
Branch for Program Operations

Office of Program Support

Operations and Procedures Manual

10/8/2014

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Introduction

The Office of Program Support (OPS) is within the Branch for Program Operations and provides oversight, coordination and monitoring to the Behavioral Health Services T/RBHAs. This document is a reference guide describing the procedural requirements between the T/RBHAs, the Arizona Department of Health Services/Office of Program Support (ADHS/OPS), and the Arizona Health Care Cost Containment System (AHCCCS).

The Operations and Procedures Manual is available on the ADHS website (<http://www.azdhs.gov/bhs/ops.pdf>) and is to be used as the first point of reference when procedural questions arise.

Individuals with questions should contact the Office of Program Support through the OPS e-mail at OPS@azdhs.gov.

Definitions

<i>Aged Pended Encounter</i>	An encounter that has pended for more than 120 calendar days, after the initial processing date at AHCCCS, without resolution.
<i>ADHS Error</i>	A pended encounter which ADHS acknowledges to be the result of its own error and has been communicated to the RBHA by way of an e-mail, phone conversation, typed letter or other forum.
<i>ADHS Client ID</i>	The Client ID must match the ADHS database record's Client ID for each related encounter found.
<i>AHCCCS</i>	Arizona Health Care Cost Containment System
<i>AHCCCSA</i>	Arizona Health Care Cost Containment System Administration
<i>AHCCCS Error</i>	A pended encounter which AHCCCS acknowledges to be the result of its own error and has been communicated to the T/RBHA by way of an e-mail, phone conversation, typed letter or other forum.
<i>Check Register</i>	A detailed log of all checks written and paid to providers for services rendered by a RBHA. The check register should include, but is not limited to, check number, date the check was written, check amount, and provider name and ID number.

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<i>Client AHCCCS ID</i>	The Client AHCCCS ID, assigned by AHCCCS, must match the ADHS database record's AHCCCS ID for each related encounter found.
<i>Client Information System (CIS)</i>	A data system used by ADHS.
<i>Codes</i>	The Procedure, NDC, or Revenue code for the service provided must match the ADHS database records procedure, NDC or revenue code for each related encounter found.
<i>Contract Year/Fiscal Year</i>	A period from July 1 of a calendar year through and including June 30 of the following year.
<i>CRN</i>	Claim Reference Number used to track and review encounters in the PMMIS system at AHCCCS.
<i>Days</i>	A calendar day unless otherwise specified.
<i>DBHS</i>	Division of Behavioral Health Services
<i>Demographic</i>	A set of data elements T/RBHAs are required to collect and submit to ADHS/DBHS
<i>Denied</i>	An encounter that was sent to AHCCCS from the RBHA that did not cleanly adjudicate but resulted in an error, known as a "denied."
<i>Encounter</i>	A record of a covered service rendered by a provider to a person enrolled with a capitated RBHA on the date of service.
<i>Enrollment</i>	The process by which a person is enrolled into the T/RBHA and ADHS data system.
<i>Episode of Care</i>	The period between the beginning of treatment and the ending of behavioral health services for an individual. Within an episode of care, a person may transfer to a different service, facility, program or location. The beginning and end of an episode of care is marked with a demographic file submission. Over time, an individual may have multiple episodes of care.
<i>Error Code 1-4</i>	Indicates the AHCCCS pend errors that caused the encounter record to pend at AHCCCS (if applicable).

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<i>Fee-For-Service (FFS)</i>	A fee paid for each service based on actual utilization of services using payment rates set for units of care provided.
<i>Form Type</i>	Indicate the form type for this encounter. A = CMS 1500, B = UB and C = NCPDP, D = DENTAL.
<i>Fraud</i>	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to the person or some other person. It includes any act that constitutes fraud under applicable Federal or State Law.
<i>GSA</i>	Geographic Service Area
<i>ICN</i>	Internal Control Number used in the CIS system.
<i>ICN/Line Number/CRN</i>	The encounter ICN, line number and CRN must match the ADHS database records ICN, line number and CRN for each related encounter found.
<i>NPI</i>	The National Provider Identifier (NPI) must match the ADHS database record's NPI for each related encounter found.
<i>Override (of Encounter)</i>	A process performed by a RBHA to bypass a pend status on an AHCCCS encounter which will allow the encounter to adjudicate cleanly.
<i>Pended Encounter</i>	An encounter that was sent to AHCCCS from the RBHA that did not cleanly adjudicate but resulted in an error, known as a "pend."
<i>Provider</i>	Provider refers to any individual/organization providing services to a T/RBHA's enrolled/eligible members (any individual/organization that the T/RBHA will receive a claim/encounter from).
<i>Quarter</i>	Three months of the state fiscal year as broken into four quarters. July 1 through September 30 is referred to as the first quarter of the state fiscal year.
<i>RBHA ID</i>	The RBHA ID must match the ADHS database records RBHA ID for each related encounter found.
<i>Reason Code/Description</i>	Indicates the reason for the override or voided encounter from the AHCCCS PMMIS system. If applicable, the reason code must appear in the log and must match the record for each related encounter found. RBHAs must use one of the Office of Program Support approved reason codes (RL Attachment 2).

