

CHAPTER 12 – BILLING AND CLAIM SUBMISSION

REVISION DATE: 9/11/2019, 6/17/2016, 4/16/2014 EFFECTIVE DATE: March 29, 2013
REFERENCES: [AHCCCS](#); [Billing Information](#), ARS §36-2904 (G), §36-2904 (G) (1), §36-2903.01(K) Per 42 CFR 455.410.

Purpose

This policy outlines the requirements for the Division of Developmental Disabilities (the Division) American Indian Health Plan (AIHP) for Fee for Service (FFS) acute care claims billing and claims submissions.

Definitions

- A. American Indian Health Program (AHIP) – The program provides medically necessary services for Division enrolled members. The program also provides coverage for preventive and behavioral health care services.
- B. Fee for Service (FFS) - A method in which doctors and other health care providers are paid for each service performed.
- C. Clean claim - As defined by ARS §36-2904 (G) (1) a “clean claim” is: A claim that may be processed without obtaining additional information from the subcontracted provider of care, from a non-contracting provider, or from a third party, but does not include claims under investigation for fraud or abuse or claims under review for medical necessity.
- D. Void - A void is a recoupment of a claim, with the entire claim being recouped.
- E. Claim Reference Number (CRN) - Claim Reference Number that is unique to each claim and remains the same over the life of the claim.
- F. Evaluation and Management codes (E&M) - a category of CPT codes are used for billing purposes. The majority of patient visits require an E/M code. There are different levels of E/M codes, which, are determined by the visit complexity and documentation requirements. (<https://www.aafp.org/practice-management/payment/coding/evaluation-management.html>)
- G. International Classification of Diseases 10th revision (ICD-10) – the diagnosis coding system used by physicians and facilities.

Policy

All providers who serve the Division members must participate in the Arizona Health Care Cost Containment System (AHCCCS) program, be registered with AHCCCS, and be assigned an AHCCCS Provider Identification Number (i.e., a six-digit registration number). Additionally, providers are required to register their National Provider Identifier (NPI) with AHCCCS. Your current Federal Tax ID number associated with your Division contract and NPI is required on claims. Information about AHCCCS requirements and use of an NPI can be found on the AHCCCS website.

Acceptable Claim Forms

For Home and Community Based Services (HCBS), the Division requires Qualified Vendors to submit claims using the Division's FOCUS system which is the Division's automated service authorization and payment processing system). Please refer to the Division's **HCBS Claims Submission Guide** for more information.

For American Indian Health Plan (AIHP), Fee-for-Service (FFS), Acute Care Services, there are three different nationally standardized claim forms that must be used.

1. CMS-1500 Form: For claims for professional services.
2. UB-04 Form: For claims for hospital in-patient and out-patient services, dialysis, hospice, and skilled nursing facility services.
3. ADA Claim Form: For claims for dental services.

The Division complies with all AHCCCS billing and payment requirements when processing claims. AIHP FFS Acute Care claims processed through QNXT™ must be submitted with current code sets from the International Classification of Diseases (ICD-10), Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS), Current Dental Terminology (CDT), and National Drug Codes (NDC).

Claim Submission Time Frames

In accordance with ARS §36-2904 (G), an initial claim for services provided to a Division member must be received by the Division no later than six months after the date of service, unless the claim involves retro-eligibility. In the case of retro-eligibility, a claim must be submitted no later than six months from the date that eligibility is posted. For hospital inpatient claims, "date of service" means the date of discharge of the patient. For DME claims, "date of service" means the first date the item(s) were given to the member.

- A. Claims initially received beyond the six-month time frame, except claims involving retro-eligibility, will be denied.
- B. If a claim is originally received within the six-month time frame, the provider has up to 12 months from the date of service to correctly resubmit the claim in order to achieve clean claim status, or to adjust a previously processed claim, unless the claim involves retro-eligibility. If a claim does not achieve clean claim status, or is not adjusted correctly within 12 months, the Division is not liable for payment.

When the Division Bills Members

Arizona Revised Statute §36-2903.01(K) prohibits providers from billing Division members, including QMB Only members, for Division covered services.

