

BILLING AND REIMBURSEMENT OVERVIEW

I. BILLING PROCEDURES - SUBMITTING

Your claim(s) are to be submitted on a CMS 1500 (Formerly HCFA 1500) for professional services. Providers are encouraged to begin billing on the Revised CMS claim form which includes the required National Provider ID Number (NPI). Dental claims should be submitted effective for DOS January 1, 2007, on the revised ADA 2006 claim form which includes the required NPI Number. Hospital services, dialysis, SNF, and hospice need to be billed on the UB-92 form. Providers are encouraged to bill on the revised claim form version (UB04) which includes the eventual required National Provider ID Number (NPI). Original hardcopy claim forms may be mailed or hand-delivered, but should not be faxed due to HIPAA. Universal C forms are to be submitted electronically (for pharmacy claims). Instructions for completion of these forms are included within this section.

If you are a contracted provider, PHS requires that you initially submit your clean claim within your contract deadline. If you have no contract, submission requirements are 180 days from the date of service, or 180 days from the date of Medicare EOB. PHS requires that you resubmit a previously denied claim within your contract deadline for resubmitting claims. If you have no contract, you have one year from the date of service to resubmit a claim. A "clean claim" is defined in Arizona Revised Statutes as one that can be processed without obtaining additional information from the provider of service or from a third party. All claims should be submitted to:

Pima Health System
Claims Division
3950 S. Country Club Rd., Suite 350
Tucson, AZ 85714
Fax: (520) 243-8453

In the absence of a contract, you will be paid 100% of the AHCCCS Fee-For-Service (AFFS) schedule if a rate is on file, 100% of billed charges if less than the AFFS rate or 65% of billed charges for rates not in the AHCCCS Fee-For-Service Schedule. Contracted providers will be paid at the contracted rate.

Failure to adhere to these submittal requirements may result in the denial of your claim(s). Denied claims may be disputed as per the dispute procedures as stated in this manual. Providers may submit denied claims for reconsideration prior to filing a claim dispute.

Claims are processed on a first in, first out basis. Per AHCCCS regulations, PHS has 30 days, from the date the claim is received, to process your clean claims.

PHS' Claims Customer Service is available to assist with claims issues Monday through Friday from 8 a.m. to 5 p.m. at (520) 243-8063.

Check claim status on our web site at www.phs.pima.gov. To register click on "Provider Assistance", then "On-Line Claims Inquiry", and then "Create an Account". If you need assistance with the registration process, call (520) 243-8500.

In addition to PHS' Claims Customer Service, Provider Services is available to provide assistance. PHS' philosophy is to address concerns on an informal basis whenever possible. Provider Services is available at (520) 243-8500.

II. II. COMPLETING FORMS

A. COMPLETING A CMS 1500 FORM (Revised Version Effective 1/1/07)

When filing a claim on a CMS 1500 (HCFA 1500), there are required fields that are to be completed. These required fields will be noted with a "Y" to the left of the field description. The Reference Box identifies information which may be helpful in completing the particular field.

CMS BOX #	YES/NO REQ	DESCRIPTION	REFERENCE
1	Y	Program Box - Check Medicaid	
1A	Y	Insured's ID Number - Enter nine digit AHCCCS ID number. Contact number to verify AHCCCS eligibility is 1-800-962-6690.	
2	Y	Patient's Name - Enter member name Last Name, First, MI	
3	Y	Patient's DOB and Sex - Enter DOB as MM, DD, YY and indicate M or F	
4	N	Insured's Name	
5	N	Patient's Address - Enter patient's Address, Street, City, State and Zip Code.	
6	N	Patient Relation to Insured	
7	N	Insured's Address	
8	N	Patient Status	
9	Y	Other Insured's Name - Enter if applicable	
9A	Y	Other Insured's Group Name - Enter if applicable	
9B	Y	Other Insured's DOB/Sex - Enter if applicable	
9C	Y	Other Insured's Employer/School - Enter if applicable	
9D	Y	Insurance Plan or Program Name - Enter if applicable	
10 -10C	Y	Relation of Patient Condition -Check appropriate boxes to indicate whether the patient's condition is the result of employment, an auto accident, or another type of accident.	
11-11D	Y	Insured's Policy Group or FECA Number -Enter if applicable. If the patient is a newborn, enter the mother's AHCCCS ID no. If other coverage exists, other than AHCCCS, you must complete Fields 9a-d.	
12	N	Patient's Authorization - The patient signature authorizes the release of medical treatment data. (Signature on File)	
13	N	Insured's or Authorized Person's Signature	
14	Y	Date of Illness or injury - Enter original date of illness or injury if applicable.	
15	N	Date of Same or similar illness	
16	N	Dates Patient Unable to Work in Current Occupation	
17a	Y	Name of Referring Physician - Enter name of referring physician if the service was ordered by another physician. Required only for podiatry services.	
17b NPI	Y	NPI – National Provider ID #	
18	N	Hospital Dates Related to Current Services.	
CMS BOX #	YES/NO REQ	DESCRIPTION	REFERENCE
19	N	Reserved for Local Use	