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<i>Record Missing</i>	If a RBHA's log is missing encounter records when compared to the ADHS database records for each related encounter, the number of missing records will be calculated in the findings.
<i>Regional Behavioral Health Authority (RBHA)</i>	An organization under contract with the ADHS to coordinate the delivery of behavioral health services to eligible and/or enrolled persons in a geographically specific service area of the state.
<i>Start/End Date</i>	The start date and end date must match the ADHS database records start and end date for each related encounter found.
<i>T/RBHA</i>	A reference to both RBHAs and Tribal RBHAs.
<i>Tribal RBHA</i>	A Native American Indian tribe under Intergovernmental Agreement with ADHS to coordinate the delivery of behavioral health services to eligible and enrolled persons who are residents of the Federally recognized Tribal Nation that is the party to the Intergovernmental Agreement.
<i>Type of Transaction</i>	Indicates the type of action taken relating to the record. V = Void transaction or O = Override transaction.
<i>Units</i>	Indicates the number of units for each related encounter found.
<i>Voided Encounter</i>	An encounter previously accepted or pended at AHCCCS, but was voided by request from a RBHA because the encounter was sent to AHCCCS in error.

Related Information Resources

The T/RBHA should use the following resources in addition to this manual:

- Client Information System (CIS) File Layout and Specifications Manual
- ADHS/DBHS Covered Behavioral Health Services Guide
- ADHS/DBHS Demographic and Outcome Data Set User Guide (DUG)
- The ADHS Contract with each T/RBHA
- Tribal IGA
- AHCCCS Encounter Resources, including
 - Encounter Reporting Manual
 - Medical Policy Manual
 - Encounter Keys and Claims Clues Newsletters

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- AHCCCS Behavioral Health Services Technical Interface Guidelines
- Coding Documentation
 - UB-92 Manual/UB-04 Manual
 - ICD-9-CM Diagnosis & Procedure Code Manual
 - Physician's Current Procedural Terminology (CPT) Manual
 - HCFA Common Procedures Coding System (HCPCS) Manual
 - Medi-Span® - NCPDP
 - HIPAA Guidelines via www.cms.hhs.gov/HIPAAGenInfo

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Provider Registration

Introduction

All providers are required to register with the AHCCCS Administration and obtain an AHCCCS provider identification number.

Providers are required to:

- Complete an application
- Sign a provider agreement
- Sign all applicable forms
- Submit documentation of their applicable licenses and/or certificates

AHCCCS Provider Registration materials are available on the AHCCCS Web site <http://www.azahcccs.gov/commercial/ProviderRegistration/packet.aspx>

National Provider Identifier (NPI)

All providers are required to obtain a National Provider Identifier (NPI) when providing/billing for services. Providers can apply for an NPI online at <https://nppes.cms.hhs.gov> or can call the NPI enumerator to request a paper application at 1-800-465-3203.

Health Care Providers must communicate their National Provider Identifiers [NPIs] directly to the AHCCCS Administration.

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Communications

Introduction

The Office of Program Support ensures all communications are tracked and monitored. Communications from T/RBHAs to the Office of Program Support must be submitted through the OPS e-mail at OPS@azdhs.gov. T/RBHAs are not to contact Office of Program Support staff directly. The Office of Program support will provide an e-mailed response to the T/RBHA acknowledging receipt of the communication within three (3) business days with an expected response within thirty (30) days.

OPS Mailbox Procedures

Communications: T/RBHAs to the Office of Program Support/ Office of Program Support to the T/RBHAs.

- E-mail with request, question, or information is sent to OPS@azdhs.gov.

From: T/RBHA Staff
Sent: DAY MM/DD/YYYY Time
To: OPS
CC: T/RBHA internal staff only
Subject: Title of request, question, or information

- A Record ID is automatically assigned from the Office of Program Support Database the communication is entered as either a new communication or response as shown below:

Thank you. Your e-mail has been received and has been forwarded to the appropriate individual(s) to address your inquiry.

This e-mail has been assigned to Record ID: _____

Thank you,

*Arizona Department of Health Services
Office of Program Support
ops@asdhs.gov*

- The e-mail is forwarded to the appropriate Office of Program Support team or an ADHS internal individual staff to address the inquiry.

