Overview of Billing Guidelines and Other Helpful Resources
<table>
<thead>
<tr>
<th>Section</th>
<th>Slide Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Billing Guidelines (multiple topics), and Provider Website Resources</td>
<td>Slide 3-21</td>
</tr>
<tr>
<td>Member Identification Cards, Billing and Remits for AHCCCS, CRS and UnitedHealthcare Dual Complete plans</td>
<td>Slides 22-33</td>
</tr>
<tr>
<td>Policy Changes and Other Billing Guidelines</td>
<td>Slides 34-46</td>
</tr>
<tr>
<td>Behavioral Health Billing Resources</td>
<td>Slides 47-50</td>
</tr>
<tr>
<td>AHCCCS Registration and CMS1500 Claim Form General Requirements</td>
<td>Slides 51-64</td>
</tr>
<tr>
<td>Claim Submissions and Mailing Addresses</td>
<td>Slides 65-72</td>
</tr>
</tbody>
</table>
General Billing Guidelines, (multiple topics), and Provider Website Resources
General Billing Guidelines

General Billing Guidelines for:
- Duplicate Denials
- Overuse and Misuse of CPT Code 99285
- CPT Code 99285 Reminder
- Hospital IP/OP Services
- UB-04 Reminder
- Provider Website Resources
Duplicate Denials

To reduce receiving duplicate denials, submit one claim with all billed services for one member, one date of service when rendered by same provider. If you bill for multiple dates of service, please ensure all billable services are listed for the dates of service.

The exception to these guidelines apply when the service(s) include:

- Different procedure codes
- Different modifiers
- Different NDC numbers
- Different place of service (POS)
- Billing by provider of different specialty

All services billed on a UB-04 form need to be listed on one claim form. Multiple claim form submissions will be denied as duplicate.
Duplicate Denials (Cont’d.)

**How to submit corrected Medical claims for Acute/Dual/CRS/DD:**

- Corrected claims can be submitted **electronically** by placing a frequency type code of ‘7’ (replacement of prior claim/correction) in the appropriate loop/segment of the 837p transaction to payor ID # 03432.

- Corrected claims can be submitted on **paper**, with a Reconsideration Form and the Resubmission code 7 (replacement of prior claim/correction) and original claim number located in box 22 of the CMS-1500 claim form to:
  
  UnitedHealthcare Community Plan  
  P.O. Box 5290  
  Kingston, NY 12402-5290

- Submit corrected claims electronically with attachments via Optum Cloud Dashboard.

Use the EDI Issue Reporting Form available at [UHCCommunityPlan.com](http://UHCCommunityPlan.com) under Electronic Data Interchange (EDI) left for EDI-specific issues.

Call UnitedHealthcare Community Plan at 800-842-1109 or EDI Support at 800-210-8315, or email [ac_edi_ops@uhc.com](mailto:ac_edi_ops@uhc.com).
Duplicate Denials (Cont’d.)

How to submit corrected Medical claims for Long Term Care:

• Corrected claims can be submitted electronically by placing a frequency type code of ‘7’ (replacement of prior claim/correction) in the appropriate loop/segment of the 837p transaction to payor ID # 03432.

• Corrected claims can be submitted on paper, with a Reconsideration Form and the Resubmission code 7 (replacement of prior claim/correction) and original claim number located in box 22 of the CMS-1500 claim form to:

  UnitedHealthcare Community Plan
  P.O. Box 30995
  Salt Lake City, UT 84130

Use the EDI Issue Reporting Form available at UHCCommunityPlan.com under Electronic Data Interchange (EDI) left for EDI-specific issues.

Call UnitedHealthcare Community Plan at 800-842-1109 or EDI Support at 800-210-8315, or email ac edi ops@uhc.com.
Duplicate Denials (Cont’d.)

How to submit corrected Behavioral Health claims:

• Corrected claims can be submitted electronically by placing a frequency type code of ‘7’ (replacement of prior claim/correction) in the appropriate loop/segment of the 837p transaction to payor ID # 03432.

• Corrected claims can be submitted on paper with “Corrected” on the top of the claim form with the previous claim number located in box 22 of the CMS-1500 claim form.

    UnitedHealthcare Community Plan – Optum
    P.O. Box 30760
    Salt Lake City, UT 84130-0760
The Arizona Healthcare Cost Containment System’s (AHCCCS) Claims Medical Review Unit has noted an increased use of CPT code 99285 on claims for billed emergency room visits.

When submitting a claim using CPT code 99285, please document the following:

- Comprehensive history
- Comprehensive examination
- Medical decision for services involving high complexity conditions. Usually the presenting problem(s) are of high severity, are a potential life threatening problem and require the immediate attention of the physician.

Services for constipation, earaches and colds, for example, should not be billed using CPT code 99285. AHCCCS will refer any improper billing trends to the Office of the Inspector General.
Reminder on Same Services Billing

Please bill same services on one line item with the corresponding number of units.