Upon oral or written notice from the patient, that the patient believes the claims to be covered by Medicaid, a provider or non-provider of health and medical services prescribed in §36-2907 shall not do either of the following unless the provider or non-provider has verified through the Administration that the person has been determined ineligible, has not yet been determined eligible, or was not, at the time services were rendered, eligible or enrolled:

- A. Charge, submit a claim to, and/or demand or otherwise collect payment from a member or person who has been determined eligible unless specifically authorized by this article or rules adopted pursuant to this article.
- B. Refer or report a member or person, who has been determined eligible, to a collection agency or credit reporting agency for the failure of the member or person, who has been determined eligible, to pay charges for system covered care or services, unless specifically authorized by this article or rules adopted pursuant to this article.

Note: "QMB Only" is a Qualified Medicare Beneficiary under the federal program, but does not qualify for Medicaid. Under A.A.C. R9-29-301 the Division only reimburses the provider for the Medicare deductible and coinsurance amount when Medicare pays first.

Claim Submission Requirements for Paper Claims

When a claim is submitted, ensure that the printed information is aligned correctly with the appropriate section/box on the form. If a claim is not aligned correctly, it may cause the OCR scanning system to misread the data, and the claim will be rejected

- A. The preferred font for claims submission is Lucinda Console, and the preferred font size is 10.
- B. Claims for services must be legible and submitted on the correct form for the type of service(s) billed. Claims that are not legible or that are not submitted on the correct form will be returned to providers without being processed.
 - 1. If a claim is returned, you must resubmit the claim on the correct type of claim form, submit it within the required time frame, and ensure that it is legible.
 - 2. This resubmitted claim cannot be a black and white copy of the previously submitted claim. The resubmitted claim must be submitted on a new claim form.
- C. The Division retains a permanent electronic image of all paper claims submitted, in accordance with State retention record requirements, requiring providers to file clear and legible claim forms.
- D. Paper claims or copies that contain highlighter or color marks, copy overexposure marks or dark edges are not legible on the imaging system. Liquid paper correction fluid ("White Out") may not be used. Correction tape may not be used.
- E. Any documentation submitted with a claim is imaged and linked to the claim image. Documentation is required when resubmitting claims, even if the documentation was submitted with an earlier version of the claim and the claim number is referenced on the resubmitted claim. Documentation must be resubmitted. Each claim must stand on its own, as the system is unable to pull documentation from the previously submitted claim.

- F. All paper claims should be mailed, with adequate postage, to:

Division of Developmental Disabilities
Attn: Claims Department
Mail Drop 2HC6
P.O. Box 6123
Phoenix, AZ 85005-6123

Replacements and Voids

The Division Claims Processing system will deny claims with errors that are identified during the editing process. These errors will be reported to the provider on the Division Remittance Advice. The provider should correct claim errors and resubmit claims to the Division for processing within the 12-month clean claim time frame.

A replacement can be used to adjust a paid or denied claim, and it can also be used to recoup previously paid lines. A replacement will allow individual lines to be recouped, rather than the entire claim to be recouped.

A. Replacements

For this section, when a claim is resubmitted, it will be referred to as a replacement. A replacement *is* the resubmission of a claim.

Occasionally, when a previously submitted claim (paid or denied) will need to be replaced with a new submission.

1. To replace a corrected claim for any of the following:
 - a. The original claim was denied or partially denied.
 - b. When a claim was paid by the Division and errors were discovered afterward in regards to the amounts or services that were billed on the original claim. For example, you may discover that additional services should have been billed for on a service span, or that incorrect charges were entered on a claim paid by the Division.

When replacing a denied claim or adjusting a previously paid claim, you must submit a new claim form containing all previously submitted lines. The original Division Claim Reference Number (CRN) must be included on the claim to enable the Division system to identify the claim being resubmitted. Otherwise, the claim will be entered as a new claim and may be denied due to it appearing to have been received beyond the initial submission time frame, or it may be denied as a duplicate submission.

If any previously paid lines are blanked out the Division system will assume that those lines should not be considered for reimbursement and payment will be recouped.

When replacing a claim, you must resubmit any documentation that was sent with the denied or previously paid claim.

Every field can be changed on the replacement except the service provider ID number, the billing provider ID number, and the tax ID number. If these must be changed, you must void the claim and submit a new claim.

2. To **replace** a denied CMS 1500 claim:
 - a. Enter "A" or "7" in Field 22 (Medicaid Resubmission Code) and the CRN of the denied claim or the CRN of the claim to be adjusted in the field labeled "Original Ref. No." Failure to replace a 1500 claim without Field 22 completed will cause the claim to be considered a "new" claim, and then it will not link to the original denial/paid claim. The "new" claim may be denied as timely filing exceeded.
 - b. Replace the claim in its entirety, including all original lines if the claim contained more than one line.