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- The original e-mail, as well as any subsequent incoming or outgoing communications related to the original, is saved in the appropriate T/RBHA assigned folder in the OPS Microsoft Outlook database.
- The Office of Program Support staff will compose the communication response to reply to all individuals from the original e-mail with a copy (cc) to the OPS mailbox at ops@azdhs.gov and others, if instructed.

OPS Internal Reports

Two reports are generated within the OPS database for internal use only. They are distributed to ADHS management within the Office of Program Support Unit for review on a weekly basis. The purpose of the first report, *Outstanding Question*, is to track/monitor the different Teams unanswered questions. The second report, *Performance Measures*, is used to monitor the response time for the questions being answered (see Attachments 1 and 2).

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Attachment 1

Outstanding Question Report

Arizona Department of Health Services/Division of Behavioral Health
Services

Outstanding Questions

Type	RBHA	Date Opened	Days Open	Subject
Demographics				
18381		3/4/2014	3	RE: [Secure] Demographic- Void Req
18384		3/4/2014	3	RE: SECURED1: REFERRAL PDATE
Eligibility/Enrollment				
18328		2/20/2014	15	SECURED1: 2 active segment open
18329		2/20/2014	15	SECURED1: MBR NEEDS CIS ID
18332		2/21/2014	14	SECURED1:2 ACTIVE CIS ID'S
18334		2/21/2014	14	[Secure] RE: SECURED1:SMI MBR
18355		2/26/2014	9	[Secure] Enrollment –No CIS ID – KH
18360		2/27/2014	8	Incorrect AHCCCS ID's
18367		2/28/2014	7	SECURED1: decertification
18368		2/28/2014	7	SECURED1: DECERTIFICATION
18379		3/3/2014	4	RE: SECURED1: SMI MEMBER
18385		3/4/2014	3	secured1-T19 segmt need BHC update
18386		3/4/2014	3	secured1-T19 segmt need BHC update
18387		3/5/2014	2	FW: SECURED1: SMI member
18388		3/5/2014	2	secured –T19 segmt need BHC update
18393		3/5/2014	2	RE: [secure] Duplicate Member – HH
18397		3/6/2014	1	SECURED1: SMI MEMBER
Encounters/ Pends BHS				
18309		2/21/2014	22	RE: ENC013 errors on older claims
18370		2/28/2014	7	RE: Pharmacy Medicare Claims
ITS				
18383		3/4/2014	3	RE: Date of Trtmnt Plan Demog Edit
18396		3/5/2014	2	RE: ICD-10 Update –February
<i>Average Days Open</i>			7	

[Month Day, Year]

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Performance Measures Report Attachment 2

Arizona Department of Health Services/Division of Behavioral Health Services
Performance Report

Area	Total Questions	From	New in the last 5 days	To	Outstanding	Closed in the last 5 days	Average Time to Answer (Days)
834 ITS	0	0	0	0	0	0	0
834 MIKE	0	0	0	0	0	0	0
DATA VALIDATION	0	0	0	0	0	0	0
DELIVERABLES	0	0	0	0	0	0	0
DEMOGRAPHICS	2	0	0	0	2	2	3
ELIGIBILITY/ENROLLMENT	15	7	7	5	3	3	15
ENCOUNTERS/ PENDING BH	2	0	0	1	1	1	10
ITS	1	1	1	1	0	0	1
KAYLA	0	0	0	0	0	0	0
MADONNA	0	0	0	0	0	0	0
OTHER	1	1	1	0	1	1	1
POLICY	0	0	0	0	0	0	0
TESTING	0	0	0	0	0	0	0
	21	9	7	7	7	7	5

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Demographics

Introduction

All behavioral health providers are required to conduct an intake and assessment that includes the collection of demographic and clinical data as outlined in the Provider Manual at http://www.azdhs.gov/bhs/provider/sec3_9.pdf. These demographic collections are subject to monitoring by the Office of Program Support.

For information and guidance, the T/RBHA should refer to the Demographic and Outcome Data Set User Guide (DUG). The DUG can be found on ADHS' website at http://www.azdhs.gov/bhs/provider/documents/DUG_6.01.pdf.

Monitoring

The Office of Program Support will monitor the T/RBHA's demographic submissions using the *Daily Detail Demographic Acceptance Report* (Demog Attachment 1). The Office of Program Support will follow the procedures listed in the Demographic Submission Acceptance Rates Policy of this manual to produce this report.

Test Environment

A T/RBHA may be placed into the testing environment if it fails to maintain an average acceptance rate of 90% or greater for the period of one fiscal year quarter. Upon removal from the testing environment, due to satisfactory completion of the test criteria, a T/RBHA may be moved back into test if any one of the first three submissions to production does not meet the 90% acceptance threshold. The T/RBHA will then have to achieve a 90% or greater acceptance rate on a minimum of three additional test files before being placed back into the production environment. Complete information regarding being placed in "test" can be found in the Test Criteria Section of this manual.