**Incorrectly Billed:**

<table>
<thead>
<tr>
<th>A</th>
<th>DATE(S) OF SERVICE</th>
<th>B</th>
<th>PROCEDURE(S)</th>
<th>C</th>
<th>MODIFIER</th>
<th>E</th>
<th>DIAGNOSIS POINTER</th>
<th>F</th>
<th>CHARGES</th>
<th>G</th>
<th>DRG OR UNITS</th>
<th>H</th>
<th>PPA</th>
<th>I</th>
<th>ID</th>
<th>J</th>
<th>RENDERING PROVIDER ID</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MM</td>
<td>DD</td>
<td>YY</td>
<td>MM</td>
<td>DD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>04</td>
<td>05</td>
<td>14</td>
<td>04</td>
<td>05</td>
<td>14</td>
<td>T1016</td>
<td>HO</td>
<td>1, 2, 3</td>
<td>XX</td>
<td>XX</td>
<td>1</td>
<td>NPI</td>
<td>1234567890</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>04</td>
<td>05</td>
<td>14</td>
<td>04</td>
<td>05</td>
<td>14</td>
<td>T1016</td>
<td>HO</td>
<td>1, 2, 3</td>
<td>XX</td>
<td>XX</td>
<td>1</td>
<td>NPI</td>
<td>1234567890</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>04</td>
<td>05</td>
<td>14</td>
<td>04</td>
<td>05</td>
<td>14</td>
<td>T1016</td>
<td>HO</td>
<td>1, 2, 3</td>
<td>XX</td>
<td>XX</td>
<td>1</td>
<td>NPI</td>
<td>1234567890</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Correctly Billed:**

<table>
<thead>
<tr>
<th>A</th>
<th>DATE(S) OF SERVICE</th>
<th>B</th>
<th>PROCEDURE(S)</th>
<th>C</th>
<th>MODIFIER</th>
<th>E</th>
<th>DIAGNOSIS POINTER</th>
<th>F</th>
<th>CHARGES</th>
<th>G</th>
<th>DRG OR UNITS</th>
<th>H</th>
<th>PPA</th>
<th>I</th>
<th>ID</th>
<th>J</th>
<th>RENDERING PROVIDER ID</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MM</td>
<td>DD</td>
<td>YY</td>
<td>MM</td>
<td>DD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>04</td>
<td>05</td>
<td>14</td>
<td>04</td>
<td>05</td>
<td>14</td>
<td>T1016</td>
<td>HO</td>
<td>1, 2, 3</td>
<td>XX</td>
<td>XX</td>
<td>3</td>
<td>NPI</td>
<td>1234567890</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Doc#: PCA13506_20140828
Billing Reminder – 59 Modifier

Modifier 59 must be attached to a component code to indicate that the procedure was distinct or separate from other services performed on the same day and was not part of the comprehensive service. Claims submitted utilizing modifier 59 may be subject to Medical Review.

Medical records must reflect appropriate use of the modifier. Modifier 59 cannot be billed with certain codes, including evaluation and management codes (99201-99499) or radiation therapy codes (77261-77499).
The AHCCCS Inpatient Tiered Per Diem Capped Fee-For-Service Schedule requires all services related to an inpatient stay to be included on the UB04 when a member is admitted as an inpatient to the same hospital where they received emergency room treatment or observation or other outpatient hospital services. Additional information is available in the AHCCCS' Claims Clues newsletter.

The UB04 billing must have dates of service for all services related to the inpatient stay. Claims submitted with service dates that do not match the itemization and medical records will be denied. This is considered a billing error denial, not a denial of service.
Here are several reminders:

• Indicate the Attending Provider Name and Identifiers for the patient’s medical care and treatment on institutional claims for any services other than non-scheduled transportation claims.

• Also send the Referring Provider NPI and name on outpatient claims when the Referring Provider for the services is different than the Attending Provider.

• As of Jan. 1, 2013, claims must include the NPI of the attending provider in the Attending Provider Name and Identifiers Fields (UB-04 FL76 or electronic equivalent) of your claims. That NPI must not be your billing NPI or an organizational NPI; it must an individual provider NPI.

• For Behavioral Health providers, currently, our systems have been updated to receive more than one NPI per agency. Providers can now bill using multiple site-specific NPIs.
- Provider Manual
- Claim Reconsideration and Appeals
- Bulletins
- Reimbursement policies
- Provider forms
- Access to UnitedHealthcareOnline.com
Check Member Eligibility on UnitedHealthcareOnline.com

To see the various programs a member belongs to, search for member by ‘Alpha Search’ and enter the member’s name and date of birth.
Select ‘Details’ for the program information and to view the member’s ID Card which will show the member’s correct Member ID Card number.
To view the member’s correct ID number – select ‘View Patient’s ID Card.’

Another window will open showing you the correct member ID number.
Online training and education available on UHCOnline.com.

Training & Education

Seminar Catalog

Take advantage of free instructor-led trainings, previously recorded on-demand sessions, slide presentations and more. Topics covered include Website, HIPAA 5010 and ICD-10 Courses for CME Credit, Medicaid and Medicare Topics and Additional Learning Opportunities.

Check back often as new training opportunities will be added as available.

Need help? Visit the Help section for step-by-step help and more. Also, tour the site for an overview of available tools and information.

