CHAPTER 7:

General Billing Rules

Reviewed/Revised: 10/1/18, 9/25/19, 1/1/20, 9/1/20, 1/1/21, 7/1/21, 3/22, 4/15/22, 5/17/22, 7/28/22, 9/26/22, 10/01/22, 6/27/23, 8/1/23, 9/1/23, 1/1/24, 4/1/24, 07/15/24

7.0 GENERAL INFORMATION

This chapter contains general information related to BCBSAZ Health Choice's billing rules and requirements.

In addition to AHCCCS requirements, BCBSAZ Health Choice follows the HIPPA Compliant 837 transaction guidelines and the coding standards described in the current editions of the Uniform Billing (UB-04) Manual; the 1500 Manual; the ADA Manual; International Classification of Diseases (ICD) Clinical Modification (CM) and Procedure Classification System (PCS) Manuals; Physicians' Current Procedural Terminology (CPT Manual; Healthcare Common Procedure Coding System (HCPCS) Guidelines; Centers for Medicaid and Medicare Services (CMS), and the Current Dental Terminology (CDT) Manual.

BCBSAZ Health Choice subcontracted providers are required to submit claims or encounters in conformance with the AHCCCS Office of Program Support Operations and Procedures Manual, AHCCCS FFS Provider Manual, AHCCCS AMPM, AHCCCS Behavioral Health Services Matrix, the AHCCCS Financial Reporting Guide the Client Information System (CIS) File Layouts and Specifications Manual requirements, AHCCCS Rules and Regulations, the AHCCCS Companion Guides, and in accordance with HIPAA for each covered service delivered to a member.

Specific information regarding covered services, limitations, and exclusions can be found in the AHCCCS Medical Policy Manual (AMPM) and Arizona Administrative Codes (A.A.C.) R9-22-201 et. seq.

AHCCCS Claims Clues articles can be found on the AHCCCS website at:
https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/claimsclues.html

The BCBSAZ Health Choice Claims Department is responsible for claim/encounter adjudication; resubmissions, claim/encounter inquiry/research and provider claim/encounter submissions to AHCCCS.

BCBSAZ Health Choice Provider Notices can be found on our website at:
www.HealthChoiceAZ.com - 'For Providers' -> 'Provider Notices'.

7.1 AHCCCS REGISTRATION ID NUMBER

BCBSAZ Health Choice will not pay claims to a provider who is not registered with AHCCCS. Please ensure that the provider of services has current registration with AHCCCS before submission of the claim.

All providers who participate with BCBSAZ Health Choice must first register with AHCCCS to obtain an AHCCCS Provider Identification Number. AHCCCS requires all providers providing and billing for AHCCCS covered services to have an NPI number. Please contact AHCCCS directly for this number (**AHCCCS Provider registration link**). Once you have obtained your 6-digit AHCCCS provider ID, notify BCBSAZ Health Choice's Provider Network Department at (800) 322-8670.

Referring, Ordering, Prescribing, Attending (ROPA) Providers Required to Register with AHCCCS
Per 42 CFR 455.410 of the Affordable Care Act, the State Medicaid agency (AHCCCS) encourages 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 are encouraged to be registered with AHCCCS in order to facilitate timely and accurate reimbursement for covered services provided to AHCCCS members. For additional information on 42 CFR 455.410, please refer to Chapter 3, Provider Records and Registration, of the AHCCCS Fee-For-Service Provider Billing Manual.

For additional guidance visit the AHCCCS ROPA website: ROPA (azahcccs.gov).

ROPA providers will need to register with AHCCCS by visiting the AHCCCS Provider Enrollment Portal (APEP) at: https://www.azahcccs.gov/PlansProviders/APEP/ProviderEnrollment.html

7.2 NATIONAL PRACTITIONER IDENTIFICATION (NPI)

AHCCCS and BCSAZ Health Choice also require each provider to be registered with an active National Provider Identification (NPI) number as well as an active AHCCCS provider ID number in order to coordinate benefits and process claims/encounters. The NPI number is to be used as the healthcare provider identifier for all claim/encounter submissions.
Contracted providers can submit their NPI number to the BCBSAZ Health Choice Network Services Department. To submit the NPI number, providers can mail or fax a copy of their NPI notification to:

BCBSAZ Health Choice
Attention: Network Services
8220 N. 23rd Ave.
Phoenix, AZ 85021
Fax: (480) 303-4433

The documentation must include the provider's name and AHCCCS ID number and provider's signature. NPI numbers will also be accepted via written notification mailed or faxed to the address

or fax number listed above.

All claims/encounters must be submitted with the NPI as applicable. In accordance with AHCCCS's guidelines, all rendering providers must bill under their own NPI number. As a result, incident-to billing is not permissible for advance practitioners. (A rendering provider is defined as the individual who provided care to the client and needs to be reported as such in box 24J of the CMS 1500 claim form.)