Demographic Submission Acceptance Rate (DAR)

Introduction

The T/RBHAs are required to maintain an acceptance rate of 90% or greater for demographic submissions. Acceptance rates are significant as they may be the first indication of possible systemic problems. The Office of Program Support monitors acceptance rates daily. In addition, acceptance rates may be part of each T/RBHA's yearly Administrative Review for demographics.

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Daily Demographic Acceptance Reports

The T/RBHAs place daily demographic files on the FTP server to be processed. The files are processed through the new-day batch process on a nightly basis by the ADHS/ITS Department. Demographic acceptance rates are calculated by the ADHS/ITS Department based on the number of rejected demographic records versus the number of submitted demographic records. ADHS/ITS places a text file containing all of the demographic acceptance data into the M:\Common\Program Support\Daily Demog Rpts directory.

Reviewing Daily Demographic Acceptance Reports

The Office of Program Support reviews the T/RBHA's acceptance rates on a daily basis using the Daily Demographic Acceptance Report (DAR Attachment 1) for all T/RBHAs. The following are the steps to be performed to review the T/RBHA report:

1. Open the M:\COMMON\Program Support directory. The reports are listed with the following naming convention:
h74_demog_daily_rpt_all.yyyymmdd.xx
2. Select the desired report and open using notepad.
3. Change from portrait to landscape to print.

Analyzing Data

The Office of Program Support will examine the T/RBHA's demographic submissions to ensure a minimum 90% acceptance rate is achieved for each demographic submission. For any demographic file that does not meet the 90% acceptance rate threshold, an explanation of the cause(s) is/are mandatory from the T/RBHA.

T/RBHA Documentation

The T/RBHAs are required to provide ADHS with an explanation within two (2) business days, when acceptance rates fall below the minimum 90% acceptance rate. The Office of Program Support will maintain this documentation by adding the explanations provided by the T/RBHA to the Daily Demographic Acceptance Report database. ADHS will consider systemic problems when analyzing the demographic acceptance rates.

Results

If 90% minimum acceptance rates are not maintained for demographic submissions during the period of one quarter, a letter is sent to the T/RBHA's Chief Financial Officer (CFO) before the end of the quarter notifying them the T/RBHA could be placed in the testing environment (See Test Criteria Section of this manual). If the T/RBHA continues to average below 90% acceptance rates through the remainder of the quarter, the T/RBHA will be placed in the test environment at the end of the quarter and will not be

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allowed to submit to production until the T/RBHA achieves a 90% or greater acceptance rate.

Administrative Review Scoring

The T/RBHA's ability to submit complete, accurate and timely demographic information will be monitored and may be scored as part of the T/RBHA's yearly Administrative Review.

Daily Demographic Acceptance Report

ARIZONA DEPARTMENT OF HEALTH SERVICES, CLIENT INFORMATION SYSTEM PAGE: 1
DAILY DEMOGRAPHIC REPORT FOR ALL RBHAs RUN DATE: 03/11/14

RBHA	TOTAL RECORDS	HEADER RECORDS	DETAIL RECORDS	RECORDS ACCEPTED	RECORDS REJECTED	PROCESS DATE	% ACCEPTED
X1	563	1	562	558	4	03/11/14	99.00
X2	1490	1	1489	1469	20	03/11/14	99.00
X3	26	1	25	13	12	03/11/14	52.00
X4	286	1	285	277	8	03/11/14	97.00
X5	368	1	367	362	5	03/11/14	99.00
X6	213	1	212	206	6	03/11/14	97.00
X7	235	1	234	232	2	03/11/14	99.00

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T/RBHA Demographic Test Conditions (TC)

Introduction

There are several scenarios that may require a T/RBHA to submit data into the ADHS test environment, rather than directly into production.

Conditions for Placing a T/RBHA into the Demographic Testing Environment

1. A new contract has been awarded.
2. System modifications have been implemented in an ADHS Data System (e.g., Covered Services and HIPAA) or as requested by the Bureau of Business Information.
3. The T/RBHA fails to maintain an average 90% or greater acceptance rate for the period of one fiscal year quarter.
4. Upon removal from the testing environment, due to satisfactory completion of the test criteria, a T/RBHA may be moved back into test if any one of the first three submissions to production does not meet the 90% acceptance threshold. The T/RBHA will then have to achieve a 90% or greater acceptance rate on a minimum of three additional test files before being placed back into the production environment.