Website

<table>
<thead>
<tr>
<th>Topic</th>
<th>Format/Training</th>
<th>Additional Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optum Cloud Dashboard*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
UnitedHealthcareOnline.com Training & Education – Topics

- Optum Cloud Dashboard
- Optum Cloud Dashboard – Eligibility & Benefits Center and the Claims Management Application
- UnitedHealthcareOnline.com – Overview
- UnitedHealthcareOnline.com – Notification/Prior Authorization Function Overview
- UnitedHealthcareOnline Password Owner Training
- Electronic Payments & Statements (EPS) Introduction
- EDI 101 – Basics and Beyond
- HIPAA 5010 and ICD-10 Implementation
- Compliance, Fraud, Waste and Abuse Training
Member Identification Cards, Billing and Remits for AHCCCS, CRS and UnitedHealthcare Dual Complete plans
Member Identification (ID) Cards, Billing and Remits for the following plans:

- Arizona Health Care Cost Containment System
- Children's Rehabilitative Services
- UnitedHealthcare Dual Complete
New AHCCCS Member ID Cards
Effective April 1, 2014

1. Group ID goes from five digits to five letters
2. Program name changes

Note: These are not the AHCCCS member eligibility codes
New CRS Member ID Cards
Effective April 1, 2014

A Group ID goes from five digits to five letters

B Program Name Changes

Note: These are not the AHCCCS member eligibility codes
CRS Billing Guideline Reminders

• Providers should use the Children’s Rehabilitative Services (CRS) member ID when billing for services covered under the member’s CRS Program. That ID begins with a “2.”

• CRS members will also receive an AHCCCS ID number that begins with an “A”.
  – If the member is dually enrolled in UnitedHealthcare-Dual Complete (special needs plan), please bill the claim using the Dual SNP member ID. Dual SNP member IDs are nine digits and begin with an “8.”
  – When billing services for members with developmental disabilities, please use the member’s AHCCCS ID that begins with an A.
  – Members enrolled in the Comprehensive Medical and Dental (CMDP) Program will receive a separate CMDP member ID starts with “00.” Please use that number when billing CMDP directly.

• Include the member’s CRS diagnosis on the claim if related to the service being rendered when billing for CRS-covered medical services. A list of CRS covered conditions is available at UHCCommunityPlan.com.
More information about CRS benefits and billing for medical and behavioral health is available at UHCCCommunityPlan.com or the AHCCCS website at Azahcccs.gov, including:

- AHCCCS medical policy manual (AMPM), including AMPM Policy 330 and AHCCS policy 432
- UnitedHealthcare Community Plan Provider Administrative Guide available at UHCCCommunityPlan.com
New UnitedHealthcare Dual Complete Member ID Card Effective April 1, 2014

UnitedHealthcare Dual Complete (HMO SNP)
*Medicare ID cards with the Group ID will not be mass re-issued at this time

**Long Term Changes (No Changes)**
Long Term Care utilizes multiple Group numbers.
See provider manual for more information.
Member IDs on UnitedHealthcare Dual Complete Remits

UnitedHealthcare Community Plan transitioned to a new technology platform on April 1, 2014 causing a temporary issue displaying the appropriate member ID number on our UnitedHealthcare Dual Complete remits.

All other information in the remit is correct. If you use patient account numbers in your reconciliations, this should not affect you. If you need to obtain a Medicare Dual Complete ID number, go to UnitedHealthcareOnline.com > Patient Eligibility and follow the instructions below:

- Use the Alpha Search button to see all the member’s groups.
- Choose the member’s Medicare Dual Complete record to display the eligibility information.
- Select the link for the Member ID Card (top of page) to see the member’s Medicare Dual Complete ID card with the correct ID number.

If you have any questions, please contact Provider Services at 800-445-1638.
New Remits Effective April, 1 2014

Each remit will have the individual products separated.

Your claims will be separated to show their individual totals.
Each remit will include a Payee Total including Overpayment Totals, Recovered Totals and Net Paid Amounts.

<table>
<thead>
<tr>
<th>Payee Totals</th>
<th>Billed</th>
<th>Allowed</th>
<th>Disc/Disp</th>
<th>Allowed</th>
<th>Total</th>
<th>Discount</th>
<th>Deductible</th>
<th>Copay</th>
<th>Co-Ins</th>
<th>Paid</th>
<th>Interest</th>
<th>Recall</th>
<th>Net Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>183.55</td>
<td>183.55</td>
<td>183.55</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>88.75</td>
<td>2.25</td>
<td>0.00</td>
<td>88.15</td>
</tr>
</tbody>
</table>

Net Payable: 88.15

Overpayment Amount: 0.00

Recovered Amount: 0.00

Net Paid Amount: 88.15

Summary of Overpayments / Payments Recovered

<table>
<thead>
<tr>
<th>Claim Number</th>
<th>Member Number</th>
<th>Patient Account Number</th>
<th>Member Name</th>
<th>Create Date</th>
<th>Date of Service</th>
<th>Original Amount</th>
<th>Recovered</th>
<th>Recovered</th>
<th>Remaining</th>
</tr>
</thead>
</table>

Explanation Code Legend

Reason Code | Description
45          | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).