Per the AHCCCS Participating Provider Agreement General Terms and Conditions: "No provider may bill with another provider's ID number, except in locum tenens situations. Locum Tenens providers must submit claims using the AHCCCS provider ID number of the physician for whom the Locum Tenens provider is substituting or temporarily assisting." Locum Tenens arrangements will be recognized and restricted to the length of the Locum Tenens registration with the American Medical Association.

7.3 MEMBER ID NUMBER AND PROVIDER CLAIM SUBMISSION

On January 1, 2022 BCBSAZ Health Choice and BCBSAZ Health Choice Pathway member ID numbers changed format to include the addition of a three-character prefix. As a Blue Cross Blue Shield of Arizona plan, this is a key element used to identify which Blue Plan the member belongs. This change only affects billing for services rendered to a Health Choice member outside of Arizona. Providers rendering services outside of Arizona will submit claims directly to the Blue plan within that state.

EXCEPTION: *Health Choice contracted providers located in contiguous (bordering) counties to Arizona will submit claims directly to Health Choice.*

Below is a current listing of contiguous counties (subject to change upon county boundary changes by each state).

- California: San Bernardino County
- Nevada: Clark County and Lincoln County
- Utah: Kane County and Washington County
- Colorado: Montezuma County
- New Mexico: San Juan County, McKinley County, Cibola County, Catron County, Grant County,
- and Hidalgo County

As a reminder, Arizona providers and contracted providers located in contiguous counties to Arizona will submit claims to Health Choice directly.

The HCI prefix for Health Choice members does not impact any information that would be input or used for AHCCCS related portals for example the DUGless portal and AHCCCS online.

When doing business with AHCCCS Administration, providers must continue to use the standard 'A' number without the three-character prefix.

Here's what the Health Choice ID format looks like for each line of business:

Health Plan	ID #
Health Choice Arizona (Medicaid)	**HCI**A12345678
Health Choice Pathway (Medicare)	**MZH**HC12345678
ACA StandardHealth with Health Choice (ACA)	**IAZ**987654321

The HCI, MZH, and IAZ prefixes for Health Choice members is required when doing business directly with Health Choice only. If you do not use the correct Health Choice ID number when submitting claims or requesting prior authorization, claims will be rejected, and we will not be able to process your request(s).

7.4 ELECTRONIC SUBMISSIONS

All providers are recommended to submit claims/encounters electronically. Electronic billing ensures faster processing and payment of claims, eliminates the cost of sending paper claims, allows tracking of each claim/encounter sent, and minimizes clerical data entry errors. BCBSAZ Health Choice offers the ability to submit claims/encounters electronically through our clearinghouse or direct submission as documented below.

Methods:

a. **Clearinghouse**:
b. **Direct Submission**: **Upon approval,** qualified Providers have the option of submitting electronic files directly to BCBSAZ Health Choice.

All electronic submissions shall be submitted in compliance with applicable law including HIPAA regulations, AHCCCS policies and procedures, and BCBSAZ Health Choice policies and procedures. For contracted providers, please contact your software vendor or your BCBSAZ Health Choice Provider Performance Representative can provide more information about electronic billing. For non-contracted providers, please contact your software vendor for more information about electronic billing.

EDI Claim/Encounter Submission

	Electronic Submission*
All HCA Form Types	Through Electronic Clearinghouse, Payer ID 62179

All HCP Form Types	Through Electronic Clearinghouse, Payer ID 62180
All HCS Form Types	Through Electronic Clearinghouse, Payer ID RP105

In some instances (described throughout this manual), medical records may be required to support payment. If medical records are required to support electronic claim/encounter submissions, records may be mailed to the BCBSAZ Health Choice Claims Department. Refer to Section 7.14 *Documentation Requirements* for additional guidance.

7.5 PAPER CLAIM SUBMISSION REQUIREMENTS

All providers are recommended to submit claims/encounters electronically. Electronic billing ensures faster processing and payment of claims, eliminates the cost of sending paper claims, allows tracking of each claim/encounter sent, and minimizes clerical data entry errors.

We understand that at times you may need to submit a claim through the mail, here's some reminders:

- When a claim is submitted, please ensure that the printed information is aligned correctly with the appropriate section/box on the form.
- Claims for services must be legible and submitted on the correct form for the type of service billed. Claims that are not legible or not submitted on the correct form will be returned to the provider without processing.
- 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.
- 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 that all pages of a multiple-page, UB-04 claim are processed as a single claim the pages **must** be numbered. 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.**
- Please do not staple documents or claims. If there is a document being submitted with the claim, the document should lay directly behind the claim and can be paper-clipped or rubber-banded together.

If your claim is not accepted, this submission does not count as a clean claim submission. If you receive a returned claim, the provider must re-file a legible copy of the claim on the correct claim form type and it must be refilled within the appropriate time frame detailed in an upcoming section. ***Please note**: *Faxed claims are not accepted for processing*.

MAILING ADDRESS FOR PAPER CLAIMS:

BCBSAZ Health Choice
P.O. BOX 52033
PHOENIX, AZ 85072-2033

BCBSAZ Health Choice Pathway
P.O. BOX 52033
PHOENIX, AZ 85072-2033

7.6 CLAIM/ENCOUNTER SUBMISSION TIME FRAMES

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.

