Section 6.1 Submitting Claims and Encounters

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I. STATEMENT OF PURPOSE:

Upon rendering a covered behavioral health service, billing information is submitted by behavioral health providers as a "claim" or as an "encounter." Some behavioral health providers are reimbursed on a fee-for-service basis (these providers submit "claims") and others are paid on a capitated basis or contract under a block purchase arrangement (these providers submit "encounters"). Regardless of how a provider is reimbursed, the data must be submitted using the same standardized forms.

The intent of this section is to:

- Identify the standardized forms used to submit billing information;
- Provide instructions for completing the standardized billing forms;
- Articulate the timelines for submitting billing information; and
- Provide Tribal Regional Behavioral Health Authorities (TRBHA) specific information for submitting billing information.

II. REFERENCES:

The following Pascua Yaqui (PY) Centered Spirit Program (CSP) Provider Manual sections can be used as resources for this section:

Section 3.4, Co-Payments
Section 3.5, Third Party Liability and Coordination of Benefits

The following citations and Federal and Arizona Health Care Cost Containment System (AHCCCS) documents can serve as additional resources for this content area:

45 CFR 162.1101
45 CFR 162.1102

A.R.S. §36-2904
9 A.A.C. 34
AHCCCS/TRBHA Intergovernmental Agreement 2021 (IGA)
ICD-10-CM Manual
First DataBank
Physicians' Current Procedural Terminology (CPT) Manual
Health Care Procedure Coding System (HCPCS) Manual
Medicare Claims Processing Manual

III. STANDARDS:

1. Submission of legible and accurate billing data facilitates timely reimbursement for fee-for-service providers.

2. Paper claims are not considered legible if they contain highlighter or color marks, copy overexposure marks or dark edges.

3. Behavioral health providers must not bill, nor attempt to collect payment directly or through a collection agency from a person claiming to be AHCCCS eligible without first receiving verification from AHCCCS that the person was ineligible for AHCCCS on the date of service, or that services provided were not Title XIX/XXI covered services.

IV. PROCEDURES:

A. What general requirements apply to Tribal fee-for-service providers when submitting claims?

All paper claims and encounters must be submitted using the CMS 1500, UB04- or the Universal Pharmacy Claim Form**.**

Providers must use the following forms to submit paper claims and encounters:

- *PM Form 6.1.1, CMS 1500 Claim Form* (formerly HCFA 1500) is used to bill or encounter most non-facility services, including professional services, transportation and independent laboratories.

- *PM Form 6.1.2, UB-04 Claim Form* is used to bill or encounter for all hospital inpatient, outpatient, emergency room, hospital-based clinic and residential treatment center services.

- The *UB04, Universal Pharmacy Claim Form* is used by pharmacists to bill or encounter pharmacy services using NDC codes.

All claims and encounters or copies of paper claims and encounters:

- Must be legible and submitted on the correct form.
- May be returned to the provider without processing if they are illegible, incomplete, or not submitted on the correct form.

HIPAA regulations specify the format for the submission of all electronic claims and encounter submitted to AHCCCS.

- *HIPAA Format 837P* is used to bill or encounter most non-facility services, including professional services, transportation and independent laboratories.
- *HIPAA Format 837I* is used to bill or encounter for all hospital inpatient, outpatient, emergency room, hospital-based clinic and residential treatment center services
- *HIPAA Format NCPDC* is used by pharmacists to bill or encounter pharmacy services using NDC codes.

If more information is needed regarding electronic submission of claims and encounters to AHCCCS please contact AHCCCS Electronic Claims Submission Unit at (602) 417-7670 #4.

What happens after a claim is submitted?

Submitted claims for services delivered to a Title XIX or Title XXI eligible person will result in one of the following dispositions:

1. Denied;
2. Pended; or
3. Approved.

Denied claims: Claims are typically denied because of a discrepancy between form field(s) and AHCCCS' edit tables. A denied claim may be resubmitted as long as the claim is submitted within **12 months of the date of service.** Tribal RBHA claims will be denied in the event the claim is untimely, illegible or incomplete.

Pended claims: A claim may stop processing and "pend" for internal review when the error detected concerns data or procedures that may be resolved by AHCCCS. Internally pended claims are generally processed without further information from the provider.

Approved claims: Approved claims have passed the timeliness, accuracy and completeness standards and have been successfully processed by AHCCCS.

B. What specific requirements apply to Tribal fee-for-service providers when submitting claims?

Behavioral health providers must submit accurate, timely and complete claims data to AHCCCS for all covered behavioral health services, either on paper or electronically.

All paper claims must be mailed to:
AHCCCS Claims
P.O. Box 1700
Phoenix, Arizona 85002-1700

Claim submission timeframes:

All initial claims must be received by AHCCCS no later than six months from the date of service unless the behavioral health recipient has retro-eligibility. For hospital inpatient claims, "date of service" means the date of discharge of the behavioral health recipient. Claims initially received beyond the six-month timeframe, except retro-eligibility claims, will be denied. If a claim is originally received within the six-month timeframe, the provider has up to 12 months from the date of service to resubmit the claim in order to achieve clean claim status or to correct a previously processed claim, unless the claim is a retro-eligibility claim. If a claim does not achieve clean claim status or is not corrected within 12 months, AHCCCS is not liable for payment.

What is a retro-eligibility claim?

A retro-eligibility claim is a claim where no eligibility was entered in the AHCCCS system on the date(s) of service but, later eligibility was posted retroactively to cover the date(s) of service. Retro-eligibility fee-for-service claims are considered timely submissions if the initial claim is received by AHCCCS no later than six months from the AHCCCS date of eligibility posting. Retro-eligibility claims must attain clean claim status no later than 12 months from the AHCCCS date of eligibility posting. Corrections to paid retro-eligibility claims must be received by AHCCCS no later than 12 months from the AHCCCS date of eligibility posting.

Can a denied claim be resubmitted?

AHCCCS will deny claims with errors that are identified during the editing process. These errors will be reported to the provider in the AHCCCS remittance

advice. Providers must correct claim errors and resubmit claims to AHCCCS for processing within the 12-month clean claim timeframe.

When resubmitting a denied claim, the provider must submit a new claim form containing all previously submitted lines. The original AHCCCS Claim Reference Number (CRN) must be included on the claim to enable the AHCCCS system to identify the claim being resubmitted. Otherwise, the claim will be entered as a new claim and may be denied for being received beyond the initial submission timeframe.

Requirements for Medicare Part A and B, and Medicare Part D Prescription Drug Plan:

Coordination of Benefits for persons eligible for Medicare Part A, Part B or Part D must follow the procedures established in *Section 3.5, Third Party Liability and Coordination of Benefits*.