Remark Code | Description
Electronic Funds Transfer (EFT)

Electronic Data Interchange (EDI)

EDI Support Services
EDI Support Services provides support for all electronic transactions involving claims and electronic remittances. Please call us for assistance with any of these transactions at 1-800-210-8315 or e-mail: ac_edi_ops@uhc.com

If you are experiencing technical problems, need assistance in using UnitedHealthcare Community Plan Online, have login or User ID/Password issues please call UnitedHealthcare Community Plan EDI Support: 1-800-210-8315 or e-mail: ac_edi_ops@uhc.com

UnitedHealthcare Electronic Payments and Statements (EPS)
UnitedHealthcare’s Electronic Payments and Statements (EPS) program is not available for Community Plan at this time. We are working to make EPS available for additional UnitedHealthcare plans later this year.

EDI Training

<table>
<thead>
<tr>
<th>Claims Payer ID</th>
<th>03432</th>
</tr>
</thead>
<tbody>
<tr>
<td>ERA Payer ID</td>
<td>03432</td>
</tr>
</tbody>
</table>

CRS Behavioral Health EDI

Electronic Claim Submission and Electronic Data Interchange

Companion Guides

Link to Companion Guides

Informational Material on EDI, EFT and ERA

EFT Enrollment Form: (PDF 718.41 KB)
EFT Appendix (PDF 104.12 KB)
Policy Changes and Billing Reminders
Updated prior authorization lists are also available on [UHCCommunityPlan.com](http://UHCCommunityPlan.com):

- [Prior Authorization Lists for AHCCCS, DD, CRS and UnitedHealth Care Dual Complete Plans](#)
- [Prior Authorization List for CRS Plan](#)
- [CRS Medication Prior Authorization Request Form](#)

Update: Respite services are no longer included on prior authorization lists.
Non-Emergency Transportation

Acute, Dual Complete, CRS and DD Non-Emergency Medical Transportation:

Members and providers can schedule non emergency transportation including support services through Medical Transportation Brokerage of Arizona (MTBA) at 888-700-6822. Please schedule transportation at least three days before the appointment.

In addition, we offer bus passes for local trips and access to shuttle vans and buses for members who live farther away.

Long Term Care Non-Emergency Medical Transportation:

Members and providers can schedule non emergency transportation including support services through Logisticare at 866-252-1735. Please schedule transportation at least three days before the appointment, but no more than 2 weeks before.

Logisticare Transportation Help Line: 866-252-3865
Wellness Exams and Lab Screenings

**AHCCCS has the following policy changes for Wellness exams and lab screenings:**

- These services are covered for members 21 and older.
- Well visits include well woman exams, breast exams and prostate exams.
- AHCCCS covers medically necessary services for members younger than 21 under the Early Periodic Screening, Diagnosis, and Treatment program.
- **LabCorp** is the in-network laboratory for all members (AHCCCS, DD, CRS and Medicare).
Laboratory Billing – Referring Provider

The ordering or referring provider’s name should be included on all CMS-1500 claims submitted with laboratory services in boxes 17, 17a, 17b or its electronic equivalent.

- Lab Corp: the contracted laboratory for UnitedHealthcare Community Plan
- Non-participating laboratories: such as Sonora Quest or Millennium
- Physicians: submitting claims with services listed as ‘allowed’ per the Laboratory Services Update Bulletin
New Benefit Changes

The PT benefit is no longer 30 PT visits total, but divided into:

• 15 outpatient PT visits to bring back function
• 15 outpatient PT visits to get or maintain function

Prior authorization requirements remain the same.
Effective April 1, 2014, Adjunct Professional Service: A medical service performed by an anesthesiologist, pathologist, radiologist or inpatient consultant professional provider that is an integral but separate adjunct component of an authorized or covered medical service. Please view this policy at UHCCommunityPlan.com in the Reimbursement Policy section.
Effective April 1, 2014, fluoride varnish application is now covered when provided in a primary care physician’s (PCP’s) office for children 6 months to 2 years.

- Only PCPs who have completed the AHCCCS required training may be reimbursed for fluoride varnish applications completed at the Early Periodic Screening, Diagnosis and Treatment (EPSDT) visits for members 6 months and older with at least one tooth eruption.

- Application of fluoride varnish may be billed separately from the EPSDT visit using code D1206. (Need for prophylactic fluoride administration).

- Additional applications occurring every six months during an EPSDT visit up to age 2 may be reimbursed according to AHCCCS approved fee schedules.

- Application of fluoride varnish by the PCP does not take the place of an oral health visit. Members should be referred for routine dental visits starting at age 1.

See the bulletin on UHCCommunityPlan.com with a link to the required training module.
The EPSDT Tracking Form has been updated to reflect fluoride varnish administered by the primary care physician.