20	N	Outside Lab	
21	Y	Diagnosis or Nature of Illness or Injury – Enter at least one and a maximum of four valid ICD9 codes.	Current ICD-9 Manual
22	Y	Medicaid Resubmission Code -Original CRN – Leave blank for 1 st submission. If a claim is a resubmission enter the appropriate code to indicate whether this claim is: Code A - Adjustment of previous claim Code V - Void of a previous claim or Code R - Resubmission of a previous claim. Enter the original CRN of the claim being adjusted, voided, or the denied claims being resubmitted in the field labeled “Original Reference No.” Note - Only claims that have been denied or adjusted by PHS can be resubmitted.	
23	N	Prior Authorization Number - Enter PHS authorization no.	
24A	Y	Dates of Service - Enter beginning and ending service dates as MM/DD/YY. If service was completed in one day the dates will be the same. If services covers a span of time, the FROM and TO dates will be different. The FROM date must be equal to or prior to the TO date. The TO date must be equal to or prior to the billing date	
24B	Y	Place of Service - Enter the appropriate POS code from list below: School 03 Homeless shelter 04 IHS Free-standing Facility 05 IHS Provider-based Facility 06 Tribal 638 Free-standing Facility 07 Tribal 638 Provider-based Facility 08 Office Visit 11 Home 12 Assisted Living Facility 13 Group Home 14 Mobile Unit 15 Urgent Care Facility 20 Inpatient Hospital 21 Outpatient Hospital 22 Emergency Room 23 Ambulatory Surg. Cntr. 24 Birthing Center 25 Military Treatment Facility 26 Skilled Nursing Facility 31 Nursing Facility 32 Custodial Care Facility 33 Hospice 34 Ambulance - Land 41 Ambulance - Air or Water 42 Independent Clinic 49 FQHC 50	

24 B Cont.	Y	Inpatient Psychiatric Fac. 51 Psychiatric Facility/Par Hosp. 52 Community Mental Hlth Ctr 53 Intermediate Care/MR 54 Residential Sub. Abuse Treatment 55 Psychiatric Residential Treatment 56 Non-residential Substance Abuse Treatment Facility 57 Mass Immunization Center 60 Comprehensive Inpatient Rehab 61 Comprehensive Outpatient Rehab End Stage 62 Renal Disease 65 State or Local Public Health Clinic 71 Rural Health Clinic 72 Independent Laboratory 81 Other Unlisted Facility 99	
24C	N	Type of Service	
24D	Y	Procedure and Procedure Modifier - Enter valid HCPCS/CPT code that identifies the services provided. Enter a valid modifier if applicable for each service code.	CPT and/or HCPC books. PHS Contract
24E	Y	Diagnosis Code - Relate the service provided to a diagnosis stated in field 21 by entering the line number of the diagnosis, 1-4. More than one diagnosis reference may be entered for each procedure, and if more than one is entered they should be in descending order of importance. Do not enter the diagnosis code itself in field 24e, but only the reference to field 21. (1, 2, 3 or 4) Identify which of the diagnoses in box 21 pertain to the service provided.	
24F	Y	\$Charges - Enter total charges for the total number of units for each procedure code. If more than one unit of the service is provided, the charges for all units should be entered. For example, if each unit of service is billed at \$50.00, and 3 units were provided, the total of \$150.00 should be entered here, and the number of units, 3, is entered in field 24g.	
24G	Y	Units - Enter the units of service provided during the dates in field 24A. Unit definitions must be consistent with the HCPCS manual and must be expressed in whole numbers. When billing anesthesia services, report time units. Each 15 minutes or portion thereof represents 1 unit.	
24H	N	EPSDT - Family Planning - If the service billed on this line is an EPSDT service, the result of an EPSDT referral, or a family planning service, enter the appropriate code in this field. Y The service resulted from an EPSDT Referral 1 Partial EPSDT Exam/Referral Made 2 Partial EPSDT Exam/ No Referral Made 3 Full EPSDT Exam/ Referral Made 4 Full EPSDT Exam/No Referral Made F The Service was a Family Planning Service N Not EPSDT	
24I	Y	Emergency - Check this box if services billed on this line was an emergency.	

24J	N	COB - Check this box if there is Medicare or other insurance coverage, for the services billed on this line.	
24K	N	Reserved for Local Use	
25	Y	Federal Tax ID Number - Enter the tax id for the facility or facility payee	
26	Y	Patient Account No. - Enter patient account number if you wish a cross reference between PHS and provider records or if you wish PHS to report the patient account number in correspondence or remits pertaining to this claim. Required if applicable.	
27	N	Accept Assignment	
28	Y	Total Charges - Enter the total charges for all lines on the claim	
29	Y	Amt. Paid - Enter any amount that was already paid by PHS or any other payer (i.e. Medicare).	
30	N	Balance due - Enter balance due by subtracting sum of payments in field 29 from total charges.	
31	Y	Signature - Claims must be signed by provider or authorized representative. Rubber stamp signatures are acceptable.	
32	Y	Name and Address of Facility Where Services Were Rendered - Enter facility name if applicable.	
32a	Y	Provider AHCCCS ID #	
32b		PIN# - Enter PIN for facility where services rendered	
33	Y	Physician's Supplier's Billing Name, Address, Zip Code & Phone # - Enter provider's AHCCCS ID Number.	
33a	Y	Provider AHCCCS ID - Enter six digit AHCCCS provider ID #	
33b	Y	PIN# - Enter PIN for provider rendering services	

CMS 1500 Documentation

All claims that involve Medicare or other insurance must be accompanied by an explanation of benefits (EOB) or remittance advice unless otherwise stated in contract.

All emergency transport claims must include the trip ticket.

COMPLETING A UB-92

A UB-92 is the only acceptable claim form for submitting inpatient or outpatient hospital (technical services only) charges for reimbursement by PHS. In addition, a UB-92 is also required for nursing home admissions, inpatient and home care hospice services, and dialysis services. Required fields are indicated with a Y in the required field box and the description is in bold face.

