2019 Billing Support Guide

Avoiding Common Claim Denials

Call Us at:
1-866-796-0542

arizona complete health™
Complete Care Plan

AZCompleteHealth.com

Provider Billing Guide

Provider Services

Contact the Arizona Complete Health-Complete Care Plan's Provider Services Department at 1-866-796-0542 for assistance with the following services:

- Answer questions regarding claim status
- Provider education
- Network Participation
- Member eligibility/verification
- Change, update or correct demographic information
- Provider Engagement Specialist Assignment (Or email AzCHProviderEngagement@azcompletehealth.com)

The following information is available by logging into Arizona Complete Health-Complete Care Plan's Secure Provider Portal at provider.azcompletehealth.com:

- PCP Verification
- Member Eligibility
- Submit Claims
- Claims Inquiry
- Request Prior Authorization for Services

Providers can visit Arizona Complete Health-Complete Care Plan's website at azcompletehealth.com to access the following:

- Provider Operations Manual
- Find a Provider Search Tool
- Preferred Drug List
- Prior Authorization Forms
- Arizona Complete Heath-Complete Care Plan News & Updates
- Clinical and Payment Policies
- And much more

Frequently Used Addresses

Submit Paper Claims To:
Arizona Complete Health-Complete Care Plan
P.O. Box 9010
Farmington, MO 63640-9010

Electronic Claims Submission:
EDI Telephone# 1-800-225-2573 ext. 25525
EDI email: EDIBA@centene.com
Payer ID# 68069

Providers are encouraged to review this document often, as updates frequently occur.

Provider Billing Guide

Claims Services

Arizona Complete Health-Complete Care Plan follows Arizona Health Care Cost Containment System (AHCCCS) billing requirements for paper, electronic data interchange (EDI), and secure web-submitted claims. Arizona Complete Health-Complete Care Plan 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 Arizona Complete Health-Complete Care Plan's Home Health provider network.

Preventative Vision Services need to be verified by **Envolve Vision**.
Dental Services need to be verified by **Envolve Dental**.
Complex imaging, MRA, MRI, PET, Cardiac and CT scans need to be verified by **NIA**.
Chiropractic services are handled by **American Specialty Health Network (ASH)**.
Transportation services are handled by **Veyo**.

Avoiding Common Claims Denials

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

1. Denial Code- EXBS- invalid dates of service, please resubmit

Ensure the date(s) or date spans are correct in conjunction with the number of units billed on the claim. Units should not exceed authorized unit limits. Use the appropriate discharges status and occurrence codes when applicable.
Please reference the manuals listed below for more information on date(s) or date spans:

- AHCCCS fee for service Provider Manual, Chapter 6 – Billing on the UB-04 Claim form AHCCCS fee for service Provider Manual, Chapter 11 – Addendum APR- DRG Reimbursement
- For questions about proper usage of patient discharge status codes, providers should utilize the "UB-04 Manual" which is maintained by the National Uniform Billing Committee.
- For questions concerning clarification on the proper usage of occurrence codes, please reference link below. https://www.cms.gov/Regulations-and- Guidance/Guidance/Transmittals/downloads/r81cp.pdf

2. Denial Code- EXCc- AHCCCS guidelines for submitting corrected claims were not followed

When resubmitting a claim as a corrected claim, please follow the AHCCCS guidelines. CMS-1500 professional claims require box 22 to be populated with original claim number and correct resubmission code to be placed on the 253 Claims Codes and Encounters 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.
The UB-04 requires correct bill type xx7 for corrections, and the original claim number in box 64. Previously, Box 80 was the correct box for the claim number. On 3/3/16 AHCCCS updated the billing rules to indicate box 64 is the correct box.

- If the claim does not contain this information, it will process as an original claim and deny as a duplicate. This can also cause timely fi ling issues as the claim will not link to the original claim and cannot be used as proof of timely filing.
- AHCCCS provides specific guidelines on the submission of claims and corrected claims.
- AHCCCS clearly states in the billing guidelines that handwriting on claims is not allowed. AHCCCS states that “paper claims or copies that contain highlighter or color marks, copy overexposure marks, or dark edges are not legible on the imaging system.”

Please reference the manuals listed below for more information on guidelines for submitting corrected claims: AHCCCS fee for service Provider Manual, Chapter 4 - General Billing Rules AHCCCS fee for service Provider Manual, Chapter 6 – Billing on the UB-04 Claim form AHCCCS fee for service Provider Manual, Chapter 5 – Billing on the CMS 1500 Claim form

3. Denial Code- EXL0- please resubmit with the primary Medicare explanation of benefits (EOB)

- Claims are being received with blank EOBs
- Claims have EOBs attached but they only have partial information, need complete EOB

Billing tip- Be sure to look on the provider web portal located at: https://provider.azcompletehealth.com and AHCCCS online https://azweb. statemedicaid.us/Account/Login to verify member’s eligibility. You can verify eligibility and verify if the member has other insurance coverage.

4. Denial Code- EX18- deny: duplicate claim service

Multiple claim submission for same date can cause duplicate denials.