<table>
<thead>
<tr>
<th>Admitted to NICU: (Birth)</th>
<th>Current Medications/Vitamins/Herbal Supplements:</th>
<th>Risk Indicators of Hearing Loss:</th>
<th>Birth Weight:</th>
<th>Weight:</th>
<th>Length:</th>
<th>Head Circumference:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes □ No</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
<td>lb oz</td>
<td>lb oz</td>
<td>%</td>
<td>cm</td>
</tr>
</tbody>
</table>

**FAMILY/SOCIAL HISTORY:** (Current Concerns/ Follow-Up on Previously Identified Concerns)

**PARENTAL CONCERNS:** How are you feeling about baby? Do you feel safe in your home?

**VERBAL LEAD RISK ASSESSMENT:** Child At Risk ☐ Yes □ No (If Yes, Appropriate Action to Follow) Lives in High Risk Zip Code ☐ Yes □ No

**ORAL HEALTH:** □ Parent Cleaning Baby’s Gums With Washcloth/Infant Toothbrush ☐ Fluoride Supplement ☐ Fluoride Varnish by PCP

**NUTRITIONAL SCREENING:** ☐ Breastfeeding Frequency/Duration: _____________ ☐ Supplements: _________ ☐ Vit D
After completing the required training, submit a copy of your certificate to:

UnitedHealthcare Community Plan
Quality Management Department
1 East Washington St., Suite 900
Phoenix, AZ 85004
PT/CT Reimbursement Policy Changes

Effective for claims processed on or after May 17, 2014, UnitedHealthcare Community Plan will make the following changes to the Professional/Technical Component Policy (PT/CT).

- **Will not reimburse claims submitted** with CPT 96360-96379, 96401-96425 and 96521-96523 reported by a physician or other health care professional in a POS 24.

- **Will not reimburse claims submitted with** PT/CT Indicator 8, CPT code 85060 when reported by a physician or other health care professional with a POS code other than inpatient hospital (POS 21).
Behavioral Health Resources
AHCCCS AMPM – Medical Policy Guide provides information about services covered within the AHCCCS program for both managed care and fee-for-service members. More information is available through the AHCCCS Medical Policy Manual.

AHCCCS Behavioral Health Services Guide provides the following information:
• Descriptions of covered services
• Explanations about service limitations
• Process and requirements of becoming an AHCCCS Provider
• List of service codes
Covered Behavioral Health Services Appendices

Appendix A: Billing for Behavioral Health Services, Indian Health Services and 638 Tribal Fact Sheets

- A–1: Memorandum
- A–2: 638 Billing Matrix
- A–3: PowerPoint
- A–4: Case Management Billing Guidelines

Appendix B: Reference Tables

- B–1: Rehabilitation & Support Services Billing Crosswalk
- B–2: Allowable Procedure Codes And Provider Types
- B–3: Encounter/Claims Principle Behavioral Health ICD-9 Diagnostic Codes
- B–4: Reserved
- B–5: Procedure and Transportation Codes Billing Limitations

http://www.azdhs.gov/bhs/covserv.htm
Important References

Please check the AHCCCS, ADHS and UnitedHealthcare Community Plan websites for important announcements and a few good references to bookmark include:

**AHCCCS**

**ADHS**
http://www.azdhs.gov/bhs/4providers.htm

**UnitedHealthcare community Plan:**
http://www.uhccommunityplan.com/health-professionals/AZ/provider-information
http://www.uhccommunityplan.com/health-professionals/az/provider-bulletins.html

**CMDP:**
https://www.azdes.gov/dcyf/provider/
AHCCCS Registration and CMS 1500 Claim Form General Requirements
AHCCCS Registration for Providers

All providers must register with AHCCCS here:
http://www.azahcccs.gov/commercial/ProviderRegistration/packet.aspx

You need an NPI before you may apply for the AHCCCS ID. If you do not have an NPI and your provider type requires you to have one, use this link; NPI Registration to obtain your NPI number.

You will need to bill your AHCCCS registered NPI number in box 24J of the CMS 1500 claim form.
AHCCCS Provider Types and Category of Service (COS)

Based upon your AHCCCS provider registration, you will be assigned a provider type and category of service type, which drives the codes you may bill and reimbursement.

AHCCCS Provider Types

All AHCCCS providers are registered under a provider type (e.g., hospital, nursing facility, physician, etc.) established by AHCCCS. The AHCCCS Provider Registration Unit will help providers identify the most appropriate provider type, based on the provider's license/certification and other documentation.

AHCCCS Provider Categories of Service

Within each provider type, mandatory and optional categories of service (COS) are identified.

- Mandatory COS are defined by mandatory license or certification requirements.
  - The provider must submit documentation of license and/or certification for each mandatory COS.
- Optional COS are those that the provider may be qualified to provide and chooses to provide.
  - Optional COS which do not require additional license and/or certification are automatically posted to the provider's file.
  - Optional COS which do require license/certification are posted once proof of current, valid licensure and/or certification is received.
## Common Provider Types