Note: Unlabeled boxes are not addressed below

UB BOX	YES/NO # REQ	DESCRIPTION	REFERENCE
1	Y	Provider Name, (Facility Name) Address, and Phone Number – This is the name of the provider submitting the bill and complete mailing address to which the provider wishes payment sent.	
2	N	Unassigned	
3	Y	Patient Control Number - AHCCCS ID # must be entered either in this field or field 60.	
4	Y	Type of Bill - Enter the code indicating the specific type of bill: inpatient, outpatient etc.	UB Manual
5	Y	Federal Tax No. of Facility or Facility Payee - Enter the number assigned to the provider by the federal government for tax reporting purposes.	
6	Y	Statement covers from begin through- The begin date is the begin date of your member's claim in MMDDYY format. The begin date is equal to or greater than the admission date, or for newly enrolled members, the begin date is equal to the enrollment date. The through date is the last date of your member's claim in the same MMDDYY format, for the status code included in box 22. For services received on a single day, both dates will be the same. Remember that a separate claim must be submitted if a member's status code changes. PHS pays for the admission date but not the discharge date unless the admission date and discharge date are the same, in which case, PHS will pay for one day. PHS will pay date of death if status code =20 and services on the DOD are included on the bill. If bill type is 210, 211, 212 the begin date must equal the admission or readmission date in Box 17.	
7	N	Covered Days - The number of days covered by primary payor.	
8	N	Non - Covered Days - Days of care not covered by primary payer.	
9	N	Coinsurance Days - Used to indicate days covered by Medicare Co-Insurance. These are inpatient Medicare days occurring after the 60 th day and before the 91 st day in a single spell of illness.	

UB BOX	YES/NO # REQ	DESCRIPTION	REFERENCE
10	N	Lifetime Reserve Days - Under Medicare, each beneficiary has a lifetime reserve of 60 additional days of inpatient hospital services after using 90 days of inpatient hospital services during a spell of illness.	
11	N	Group Pay to Identifier	
12	Y	Patient Name - Last Name, First Name, MI	
13	N	Patient Address -Enter address of the patient as defined by the payor organization.	
14	Y	Patient's Date of Birth - Enter DOB in MMDDYY format	
15	Y	Patient Sex -Enter M or F	
16	N	Patient Marital Status -as recorded at date of admission, outpatient service, or start of care.	
17	Y	Admission Date/Start of Care Date - Date patient admitted to facility, received outpatient services or start of care.	
18	Y	Admission Hour - The hour during which the patient was admitted for inpatient care ONLY. (Not required for Outpt.)	UB Manual Form Loc 18
19	Y	Type of Admission - The code indicating the priority of this admission.	UB Manual Form Loc 19
20	Y	Source of Admission - The code indicting the source of admission.	UB Manual Form Loc 20
21	Y	Discharge Hour -Hour patient was discharged from inpatient care. (Not required for Outpt.)	UB Manual Form Loc 21
22	Y	Patient Status - Codes are as follows: 01 Discharged to home or self care (routine discharge) 02 Discharged/transferred to another short term general hospital for inpatient care 03 Discharged/transferred to skilled nursing facility (SNF) 04 Discharged/transferred to an intermediate care facility (ICF) 05 Discharged/transferred to another type of institution (including distinct parts) for inpatient care or referred for outpatient services to another institution. 06 Discharged/transferred to home under care of organized home health service organization 07 Left against medical advice or discontinued care 08 Discharged/transferred to home under care of Home IV provider 20 Expired 30 Still patient or expected to return for outpatient services. 50 Hospice (home) 51 Hospice (medical facility)	UB Manual Form Loc 22
23	Y	Medical Record No. Number assigned to the member's medical/health record at facility.	

UB BOX	YES/NO # REQ	DESCRIPTION	REFERENCE
24-30	N	Condition Codes- Codes used to identify conditions relating to this bill that may affect payor processing (required for outlier).	
32-36	N	Occurrence Codes and Dates- Codes and associated dates defining a significant event relating to this bill that may affect payor processing.	
37	N	Internal Control Number/Document Control Number (ICN/DCN)-Control number assigned to the original bill by the payor or the payor's intermediary.	
38	N	Responsible Party Name, Address-Name and address of the party responsible for this bill.	
39-41	N	Value Codes and Amounts-Code structure to relate amounts or values to identified elements necessary to process this claim as qualified by the payor organization.	
LINE LEVEL INFORMATION			
42	Y	Revenue Code - Enter appropriate revenue code and modifier as authorized.	UB Manual
43	Y	Revenue Code Description - Enter description for revenue codes and modifiers.	
44	Y	HCPC/RATES identify the dollar amount billed for the particular revenue code and the HCFA Common Procedure Coding System (HCPC) applicable outpatient services.	HCPC Manual
45	Y	Service Date - The date the indicated service was provided if it differs from Box 6.	
46	Y	Total Service Units - A service unit equals a reimbursable day in the facility. Admission date is reimbursable to the date of discharge. Do not include date of discharge as a service unit. If the member expires in the facility, do include date of death as a service unit as it is a reimbursable day. For outpatient services units may equal treatments, pints of blood, miles etc.	
47	Y	Total Charges (by revenue code) - equals total units charged for the current billing period as entered in the statement covers period.	
48	Y	Non-Covered Charges - Enter the amount, paid by Medicare or other primary payor.	
END LINE LEVEL			
BEGIN PAYER DATA			
50	Y	Payer Identification – Name of payer organization from which the provider expects payment for the bill-PHS.	
51	Y	Provider No. - Enter the provider number assigned to the provider by PHS.	

