific steps for processing Other Payor (TPL) documentation at each stage of the billing process. Steps may include, but are not limited to, resubmitting claims, making follow-up phone calls, and submitting additional requested information.

Responsibilities for Other Payor (TPL) Documentation

A. The Qualified Vendor must report to TPLBenefits@azdes.gov any updates to the member-specific Other Payor (TPL) information within ten (10) business days of learning of the new information.

B. A Qualified Vendor who has been paid by the Division and subsequently receives reimbursement from an Other Payor (third party) must request a claim reversal and report TPL payment.

C. The Division/AHCCCS makes payments to Qualified Vendors on behalf of members for medical services rendered, but only to the extent that the member has a legal obligation to pay. This means that if a Division member has third party insurance, the Division's payment will be limited to the member's responsibility (usually the deductible, copay and/or coinsurance).

D. When a Qualified Vendor receives payment from an Other Payor (third party) in an amount that meets or exceeds the published rate, the Qualified Vendor must report the provision of service on the claim document indicating no amount due from the Division.

E. When a Qualified Vendor receives payment from an Other Payor (third party) in an amount that is lower than the published rate, the Qualified Vendor must report the provision of service on the claim document up to the Division's contracted rate (the Qualified Vendor can bill the Division for the difference between the Other Payor (third party) paid amount and up to the Division's contracted rate).

Time Frames - Initial Billing Submission and Resubmissions

According to standard terms and conditions of the Qualified Vendor Agreement, the Division is not obligated to pay for services provided without prior authorization. Claims for services delivered must be initially received by the Division no later than six (6) months after the last date of service as indicated on the claim or as otherwise authorized by contract. Claims should be submitted within the specified time period from the date of service for a first submission to retain appeal rights, whether the other insurance explanation of benefits has been received or not. A resubmitted claim shall not be considered for payment unless it is received by the Division as a clean claim no later than twelve (12) months after the last date of service shown on the original claim.

Billing Codes

Qualified Vendors can only bill for service of categories for which they are approved from AHCCCS. It is the responsibility of the Qualified Vendor to be aware of the most updated CPT/HCPCS codes for billing purposes. CPT/HCPCS codes related with specific category of services may change. Information regarding this topic is available at http://www.cms.gov/ (Center for Medicare & Medicaid Services).

CHAPTER 57-H PROCESS FOR UPDATING INSURANCE CHANGES IN FOCUS

EFFECTIVE DATE: August 5, 2016

Internal documentation created by the Qualified Vendor for data collection or member tracking purposes is not sufficient insurance updates. The Qualified Vendor is required to submit updated insurance information to the Third Party Liability (TPL) unit via e-mail to TPLBenefits@azdes.gov for requested TPL changes in Focus. The following chart identifies common scenarios and the information Qualified Vendors are required to submit to the TPL unit when requesting an insurance change in Focus:

	Scenarios	Required Information
1	New Insurance	• Insurance Card or • Member Eligibility Page or • Explanation of Benefits (EOB)
2	Termed Insurance (Policy expired)	• Member Eligibility Page or • EOB and • 4 Alpha Vendor Code and • Service Codes for Billed Services
3	Duplicate Insurance More than one policy reflected in the system with similar: • Insurance company name • Effective/end dates • Policy number	• 4 Alpha Vendor Code and • Service Codes for Billed Services and • Details about the policy requested for removal (Policy number plus Master Carrier ID [MCID])
4	Invalid Insurance (Insurance policy does not exist)	• EOB with denial/rejection indicating member not enrolled (e.g., "member not found") or • The following information from the insurance company contacted: ○ Phone number of the insurance company ○ Name of the representative spoken to ○ Reference/confirmation number associated with the call
For all scenarios, member name and member ASSIST ID is required information.		

CHAPTER 57-I OTHER PAYOR (THIRD PARTY LIABILITY) BILLING SCENARIOS

EFFECTIVE DATE: August 5, 2016

Other Payor (TPL) Billing Scenarios

Third Party Liability (TPL) billing scenarios can be divided into two groups:

Group A - No waiver required, as discussed in Scenarios #1 through #4.

Group B - Waiver required, as discussed in Scenarios #5 and #6.

Group A - No Waiver Required

A. Scenario #1

1. If insurance pays **equal** to the Division contracted rate:

   a. Division does not pay.

   b. No Waiver is required.