In accordance with ARS §36-2904 (G),

- An initial claim for services provided to an AHCCCS member must be received no later than 6 months after the date of service unless the claim involves retro-eligibility. Claims initially received beyond the 6-month time frame, except claims involving retro-eligibility, will be denied.
- If a claim is originally received within the 6-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 to adjust a previously processed claim, unless the claim involves retro-eligibility. Resubmission of a claim/encounter denied for any reason other than timeliness of submission must be received within twelve (12) months from the date of service, or the date of eligibility posting for prior period coverage, with the appropriate corrections or documentation. If a claim/encounter does not achieve a clean claim status or is not adjusted correctly within 12 months, BCBSAZ is not liable for payment.

7.7 RETRO-ELIGIBILITY CLAIMS/ENCOUNTERS

A retro-eligibility claim/encounter is identified as a claim/encounter for services where the eligibility was posted retroactively to cover the date(s) of service by AHCCCS. Retro-eligibility claims/encounters are considered timely submissions if the initial claim/encounter is received no later than 6 months from the date of the eligibility posting. Retro-eligibility claims/encounters must attain clean claim status no later than 12 months from the date of eligibility posting. For hospital inpatient claims, "date of service" means the date of discharge of the patient.

7.8 PRIOR PERIOD COVERAGE

On occasion AHCCCS eligible members are enrolled retrospectively into BCBSAZ Health Choice. The retrospective enrollment is referred to as Prior Period of Coverage (PPC).

Members may have received services during PPC, and BCBSAZ Health Choice is responsible for payment of covered services that were received.

For services rendered to the member during PPC, the provider must submit PPC claims/encounters to BCBSAZ Health Choice for payment of covered benefits. The provider must promptly refund, in full, any payments made by the member for covered services during the PPC period.

While prior authorization is not required for PPC services, BCBSAZ Health Choice, at its discretion, retroactively review medical records to determine medical necessity. If such services are deemed not medically necessary, BCBSAZ Health Choice reserves the right to recoup payment, in full, from the provider. The provider may not bill the member.

7.9 BILLING MEMBERS FOR SERVICES

Billing Members for Services (Cannot Bill a BCBSAZ Health Choice Member for covered services)

In accordance with Arizona Revised Statute A.R.S. §36-2903.01 (K) which prohibits providers from billing AHCCCS members, including QMB Only members, for AHCCCS covered services and in adherence to Administrative Codes R9-22-702, R9- 27-702, R9-28-702, R9-30-702 I and R9-31-702, the following billing guidelines and restrictions must be adhered to:

- BCBSAZ Health Choice members may **NOT** be billed for covered services or for services not reimbursed due to the failure of the provider to comply with BCBSAZ Health Choice's prior authorization or billing requirements.
- BCBSAZ Health Choice members should not be billed or reported to a collection agency for any covered services your office provides.

Arizona Administrative Code R9-22-702 states in part, "an AHCCCS registered provider shall not do either of the following, unless services are not covered or without first receiving verification from the Administration [AHCCCS] that the person was not an eligible person on the date of service:

1. Charge, submit a claim to, or demand or collect payment from a person claiming to be AHCCCS eligible; or

2. Refer or report a person claiming to be an eligible person to a collection agency or credit reporting agency".

A member may only be billed when the member knowingly receives *non-covered services* if:

- The Provider notifies the member in advance of the charges; and
- Provider has the member sign a statement agreeing to pay for the AHCCCS non-covered services. services and place the document in the member's medical record.

Providers also may NOT collect copayments, coinsurance, or deductibles from members with other insurance, whether it is Medicare, a Medicare HMO, or a commercial carrier. Providers must bill BCBSAZ Health Choice for these amounts and BCBSAZ Health Choice will coordinate benefits. Unless otherwise stated in contract, BCBSAZ Health Choice adjudicates payment using the lesser of methodology and members may not be billed for any remaining balances due to the lesser of methodology calculation.

Note: "QMB Only" members; a Qualified Medicare Beneficiary under the federal program but does not qualify for Medicaid. Under A.A.C. R9-29-301 AHCCCS shall only reimburse the provider for the Medicare deductible and coinsurance amount when Medicare pays first. For further information on QMB Only please refer to Chapter 14, *Medicare and Other Insurance Liability, or the AHCCCS Contractor Operations Manual, Policy 201*.

7.10 GENERAL BILLING RULES

Most of the rules for billing BCBSAZ Health Choice follow those observed by Medicare and other third-party payers. However, the following requirements are emphasized by the AHCCCS Administration and BCBSAZ Health Choice:

Billing must follow completion of service delivery

- A claim/encounter 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.