UB BOX	YES/NO # REQ	DESCRIPTION	REFERENCE
52	Y	Release of Information Certification Indicator - Enter "Y" if the provider has on file a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim.	
53	Y	Assignment of Benefit Indicator - Enter code to indicate whether the provider has a signed form authorizing the third party payor to pay the provider.	
54	Y	Prior Payments - Enter payments from Medicare, and/or other insurance towards payment of this bill prior to the billing date by the indicated payor.	
55	Y	Estimated Amount Due - If another payor paid towards this claim, enter amount estimated to be due from PHS.	
58	Y	Insured Name - The name of the individual in whose name the insurance is carried.	
59	N	Patient Relationship to Insured - Code indicating relationship of the patient to the insured.	
60	Y	Certificate/Social Security No./Health Insurance Claim No. - Enter Members AHCCCS ID Number (Not the Medicare No.) if not in Box 3.	
61	N	Insured Group Name - Name of group or plan through which the insurance is provided to the insured.	
62	N	Insurance Group No. - The identification number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered.	
63	Y	Treatment Authorization Code - Enter the number that designates that the treatment covered by this bill has been authorized by the payor.	
64	N	Employment Status Code of the Insured - Code used to define the employment status of the individual identified in Box 58.	
65	N	Employer Name of the Insured - The name of the employer that might or does provide health care coverage for the insured individual identified in Box 58.	
66	N	Employer Location of the Insured - The specific location of the employer of the insured individual in Box 58.	
67	Y	Principle Diagnosis Code for Member – Enter the ICD-9 code describing the principal diagnosis chiefly responsible for this member’s care at this time.	ICD-9 Manual
END PAYER DATA			
68-75	Y	Other Diagnosis Codes – Enter a maximum of 6 Diagnosis Codes that co-exist at the time of admission or develop subsequently, which have an effect on the treatment received or length of stay.	ICD-9 Manual
76	Y	Admitting Diagnosis - Enter the ICD-9 code provided at the time of admission as stated by the physician.	ICD-9 Manual

UB BOX	YES/NO # REQ	DESCRIPTION	REFERENCE
77	Y	External Cause of Injury Code - Enter the ICD-9 code for the external cause of an injury, poisoning, or adverse effect if applicable.	ICD-9 Manual
78	N	DRG	
79	N	Procedure Coding Method Used - An indicator that identifies the coding method used for procedure coding on the bill.	
80	Y	Principle Procedure Code and Date - Enter the code that identifies the principal procedure performed during the period covered by this bill and the date on which the principal procedure described on the bill was performed.	
81	Y	Other Procedure Code and Dates - Enter the codes identifying all significant procedures other than the principal procedure and the dates (identified by code) on which the procedures were performed.	
82	Y	Attending Physician ID - Enter the name and/or number of the licensed physician who would normally be expected to certify and recertify the medical necessity of the services rendered and/or who has primary responsibility for the patient's medical care and treatment.	
83	N	Other Physician ID - The name and/or number of the licensed physician other than the attending physician as defined by the payor organization.	
84	N	Remarks - Notations relating specific state and local needs providing information necessary to adjudicate the claim or otherwise fulfill state reporting requirements.	
85	Y	Provider Representative Signature and Date - Authorized signature and date indicating that the information entered on the face of this bill is in conformance with the certifications on the back of this bill.	
86	Y	Date Bill Submitted - Enter the date bill submitted to PHS.	

Unless your contract specifies differently, all UB-92's must be submitted with the required documentation identified below. All documentation must be legible and complete.

UB-92 INPATIENT DOCUMENTATION REQUIRED: (unless contract notes otherwise)

Itemized statements of accounts on all UB-92 claims.

Dated discharge summary.

ER reports when patient is subsequently admitted.

Operative reports for all surgeries.

Outlier requests must include all documentation including but not limited to: itemized bill, doctor's orders, OP report, anesthesia report, and discharge orders.

Specific additional information upon request by PHS.

COMPLETING AN ADA 2002 FORM

There are required fields when completing and filing an ADA 2002 form. These required fields are noted with a “Y” to the left of the field description. The Reference Box identifies information which may be helpful in completing the particular field.

ADA BOX #	YES/NO REQ	DESCRIPTION	REFERENCE
1	N	Type of Transaction - Select applicable box	
2	Y	Predetermination/Preauthorization # - Enter “A” for an adjustment to an original claim or “V” for a void of a paid claim. Enter AHCCCS Claim Reference # (CRN) of original claim when submitting a claim	Enter if applicable
3	Y	Primary Payer Information - Enter Payer name, Address, City, State and Zip Code	Enter if applicable
4	Y	Other Coverage - Enter name of other dental or medical coverage	
5	Y	Subscriber Name - Enter Subscriber’s Name (Last, First, Middle Initial, Suffix)	Enter if applicable
6	Y	Date of Birth - Enter Subscriber’s DOB (mm/dd/ccyy)	Enter if applicable
7	Y	Gender - Enter Subscriber’s gender	Enter if applicable
8	Y	Subscriber’s Identifier - (SSN or ID#)	Enter if applicable
9	Y	Plan/Group Number - Enter Subscriber’s Plan/Group #	Enter if applicable
10	Y	Relationship to Primary Subscriber - Check appropriate box	Enter if applicable
11	Y	Other Carrier’s Name, Address, City, State, Zip Code - Indicate if additional dental/ medical coverage is identified	Enter if applicable
12	Y	Primary Subscriber’s Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code	
13	Y	Date of Birth - Enter Subscriber’s DOB (MM/DD/CCYY)	
14	Y	Gender - Enter Subscriber’s Gender	
15	Y	Subscriber’s Identifier - Enter Subscriber’s SSN or ID#	
16	N	Plan/Group Number - Enter Subscriber’s Plan/Group #	
17	N	Employer Name	
18	N	Patient Relationship to Primary Subscriber - Check appropriate box	
19	N	Student Status	
20	N	Patient Name - Enter patient’s name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code	
21	N	Date of Birth - Enter patient’s DOB (MM/DD/CCYY)	
22	N	Patient Gender - Enter Patient’s Gender	
23	Y	Patient ID/Account # (Assigned by Dentist) - Number assigned to uniquely identify this claim in the provider’s record.	Enter if applicable
24	Y	Procedure Date - Enter the service date as MM/DD/CCYY. Must be equal to or prior to the date the claim is being billed.	
25	Y	Area of Oral Cavity - Include tooth number or letter if procedure directly involves a tooth. Area of the Oral Cavity set from ANSI/ADA/Specification No. 3950	