Insurance Paid Amount = $50.00
Division Contracted Rate = $50.00
Payment To Provider = $0.00

2. Detail and Explanation

   When the Qualified Vendor receives payment from a third party payor in an amount that meets the Division published rate, the Qualified Vendor must report the provision of service on the claim document showing no amount due from the Division. This process can be completed by entering the Division rate for the specific service in column "J," MCID number in column "K," amount paid by the insurance company "TplAmt1" in column "L" and entering $0.00 in column "T," of the Uniform Billing Template as shown below.

   Legend - Uniform Billing Template

Column Name	Explanation
J	Division rate for specific service
K	MCID number
L	Amount paid by insurance company
T	Total amount due

   Sample Row - Uniform Billing Template

J	K	L	T
Rate	TplCode1	TplAmt1	Total Amt Due
50.00	90655	$50.00	$0.00

B. Scenario #2

1. If insurance pays **higher** than the Division contracted rate:

   a. Division does not pay.

   b. No Waiver is required.

Insurance Paid Amount = $60.00
Division Contracted Rate = $50.00
Payment To Provider = $0.00

2. Detail and Explanation

In the event the Qualified Vendor receives payment from a third party payor in an amount that exceeds the published rate, the Qualified Vendor must report only an amount up to the Division's contracted rate. The claim line should show no amount due from the Division. This process can be completed by entering the Division rate for the specific service in column "J," MCID number in column "K," amount paid by the insurance company - "TplAmt1" in column "L" and entering $0.00 in column "T," of the Uniform Billing Template as shown below.

Legend - Uniform Billing Template

Column Name	**Explanation**
J	Division rate for specific service
K	MCID number
L	Amount paid by insurance company
T	Total amount due

Sample Row - Uniform Billing Template

J	K	L	T
Rate	TplCode1	TplAmt1	Total Amt Due
$50.00	90655	$60.00	$0.00

C. Scenario #3

1. If insurance pays **lower** than the Division contracted rate:

   a. The Division pays the difference between the contracted rate and insurance payment.

   b. No Waiver Required.

Insurance Paid Amount = $30.00
Division Contracted Rate = $50.00
Payment To Provider = $20.00

2. Detail and Explanation

This process can be completed by entering the Division rate for the specific service in column "J," MCID number in column "K," amount paid by the insurance company (TplAmt1) in column "L" and the difference between column "J" (Division rate for the service) and column "L" (amount paid by the insurance company) in column "T," of the Uniform Billing Template as shown below.

Legend - Uniform Billing Template

Column Name	**Explanation**
J	Division rate for specific service
K	MCID number
L	Amount paid by insurance company
T	Total amount due

Sample Row - Uniform Billing Template

J	K	L	T
Rate	TplCode1	TplAmt1	Total Amt Due
$50.00	90655	$30.00	$20.00

D. Scenario #4

Insurance applies claim towards the deductible, copay, or coinsurance. The following different scenarios may occur.

1. Scenario: No Payment Issued

a. If the insurance processes the claim and applies the claim towards the deductible, copay, or coinsurance and does **not** issue a payment. Provider submits monthly billing to Division and no waiver required.

b. Detail and Explanation

This process can be completed by entering the Division rate for the specific service in column "J," MCID number in column "K," entering "01" in column "M" and entering the rate which the Division would pay for the service in in column "T," of the Uniform Billing Template as shown below.

Legend - Uniform Billing Template

Column Name	**Explanation**
J	Division rate for specific service
K	MCID number
M	Deductible Code 01
T	Total amount due

Sample Row - Uniform Billing Template

J	K	M	T
Rate	TplCode1	TplReCode2	Total Amt Due
$50.00	90655	01	$50.00

2. Scenario: Payment Issued Greater than Division Rate

a. If the insurance processes the claim and applies a portion of the claim towards the deductible, copay, or coinsurance and makes a payment that is more than the Division contracted rate.

Insurance Paid Amount = $60.00
Division Contracted Rate = $50.00
Payment To Provider = $0.00

b. Detail and Explanation

In the event the Qualified Vendor receives payment from a third party payor in an amount that exceeds the published rate, the Qualified Vendor shall report only an amount up to the Division's contracted rate. This process can be completed by entering the Division rate for the specific service in column "J," MCID number in column "K," amount paid by the insurance company - "TplAmt1" in column "L" and entering $0.00 in column "T," of the Uniform Billing Template as shown below.