Ordering/Referring provider information

- Referring/ordering provider information is a claim submission requirement for all services rendered as a result of a referral/order. The claim must contain the name and individual NPI of the provider who referred/ordered the service(s)/item(s). If the referring provider information is not reported on the claim or if the provider is not enrolled in BCBSAZ Health Choice, the claim cannot be paid. On the CMS-1500 form, referring/ordering physician information is required in box 17a when ordering provider is any of the following:

o Laboratory o Radiology o Medical and Surgical Supplies o Respiratory DME	o Enteral and Parenteral Therapy o Durable medical Equipment o Drugs (J-Codes) o Temporary K and Q codes o Chiropractic Services*	o Orthotics o Prosthetics o Vision codes(V-codes) o 97001-97150 or 97159-97546 o Diabetes Self-Management*

Ordering providers can only be one of the following provider types:
M.D.
D.O.
Optometrist Physician Assistant
Registered Nurse Practitioner

Dentist
Podiatrist
Psychologist
Certified Nurse Midwife
Clinical Nurse Specialist (limited to DME and prescribing pharmacological agents in specific licensed health care institutions)

Claims submitted without the ordering provider listed will be denied.

*Optometrists, dentists & psychologists would not be acceptable as the ordering provider for these services.

For Electronic claim/encounter submissions, please refer to the ASCX12 HIPAA Guidelines for the appropriate loop/segment to utilize for reporting the referring/ordering physician information. A copy of the HIPAA Guidelines can be purchased from the Washington Publishing Company at http://www.wpc-edi.com/.

If applicable, enter the Qualifier:
DN Referring Provider **DK** Ordering Provider* **DQ** Supervising Provider

National Drug Code (NDC) Requirements

These requirements are in accordance with and support of the Federal Deficit Reduction Act of 2005, which mandates that all providers submit National Drug Codes (NDC) on all claims with procedure codes for physician-administered drugs in outpatient clinical settings. These services are currently represented on submitted claims by use of the Healthcare Common Procedure Coding System (HCPCS) codes.

NDC Definition

The NDC is the number which identifies a drug. The NDC number consists of 11 digits in a 5-4-2 format. The first 5 digits identify the labeler code representing the manufacturer of the drug and are assigned by the FDA. The next 4 digits identify the specific drug product and are assigned by the manufacturer. The last 2 digits define the product package size and are also assigned by the manufacturer.

Providers of "physician-administered" drugs include any AHCCCS registered provider whose license and scope of practice permits the administration of drugs, such as a medical doctor (MD), Doctor of Osteopathic Medicine (DO), nurse practitioner (NP), physician assistant (PA), ambulatory surgery centers (ASCs), hospital outpatient clinic/services and skilled nursing facilities (SNFs).

In order to ensure compliance with AHCCCS guidelines for NDC codes, BCBSAZ Health Choice has adopted the Noridian NDC crosswalk for reference.
The NDC/HCPCS crosswalk provides a listing of each National Drug Code that is assigned to a HCPCS. Please refer to the NDC crosswalk as applicable for your Jurisdiction located at https://med.noridianmedicare.com/ .

***HCPCS codes that will require the NDC information on the claim submission*

Drugs billed using HCPCS codes include:

- A, C, J, Q and S codes as applicable.
- "Not otherwise classified" (NOC) and "Not otherwise specified" (NOS) drug codes (e.g., J3490, J9999, and
- C9399).
- CPT codes, 90281-90399 for immune globulins
- CPT Codes 90476-90749 for vaccines and toxoids
- Providers **must** submit a valid 11-digit NDC when billing a HCPCS drug or CPT procedure code as defined above.
- The qualifier "N4" must be entered in front of the 11-digit NDC. The NDC will be submitted on the same detail line as the CPT/HCPCS drug procedure code in the pink shaded area for Electronic claims/encounters, the drug information is reported in Loop 2410

Billing multiple units

- If the same service is provided multiple times on the same date, and the service is not required to be reported with a modifier to indicate an additional procedure was performed, then services for the same provider/member/location/modifier(s), are required to have the service code entered once on the claim form with the appropriate units rolled up.
- The unit field is used to specify the number of times the procedure was performed on the date of service.
    - For time/unit-based services, units should first be calculated for each instance of the service, then the total units reported should be a combination of all units for that particular service/day/provider/member/location/modifiers(s) added together.
        - For example: for a T1016 the unit duration is 15min so for a service that lasted an hour, the units would be 4 (60/15). If an additional T1016 for the same day/provider/ member/location/modifier(s) was provided for 30 minutes, the units for that instance would be 2 (30/15), the total units reported on the one T1016 claim line would be 6.
- The total billed charge is the unit charge multiplied by the number of units.

Age, gender, and frequency-based service limitations.

BCBSAZ Health Choice uses the limitations on services based on recipient age and/or gender as set forth by AHCCCS.

- Some procedures have a limit on the number of units that can be provided during a given time span. BCBSAZ Health Choice uses these limitations as set by AHCCCS.

Medicare and Third-Party Payments

- By law, AHCCCS has liability for payment of benefits after all other third-party payers, including Medicare.
- Providers must determine the extent of third-party coverage and bill all third-party payers prior

to billing AHCCCS.