Note: Failure to include all lines of a multiple-line claim will result in a recoupment of any paid lines that are not accounted for on the resubmitted claim.

Example 1:

You submit a three-line claim to the Division. Lines one and three are paid, but Line two is denied.

When replacing the claim, you should replace all three lines. If only Line two is replaced, the Division system will recoup payment for Lines one and three.

Example 2:

You replace a three-line claim to the Division. All three lines are paid.

Discovery of an error in the number of units billed on line three and submit an adjustment.

When submitting the adjustment, you should replace all three lines. If only line three is replaced, the Division system will recoup payment for lines one and two.

An adjustment for additional charges to a paid claim must include all charges the original billed charges plus additional charges.

Example 3: You bill for two units for a service with a unit charge of \$50.00 and are reimbursed \$100.00. After receiving payment, you discover that three units of the service should have been billed.

When adjusting the claim, you should bill for three units and total billed charges of \$150.00 (3 units X \$50.00/unit). The Division system will pay the claim as follows: Allowed Amount (3 units) \$150.00

- Previously Paid to Provider <\$100.00>

- Reimbursement \$50.00

If you billed for the one additional unit at \$50.00, the Division system would recoup \$50.00, as shown below:

- Allowed Amount (1 unit) \$50.00
- Previously Paid to Provider <**\$100.00**>
- Reimbursement (Amount recouped) <\$50.00>

3. To **replace** a denied UB-04 claim:

- a. Replace the UB-04 with the appropriate Bill Type: xx7 for a replacement and corrected claim

Note: Failure to replace a UB-04 without the appropriate Bill Type will cause the claim to be considered a "new" claim, and it will not link to the original denial. The "new" claim may be denied as timely filing exceeded.

- b. Type the CRN of the denied claim in the "Document Control Number" (Field 64).
- c. To **replace** a denied **ADA claim** or a previously paid ADA claim, the CRN of the denied claim must be entered in Field 2 (Predetermination/Preauthorization Number).
 - i. Failure to replace an ADA claim without Field 2 completed will cause the claim to be considered a "new" claim and it will not link to the original denial or the previously paid claim. The "new" claim may be denied as timely filing exceeded.
 - ii. Do not put the CRN in the Remarks section or in the white space at the top of the form. Replacements that have the CRN in the wrong section will be denied. The CRN must go in Field 2.

B. Voids

When **voiding a claim**, you should submit documentation stating the reason for the void. Only the provider who submitted the original claim may void the claim. When a claim is voided, all payment is recouped. This process should only be used when there is no other alternative.

Unlike resubmissions and adjustments, you should submit only the line(s) to be voided. Lines that should not be voided should be blanked out to avoid recoupment of payment for those lines.

1. To **void** a paid CMS 1500 claim enter "V" or "8" in Field 22 (Medicaid Resubmission Code) and the CRN of the claim to be voided in the "Original Ref. No." field.
2. To **void** a paid UB-04 claim, use bill type xx8

3. Enter the CRN of the claim to be voided in the "Remarks" field (Field 80).
4. If Field 80 is used for other purposes, type the CRN at the top of the claim form.
5. To **void** a paid ADA claim type the word "VOID" and enter the CRN of the paid claim to be voided in Field 2 (Predetermination/Preauthorization Number).

General Division Billing Rules

Most of the rules for billing the Division follow those observed by Medicare and other third party payers. However, the following requirements are emphasized by the Division:

- A. Billing must follow completion of service delivery. A claim may cover a time span over which service was provided, but the last date of service billed must be prior to or the same date that the claim is signed.

- B. Billing Multiple Units:

If the same procedure is provided multiple times on the same date of service, the procedure code must be entered **only once** on the claim form.

The unit's field is used to specify the number of times the procedure was performed on the date of service.

The total billed charge is the unit charge multiplied by the number of units.

- C. Medicare and Third Party Payments

By law, the Division has liability for payment of benefits after all other third party payers, including Medicare.

The provider must determine the extent of third party coverage and bill all third party payers **before** to billing the Division.

- D. Age, Gender, and Frequency-Based Service Limitations:

1. The Division imposes some limitations on services based on member age and/or gender.
2. Some procedures have a limit on the number of units that can be provided to a member during a given time span.
3. The Division may revise these limits as appropriate.

- E. All claims are considered non-emergent and subject to applicable prior authorization requirements unless the provider identifies the service(s) billed on the claim form as an emergency.