		'Designation System for Teeth and Areas of the Oral Cavity'.	
26	Y	Tooth System - Use "JP" when designating teeth using the ADA's Universal/National tooth Designation System. Use "JO" when using the ANSI/ADA/ISO Specification No. 3950	
27	Y	Tooth Number(s) or Letter(s) - Include tooth number or letter if procedure directly involves a tooth.	Enter if applicable
28	Y	Tooth Surface - Enter the tooth surface(s): B = Buccal, D = Distal, F = Facial, L = Lingual, M = Mesial, O = Occlusal	
29	Y	Procedure Code - Enter appropriate dental code(s) CDT	Current HCPCS
30	Y	Description - Include the description of service(s)	
31	Y	Fee - The amount charged for each service	
32	N	Other Fees	
33	Y	Total Fee	
34	Y	Missing Teeth - Identify any missing teeth	Enter if applicable
35	N	Remarks	
36	N	Parent/Guardian Signature and Date -	
37	N	Subscriber Signature and Date -	
38	Y	Place of Treatment - Check appropriate box	
39	Y	Number of Enclosures - Indicate number of each (00-99)	Enter if applicable
40	Y	Treatment for Orthodontics - Check appropriate box	Enter if applicable
41	Y	Date Appliance Placed (MM/DD/CCYY)	Enter if applicable
42	Y	Months of Treatment Remaining	Enter if applicable
43	Y	Replacement of Prosthesis - Check appropriate box	
44	Y	Date of Placement - (MM/DD/CCYY) complete if "Yes" in box 43	Enter if applicable
45	Y	Treatment Resulting From - Check appropriate box	Enter if applicable
46	Y	Date of Accident - (MM/DD/CCYY)	Enter if applicable
47	Y	Auto Accident State	Enter if applicable
48	Y	Billing Dentist or Dental Entity - Dentist or Dental Entity Name, Address, City, State, Zip Code	
49	Y	Provider ID - The Treating Dentist's AHCCCS Provider ID	
50	Y	License Number - Enter Provider License #	Enter if applicable
51	Y	SSN or TIN - Enter the SSN or Tax ID Number of the billing dentist/dental entity	
52	N	Phone Number - The dentist/dental entity's phone number	
53	Y	Treating Dentist's Signature and Date	
54	Y	Provider ID - The Treating Dentist's AHCCCS Provider ID	
55	Y	License Number - Enter the treating dentist's license #	
56	N	Address, City, State, Zip Code - Enter the treating dentist's information	
57	N	Phone Number - Enter the treating dentist's phone number	
58	N	Treating Provider's Specialty - Enter the code that indicates the type of dental professional rendering the	http://www.wpc-edi.com/codes/tax

	<p>service from the 'Dental Service Provider's section of the <i>Healthcare Provider's Taxonomy code list</i> posted at http://www.wpc-edi.com/codes/taxonomy</p> <p>122300000X Dentist</p> <p>1223G0001X General Practice</p> <p>1223D0001X Dental Public Health</p> <p>1223P0221X Pediatric Dentistry</p> <p>1223E0200X Endodontics (Pedodontics)</p> <p>1223P0106X Oral & Maxillofacial Pathology</p> <p>1223P0300X Periodontics</p> <p>1223D0008X Oral & Maxillofacial Radiology</p> <p>1223P0700X Prosthodontics</p> <p>1223S0112X Oral & Maxillofacial Surgery</p> <p>1223X0400X Orthodontics</p>	onomy
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COMPLETING THE UNIVERSAL C FORM

Pharmacy claims are transmitted to PHS through the ARGUS pharmacy network. The Universal C form may only be submitted to PHS through ARGUS unless specific arrangements have been made with PHS. When filing a Universal C form there are required fields to be completed. The required fields are noted with an "R" to the left of the field description.