Correct Coding Initiative

BCBSAZ Health Choice follows Medicare's Correct Coding Initiative (CCI) policy and performs CCI edits and audits on Fee-For-Service claims for the same provider, same member, and same date of service.

Correct coding means billing for procedures with the appropriate comprehensive code. "Unbundling" is the billing of multiple procedure codes for services that are covered by a single comprehensive code. Some examples of **incorrect** coding include:

- Fragmenting one service into components and coding each as if it were a separate service.
- Billing separate codes for related services when one code includes all related services.
- Breaking out bilateral procedures when one code is appropriate.
- Down-coding a service in order to use an additional code when one higher level, more comprehensive code is appropriate.

All services that are integral to a procedure are considered bundled into that procedure as components of the comprehensive code when those services:

- Represent the standard of care for the overall procedure, or
- Are necessary to accomplish the comprehensive procedure, or
- Do not represent a separately identifiable procedure unrelated to the comprehensive procedure.

Modifiers

- Modifier 59 must be attached to a component code to indicate that the procedure was distinct or separate from other services performed on the same day and was not part of the comprehensive service and clinically justified as demonstrated in the medical record. Claims submitted to BCBSAZ Health Choice utilizing modifier 59 will be subject to Medical Review. **Documentation in the medical record must satisfy the criteria required for appropriate use of the modifier.** Modifier 59 cannot be billed with evaluation and management codes (99201-99499) or radiation therapy codes (77261 -77499).

- To align with Medicare billing rule, **bilateral procedures** are to be billed on one line with the "50" modifier and the appropriate number of units. The rate valuation is 150% of the capped fee schedule.

- **Separate services during the post-operative period** may be billed with modifier 58 or 78.

- Other modifiers may be appropriately attached to comprehensive codes (e.g., professional component (26), assistant surgeon (80), etc.).

Changes in Reimbursement Rate

- It is not necessary to split bill an inpatient hospital claim when the claim dates of service span a change in the inpatient hospital reimbursement rates.

- 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.

Emergency services claims

- All claims are considered non-emergent and subject to applicable prior authorization unless the provider clearly identifies the service billed on the claim form as an emergency.
- On the UB claim form, the Admit Type must be "1" (emergency), "5" (trauma) or "4" (newborn) on all emergency inpatient and outpatient claims.
- All other Admit Types, including "2" for urgent, designate the claim as non-emergent.
- On the CMS 1500 claim form, Field 24C must be marked to indicate that the service billed on a particular claim line was an emergency or the place of service that the procedure was billed with must be "23" for emergency room or "20" for urgent care facility.
- For electronic Professional claims/encounters, loop 2400 segment SV109 must indicate a 'Y' for emergency services. For electronic Institutional claims/encounters the admit type reported in loop 2300 segment CL101 must be included as indicated above.

Payment Processing Documentation and/or Medical Review

Medical review is a function of BCBSAZ Health Choice and is performed to determine medical necessity and coding appropriateness.

BCBSAZ Health Choice reserves the right to review claims for emergency services to determine medical necessity and appropriate billing and coding. Physicians and facilities must bill the level of service as documented in medical record and as identified in the CPT coding descriptions to ensure proper reimbursement.

As a reminder, claim reimbursement may require additional information to process in accordance with Federal and/or State requirements as well as contractual agreements between our providers and our plan. BCBSAZ Health Choice may need additional information such as medical records, which can be included with the initial claim submission, or which may be requested by BCBSAZ Health Choice in order to proceed with the processing/adjudication of the claim.

BCBSAZ Health Choice requests that all submitted medical records include the following components:

- **Medical records to support Level 4 and 5 emergency department claims:**
  - UB Form
  - Progress notes
  - History/Physical & Consultation Summary (If Applicable)
  - MAR (Medication Admin Record)
  - Discharge / Visit Summary

- **For all Prior Period Coverage (PPC) inpatient admissions and all inpatient admissions which are Level 4 APR-DRG and/or outlier claim:**

- Itemized UB-04 (“IZ”)
- History & Physical (Admitting)
- Consultations
- Progress notes
- MAR (Medication Admin Record)
- Discharge Summary
- Other documentation as needed

- **Additional Requirements if Applicable to the Patient Stay:**
  - Emergency Department Records
  - Observation
  - Clinical Evaluations
  - Operative Reports
  - Ancillary Reports
  - Anesthesia Record
  - Pathology Reports
  - Therapeutic Treatments (Physical Therapy, Respiratory Therapy, Occupational Therapy)
  - Other Documentation as Necessary to Justify Claim

If records are not submitted with a claim for a service that requires supporting documentation, the claim will be denied with all applicable denial reason/codes reflected on the remittance advice.