Legend - Uniform Billing Template

Column Name	**Explanation**
J	Division rate for specific service
K	MCID number
L	Amount paid by insurance company
T	Total amount due

Sample Row - Uniform Billing Template

J	K	L	T
Rate	TplCode1	TplAmt1	Total Amt Due
$50.00	90655	$50.00	$0.00

3. Scenario: Payment Issued Less than Division Contracted Rate

a. If the insurance processes the claim and applies a portion of the claim towards the deductible, copay or coinsurance payment made by the insurance company is **less** than the Division contracted rate, no waiver required.

Insurance Paid Amount = $30.00
Division Contracted Rate = $50.00
Payment To Provider = $20.00

b. Detail and Explanation

This process can be completed by entering the Division rate for the specific service in column "J," MCID number in column "K," amount paid by the insurance company (TplAmt1) in column "L", the difference between column "J" (Division rate for the service) and column "L" (amount paid by the insurance company) in column "T," of the Uniform Billing Template as shown below.

Legend - Uniform Billing Template

Column Name	**Explanation**
J	Division rate for specific service
K	MCID number
L	Amount paid by insurance company
T	Total amount due

Sample Row - Uniform Billing Template

J	K	L	T
Rate	TplCode1	TplAmt1	Total Amt Due
$50.00	90655	$30.00	$20.00

<u>Group B - Waiver Required</u>

A. Scenario #5

1. Insurance company does not pay.

a. The Qualified Vendor receives EOB from the primary insurance(s).

b. The Qualified Vendor applies for Waiver Request with the Division.

c. The Division processes Waiver Request.

d. If Waiver is approved, the Division pays contracted rate, if clean claim status exists.

2. Detail and Explanation

This process can be completed by entering the Division rate for the specific service in column "J," and entering the total amount due up to the contracted rate in column "T," off the Uniform Billing Template as shown below (assuming that the waiver has been approved).

Legend - Uniform Billing Template

Column Name	**Explanation**
J	Division rate for specific service
T	Total amount due

Sample Row - Uniform Billing Template

J	K	M	T
Rate	TplCode1	TplReCode1	Total Amt Due
$50.00			$50.00

B. Scenario #6

1. Primary insurance does not respond.

a. The Qualified Vendor is unable to obtain documentation or resolution from the insurance company, file a grievance with the insurance carrier as all other efforts to procure the documentation have failed.

b. The Qualified Vendor applies for Waiver Request with the Division.

c. The Division will use the grievance decision documentation to make appropriate determination regarding the finalization of the waiver process.

d. The Division processes Waiver Request.

e. If the Waiver Request is approved, the Division pays contracted rate.

2. Detail and Explanation

This process can be completed by entering the Division rate for the specific service in column "J," and entering the total amount due up to the contracted rate in column "T," of the Uniform Billing Template as shown below (assuming that the waiver has been approved).

Legend - Uniform Billing Template

Column Name	**Explanation**
J	Division rate for specific service
T	Total amount due

Sample Row - Uniform Billing Template

J	K	M	T
Rate	TplCode1	TplReCode1	Total Amt Due
$50.00			$50.00

CHAPTER 57-J RECOMMENDATIONS FOR WORKING WITH INSURANCE COMPANIES

EFFECTIVE DATE: August 5, 2016
REFERENCES: A.R.S § 20-3101, A.R.S § 20-3102

A. Submit a claim to the insurance company as soon as possible after the delivery of service.

B. If no response has been received after 14 days, call the insurance company's customer service department to determine the status of the claim.

C. If the insurance company has not received the claim, refile the claim.

1. If sending by mail, stamp the claim as a repeat submission, or

2. If sending by fax, use a cover note indicating as a repeat submission.

D. If the insurance company has received the claim but considers the billing insufficient:

1. Supply all additional information requested by the insurance company.

2. Confirm that all requested information has been submitted.

E. Allow seven (7) more days for the claim to be processed. If there is no response after seven (7) days and all information has been supplied as requested, contact the insurance company again. If the company acknowledges the receipt of the claim and considers the billing valid, but has not responded to the claim, make a note and follow-up with a written request for a response

F. If there is no response after an additional seven (7) to eight (8) days, based on A.R.S § 20-3102, consider filing a grievance with the insurance carrier, as all other efforts to procure the documentation have failed. "Grievance" means any written complaint that is subject to resolution through the insurer's system as discussed in A.R.S § 20-3101.