UNIVERSAL DRUG CLAIM FORM			
Field	Name/Status	Yes/No Req.	Instructions
1.	Group Number		The Group Number is not required for PHS claims.
R 2.	Card Holder ID	Y	Enter the 9 digit AHCCCS ID of the member for whom the prescription was written.
R 3.	Card Holder Name	Y	Enter the name of the member for whom the prescription was written
R 4.	Other Third Party Coverage	Y	Check the appropriate box to indicate whether the member has third party coverage
R 5.	Patient Information	Y	Enter the last name, first name and initial of the patient, the date of birth if available, sex and the relationship to the cardholder.
R 6.	Pharmacy Information	Y	Enter the name, street number, city, state and zip code of the provider who filled the prescription.
R 7.	Pharmacy Number	Y	Enter the NABP No.
8.	Phone	Y	Enter the phone number, including the area code, of the pharmacy that filled the prescription.
R 9.	Date Rx was Written	Y	Enter the date of the prescription as MM/DD/YY.
R 10.	Date Rx was Filed	Y	Enter the date of services for this billing. If the prescription is a refill, the date of the refill being billed should be entered.
R 11.	RX Number	Y	Enter the prescription number. This will serve as cross-reference with the PHS claim reference number (CRN). Correspondence from PHS regarding the claim will reference this number.
R 12.	New or Refill	Y	Enter "N" if the claim is new, "R" if it is a refill.
R 13.	Metric Quantity	Y	Enter the quantity provided. If the form is tablets or capsules, the number should be the number of pills dispensed.
R 14.	Days Supply	Y	Enter the number of days the prescription is expected to cover.
R 15.	National Drug Code	Y	Enter the labeler number, the product number and the package number for the items dispensed.
R 18.	Ingredient Costs pharmacy	Y	Enter the cost of the ingredients of the dispensed items to the pharmacy.
R 19.	Dispensing Fee		Enter the standard PHS dispensing fee in this field.
R 20.	Tax		Do not enter sales tax amounts. PHS is exempt from payment of sales tax.

UNIVERSAL DRUG CLAIM FORM

Field	Name/Status	Yes/No Req.	Instructions
R 21.	Total Price	Y	Enter the sum of the component cost and the dispensing fee in this field.
R 22.	Deductible Amount	Y	Enter the amount of any third party payments received in this field. If a third party payor was billed and the claim was denied or no payment resulted, enter 0 in this field.
R 23.	Balance	Y	Enter the amount due from PHS in this field.
R 24.	Authorized Pharmacy Representative	Y	An authorized representative of the pharmacy must sign before submission and date the signature.

III. HOW TO READ YOUR PROVIDER REMITTANCE ADVICE

PHS will mail a remittance advice along with every fee-for-service check we send to you. It will provide you with the information needed to properly apply any payments, to debit any credits which we might take, and to explain any denials of billed services.

A copy of a typical remittance advice is contained in *Attachment 4* of this section. The fields are explained here:

Provider Remittance Advice:

1. Pay to Provider Name
2. Service Provider Name
3. Program
4. PHS Payment I.D. Number
5. Patient Name, Patient AHCCCS I.D. Number (If member not found, see #22 Remarks).
6. PHS Encounter/Claim Number, Claim Status, Patient Account Number, Authorization Number.
7. Line Number
8. Month and Day of Service (Note: If this is for a bill of continuous services, such as an inpatient stay or continuous home IV therapy, the date range will be entered here).
9. CPT-4 procedure code & modifier
10. Principal diagnosis code
11. Dollar amount billed
12. Amount disallowed
13. Contract amount paid for CPT/Rev Code or AHCCCS FFS Rate
14. Patient Portion
15. PHS Benefit Amount
16. Other adjustments (Medicare payments, third party)
17. Quick Pay Discount/Penalties (UB's only)
18. Amount Withheld
19. Amount Capped
20. Total amount paid after discount and denials
21. Shows the total amount billed for all services listed in the remit (SEE BELOW)
22. Remarks - includes the reasons for any adjustments or non-payments
23. Summary of Remittance Advice including: Check#, Amount Billed, Ineligible Amount, Contract Amount, Pool Amount, Deductions, Benefit Amount, COB Applied, Capped Amount, Pay Discount/Penalty, Amount Advanced, Refund Amount, Check Amount.
24. Payment Date

The remarks section contains the reason for any payment less than the billed amount. The most common reasons are:

Denied because service required prior authorization and either the prior authorization number was not included on claim was not obtained, or the number which was included does not cover the dates of service on the claim.

Duplicate claim submission

Claim submission window exceeded. Claim was not submitted within the timeframe specified within the contract.

Pima Health System

Herbert K. Abrams Public Health Center
 3950 S. Country Club Road, Suite #600
 Tucson, Az 85714

Provider Remittance Advice With Claims Grouped By Payee By Provider

24. Pay Date: 03/01/2007

1. **Payee:** PROVIDER (FACILITY/MEDICAL GROUP) NAME HERE
 PROVIDER ADDRESS
 PROVIDER CITY, ST ZIP

2. **Provider:** SMITH, DOCTOR

3. **Program:** ACUTE PROGRAM

4. **Payment ID:** QP#####

Line	Svc Date	Rev Code	CPT - Mod	Prin Diag	Amt Billed	Not Allowed	Contract Paid	Patient Portion	Benefit Amt	Other Disc	Discount/ Penalty	Amt Withheld	Amt Capped	Amt Paid
5. DOE, JOHN		#A23456789			6. Claim: 011111111111		Status: PAID		Patient #: 101010-00		Amt#: 333222			
7.1	8.1/25/2007	9.9921B	10.799.9		11. \$95.10	12 \$0.00	13. \$95.10	14 \$0.00	15. \$95.10	16 \$0.00	17. \$0.00	18 \$0.00	19 \$0.00	20. \$95.10
					21. \$95.10	\$0.00	\$95.10	\$0.00	\$95.10	\$0.00	\$0.00	\$0.00	\$0.00	\$95.10
22. Paid at contracted rate														

Disbursement of funds by Check Number

23. Check #:	21212121	Total
Amt Billed:	\$95.10	\$95.10
Ineligible:	\$0.00	\$0.00
Contract Amount:	\$95.10	\$95.10
Pool Amount:	\$0.00	\$0.00
Deductions:	\$0.00	\$0.00
Benefit Amount:	\$95.10	\$95.10
COB Applied:	\$0.00	\$0.00
Capped Amount:	\$0.00	\$0.00
Pay Discount/Penalty:	\$0.00	\$0.00
Amt Advanced:	\$0.00	\$0.00
Refund Amount:	\$0.00	\$0.00
Check Amount:	\$95.10	\$95.10