Pseudo Identification Numbers

Pseudo identification numbers are only applicable to behavioral health providers under contract with BCBSAZ Health Choice. On very rare occasions, usually following a crisis episode, basic information about a behavioral health recipient may not be available. When the identity of a behavioral health recipient is unknown, a behavioral health provider may use a pseudo identification number to register an unidentified person. This allows a claim/encounter to be submitted to AHCCCS, allowing BCBSAZ Health Choice and the provider to be reimbursed for delivering certain covered services. Covered services that can be encountered/billed using pseudo identification numbers are limited to:

- Crisis Intervention Services (Mobile);
- Case Management; and
- Transportation

Pseudo identification numbers must only be used as a **last option** when other means to obtain the needed information have been exhausted.

Inappropriate use of a pseudo identification number may be considered a fraudulent act. Please use the Pseudo ID# ‘S03129368’ when submitting these claims to BCBSAZ Health Choice.

Coding for School Based Services – CTDS code
Effective March 1, 2022, AHCCCS will be implementing an encounter edit for school-based services. All school-based fee-for-service claims will need to be submitted with a CTDS (County Code, Type Code, and District Code and Site Number) code.

You may access this code by looking it up on the **AHCCCS School CTDS RF7C4 (under the Coding Related Exhibits and Policy Reference drop-down)** document or by using the **Arizona Department of Education CTDS search tool**.

Detailed information on how to bill for CTDS code is available for further review in the **AHCCCS-Fee For-Services Manual under Chapter 10 - Reporting School Site Information for Services Performed in Schools**. The code must be added to the claim as specified in the AHCCCS Fee For Services Manual.

AHCCCS Participating Provider Information Requirement for Provider Types 77, IC, 05
AHCCCS Providers must begin to report the individual practitioner who rendered services on professional and dental service claims. This requirement impacts all claims for AHCCCS providers registered as integrated claims (Provider Type IC), behavioral health outpatient clinics (Provider Type 77), and clinics (Provider Type 05).

Claims for dates of service on and after July 1, 2023 will be denied if the individual practitioner who performed the services associated with the clinic visit is not reported. Please see the AHCCCS Fee-For-Service Provider Manual Chapter 10, Exhibit 10-1 for billing instructions for proper claim submissions.

7.11 EVALUATION AND MANAGEMENT SERVICES (E&M)

When determining the level of "established patient" Evaluation and Management (E&M) services (i.e., 99211-99215), code selection is based on Medical Decision Making (MDM) or total time, including face-to-face and non-face-to-face time spent on the date of the encounter. History and physical examination elements are not required for code level selection for office and other outpatient services. However, a medically appropriate history and/or physical examination should still be documented. *Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported*. [CMS 100-04, Chapter 12, Section 30.6.1]

Medical Decision Making (MDM) is defined by the complexity of a physician's work that is necessary to establish a diagnosis and/or to select a healthcare management option.

Evaluation and Management services are assigned based on the medical appropriateness and/or necessity of the physician patient encounter. E&M services must meet the specific requirements

of the Current Procedural Terminology (CPT) code billed on the claim with the caveat that 1 of the determining components must include medical decision making. A physician should not submit a CPT code for a high-level E&M service (i.e., 99214 or 99215), when the circumstances surrounding the physician patient encounter do not **support medical decision making of moderate to high complexity**.

7.12 RECOUPMENT

A.R.S. 36-2903.01 (L). requires to conduct post-payment review of all claims and recoup any monies erroneously paid.

- Under certain circumstances, BCBSAZ Health Choice may find it necessary to *recoup* or take back money previously paid to a provider.
- 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, BCBSAZ Health Choice will send a remittance advice explaining the action, date of the action, recipient, date of service, date of original remittance advice, and reason for the recoupment.

In the case of recoupments, the time frame for submission of a clean claim differs from the time frames described earlier in this chapter. In the case of recoupments, the time span allowed for resubmission of a clean claim will be the *greatest* of:

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

7.13 RESUBMISSIONS, ADJUSTMENTS, AND VOIDS

When **resubmitting a denied claim or adjusting (correcting) a previously paid claim** you must submit a new claim form containing all previously submitted lines. If any previously paid lines are blanked out the BCBSAZ 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.

Resubmitting a denied CMS 1500 claim or requesting adjustment to a previously adjudicated claim:

- Enter an “A” or “7” in Field 22 (Medicaid Resubmission Code) and the CRN (claim reference number which is found on the remittance advice) of the claim in the field labeled "Original Ref. No." *Failure to replace a 1500 claim without Field 22 completed can cause the claim to be considered a "new" claim and then not link to the original denial/paid claim. The "new" claim may be denied for timely filing limits exceeded.*
- **Resubmit the claim in its entirety,** including all original lines if the claim contained more than one line. Handwritten information or corrections on 1500 forms are not accepted and will be denied. Failure to include all lines of a multiple-line claim will result in recoupment of any paid lines that are not accounted for on the resubmitted claim.

Resubmitting a denied UB claim or requesting adjustment to a previously adjudicated claim:

- Replace UB with the appropriate Bill Type and **resubmit the claim in its entirety**, including all original lines.
    - Bill type - xx7 for a replacement and corrected claim

  Failure to replace a UB-04 without the appropriate Bill Type can 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.
- Enter the CRN of the denied claim in the "Document Control Number" (Field 64) and/ "Remarks" field (Field 84).
- Handwritten information or corrections on the UB form is not accepted and will be denied.

