2019 Billing Support Guide

Avoiding Common Claim Denials

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Provider Billing Guide

Claims Services

As referenced in our Provider Operations Manual in general, Allwell follows the Center for Medicare and Medicaid Services (CMS) billing requirements for paper, electronic data interchange (EDI), and secure web-submitted claims. Allwell is required by state and federal regulations to capture specific data regarding services rendered to its members. The provider must adhere to all billing requirements in order to ensure timely processing of claims and to avoid unnecessary upfront rejections or denials on the explanation of payment if not submitted correctly. Claims will be rejected or denied if not submitted correctly.

Third-Party Partners

Effective August 1, 2019, **Professional Health Care Network (PHCN)** is responsible for managing service coverage, credentialing and claims adjudication of Allwell from Arizona Home Health provider network through contractual relationships with home health agencies.

EyeMed administers Vision Services.
Envolve Dental administers Dental Services
NIA handles High Tech Imaging authorizations services.
Evicore handles Radiation Therapy and Sleep Studies.
MHN handles Behavioral Health services.
ASH handles Chiropractic & Acupuncture services.
Veyo handles transportation services.

Avoiding Common Claims Denials

The following are tips on how to avoid common claim denials:

1. **Denial Code- EXA1: No Record of prior authorization for service billed,**
2. **Denial Code- EXAN: No Record of prior authorization for service billed or**
3. **Denial Code- EXhf: No Authorization or referral on file that matches services billed**

Providers are encouraged to utilize our online authorization tool to help determine whether services require plan prior authorization. To access the online tool visit: https://allwell.azcompletehealth.com/ and follow the steps below.

1. Hover over the I'm A Provider Tab
2. Click-Pre-Auth Check Tool
3. Answer the populated yes or no questions. (HINT: If any of the answers are yes a prior authorization will be required.)
4. If all answers are no, a box will populate and allow you to key in a procedure code.
5. Once the code is entered click the green "check" button and the new window will indicate if the service requires prior authorization.

4. Denial Code- EX83: Duplicate of previously submitted claim

If a provider is attempting to change the information on the original claim submission a corrected claim is required. Corrected claims must clearly indicate they are corrected in one of the following ways:

- CMS 1500 professional claims require box 22 to be populated with the original claim number and correct submission code to be placed on the claim the two correct resubmission codes are 7 and 8. 7 (the “Replace” billing code) is used to notify us of a corrected or replacement claim. 8 (the “Void” billing code) is used to notify us that you are voiding a previously submitted claim.

- A UB-04 requires correct bill type xx7 for corrections and the original claim number in box 64. If the claim does not contain this information, it will process as an original claim and deny as a duplicate.

- Corrected claims must be submitted on standard red and white forms. Handwritten corrected claims will be rejected upfront.

Denial Code- EX83: Duplicate of previous submitted claim continued

- Corrected claims can also be submitted via our secure Provider Portal: https://provider.azcompletehealth.com Follow the instructions on the portal for submitting a correction.

5. Denial Code- EXTF: Filing limit exceeded

Please ensure Timely Filing guidelines are met.

Allwell from Arizona Complete Health requires contracted providers to submit first-time claims within 95 days from the date of service. Claims received outside of this timeframe will be denied for untimely submission.

All requests for corrected claims, reconsiderations or claim disputes must be received within 90 days from the date of explanation of payment or denial is issued. Prior processing will be upheld for corrected claims or provider claim requests for reconsideration or disputes received outside of the 90 days from the date of explanation of payment unless a qualifying circumstance is offered and appropriate documentation is provided to support the qualifying circumstance. Please refer to our provider operations manual for additional details on qualifying circumstances.

6. Denial Code- EXUZ: Services billed on incorrect form, please re-bill

Allwell from Arizona Complete Health only accepts the CMS 1500 (02/12) and CMS 1450 (UB-04) paper Claims forms. Other claim form types will be upfront rejected and returned to the provider.

Professional providers and medical suppliers complete the CMS 1500 (02/12) Claim Form and institutional providers complete the CMS 1450 (UB-04) Claim Form. Allwell from Arizona Complete Health does not supply claim forms to providers. Providers should purchase these from a supplier of their choice. All paper claim forms must be typed with either 10 or 12 Times New Roman font, and on the required original red and white version to ensure clean acceptance and processing. Black and white forms, handwritten and nonstandard forms will be upfront rejected and returned to the provider. To reduce document handling time, do not use highlights, italics, bold text or staples for multiple page submissions.