Pima Health System

Herbert K Abrams Public Health Center
3950 S. Country Club Road, Suite 400
Tucson, Az 85714

Provider Remittance Advice With Claims Grouped By Payee By Provider

21. Pay Date: 03/01/2007

1. Payee: PROVIDER (FACILITY/MEDICAL GROUP) NAME HERE
PROVIDER ADDRESS
PROVIDER CITY, ST ZIP

If you have any questions or problems with this remit, please call our office at 243-8063. If your claim was denied for additional information, for example, EOB or documentation, please resubmit the claim marked "RESUBMITTAL" to our Claims Division with the information requested in accordance with your contract, or AHCCCS guidelines. If you feel your claim was denied inappropriately and have been unsuccessful in your attempt to rectify the denial through our Claims Division, you may file a claim dispute no later than 12 months from the last date of service or 60 days after the date of the denial of a timely claim submission, whichever is later. Your claim dispute must be in writing, stating the factual and legal basis of the dispute and the relief requested (A.A.C. R9-22-802). All disputes must be submitted to: PHS Claim Dispute Coordinator, 3950 S. Country Club, Suite #400, Tucson, AZ 85714. Phone (520) 243-8006 Fax (520) 243-8314.

AHCCCS regulations require that PHS process clean claims for acute services within 30 days of receipt date.

PHS makes it easy for you to check claim status. You can use our on-line claims inquiry at www.phs.pima.gov or call our Claims Customer Service Line at (520) 243-8063.

You may use our web site to access other important information such as our Provider Manual and Prior Authorization information.

Please visit us at www.phs.pima.gov

IV. SERVICE LIMITS

AHCCCS has established limits on the daily maximum number of units that can be reimbursed for CPT and HCPCS Codes. PHS will deny claims when billed units exceed the daily maximum allowed by AHCCCS.

PHS maintains a listing of CPT and HCPCS Codes including the daily maximum number of units for each procedure. You may access this information on the PHS website at www.phs.pima.gov. Click on Provider Assistance then on PHS Service Limits.

V. CLAIMS INQUIRY

PHS claims unit will take telephone or written inquiries from providers concerning claims issues.

By following a few guidelines, you can help PHS provide you with prompt, efficient service. Please have all the information ready before you call.

- A. Please provide the Member I.D. Number, date of service, provider's name and I.D. Number and date claim was submitted.
- B. Calls can be made Monday through Friday from 8 a.m. - 5 p.m. at **(520) 243-8063**.
- C. Written inquiries should be directed to PHS Claims, 3950 S. Country Club, Suite #350, Tucson, AZ 85714 or faxed to (520) 243-8452.
- D. If calling for claims status, please allow 45 days from your billing date when checking claims status. This will allow for your mailing time, our 30 day allowable processing period, and our mailing time. Also, certain claims are medically reviewed prior to payment (*See Medical Review Standards for Claims Processors policy included in the PHS Policy and Procedures section*).

We are pleased to announce our Internet Automated Claims Inquiry. You may check status of a claim at any time. Go to www.phs.pima.gov and select “Provider Assistance” and click “On-line Claims Inquiry.”

If PHS' Claims Customer Service is unable to satisfactorily assist a provider in resolving an issue, Provider Services is always able to provide additional support. PHS' philosophy is to address concerns on an informal basis whenever possible at (520) 243-8500.

VI. RE-SUBMITTING A CLEAN CLAIM

Please see **I. BILLING PROCEDURES - SUBMITTING** for timeliness information on re-submitting claims.

If you want to resubmit a claim, please submit CMS 1500 with the corrected claim information. In Box 22-A of the CMS 1500, indicate “A” for adjustment and indicate the original claim number in box marked “Original Reference Number.” Also, note RESUMMITAL across the claim form. Please briefly explain reason submitting resubmission.

To resubmit a UB-92, note in Box 84 “Remarks” field “Resubmission” and include the original claim number. Also, note “RESUBMISSION” across the claims. Please briefly explain reason submitting resubmission.

If the denial remark on the remit is not clear to you, please call Claims Customer Service for assistance. Claims Customer Service can be reached at (520) 243-8063, Monday - Friday from 8 a.m. - 5 p.m.

If a claim cannot be resubmitted as a simple correction, you may send the claim for reconsideration or file a dispute.

To file for reconsideration, please submit all pertinent information along with an explanation for claim(s) to be reprocessed. Mail to:

Claim's Reconsideration
3950 S. Country Club, Suite #350
Tucson, AZ 85714

You may file a Claim Dispute related to a claim for payment of system covered service. The claim dispute must be received within 12 months after the date of service, within 12 months after the date that eligibility is posted or within 60 days after the date of the denial of a timely submission, whichever is later (A.R.S. 36-2903.01.B.4). Your Claim Dispute must be in writing and must specify in detail the factual and legal basis of the dispute and the relief requested (A.A.C. R9-34-404).

All Disputes must be submitted to:

PHS Grievance Department
3950 S. Country Club Rd. Suite # 400
Tucson, AZ 85711
Phone: (520) 243-8006 / Fax: (520) 243-8314.

VII. COORDINATION OF BENEFITS/THIRD PARTY LIABILITY

PHS requires their providers to bill private insurance carriers and Medicare, including HMOs, prior to billing PHS. By law, PHS is the payer of last resort. It is the provider's responsibility to determine the extent of the third party coverage and comply with all required policies and procedures in order to obtain reimbursement from the third party carrier. Claims with a third-party payer shall be reimbursed up to the contract rate, in direct comparison to any patient liability (co-pay, coinsurance, deductibles) remaining after the primary carrier's processing of claim(s). PHS is responsible only for the difference between what the provider was reimbursed by the third party up to the PHS contract rate. In no case shall a provider be reimbursed more than the PHS contract rate.