Resubmitting a denied ADA dental claim or requesting adjustment to a previously paid claim:

- Enter the CRN of the denied claim in Field 2 (Predetermination/Preauthorization Number) on the ADA form.
    - Enter a note in Box 35 ("Remarks") indicating the claim as "resubmission" or "corrected claim" and provide explanation. Refer to Chapter 10 *Billing on the ADA Claim Form*, for instruction on completing Box 35.
- **Resubmit the claim in its entirety,** including all original lines if the claim contained more than one line. Handwritten information or corrections on ADA forms are not accepted and will be denied. Failure to include all lines of a multiple-line claim will result in recoupment of any paid lines that are not accounted for on the resubmitted claim.

The *original CRN must be included on the claim to identify the claim being adjusted. Otherwise, the claim will be entered as a new claim and may be denied for being received beyond the initial submission time frame or for being a duplicate of a previously paid claim.

***Please Note:** **Behavioral Health claims** billed with a primary behavioral health diagnosis (claims identified with both numeric and alpha characters i.e. 12345E67890) require the most recently processed claim number in the claim series (e.g.A1, A2, etc.), be used for claim resubmissions/replacements/reversals (when applicable), not simply the first claim processed. Please refer to your most recent EOB for the most recently processed claim number.

Claim/Encounter voids and replacements can be submitted electronically; however, we are unable to accept electronic attachments at this time. To include required or requested supporting documentation, such as members' medical records, clearly label, **include the corrected paper claim**, and send to the Claims department at the correct address.

- To submit an electronic void, the *original claim/encounter with a frequency type code of 8 should be sent in Loop 2300 CLM05-03 and the original CRN included in Loop 2300 REF02.
- To submit an electronic replacement, the corrected claim/encounter with a frequency type code of 7 should be sent in Loop 2300 CLM05-03 and the original CRN included in

Loop 2300 REF02.

- Please note: When reporting the Loop 2300 REF*F8, Payer Claim Control Number for Replacement/Reversal claims (Frequency type 7 or 8). **Behavioral Health claims** billed with a primary behavioral health diagnosis (claims identified with both numeric and alpha characters i.e. 12345E67890) require the most recently processed claim number in the claim series (e.g.A1, A2, etc.), be used for claim resubmissions/replacements/reversals (when applicable), not simply the first claim processed. Please refer to your most recent EOB for the most recently processed claim number.

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.

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.

To **void** a paid UB-04 claim:

- Use bill type xx8
- Enter the CRN of the claim to be voided in the "Remarks" field (Field 80).
- If Field 80 is used for other purposes, type the CRN at the top of the claim form.

To **void** a paid ADA claim

- Enter "VOID" and enter the CRN of the paid claim to be voided in Field 2 (Predetermination/Preauthorization Number).

***Please note:** **Behavioral Health claims** billed with a primary behavioral health diagnosis (claims identified with both numeric and alpha characters i.e. 12345E67890) require the most recently processed claim number in the claim series (e.g. A1, A2, etc.), be used for claim resubmissions/replacements/reversals (when applicable), not simply the first claim processed. Please refer to your most recent EOB for the most recently processed claim number.

7.14 OVERPAYMENTS

To improve our overpayment and refund process we have a lockbox for providers to submit overpayment/refund payments.

It is important that you use this new address to avoid delays in processing your payments.

We will accept checks with remittance documentation at our lockbox facility:

BCBSAZ Health Choice
ATTN: Overpayment/Refund
PO Box 743242
Los Angeles, CA 90074-3242

A provider must notify BCBSAZ Health Choice of an overpayment. Providers can notify by submitting an overpayment/refund to the lockbox as indicated above or on a claim by requesting an adjustment to the paid claim. The provider can notify by submitting a replacement claim, which will allow recoupment of the overpayment to occur. In the event that 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.

7.15 DOCUMENTATION REQUIREMENTS (Medical Record Submission)

BCBSAZ Health Choice reviews all submitted claims to ensure billed services are medically necessary, appropriate, and performed within AHCCCS and BCBSAZ Health Choice guidelines. This review may require review of medical records, which can be conducted during the initial claim submission, or may be required in order to proceed with processing/adjudication. Medical records are required for BCBSAZ Health Choice to process Prior Period Coverage (PPC) claims, level 4 and 5 emergency department claims as well as Level 4 APR-DRG and/or outlier claims. Additionally, itemized statements are required for PPC and Level 4 APR-DRG or outlier claims. Medical records and itemized statements to support electronic claim submissions may be mailed to the following address: BCBSAZ Health Choice Arizona P.O. Box 52033 Phoenix, AZ 85072-2033.

If records or itemized statements are not submitted with a claim for a service that requires supporting documentation to establish medical necessity or appropriateness of services, the claim will be denied with all applicable denial reason/codes reflected on the claims remittance advice, indicating what supporting documentation needs to be submitted.