Monitoring

The Office of Program Support/DBHS ITS is responsible for monitoring all aspects of the T/RBHA's submissions. If any of the above conditions are met, the Office of Program Support will send the *Initial Data Acceptance Rate Alert Letter* to the T/RBHA (TC Attachment 1). The Office of Program Support/DBHS ITS will continue to monitor the T/RBHA and, if conditions exist at the end of the quarter, the *Notification of Imposed Data Acceptance Rate Testing* (TC Attachment 2) will be sent to advise that the T/RBHA has been placed in test. The Office of Program Support/DBHS ITS will monitor test submissions to determine when the T/RBHA can be moved back to production.

Testing Environment

The Office of Program Support/DBHS ITS will work closely with any T/RBHA that has been placed in the testing environment to ensure test files are submitted appropriately and to offer assistance when system problems are identified. For data submissions that have been restricted to the test environment, the T/RBHA must coordinate the submission of test files with the Office of Program Support/DBHS ITS until the test criteria has been satisfactorily met.

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Testing for Established T/RBHA

Overview

The goal is for an established T/RBHA, who has been placed into test due to one of the aforementioned conditions, to satisfy all elements of the testing requirements and begin submitting to the production environment for the affected form type. To accomplish this, the T/RBHA must submit test files, containing at least the outlined criteria, to ADHS and pass with a minimum acceptance rate of 90%.

Testing for New T/RBHA

Overview

The goal is to have T/RBHA Demographic files accepted and completed through the testing process prior to the predetermined “Go Live” date. To accomplish this, the T/RBHA must submit test files containing at least the outlined criteria to ADHS and pass with a minimum acceptance rate of 90%.

Testing for Demographic System Changes

Overview

The Office of Program Support performs tests on system changes that affect the demographic data systems at the Arizona Department of Health Services. The Office of Program Support will work closely with the ITS department to ensure that changes perform as expected.

Test Case Preparation

A Tracker is initiated to request any type of data system change. After the Tracker is written the originator will notify ITS.

Testing

The ITS department will notify the Test Unit when a change/enhancement is ready to be tested. The Test Unit will enter all applicable scenarios to ensure the change/enhancement works as expected. Additional non-change related scenarios will be entered to ensure the change did not affect previously working programs. Any problems or issues discovered during testing are noted on the Tracker in the form of an update and ITS is notified. The Test Unit will work closely with the ITS department until the change/enhancement is approved.

T/RBHA Notification

The T/RBHA will be notified via e-mail of changes/enhancements that are ready to be moved into production.

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T/RBHA Demographic Testing Criteria

Minimum Test Criteria for Demographic Episode of Care (EOC) Transactions

1. Successfully submit Twenty Five (25) Trans_1 Initial Demographic Records
2. Successfully submit Twenty Five (25) Trans_5 Initial Short/Crisis Demographic Records
3. Successfully submit Fifty (50) Full Update Records (**must pass Test 1 prior to submitting**)
 - a. 25 records must update the initial demographics submitted in (1) above.
 - b. 25 records must update existing EOCs as of test bed creation date
4. Successfully submit Twenty Five (25) Trans_6 (Short/Crisis) Demographic Records to close the Trans_5 records submitted in (2) above (**must pass Test 2 prior to submitting**)
5. Successfully submit Fifty (50) Trans_3 Minor Update Demographic Records – each submission must change at least five (5) fields on an existing full record
6. Successfully submit 30 Trans_9 Correction Records
 - a. Fifteen (15) records must point to an existing Trans_1 and change the EOC Start Date
7. Successfully submit Fifty (50) Trans_4 Closure Records (**must pass Test 1 prior to submitting**)
 - a. 25 records must close the EOCs initialized in Test 1 above
 - b. 25 records must close any other open EOC as of test bed creation date

Test	RBHA
1	
2	
3a	
3b	
4	
5	
6	
7a	
7b	
Overall	

Legend:

No Submission	In Progress (<90%)	Test Completed (>=90%)
---------------	--------------------	------------------------

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T/RBHA Responsibilities

1. Load source data into T/RBHA system to support integration testing.
2. T/RBHA will use the testing criteria listed above to create test files containing a variety of transaction types.
3. Process demographic test data within T/RBHA system, as needed, and then submit the test transactions to ADHS using appropriate file naming conventions and an automated FTP process.
 - a. The directory for testing will be the T/RBHA's directory on the FTP server.

T/RBHA - 02, 11, 14, 15, 22, 25, 26, 28
Directory -
/sherman/u02/p/h74/rbhaftp/documents/HIPAA_TEST/RBHAXXR
BHA - 07, 32, 37
Directory -
/dhsftp1/u01/p/h74/rbhaftp/rbhaxx/test/Inbound
 - b. Filenames will follow the production standard: udemogxx.darbha.testx **
** 'xx' will be substituted with the valid T/RBHA ID.
NOTE: File names must be lowercase
4. Submit sufficient test records to validate T/RBHA system edits are in place to prevent ADHS Pre-Processor errors.
5. At least one file should contain a volume of records that is similar to the average file size.
6. Notify the Office of Program Support when the test file will be sent and of what type of data/records will be included in the file.