<table>
<thead>
<tr>
<th></th>
<th>Provider Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Group-Payment ID</td>
</tr>
<tr>
<td>02</td>
<td>Hospital</td>
</tr>
<tr>
<td>03</td>
<td>Pharmacy</td>
</tr>
<tr>
<td>04</td>
<td>Laboratory</td>
</tr>
<tr>
<td>05</td>
<td>Clinic</td>
</tr>
<tr>
<td>06</td>
<td>Emergency Transportation</td>
</tr>
<tr>
<td>07</td>
<td>Dentist</td>
</tr>
<tr>
<td>08</td>
<td>Physician</td>
</tr>
<tr>
<td>09</td>
<td>Nurse-Midwife</td>
</tr>
<tr>
<td>10</td>
<td>Podiatrist</td>
</tr>
<tr>
<td>11</td>
<td>Psychologist</td>
</tr>
<tr>
<td>12</td>
<td>Certified Registered Nurse Anesthetist</td>
</tr>
<tr>
<td>13</td>
<td>Occupational therapist</td>
</tr>
<tr>
<td>14</td>
<td>Physical therapist</td>
</tr>
<tr>
<td>15</td>
<td>Speech/Hearing Therapist</td>
</tr>
<tr>
<td>16</td>
<td>Chiropractor</td>
</tr>
<tr>
<td>17</td>
<td>Naturopath</td>
</tr>
<tr>
<td>18</td>
<td>Physicians Assistant</td>
</tr>
<tr>
<td>19</td>
<td>Registered Nurse Practitioner</td>
</tr>
<tr>
<td>20</td>
<td>Respiratory Therapist</td>
</tr>
<tr>
<td>21</td>
<td>Nursing Home</td>
</tr>
<tr>
<td>50</td>
<td>Adult Foster Care</td>
</tr>
<tr>
<td>51</td>
<td>Behavioral Health Counselor</td>
</tr>
<tr>
<td>52</td>
<td>Mental Health Clinic</td>
</tr>
<tr>
<td>53</td>
<td>Supervisory Care Home</td>
</tr>
<tr>
<td>54</td>
<td>Dental Hygienist</td>
</tr>
<tr>
<td>55</td>
<td>Hotels</td>
</tr>
<tr>
<td>56</td>
<td>Boarding Home</td>
</tr>
<tr>
<td>57</td>
<td>Residential Treatment Center (RTC)</td>
</tr>
<tr>
<td>58</td>
<td>State School for Deaf and Blind</td>
</tr>
<tr>
<td>59</td>
<td>Dental Lab</td>
</tr>
<tr>
<td>60</td>
<td>Blood Bank</td>
</tr>
<tr>
<td>61</td>
<td>Eye Bank</td>
</tr>
<tr>
<td>62</td>
<td>Audiologist</td>
</tr>
<tr>
<td>63</td>
<td>Drug &amp; Alcohol Rehabilitation</td>
</tr>
<tr>
<td>64</td>
<td>Detox Center</td>
</tr>
<tr>
<td>65</td>
<td>Hospital Outpatient Surgery Center</td>
</tr>
<tr>
<td>66</td>
<td>Organ Bank</td>
</tr>
<tr>
<td>67</td>
<td>Perfusionan</td>
</tr>
<tr>
<td>68</td>
<td>Homeopathic</td>
</tr>
<tr>
<td>69</td>
<td>Optometrist</td>
</tr>
<tr>
<td>70</td>
<td>Home Delivered Meals</td>
</tr>
</tbody>
</table>

### Provider Types and Category of Service

Example of AHCCCS provider type with Category of Service.

<table>
<thead>
<tr>
<th>PROVIDER CATEGORY</th>
<th>OPTION</th>
<th>CATEGORY DESCRIPTION</th>
<th>FROM</th>
<th>THRU</th>
<th>SERVICE TYPE</th>
<th>BEGIN</th>
<th>END</th>
<th>FILLER</th>
<th>RECORD</th>
</tr>
</thead>
<tbody>
<tr>
<td>8S 01 M</td>
<td>MEDICINE</td>
<td>90791 90791</td>
<td>H</td>
<td>20130101 99999999</td>
<td>P1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8S 01 M</td>
<td>MEDICINE</td>
<td>96150 96155</td>
<td>H</td>
<td>20020101 99999999</td>
<td>P1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8S 47 M</td>
<td>MENTAL HEALTH SERVICES</td>
<td>H0001 H0001</td>
<td>H</td>
<td>20070701 99999999</td>
<td>P1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8S 47 M</td>
<td>MENTAL HEALTH SERVICES</td>
<td>H0002 H0002</td>
<td>H</td>
<td>20031001 99999999</td>
<td>P1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8S 47 M</td>
<td>MENTAL HEALTH SERVICES</td>
<td>H0004 H0004</td>
<td>H</td>
<td>20031001 99999999</td>
<td>P1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Behavioral Health Providers NPI # for the site where the services are rendered or the clinician listed on the roster’s NPI.

Box 24J
In the non-shaded field, enter the AHCCCS-registered NPI number (individual provider or site-specific NPI).

J. RENDERING PROVIDER ID. #

1234567890
Placement of Billing vs. Rendering Clinician Name on CMS 1500 Claim Form

Box 31
• Enter the rendering provider’s name and date
  − Provider should be registered with AHCCCS under the NPI submitted in 24J
  − May be an individual provider or the group agency
• If individual provider, name needs to match exactly with the name that is registered with AHCCCS and match the Agency Roster (if roster is applicable).