For Claim Reconsiderations: If you are sending medical records in response to a claim denial, please resubmit the claim in its entirety, include the original claim number on the claim resubmission along with the medical records.

Providers must include the name and/or department of the requestor in order to ensure the records are routed appropriately. Providers should include the member name, the member ID, the line-of-business, and reason for submission and claim number (if applicable). Records submitted without specifying the reason for submission along with the member ID information may not be routed to the intended recipient. Faxed records must be faxed directly to a specific person or department only after providers have verified the fax number and recipient.

Providers may also request a Medical Review which would require the submission of medical records when there are questions regarding coding, authorization, leveling of care, risk issues, etc. Contact us at (800) 322-8670.

7.16 AHCCCS DATA VALIDATION REVIEWS

In compliance with federal reporting requirements, AHCCCS conducts an annual review data validation audit, which verifies reported services against corresponding medical records to

ensure completeness, accuracy, and timeliness of encounters submissions. AHCCCS may request providers send medical records directly to their administration for this review. Specifically, the review is conducted with focus on the following:

- *Omission Errors*: a service reflected in medical records was not encountered to AHCCCS.
- *Correctness Errors*: inconsistencies between the medical record documentation and a submitted encounter with respect to procedure, diagnosis, and/or date of service.
- *Timeliness Errors*: an encounter is received at AHCCCS beyond the allowable time period after the end of the month in which the service was rendered or the effective date of enrollment with the health plan.

AHCCCS /Encounter Data Validation (Behavioral Health Providers / Sub-Capitated Providers)
AHCCCS performs periodic data validation studies. All AHCCCS contractors and subcontractors are contractually required to participate in this process. In addition, the data validation studies enable AHCCCS to monitor and improve the quality of claim/encounter data. Information regarding AHCCCS Claim/Encounter Data Validation Study procedures can be found in the **Office of Program Support Operations and Procedures Manual**.

7.17 CAPITATED SERVICES

Capitation is a prospective payment for members assigned on the first day of the month and includes a payment for those members added after the first day of the previous month. Capitation is issued by the fifteenth (15th) day of each month.

AHCCCS requires the reporting of all patient encounters for all services provided, including capitated services provided by Primary Care Providers (PCP), Specialty Providers, Ancillary Service Providers and Facilities. Correct reporting of all encounters and claims will assure both proper payment for capitated and non-capitated services. Failure to report capitated services may result in reductions to capitation for subsequent periods, or potential sanctions.

7.18 QUICK PAY DISCOUNTS/INTEREST PAYMENTS

Quick Pay Discount:
BCBSAZ Health Choice shall apply a quick pay discount of 1% on hospital claims paid within 30 days of the date the Clean Claim was received (A.R.S. §36-2903.01(G)). Quick pay discounts are applied to any acute hospital inpatient, outpatient and freestanding emergency department claims billed on a UB-04 claim form.

Interest Payments:

1. For hospital Clean Claims, BCBSAZ Health Choice shall pay slow payment penalties (interest) on payments made after 60 days of receipt of the Clean Claim.

2. BCBSAZ Health Choice shall pay interest on all claim disputes as appropriate based on the date of the receipt of the original Clean Claim submission (not the claim dispute).

- In the event a claim is reprocessed as a result of an overturned claim dispute or State Fair Hearing, the claims shall be reprocessed within 15 days from the date of the decision, and interest shall be paid back to the date the clean claim was received.

Source: AHCCCS ACOM Policy 203 *Claims Processing* (https://azahcccs.gov/).

7.19 SOCIAL DETERMINANTS

Social determinants of health are the conditions in which a person is born, grows, lives, works and ages. ICD-10 codes have been created to correspond with these social determinants. Social determinants of health take into account factors like the member's education, employment, physical environment, socioeconomic status, and social support network.

The use of social determinants allows a provider to identify things such as illiteracy, unemployment, a lack of adequate food and safe drinking water, social exclusion and rejection, homelessness, alcoholism, and many other factors that could affect a member's overall health and wellbeing. Beginning with dates of service on and after **April 1st, 2018**, AHCCCS began to monitor all claims for the presence of social determinant ICD-10 codes.
As appropriate within their scope of practice, providers should be routinely screening for, and documenting, the presence of social determinants. Information about the social determinant should be included in the member's chart.

Any social determinant ICD-10 diagnosis codes that are identified should be included on the submitted claims for AHCCCS members, in order to comply with state and federal coding requirements. Note: Social determinants are ***not*** the primary ICD-10 code. They are secondary ICD-10 codes. Dental providers will be **exempt** from the use of social determinants.

For a list of ICD-10 codes relevant to social determinants of health, please refer to the AHCCCS Fee-For-Service Provider Billing Manual Chapter 4, Exhibit 4-1, Social Determinants of Health ICD-10 Code List (https://azahcccs.gov/PlansProviders/RatesAndBilling/FFS/providermanual.html). 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.