CHAPTER 12:
Correcting Claim/Encounter Errors

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Providers have an opportunity to correct and resolve claim/encounter denials by following the guidelines in this chapter.

12.0 CLAIMS RESOLUTION SERVICES

Provider offices are encouraged to submit billings timely and review and post remittance advices upon receipt.

ACA StandardHealth with Health Choice **encourages providers to utilize our Provider Portal link,** available on our website, https://www.azblue.com/aca-standardhealth-health-choice under the "For Providers" section.

The Health Choice provider portal is specifically designed to streamline provider access to information and resources, while also serving as a valuable tool for locating health plan and provider-specific information which includes but is not limited to the following:

- *Member Eligibility Search* - is an on-line search utility for retrieving the eligibility information for members within the Health Choice system.
- *Prior Authorization* – gives providers access to check PA Guidelines, submit medical, behavioral and dental PA requests and check PA status.
- *Provider Demographic Summary* – gives provider the ability to submit provider additions/terminations as well as update provider demographic (add location) information on file.
- *Claim Status* - provides an on-line search whereby current information and status of provider's claims within the Health Choice claims system can be retrieved.
- *Claim Reconsiderations & Formal Dispute Requests* – gives providers the ability to submit request for claim reconsideration and formal dispute of a paid, denied or check not cashed claim.
    - Only claims that fall within the time frames indicated below will be eligible for reconsideration and formal dispute for a Health Choice claim:
        - **ACA StandardHealth with Health Choice:** 12-month time frame from the date of service to file a reconsideration.
    - The provider portal allows for up to 2 reconsiderations and 1 formal dispute per claim. If you would like to file a second formal dispute, review chapter *Claim Disputes, Member Appeals, and Member Grievances* of the Provider Manual for further instructions.
- *Explanation of Benefits (EOB)* – Health Choice provides a link from within the Provider Portal

to allow providers to download a printable copy of their EOB. For providers that do not have systems capable of automatically posting payments via the ERA but want the quick payment afforded by the EFT, a downloadable remit serves as an ideal complement. Each Friday, the EOBs for that week's adjudicated claims are made available for download.

12.1 UNDERSTANDING COMMON DENIAL REASONS

This section presents a summary of common denial or disallowances, including, but not limited to, the error message, a brief description of the error, and a brief statement of the action required.

Prior Authorization

This denial relates to the validity of the authorization, from the status of the authorization to the procedure and units billed. Submit claims with the full and complete Prior Authorization number reported, including leading zeros.

Diagnosis Code invalid or missing

This denial relates to the validity of the diagnosis code entered on the claim form. The following further describe the denial related to the diagnosis code.

For diagnosis related denials; determine if the primary diagnosis is a valid ICD 10 diagnosis code and entered correctly on the claim form and was valid on the date of service (date of admit for UB claim form).

Diagnosis code requires to the 6th/7th character level when applicable

This denial relates to the validity of the diagnosis code entered on the claim. The diagnosis is required to be reported to the highest applicable character level. For diagnosis related denials, determine if the primary diagnosis is a valid ICD 10 diagnosis code and entered in its entirety on the claim form.

Age/Gender to Diagnosis/CPT/HCPCS

This denial relates to the validity of the diagnosis code/CPT/HCPCS entered on the form as it relates to the recipient's age and/or gender.

Invalid Procedure/Service Code

This denial relates to the validity of the procedure/service code entered on the claim form.

For procedure/service code denials; verify that the procedure/service code was entered on the claim, that the code was entered in the correct format, and that the code is a valid five-digit CPT or HCPCS code.

Procedure/Service Modifier

This denial relates to the validity of the procedure/service modifiers entered on a claim form.

For modifier denials; verify that the first procedure/service modifier was entered on the claim line and that the modifier is valid for the procedure/service code billed on that line.

Provider Level Denials

Either the service provider was not enrolled as an active provider with Health Choice on the date of service, the service provider was not licensed/certified to provider the specific service on the date of service, or the procedure may not be billed by the service provider's type. Providers should contact their Provider Performance Representative.

Category of Service

For category of service denials, verify that the correct procedure/service was billed. If there is no error in the procedure/service billed on the claim and the provider believes that the service was billed correctly, the provider should contact Health Choice Claims Customer Service at 1-800-322-8670.

Recipient Eligibility/Enrollment

This denial relates to the recipient's eligibility for the services billed claim form.

Recipient Not Eligible/Enrolled for Entire DOS; Invalid Eligibility

For recipient eligibility denials; the recipient is either not ACA StandardHealth with Health Choice eligible or not eligible for the service on the date(s) of service. Verify the recipient's Health Choice ID number and eligibility either through the Provider Portal of the Health Choice Website or with the Health Choice Provider Services Department. See chapter *Member Eligibility and Member Services*.

Resubmit corrected claims/encounters containing only the dates of services the recipient was eligible with Health Choice.

Timeliness

This denial relates to the timeliness requirement for submitting claims to Health Choice.

We ask providers to submit complete and accurate claims within 30 days of service. Generally, we deny payment of any claims received more than one year after the date of service. Members are not liable for payment of a claim denied for untimely filing.

Proof of timely filing

Proof of timely filing must be submitted with grievances related to claims denied because of untimely filing. For more information about provider grievances, see Section 22.

<u>Claim Received - Past 12 Month Limit, Deny</u>

A resubmission of a denied claim was received by Health Choice more than 12 months from the end date of service or date of retro-eligibility posting. For hospitals, the end date

of service is the date of discharge. Verify the "from" and "through" dates of service entered on the claim.

Invalid Replacement – Invalid Reference CRN

This denial relates to the CRN number used when requesting an adjustment or void for a previously paid or denied claim.

12.2 CLAIM RESUBMISSION/REPLACEMENT

If a clean claim was denied due to a billing error, the corrected claim **must** be resubmitted/replaced within twelve (12) months of the date of service/discharge, or of the date of eligibility posting.

If the clean claim was denied due to a request for medical documentation, please include a copy of the claim, a copy of the remittance advice, and the requested documentation with the resubmission/replacement. Refer to Chapter 7 *General Billing Rules* for additional guidance.

12.3 CLAIM DENIAL DISPUTES

All Providers have the right to file a claim dispute in response to any adverse action or decision made by Health Choice. However, Health Choice encourages Providers to exhaust all other means of resolution before using the claim dispute process. See chapter *Claim Disputes, Members Appeals and Member Grievances* of the provider manual for additional information.