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Special Day Runs (SD)

Introduction

The Office of Program Support recognizes that there may be occasions when a T/RBHA will need to submit demographics separate from the normal nightly submission. These submissions are considered Special Day Runs and can be utilized to test changes made to the T/RBHA's system.

Request Process

Special Day Runs will only be performed by ADHS on Wednesdays. The T/RBHA must coordinate with the Office of Program Support to schedule a Special Day Run. The following procedures must be adhered to:

- The T/RBHA must submit an electronic request, including demographic volumes and specific details of what is being submitted and why by noon on Tuesday.
- The Office of Program Support will review the request.
- The Office of Program Support will notify the T/RBHA of the request approval or denial by COB that Tuesday by e-mail.
- If the request is approved, the Office of Program Support will copy ADHS/ITS to alert them that a Special Day Run will be submitted the next day.
- A T/RBHA cannot submit production data to be processed via the development/test system in an effort to ensure 90% accuracy.

Processing the Special Day Runs

To successfully complete the Special Day Run request the T/RBHA must:

- Ensure files are not placed on the FTP server prior to Wednesday morning (files placed on the server prior to Wednesday morning risk being picked up by the nightly processing)
- Ensure that the file provided contains the correct ADHS naming convention for a Special Day Run.
- Ensure the files are submitted to the FTP server by 10:00 a.m. on Wednesday.
- Once ADHS/ITS has completed processing of the Special Day Run, the Office of Program Support will provide an electronic notification to the T/RBHA.

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Demographic Resync Requests

Introduction

The Office of Program Support recognizes that there may be occasions when a T/RBHA will need to have a file of all demographic data as reflected in the ADHS computer system. This type of request is called a *resync* and may be utilized by the T/RBHA for the purpose of performing reconciliation due to processing problems.

Request Process

The T/RBHA must coordinate with the Office of Program Support to schedule a *resync*. The T/RBHA will send an e-mail to the Office of Program Support and will copy the Encounter Manager with a request for a *resync*. The request must contain the following information.

- RBHA Name and GSA, if applicable
- Type of Resync(s) Requested
 - Demographic
- Date Range (Optional)
 - Fiscal Year (July 1 – June 30)
 - Calendar Year (January 1 – December 31)
 - Any Other Time Increment (quarter, month, etc.)

The Office of Program Support will forward the e-mail notification to the identified ITS contact and will copy ADHS/ITS Management.

The Office of Program Support will be notified by ADHS/ITS when the files are available on the FTP Server. The Office of Program Support will then notify the T/RBHA via e-mail with the file names.

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Encounter Submission

Encounter Submission Schedules

Introduction

The Office of Program Support requires all RBHAs to establish and adhere to an Encounter Submission Schedule when submitting encounters to AHCCCS for each form type (CMS-1500, UB-04, NCPD, and Dental).

Setting an Encounter Submission Schedule

Upon completion of encounter testing with AHCCCS, a new RBHA is given ninety (90) days to select a set Encounter Submission Schedule, which must be adhered to. For all RBHAs, CMS-1500 files must be submitted at least bi-weekly, whereas UB-04 and NCPDP encounter files may be submitted according to any of the three following schedules:

1. *Monthly*: The RBHA must submit at least one encounter file for a specific form type, per GSA if applicable, in the period of one month.
2. *Bi-weekly*: The RBHA must submit at least one encounter file for a specific form type, per GSA if applicable, every two weeks.
3. *Weekly*: The RBHA must submit at least one encounter file for a specific form type, per GSA if applicable, every week.

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Submission Timeliness/240 Report (ST)

Introduction

Professional, Institutional and Dental Encounters not involving services eligible for Federal Drug Rebate processing should be received by AHCCCS no later than 240 days after the end of the month in which the service was rendered, or the effective date of the enrollment with the Contractor, whichever date is later. Pharmacy related encounter data and other encounters involving services eligible for Federal Drug Rebate processing must be provided to AHCCCS no later than 30 days after the end of the quarter in which the pharmaceutical item was dispensed. Failure to submit an encounter by the due date will result in an untimely encounter and could result in sanctions.

Collecting the Data

The Office for Data Reporting & Analysis has developed an application which allows identification of all encounters submitted greater than 240 days after the end of the month in which the service was rendered. The Office of Program Support pulls the data monthly and creates a spreadsheet covering 24 months of submission data by RBHA.

240 Report Import Instructions

1. Go to M:\Program Support Staff\VBDotNet_OPS_Application\Bin\Release and open the OPS_Application.exe file.
2. Click on Approved Encounters WIP.
3. Enter the OPSD password, select Previous 24 Months at the bottom of the screen and then click on Start
4. Please note that this process will take several hours to run (approximately 7 hours).