1. UB-04 Claim Form
 - a. On the UB-04 claim form, the Admit Type (Field 14) must be "1" (emergency), "5" (trauma), or "4" (newborn) on all emergency

inpatient and outpatient claims.

- b. All other Admit Types, including a "2" for urgent, designate the claim as non-emergent.
2. CMS 1500 Claim Form
On the CMS 1500 claim form, Field 24 C must be marked to indicate that the service billed on a particular claim line was an emergency.
3. American Dental Association (ADA) Claim Form
The Division staff will review ADA 2012 dental claims for adults to determine if the service provided was emergent.

Overpayments

A provider must notify the Division of any claim overpayments. The provider can notify the Division by submitting a replacement claim, which will allow recoupment of the overpayment to occur.

- A. If an adjustment is needed then providers should attach documentation substantiating the overpayment, such as an EOB if the overpayment was due to payment received from a third party payer.
- B. If it is necessary to void a claim, the entire payment will be recouped and documentation is not required.
- C. The claim will appear on the Remittance Advice showing the original allowed amount, and the new (adjusted) allowed amount.

*Note: **Do NOT send a check for the overpayment amount.** The claim must be adjusted, and the overpaid amount will be recouped.*

Recoupments

A.R.S. §36-2903.01 L. requires the Division to conduct a post-payment review of all claims and recoup any monies erroneously paid. Under certain circumstances, the Division may find it necessary to recoup or take back money previously paid to a provider.

- A. Overpayments and erroneous payments are identified through reports, medical review, grievance and appeal decisions, internal audit review, and provider-initiated recoupments. Upon completion of the recoupment, the Remittance Advice will detail the action taken.
- B. Payments recouped for a reason other than third party recovery (e.g., no medical documentation to substantiate services rendered), you will be afforded additional time to justify for re-payment for recoupments, as outlined below.
 1. The time frame for submission of a clean claim differs from the time frames described earlier in this chapter.
 2. The time span allowed for resubmission of a clean claim will be the *greatest*

if:

- a. Twelve months from the date of service.
- b. Twelve months from the date of eligibility posting for a retro-eligibility claim.
- c. Sixty days from the date of the adverse action.

Additional Billing Rules

A. Multiple Page Claims

1. Do not submit double-sided, multiple-page claims. Each claim page must be submitted on a separate piece of paper, with the pages numbered (e.g., 1 of 3, 2 of 3, 3 of 3, etc.). To ensure an UB-04 claim is processed as a single claim, all the pages must be numbered.
2. Keep all pages together, back-to-back. All pages should be paper-clipped or rubber-banded together. Do not staple.
3. Totals should not be carried forward onto each page, and each page can be treated as a single page. The total should be entered on the last page only.

B. Zero Charges

The Division will key revenue and procedure codes billed with zero charges. The Division will not key revenue, and procedure codes billed with blank charges. When submitting zero charges, \$0.00 must be listed and it cannot be left blank.

Revenue codes with zero charges will not be considered for reimbursement.

C. Changes in Member Eligibility

If the member is ineligible for any portion of a service span, those periods should not be billed to the Division. If a member's eligibility changes, then each eligible period should be billed separately to avoid processing delays.

D. Changes in Reimbursement Rate

It is not necessary to split-bill for an inpatient hospital claim when:

1. The claim dates of a service span change in the inpatient hospital reimbursement rates.
2. If a hospital outpatient claim is submitted with dates of service that span a change in the hospital outpatient reimbursement rates, then the claim must be split.

Documentation Requirements

Medical review is a function of the Division Claims Department and determines if services were provided according to the Division policy as it relates to medical necessity and emergency services. Medical review and adjudication also are performed to audit the appropriateness, utilization, and quality of the service provided.

- A. To conduct a medical review, providers may be asked to submit additional documentation for AIHP Acute Service CMS 1500 claims, which are identified in the Division claims processing system as near duplicate claims. The documentation is necessary to allow the Division Medical Review staff to determine whether it is appropriate to reimburse multiple providers for the same service on the same day.
 - 1. Near-duplicate claims are claims for the same procedure, on the same day, for the same member, for different providers.
 - 2. Near-duplicate claims for certain E&M codes (for example, emergency room visits, critical care visits, newborn care, and hospital visits) may pend for review. If the documentation substantiates the services, adjudication staff will release the claim for payment, assuming that the claim has not failed any other edits.
- B. If medical documentation is not submitted, the adjudication staff will deny the claim with a denial reason specifying what documentation is required. Providers will not receive a letter requesting documentation because the denial codes are very specific as to what is required.
- C. It is expected that certain E&M codes such as 90491 (Critical care, evaluation and management) and 90431-90433 (Subsequent hospital care) will frequently fail the near-duplicate edit because it is feasible that a member could be seen by more than one provider on the same day. However, each provider must submit documentation substantiating the necessity for his or her services.