G. The Qualified Vendor may visit Arizona Department of Insurance's website at www.azinsurance.gov to find information about the grievance process. Grievance documentation should include specific information regarding the claim in question, reason for the grievance, and any supporting information/documents.

H. The Division will require the grievance decision documentation in order to make the appropriate determination in reference to the finalization of the waiver process.

FREQUENTLY ASKED QUESTIONS - APPENDIX

REVISION DATE: April 25, 2018
EFFECTIVE DATE: August 5, 2016

1. How can the Qualified Vendor bill DDD when the insurance company does not pay, as the amount may be over the maximum benefit allowed amount?

If the insurance company denies the claim because the amount paid for the benefit has exceeded the maximum allowed benefit, the Qualified Vendor can request a waiver from the Division. The Division will review the denial reason provided by the primary insurance company's explanation of benefits. If a waiver is granted, the Qualified Vendor can bill the Division appropriately until the expiration or termination of the waiver.

2. How can the Qualified Vendor bill the Division if the insurance company is not willing to pay, as the claim is not an allowed expense?

If the primary insurance denies the claim because the service is not an allowed expense, the Qualified Vendor may request a waiver from the Division. The Division reviews the denial reason on the primary insurance company's Explanation of Benefits (EOB).

If a waiver is granted, the Qualified Vendor can bill the Division appropriately until the expiration or termination of the waiver.

3. When should a waiver request be submitted?

Waivers are requested when the primary insurance company or companies deny the claim.

4. How do the Qualified Vendors report two different insurance companies on the Uniform Billing Template?

The Master Carrier Identification (MCID) for each insurance company should be reported separately on the uniform billing template. Review the following examples.

J	K	L	N	P	T
Rate	TplCode1	TplAmt1	TplCode2	TplReCode2	TotalAmtDue
$50.00	90655	$30.00	94940	01	20.00

<u>Primary Insurance Company</u>

In the above example, column J is the contracted rate, column K is the primary insurance MCID number, and column L is partial payment from primary insurance.

<u>Secondary Insurance Company</u>

In the above example, column N is secondary insurance MCID number, column P is applied to deductible, and column T is total amount paid.

5. What is the typical turnaround timeframe for waiver request approval?

Waivers are generally approved within 2-3 business days.

6. How is the Qualified Vendor notified that a waiver request has been approved?

The Qualified Vendor can check the waiver report in Professional Billing System (PBS) to confirm that the waiver request has been approved. In addition, the vendor will receive an e-mail notification in reference to the status.

7. How is the Qualified Vendor notified that a waiver request is not approved?

If a waiver request is not approved, the vendor will receive an e-mail notification in reference to the status.

8. If a member has Medicare Parts A, B, C or D, what type of coverage would require a waiver?

A waiver is only required for Medicare Part B.

9. When is a Medicare waiver required?

The Division issues waivers for Qualified Vendors that are certified Medicare providers.

The Medicare Certified Provider must bill Medicare to obtain an EOB showing benefits were denied in order to request a waiver. Refer to the section "DES/DDD Waiver Request Process" for more information on this topic.

The waiver request should show the type of services that is being billed and the start date.

10. When the EOB indicates that the insurance company made a partial payment, where is the partial payment information reported on the Uniform Billing Template?

For a detailed response, please refer to the section "Third Party Billing Scenarios - Scenario #3."

11. When the EOB indicates that the insurance company paid over and above what the Division would pay, where should the information be reported on the Uniform Billing Template?

For a detailed response, please refer to the section "Third Party Billing Scenarios - Scenario #2."

12. When the EOB indicates that the payment was applied to the deductible, where should the information be reported on the Uniform Billing Template?

For a detailed response, please refer to the section "Third Party Billing Scenarios - Scenario #4."

13. What is the Qualified Vendor's responsibility if the primary insurance company refuses or fails to issue an EOB?

For a detailed response on this topic, please refer to the "Recommendation for Working with Insurance Companies"

14. What is an "MCID"?

The MCID (Master Carrier Identification) identifies a specific insurance company with a specific street address. The MCID number is on the final authorization screen (under the Medical drop-down) or on the authorization report in Focus. If the incorrect MCID number is billed, the claim will deny.

15. What process should be followed to update insurance changes (such as new insurance, policy termination, etc.)?

For a detailed response on this topic, please refer to Chapter 57-H Process for Updating Insurance Changes in Focus of the Provider Manual.