2019 Billing Support Guide

Avoiding Common Claim Denials

Call Us at:
1-866-796-0542

ambetter. FROM | arizona complete health

Ambetter.AZCompleteHealth.com

Provider Billing Guide

Provider Services

Contact the Ambetter from Arizona Complete Health'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 Ambetter from Arizona Complete Health's Secure Provider Portal at provider.azcompletehealth.com:

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

Providers can visit Ambetter from Arizona Complete Health's website at ambetter.azcompletehealth.com to access the following:

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

Frequently Used Addresses

Submit Paper Claims To:
Ambetter from Arizona Complete Health
P.O. Box 9040
Farmington, MO 63640-9040

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

As referenced in our Provider Operations Manual in general, Ambetter follows the CMS billing requirements for paper, (EDI), and secure web-submitted claims. Ambetter 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.

Avoiding Common Claims Denials

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

1. **Denial Code- EXAN: No Record of prior authorization for service billed,**
2. **Denial Code- EXhs: No Prior authorization on file that matches billed services**
3. **Denial Code- EXHN: No Authorization on File or**
4. **Denial Code- EXhp: No Record of prior authorization for service 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://ambetter.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.

5. **Denial Code- EXIM: Modifier missing or invalid**

Providers should make the appropriate corrections and submit a corrected claim for adjudication. CMS reference details have been provided to prevent further denials.

The CMS identifies the codes listed at:

http://www.cms.hhs.gov/TherapyServices/05_Annual_Therapy_Update.asp as therapy services, regardless of the presence of a financial limitation. Therapy services include only physical therapy, occupational therapy and speech-language pathology services. Therapist means only a physical therapist, occupational therapist or speech language pathologist. Therapy modifiers are GP for physical therapy, GO for occupational therapy, and GN for speech-language pathology. When in effect, any financial limitation will also apply to services represented unless otherwise noted on the therapy page on the CMS Web site.

Some HCPCS/CPT codes that are not on the list of therapy services should not be billed with a modifier. For example, outpatient non-rehabilitation HCPCS codes G0237, G0238, and G0239 should be billed without therapy modifiers. These HCPCS codes describe services for the improvement of respiratory function and may represent either "incident to" services or respiratory therapy services that may be appropriately billed in the CORF setting. When the services described by these G-codes are provided by physical therapists (PTs) or occupational therapists (OTs) treating respiratory conditions, they are considered therapy services and must meet the other conditions for physical and occupational therapy. **The PT or OT would use the appropriate HCPCS/CPT code(s) in the 97000- 97799 series and the corresponding therapy modifier, GP or GO, must be used.***

6. Denial Code- EX29: Denied: Claim was not submitted within required timeframe

Please ensure Timely Filing guidelines are meet.

Initial Claims		Reconsiderations or Claim Dispute/Appeals		Coordination of Benefits	
Calendar Days		Calendar Days		Calendar Days	
Par	Non-Par	Par	Non-Par	Par	Non-Par
120 Days	365 Days	365 days	365 days	120 days	365 days

- **Initial Claims and Claims Dispute/Appeals** - Days are calculated from the Date of Service to the date received by Ambetter or from the EOP date. For observation and inpatient stays, the date is calculated from the date of discharge.
- **Claims Dispute/Appeals** - Days are calculated from the date of the Explanation of Payment issued by Ambetter to the date received.
- **Coordination of Benefits -** Days are calculated from the date of Explanation of Payment from the primary payers to the date received.

7. Denial Code- EX06: The provider identification, tax identification and/or taxonomy numbers are either missing or do not match the records on file, or

8. Denial Code- EXAZ: Invalid taxonomy at any provider level.

Please ensure the following Taxonomy Placement guidelines are followed.

CMS 1500 Paper Submission:

- Rendering – Box 24i should contain the qualifier “ZZ.” Box 24j (shaded area) should contain the taxonomy code.
- Billing – Box 33b should contain the qualifier “ZZ” along with the taxonomy code.
- Referring – If a referring provider is indicated in Box 17 on the claim, Box 17a should contain the qualifier of “ZZ” along with the taxonomy code in the next column.

837 Professional Electronic Submission:

- Billing –Loop 2000A PRV01=“BI” PRV02 = “PXC” qualifier PRV03 = 10 character taxonomy.
- Rendering – Loop 2310B PRV01=“PE” PRV02 = “PXC” qualifier PRV03 = 10 character taxonomy code002E
- Please note that “PXC” is the correct qualifier and that there is no taxonomy number needed for referring physician.

UB-04 Paper Submission:

- Billing – Box 81CCa should contain the qualifier of “B3” in the left column and the taxonomy code in the middle column.

837I Electronic Submission:

- Billing - Loop 2000A PRV01 = “BI” PRV02 = “PXC” qualifier; PRV03 = 10 character taxonomy code