Example:

Provider A, a pulmonologist, and Provider B, a cardiologist, both see Mr. Jones in ICU on April 22. Both providers bill the Division for CPT Code 90491 for April 22

Either claim may fail the near-duplicate edit and pend to Medical Review. The Medical Review nurse will review the documentation submitted with the claim. In this case, the nurse would expect to find a critical care progress note from the provider.

If no medical documentation is provided, the claim will be denied.

Note: The Division requires all claims related to hysterectomy and sterilization procedures to be submitted with the respective consent forms.

- D. While it is impossible to offer specific guidelines for each situation, the following table is designed to give providers some general guidance regarding submission of documentation. Also, not all Fee-For-Service claims submitted to the Division are subject to Medical Review.

CMS 1500 Claims		
Billing For	Documents Required	Comments
Surgical procedures	History and physical, operative report, and emergency room report	
Missed abortion/ Incomplete abortion Procedures (all CPT codes)	History and physical, ultrasound report, operative report, and pathology report	Information must substantiate fetal demise.
Emergency room visits	Complete emergency room record.	The billing physician's signature must be on ER record
Anesthesia	Anesthesia records	Include "begin and end" time
Pathology	Pathology reports	
E&M services	Progress notes, history and physical, office records, discharge summary, & consult reports	Documentation should be specific to code(s) billed
Radiology	X-ray/Scan reports	
Medical procedures	Procedure report, history and physical	Examples: Cardiac catheterizations, Doppler studies, etc.
UB-04 Claims		
Billing for	Documents Required	Comments
Observation	Refer to AHCCCS FFS Chapter 11 Hospital Services for required documentation.	If labor and delivery, send labor and delivery records
Missed abortion/Incomplete abortion	All documents required by statute, ultrasound report, operative report, and pathology report.	Information must substantiate fetal demise.
Outlier	Refer to AHCCCS FFS Chapter 11, Hospital Services, and to Exhibit 11-4, the Outlier Record Request, for information on the required documentation.	

1. Unless specifically requested, Providers should *not* submit the following :
 - Emergency admission authorization forms
 - Patient follow-up care instructions
 - Nurses notes
 - Blank medical documentation forms

- Consents for treatment forms
- Operative consent forms (Exception: bilateral tubal ligation and hysterectomy)
- Ultrasound/X-ray films
- Medifax information
- Nursing care plans
- DRG/Coding forms
- Medical documentation on prior authorized procedures/hospital stays (Exception claims that qualify for outlier payment.)
- Entire medical records

Social Determinants

Beginning with dates of service on and after **April 1, 2018**, the Division will monitor all claims for the presence of social determinant ICD-10 codes.

- A. As appropriate within the scope of practice, providers should be routinely screening for, and documenting, the presence of social determinants. Information about social determinant should be included in the member's chart.
- B. Any social determinant ICD-10 diagnosis codes that are identified should be included on the submitted claims for the Division members, to comply with state and federal coding requirements.

Note: Social determinants are not the primary ICD-10 code. They are secondary ICD-10 codes.

- C. Dental providers will be exempt from the use of social determinants.
- D. For a list of ICD-10 codes relevant to social determinants of health, please see Exhibit 4-1, Social Determinants of Health ICD-10 Code List in the AHCCCS Fee-For-Service Provider Billing Manual. The list of social determinants of health codes may be added to or updated on a quarterly basis. Providers should remain current in their use of these codes

Claim Submission and Provider Registration

According to the 42 CFR 455.410 of the Affordable Care Act, the State Medicaid agency (AHCCCS) must require all ordering or referring physicians, or other professionals providing services under the State plan or under a waiver of the plan, to be enrolled as participating providers. All providers, including, but not limited to out-of-state providers, attending and servicing providers both within and outside of a hospital setting, and billing providers must be registered with AHCCCS in order to be reimbursed for covered services provided to AHCCCS members.

Effective January 1, 2016, if a provider is not enrolled with AHCCCS as a valid and/or active provider the Division will deny the claim.