Accessing the 240 Report

Once the import process is completed, the application will automatically generate an MS Excel file containing a spreadsheet with the 24 months of submission data for the agency and separate tab with 24 months of data for each RBHA.

1. To view/print the reports go to M:\Program Support Staff\VBDotNet_OPS_Application\ Reports.
2. A copy of the report will be provided to management.

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Reviewing the 240 Report

The Office of Program Support will review the 240 Report to identify issues the RBHAs are having submitting timely encounters.

The RBHAs are required to provide an explanation if more than five percent of their encounters are submitted over 240 days after the end of the month in which the service was rendered and/or an increase in untimely encounters is noted.

Administrative Review

Encounters submitted to AHCCCS greater than 240 days after the end of the month in which the service was rendered are monitored and may be scored as part of the yearly Administrative Review.

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ST Attachment 1

240 Report

Arizona Department of Health Services
Division of Behavioral Health Services
Approved Encounters by Month
January 2014
10/01/2013 through 12/31/2013

Number of records in 5010 A: HCFA table: 1,220,225
Number of records in 5010 B: UB table: 1,774
Number of records in 5010 C: NCPDP table: 190,826

Month	RBHA ID	Form Type	Enc Count	% within 240 Days	Member Months	Enc Per MM
2013 10	Statewide	A: HCFA Statewide	797888	100	84622	9.43
2013 10	Statewide	B: UB Statewide	1188	100	1034	1.15
2013 10	Statewide	C: NCPDP Statewide	100750	100	37436	2.69
2013 11	Statewide	A: HCFA Statewide	385107	100	56179	6.85
2013 11	Statewide	B: UB Statewide	565	100	487	1.16
2013 11	Statewide	C: NCPDP Statewide	78798	100	31974	2.46
2013 12	Statewide	A: HCFA Statewide	37230	100	11320	3.29
2013 12	Statewide	B: UB Statewide	21	100	21	1
2013 12	Statewide	C: NCPDP Statewide	11278	100	5748	1.96

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Encounter Edits

824 Encounter Validator Errors

All encounters are submitted to AHCCCS thru their pre-processor, the Validator which contains their initial edits. Encounters that fail the Validator edits are rejected and are not entered into the AHCCCS/PMMIS encounter system. These encounters must be corrected and resubmitted by the RBHA. The encounters must be resubmitted as new encounters, not replacements, and the RBHA may use the same ICNs as on the original file.

AHCCCS Internal Encounter Edits

Encounters that successfully pass the AHCCCS Validator edits are entered into the AHCCCS/PMMIS encounter system. These encounters are then adjudicated by AHCCCS. The adjudication process runs the encounters through a series of comprehensive edits which will result in the encounters being denied, pended or approved.

1. Denied encounters must be researched by the RBHA to determine if they are correctable or if they were submitted to AHCCCS in error.
 - a. Correctable denied encounters must be resubmitted as replacement encounters. The RBHA must assign the encounter a new ICN number and put the ICN from the original encounter in the Original ICN field. This ties the two encounters together and is essential for timeliness submission calculation.
 - b. Denied encounters that are determined to have been submitted to AHCCCS in error need no further action.
 - c. Denied encounters cannot be voided.
2. Encounters pended by AHCCCS generate three files sent to DBHS after each AHCCCS adjudication cycle:
RBHA_PROD_PEND_XX_030714.TXT
RBHA_PROD_PEND_DETLGIN_XX_030714.TXT
RBHA_PROD_PEND_DUPECRN_XX_030714.TXT
 - a. DBHS/IT separates these by RBHA and puts a copy of each in the RBHAs respective directories on the rbhaftp server.
3. The resulting Pended encounters must be researched by the RBHA to determine if they are correctable or if they were submitted to AHCCCS in error.
 - a. Correctable pended encounters must be resubmitted as replacement encounters. The RBHA must assign the encounter a new ICN number and put the ICN from the original encounter in the Original ICN field. This ties the two encounters together and is essential for timeliness submission calculation.

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- b. Pended encounters that are determined to have been submitted to AHCCCS in error must be voided. When submitting the void the RBHA must assign the encounter a new ICN number and put the ICN from the original encounter in the Original ICN field. This ties the two encounters together and ensures that the original encounter is voided.
- 4. Encounters that have been approved may later be determined by the RBHA to need corrections or to have been submitted to AHCCCS in error.
 - a. Corrections may be made to an approved encounter by resubmitting the corrected encounter as a replacement. The RBHA must assign the encounter a new ICN number and put the ICN from the original encounter in the Original ICN field. This ties the two encounters together and is essential for timeliness submission calculation.
 - b. An AHCCCS approved encounter determined to have been submitted to AHCCCS in error must be voided. When submitting the void the RBHA must assign the encounter a new ICN number and put the ICN from the original encounter in the Original ICN field. This ties the two encounters together and ensures that the original encounter is voided.