Claims involving third-party coverage and Medicare must be submitted for payment within the timeliness guidelines stipulated by contract or by A.R.S. 36-2904, with a complete copy of the third party or Medicare explanation of benefits (EOB).

VIII. MEDICARE SERVICES & COST SHARING

PHS has members who are eligible for both Medicare and AHCCCS services. These members are referred to as "dual-eligible" and include persons who are Qualified Medicare Beneficiaries (QMB) and non-QMB eligible persons. For all dual eligible persons, PHS is responsible for reimbursement of Medicare coinsurance and deductibles for AHCCCS covered services provided on a fee-for-service basis within the PHS provider network. PHS has no cost-sharing obligation if the Medicare payment exceeds what PHS would have paid for the same service for a non-Medicare member.

For QMB eligible persons, PHS is responsible for paying the Medicare coinsurance and deductibles up to the contracted amount for the following Medicare services not covered by AHCCCS which are provided by a Medicare provider on a fee-for-service basis, regardless whether the service is provided in or out of PHS' provider network:

- ◆ Chiropractic services
- ◆ Inpatient and outpatient occupational therapy coverage
- ◆ Inpatient psychiatric services
- ◆ Psychological services
- ◆ Respite services
- ◆ Any services covered by or added to the Medicare program which are not covered by AHCCCS

Based on an agreement between AHCCCS and CMS, Medicare cost sharing requirements for Medicare services provided on a fee-for-service basis (FFS) and those services provided by a Medicare HMO are different.

IX. PHS COST SHARING OVERVIEW

COST SHARING DEFINITION: CO-INSURANCE, DEDUCTIBLE PAID TO A PROVIDER UP TO THE PHS CONTRACT RATE OR AFFS DEFAULT RATE.

1. Payer of Last Resort

PHS AHCCCS/Medicaid is the payer of last resort. All AHCCCS and Medicare covered services shall first be billed to Medicare or any other third party liability source.

2. Prior Authorization Requirements

If a Provider's contract with PHS requires the provider to obtain prior authorization before rendering services and the Provider fails to get the prior authorization, PHS is not obligated to pay cost sharing.

3. Emergency Services

PHS cannot require prior authorization for emergency services, and therefore all medically necessary emergent care cost sharing (co-insurance and deductibles) is covered and will be considered for payment following COB guidelines. Emergency providers outside the PHS network are reimbursed up to the default AHCCCS Fee-for-Service rate.

4. Out of Network Referrals

If a PHS member is fully informed of the network and chooses to go out of network on his/her own, the member is responsible for paying the cost sharing. If an out of network referral is made by a contracted PHS Provider without PHS prior approval, PHS has no cost-sharing obligation.

5. Medicare Risk HMOs

When a PHS member is enrolled with a Medicare HMO, PHS is not responsible for the payment of premiums assessed by the Medicare HMO for Medicare services. PHS will consider for payment-co-pay, co-insurance or deductibles for medical services provided by in network providers and all emergency services. PHS pays co-payments for out of network medical services and pharmacy according to standards and procedures and COB guidelines. Call Provider Services at 520-243-8500 for further assistance.

6. Medicare Fee for Services

PHS has no cost-sharing obligation if the Medicare payment exceeds what PHS would have paid for the same service for a non-Medicare member. PHS has cost sharing obligations on Medicare covered services only up to the contract rate. If the PHS contracted rate with the provider includes the Medicare cost sharing, then PHS has no further cost-sharing obligation. PHS is responsible for the Medicare coinsurance and deductible for Medicare only (QMB) covered services that are not covered by AHCCCS. For these Medicare only services, PHS is responsible regardless of whether the provider is in the PHS network.

7. Other Non-Medicare/Medicare Risk HMO

PHS will consider for payment co-insurance and deductible as the payor of last resort for in-network providers. PHS may reimburse out-of-network providers for member's co-payments upon prior approval.

X. ELECTRONIC CLAIMS SUBMISSION

The first step in establishing electronic claim submission capability with PHS is to contact PHS' Provider Services at (520) 243-8500. You will need to provide your tax identification number, address and contact person for your facility/ practice. Provider Services will forward the necessary documents for you to complete to initiate electronic billing.

Once the completed Agreement has been returned to PHS, our Information System department will begin integrity testing with you, your staff, clearinghouse and/or billing entity. When testing is complete and successful, PHS will notify you or your staff in writing when electronic claims transmission can begin.

Once you are approved should a breakdown occur which temporarily impairs your company from submitting claims electronically or PHS from receiving claims electronically, PHS will accept paper claims, as a contingency, until electronic billing is restored. You must inform PHS in writing should this occur.

If you have questions regarding Electronic Claim Submission, please contact Provider Services at (520) 243-8500.

XI. ELECTRONIC FUND TRANSFER

Providers may choose to have PHS payments deposited directly to the financial institution of their choice. If interested, you may request this electronic function by calling Provider Services at (520) 243-8500. One or more Automated Clearing House Vendor Authorization forms will be sent to you depending on how many different contract accounts you have with PHS. Once the forms are completed and returned to us, the data is verified for accuracy and the electronic fund transfers can begin.

It will be necessary for you to submit a new form when changing financial account information, changing financial account type, changing financial institutions or for canceling the electronic fund transfer. Electronic remittance advices can also be made available to you.

12/2009