5. Denial Code- EX29- deny: the time limit for filing has expired

Claims submitted are denying for untimely filing. First time submission must be received within 120 days from the date of service for participating providers and within 180 days from the date of service for non-participating providers. Any corrections or adjustments allow up to a year from the date service or 60 days from the adverse action (whichever is later) for corrections.

6. Denial Code- EXA1- deny: authorization not on file

No authorization for the service for the period. Before submitting a claim, check the authorization to verify the dates of services and CPT/HCPCS codes match the approved authorization.

7. Denial Code- EXL6- deny: bill primary insurer 1st resubmit with EOB

Claims are being billed to the secondary insurance carrier when the member(s) have other insurance coverage (OIC). Claims must be billed to the primary insurance carrier first, then submitted to secondary insurance carrier with the primary EOB attached.

8. Denial Code- EX0B- adjust: claim to be reprocessed corrected under new claim number

Claims that are required to be rekeyed to new claim number. This occurs when corrections or adjustments need to be made and cannot be adjusted or paid against the original claim. These rekeys can occur for: claims voided, bad prov., rekeying for changes in service line, charges or procedures, and recoupments. (This is internal adjustment denial)

9. Denial Code- EXY6- deny: insufficient info for processing, resubmit with primary insurance original EOB

- Claims processed incorrectly with EOB attached, those will send back for processing
- Others claims were billed to incorrect primary payer
- Others came over with blank EOBS

10. Denial Code- EXIL- other insurance EOB submitted does not match billed, please resubmit

Amount on EOB does not match what was billed to secondary insurance, unable to process.

11. Denial Code- EXKZ- deny: invalid place of service, please consult the provider manual

- Facility billing –UB04 information not required for UB as there is no place for this on claim form
- CMS 1500 professional claims: See box 24B

12. Denial Code- EXps- deny: attending provider name or NPI missing

Box 76 on UB04 claim need to show NPI, and name of Attending provider. Per AHCCCS Box 76. Attending Provider name and identifiers required if applicable Effective 01/01/2016 this will be required.

13. Denial Code- EXLR- deny: when primary insurance receives info

Primary information missing or blank. Bill primary first then submit to secondary with attachment EOB

14. Denial Code- EXDS-deny: duplicate submission original claim still in pend

Multiple submissions on file. Original claim still in process, additional claims will deny Claims Codes and Encounters 255

15. Denial Code- EXSw- deny: category of services invalid for this procedure

Claims denied for categories of service being billed that are not allowed for provider type. The AHCCCS-PMIS database indicates what procedures are allowed to be billed by provider type. The screen for this is RF618

16. Denial Code- EX50-deny: not a MCO covered benefit

Procedure not covered by the members managed care benefit.

17. Denial Code- EXN5-deny: NDC missing/ invalid

To report the NDC on the CMS-1500 claim form, enter the following information:

- In Field 24A of the CMS-1500 Form in the shaded area, enter the NDC Qualifier of N4 in the first 2 positions, followed by the 11-digit NDC (no dashes or spaces) and then a space and the NDC Units of Measure Qualifier, followed by the NDC Quantity. All should be left justified in the pink shaded area above the Date of Service.
- The billed units in column G (Days or Units) should reflect the HCPCS units and not the NDC units. Billing should not be based off the units of the NDC. Billing based on the NDC units may result in underpayment to the provider.

To report the NDC on the UB04 claim form, enter the following information into the Form Locator 43 (Revenue Code Description):

- The NDC Qualifier of N4 in the first 2 positions on the left side of the field.
- The NDC 11-digit numeric code, without hyphens.
- The NDC Unit of Measurement Qualifier (as listed above).
- The NDC quantity, administered amount, with up to three decimal places (i.e., 1234.456). Any unused spaces are left blank.
- Form Locator 44 (HCPCS/Rate/HIPPS code): Enter the corresponding HCPCS code associated with the NDC.
- Form Locator 46 (Serv. Units/HCPCS Units): Enter the number of HCPCS units administered.

18. Denial Code- EX7V-deny: provider type is invalid for this procedure

All Providers must ensure they are billing for services covered under their assigned specialty and category of service. If a provider bills a service that is not within in their scope of practice, or in this case not within their category of service, the claim line/services will deny accordingly

19. Denial Code- EX8a-deny: Admit date or discharge hour missing/invalid

All institutional (UB04/837I) claims must include the date of admit and discharge hour (if applicable).

20. Denial Code- EX28- deny: Coverage not in effect when service provided

Prior to rendering services, it is the provider's responsibility to verify the member's eligibility.

21. Denial Code- EXNR-deny: This service is not covered for non-registered recipient

Prior to rendering services, it is the provider's responsibility to verify the member's eligibility

22. Denial Code- EW7S-deny: Procedure not covered on date by Arizona Health Care Cost Containment System (AHCCCS)

Once a member's eligibility is confirmed, providers should verify that the service(s) intended to be rendered to the member is:

a. Within the provider's scope of coverage and
b. Covered by AHCCCS and

c. Included in the member's coverage of benefits

Failure to complete all the verification steps listed above may result in denial of claim(s) payment(s).