

## **CHAPTER 18 MEDICAL CLAIMS REVIEW**

REVISION DATES: 6/15/2022, 4/16/2014

REVIEW DATES: 11/17/2025, 10/18/2023

EFFECTIVE DATE: March 29, 2013

REFERENCES: 42 CFR 438.210(b); 42 CFR 455.410; 42 CFR 447.26;  
Fee-For-Service (FFS) Billing Manual Chapter 4; Division of Developmental  
Disabilities (Division) Provider Manual Chapter 12.

### **PURPOSE**

The purpose of this policy is to outline the requirements for Medical Claims Review by the Division or its subcontracted Health Plans.

### **DEFINITIONS**

1. "Clean Claim" means the same as in A.R.S. § 20-3101(2).
2. "Health Care Acquired Condition (HCAC)" means a condition occurring in any inpatient hospital setting that has negative consequences for the member.
3. "Other Provider Preventable Condition (OPPC)" means a condition occurring in any health care setting that has a negative consequence for the members.
4. "Prior Authorizations (PA)" means a process by which the Utilization team assesses in advance whether a service that

requires prior approval will be covered, based on the initial information received.

5. "Provider Preventable Condition (PPC)" means a condition that is defined by both "Other Provider Preventable Condition" and "Health Care Acquired Condition."
6. "Quality of Care (QOC)" means an expectation that, and the degree to which, the health care services provided to individuals and patient populations improve desired health outcomes and are consistent with current professionally recognized standards of care and service provision.

## **POLICY**

### **A. MEDICAL REVIEW**

1. The Division's Claims Department shall perform medical review:
  - a. To determine if services are provided according to AHCCCS policy as it relates to medical necessity and emergency services; and
  - b. To audit appropriateness, utilization, and quality of the service provided.
2. To perform the medical review, the Division may ask the providers to submit additional documentation.

3. The Division may review any and all claims for eligible members who were provided covered services for which a provider is requesting or has requested payment from the Division.

**B. MEDICAL REVIEW PROCESS**

1. The Division shall ensure that medical claims are reviewed by health care professionals who have the clinical expertise and appropriate credentials to complete the review.
2. The medical claims review process for physical and behavioral health services paid for by the Divisions subcontracted health plans shall be completed by the Division's subcontracted Health Plans. [Please see the Health Plans' provider manual on the health plan website for more information.]

**C. REQUIREMENTS**

1. All claims shall meet the Division requirements for claims submission.
2. If no medical documentation is submitted after receiving a request from the Division, the adjudication staff shall deny the claim with a denial reason specifying what documentation is required. For example, a claim may be denied with the Medical Review denial code "MD008 - Resubmit with progress notes."

Providers shall not receive a letter requesting documentation because the denial codes are very specific as to what is required.

3. The Division may ask for additional information to complete the claims process.
4. Providers shall not submit the following unless specifically requested to do so:
  - a. Emergency admission authorization forms
  - b. Patient follow-up care instructions
  - c. Nurses' notes
  - d. Blank medical documentation forms
  - e. Consents for treatment forms
  - f. Operative consent forms (Exception: bilateral tubal ligation and hysterectomy)
  - g. Ultrasound/X-ray films
  - h. Medifax information
  - i. Nursing care plans
  - j. DRG/Coding forms
  - k. Medical documentation on prior authorized procedures/hospital stays (Exception: claims that qualify for outlier payment.)

- I. Entire medical records

**D. DENIALS**

1. Medical claims denials shall be sent to the Division Medical Director for review.
2. Provider Preventable Conditions Guidelines  
Title 42 CFR 447.26 prohibits payment for services related to Provider-Preventable conditions.
  - a. If during the concurrent review process, an OPPC, HCAC, or PPC is discovered, a Quality of Care (QOC) shall be completed.
  - b. The incident shall be reported to the Medical Director or designee and the claims department.
  - c. The Division may not pay for services provided without prior authorization.

**E. CLAIM SUBMISSION AND PROVIDER ENROLLMENT**

Pursuant to the 42 CFR 455. 410 of the Affordable Care Act, the State Medicaid agency (AHCCCS) shall 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 shall be registered with AHCCCS in order to be reimbursed for covered services provided to AHCCCS members.

**F. RECONCILING PAID CLAIMS**

Payment information, including payment status, shall be provided by the Division. Providers shall review and reconcile the remittance advice payment information and accompanying payments.

**G. TIME FRAME FOR INITIAL BILLING SUBMISSION AND RESUBMISSIONS**

1. Claims for services rendered shall be received by the Division no later than six months after the date of service as indicated on the claim.
2. Claims shall be submitted within the specified time period from the date of service for the first submission to retain appeal rights, whether the Third Party Liability (TPL) insurance explanation of benefits has been received or not.
3. A resubmitted claim shall not be considered for payment unless it is received by the Division as a clean claim no later than 12 months after the date of service shown on the original claim.

- a. Providers shall correct claim errors and resubmit claims to the Division for processing within the 12-month time period from the date of service.
- b. FFS providers shall reconcile denied claims based on the Provider Remittance Advice.

Signature: *Sondra Fields*

Date: 17/11/2025