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
(I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED John Doe. MD DATE 10/24/13
Placement of Billing Group/Agency on CMS 1500 Claim Form

Box 33 - Provider/Group/BH Agency name, address and phone number

33. BILLING PROVIDER INFO & PH #  (555) 987-6543
XYZ Agency
1234 Data St
Phoenix, AZ 12345

a. 0987654321

Box 33a - Provider/Group/BH Agency AHCCCS-registered NPI number
Prior Authorization Number Needed on CMS 1500 Claim Form

Include the prior authorization number in box 23 of the CMS 1500 claim form. If you forget, our claim system will match the prior authorization number that’s on file.

```
<table>
<thead>
<tr>
<th>Box</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>23</td>
<td>PRIOR AUTHORIZATION NUMBER</td>
</tr>
</tbody>
</table>
```

**Example:** 12345678
Billing Units on CMS 1500 Claim Form

Bill the appropriate number of units for the applicable CPT/HCPCS code.

For example, this provider performed 30 minutes of support services on Oct 1. Support services are billed with HCPCS T1016 where 1 unit = 15 minutes. Therefore, bill 2 units.
Diagnosis Codes Listed on CMS 1500 Claim Form

The revised CMS Claim Form includes an ICD indicator, an increase in the number of diagnosis codes that can be reported and the removal of several fields.

- AHCCCS does not accept DSM-IV diagnosis codes but it does accept ICD-9 codes.
- The implementation of ICD-10 has been extended to Oct. 1, 2015.

Enter at least one ICD-9 and up to 12 diagnosis codes in priority order. Behavioral Health providers must **not** use DSM-4 diagnosis codes.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>250.52</td>
</tr>
<tr>
<td>E.</td>
<td></td>
</tr>
<tr>
<td>I.</td>
<td></td>
</tr>
</tbody>
</table>

Doc#: PCA13506_20140828
**Places of Service Codes**

**What place of service do I bill on my claim?**

Enter the two-digit code that describes the place of service.

<table>
<thead>
<tr>
<th>Code</th>
<th>Place of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>03</td>
<td>School</td>
</tr>
<tr>
<td>04</td>
<td>Homeless shelter</td>
</tr>
<tr>
<td>05</td>
<td>IHS Free-standing Facility</td>
</tr>
<tr>
<td>06</td>
<td>IHS Provider-based Facility</td>
</tr>
<tr>
<td>07</td>
<td>Tribal 638 Free-standing Facility</td>
</tr>
<tr>
<td>08</td>
<td>Tribal 638 Provider-based Facility</td>
</tr>
<tr>
<td>09</td>
<td>Office</td>
</tr>
<tr>
<td>10</td>
<td>Home</td>
</tr>
<tr>
<td>13</td>
<td>Assisted Living Facility</td>
</tr>
<tr>
<td>14</td>
<td>Group Home</td>
</tr>
<tr>
<td>15</td>
<td>Mobile Unit</td>
</tr>
<tr>
<td>20</td>
<td>Urgent Care Facility</td>
</tr>
<tr>
<td>21</td>
<td>Inpatient Hospital</td>
</tr>
<tr>
<td>22</td>
<td>Outpatient Hospital</td>
</tr>
<tr>
<td>23</td>
<td>ER – Hospital</td>
</tr>
<tr>
<td>24</td>
<td>ASC</td>
</tr>
<tr>
<td>25</td>
<td>Birthing Center</td>
</tr>
<tr>
<td>26</td>
<td>Military Treatment Facility</td>
</tr>
<tr>
<td>31</td>
<td>Skilled Nursing Facility</td>
</tr>
<tr>
<td>32</td>
<td>Nursing Facility</td>
</tr>
<tr>
<td>33</td>
<td>Custodial Care Facility</td>
</tr>
<tr>
<td>34</td>
<td>Hospice</td>
</tr>
<tr>
<td>41</td>
<td>Ambulance – Land</td>
</tr>
<tr>
<td>42</td>
<td>Ambulance – Air or Water</td>
</tr>
<tr>
<td>49</td>
<td>Independent Clinic</td>
</tr>
<tr>
<td>50</td>
<td>FQHC</td>
</tr>
<tr>
<td>51</td>
<td>Inpatient Psych Facility</td>
</tr>
<tr>
<td>52</td>
<td>Psych Facility - Partial Hospitalization</td>
</tr>
<tr>
<td>53</td>
<td>Community Mental Health Center</td>
</tr>
<tr>
<td>54</td>
<td>ICF/Mentally Retarded</td>
</tr>
<tr>
<td>55</td>
<td>Residential Substance Abuse Treatment Facility</td>
</tr>
<tr>
<td>56</td>
<td>Psych Residential Treatment Center</td>
</tr>
<tr>
<td>57</td>
<td>Non-residential Substance Abuse Treatment Facility</td>
</tr>
<tr>
<td>60</td>
<td>Mass Immunization Center</td>
</tr>
<tr>
<td>61</td>
<td>Comprehensive Inpatient Rehabilitation Facility</td>
</tr>
<tr>
<td>62</td>
<td>Comprehensive Outpatient Rehabilitation Facility</td>
</tr>
<tr>
<td>65</td>
<td>ESRD Treatment Facility</td>
</tr>
<tr>
<td>71</td>
<td>Public Health Clinic</td>
</tr>
<tr>
<td>72</td>
<td>Rural Health Clinic</td>
</tr>
<tr>
<td>81</td>
<td>Independent Laboratory</td>
</tr>
<tr>
<td>99</td>
<td>Other Place of Service</td>
</tr>
</tbody>
</table>

Doc#: PCA13506_20140828
Some services may not be billed on the same day as other covered services and most codes have a daily or annual limit to the amount of services that may be provided.

**Example:**
- Max Frequency Per Day Policy: the maximum allowed amount of units for individual services
- CCI Editing Policy: services that will not be reimbursed if billed on the same day by the same health care provider

Codes may also have maximum unit, age or gender limits that flag a claim for additional review.

**Example:**
- Billing a T1016 code for the same member, same provider, same date of service in excess of 12 hours (48 units)
- Billing H0046 – MH services, not otherwise specified
Common Modifiers

Your claim could be denied if you do not bill a required modifier

Example:

- **HO, HN** modifiers are required for providers who have bachelor’s or master’s degrees and billing T1016 support services.
- **AA** modifier is required for anesthesia services performed personally by an anesthesiologist.
- **EP** modifier is required in order to receive the developmental screening tool reimbursement rate (additional requirements apply).

For a listing of code/modifier combinations, please use the AHCCCS and ADHS websites materials available at [azahcccs.gov](http://azahcccs.gov) and [azdhs.gov](http://azdhs.gov).
Claim Submissions and Mailing Addresses
Claim Submissions – Electronic

**Initial Claim Submissions:**
Please submit medical claims electronically (837p or 837i) using **Payer ID # 03432**. This applies to UnitedHealthcare Community Plan Acute, DD, CRS (both medical and behavioral) and UnitedHealthcare Dual Complete claims available at [Claim Reconsideration](https://www.unitedhealthcareonline.com).

**Electronic Resubmissions and Reconsiderations (CRS medical):**
Reconsiderations, corrected claims and medical record attachments for UnitedHealthcare Community Plan Acute, DD, CRS (medical only) and UnitedHealthcare Dual Complete claims can be submitted electronically via the Optum Cloud Dashboard available on UnitedHealthcareOnline.com under the Quick links on the home page.

Corrected claims can also be submitted electronically using Frequency Type Code ‘7’ (replacement/correction of previously submitted claim).
Claim Submissions – Paper

Medical Claim Submission
Mail initial paper claims and medical record attachments to:

UnitedHealthcare Community Plan
P.O. Box 5290
Kingston, NY 12402-5290

CRS Behavioral Health Claims
Mail initial paper claims and medical record attachments to:

UnitedHealthcare Community Plan – Optum
P.O. Box 30760
Salt Lake City, UT 84130-0760
Mail resubmitted or corrected paper claims and medical record attachments along with a copy of the claim, remittance advice, cover letter or Reconsideration Form detailing the reason for resubmitting the claim and any correction(s) made to:

**Medical Claims (Acute, CRS and DD)**

UnitedHealthcare Community Plan  
Claims Resubmission  
P.O. Box 5290  
Kingston, NY 12402-5290

**CRS Behavioral Health Claims**

UnitedHealthcare Community Plan – Optum  
P.O. Box 30760  
Salt Lake City, UT 84130-0760
Claims Information – Timely Filing

Initial Claim:
• Please follow timely filing requirements according to your contract

Third Party Claims:
• Six months from date of service
• Providers must report all encounters
• Use appropriate claim form required by the CMS and AHCCCS

Reconsiderations and Corrected Claims:
• Submit corrected claims and reconsiderations within one year from the date of service or within 60 days of claim payment, denial or recoupment (whichever is later).
Claim Disputes AHCCCS-Medicaid, DD and CRS plans

All claim disputes challenging claim payments, denials or recoupments must be filed no later than 12 months from the date of service date of eligibility posting or within 60 days after the payment, denial or recoupment of a timely claims submission, whichever is later.

All claim disputes for AHCCCS-Medicaid, Developmental Disabilities and Children’s Rehabilitative Services plans must be submitted in writing to:

UnitedHealthcare Community Plan
Appeals and Claim Disputes
1 East Washington, Suite 900
Phoenix, AZ 85004
File appeals for Long Term Care and UnitedHealthcare Dual Complete (HMO SNP) to:

<table>
<thead>
<tr>
<th>Long Term Care</th>
<th>UnitedHealthcare Dual Complete (HMO SNP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>UnitedHealthcare Community Plan Attn: Complaint and Appeals Dept. 1 East Washington, Suite 800 Phoenix, AZ 85004</td>
<td>Part C Appeals and Grievance Dept. UnitedHealthcare Community Plan Attn: Complaint and Appeals Dept. P.O. Box 31364 Salt Lake City, UT 84131-0364</td>
</tr>
<tr>
<td></td>
<td>Part D Appeals and Grievance Dept. Attn: CA124-0197 P.O. Box 6106 Cypress, CA 90630-9948</td>
</tr>
</tbody>
</table>
Thank you.