Monitoring Denied Encounters

As part of their adjudication process, AHCCCS may deny encounters. Denied encounters may or may not be correctable, depending on the error. The Office of Program Support will take the following steps to monitor and see that the correctable denied encounters are resolved:

- 1. Access “M:\Program Support Staff\yyyy OPS RESEARCH\DENIED ENCOUNTERS – RBHA RPTS. (yyyy being the current year), and locate the current month file for each RBHA, titled, “mmm yyyy Denied Encounters – RBHA XX” (mmm yyyy being the month year, and XX being the RBHA identifier). This file is created by the Office of Program Support from the files received monthly from AHCCCS. A copy of the file is placed in the RBHA’s folder on the opsftp server and an e-mail is sent to the RBHA notifying them that the file is available.
- 2. This file is a spreadsheet that contains a separate tab for each month’s denied encounters. Since AHCCCS denial reports are not cumulative, the encounters on each month’s tab must be updated monthly by the RBHA to demonstrate their progress.
- 3. The RBHAs should use the columns provided as follows:
 - a. DBHS Replacement ICN
 - i. Please enter only replacement ICNs that have been accepted by DBHS
 - b. Date Replacement ICN Submitted to AHCCCS

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- i. Submission date of the accepted replacement ICN
 - c. Reason Encounter Not Replaceable
 - i. Reason encounter cannot be replaced
 - d. Comments
 - i. Use only if columns in a. b. or c. above are not completed
- 4. This report must be updated and returned to the RBHAs folder on the opsftp server by close of business on the fifth day of the following month using the file name that was sent to the RBHA with the word **response** at the end. Example: Jun 2011 Denied Encounters – RBHA 15 response. The RBHA must send an e-mail to ops@azdhs.gov when it has been placed on the server.
- 5. The Office of Program Support will review the report and:
 - a. Follow up with the RBHA to ensure they understand how to resolve those denied encounters that are correctable.
 - b. Remove those encounters that have been replaced or have acceptable reasons why they are not replaceable
 - c. The RBHAS must justify all denials. When all encounters on a tab have been removed the tab for that month will be eliminated

[illegible]

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Monitoring Pended Encounters

The Office of Program Support will take the following measures to monitor all pends to identify problem areas, detect new issues and trends:

1. Access "M:\Program Support Staff\yyyy OPS RESEARCH\PENDS\PENDS – MONTHLY SUMMARIES and locate the current month folder. The folder contains files created by the Office of Program Support from the AHCCCS pend files received monthly from AHCCCS.
2. The files contain a summary of all encounters currently pended. They include Pend Month, Pend Code, Pend Description, Total Encounters Pended and a breakdown of the number of days encounters for each pend code were pended. There is a summary of all pends and a summary for each RBHA. A copy of each RBHAs file is placed in their folder on the opsftp server and an e-mail is sent to the RBHA notifying them that the file is available.
3. The Office of Program Support will review these reports and contact the RBHAs to discuss problem areas, new issues and trends found, determine the RBHAs plans for resolving these pends and follow up on their intended resolutions from the previous month to see that they have been accomplished.

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Total Monthly Summary Pend Report
[Month Year] Pend Summary

Run Date

Pend Month	Pend Code	Pend Description	Total Encls Pending	Pended 0-30 days	Pended 31-60 days	Pended 61-90 days	Pended 91-120 days	Pended 121-180 days	Pended 181+ days
2014-02	P353	PROVIDER TYPE NOT ELIGIBLE FOR SERVICE BILLED	36831	36686	55	81	3	4	2
2014-02	R396	DOS SPANS AHCCCS AND STATE ONLY ELIG/ENRL PERIODS	33945	31598	2346				1
2014-02	P330	PROVIDER NOT ELIGIBLE FOR CATEGORY OF SERVICE ON SERVICE DATE	25479	23071	2395	13			
2014-02	R397	NO AHCCCS OR STATE ONLY ELIG/ENRL FOR DOS	19504	13811	5576	63	5	45	4
2014-02	S430	PLACE OF SERVICE IS INVALID FOR SPECIFIED PROCEDURE	5082	2175	1077	1827	2		1
2014-02	Z300	EXACT DUPLICATE	3819	1142	2231	74	117	252	3
2014-02	Z305	NEAR DUPLICATE FOUND	2471	1008	803	270	110	266	14
2014-02	Z800	EXACT DUPLICATE FOUND	1321	28	41	1085	119	36	12
2014-02	A905	UNREASONABLE AHCCCS ALLOWED AMT IN RELATION TO BILLED AMT	864	108	48	640	28	33	7
2014-02	N020	NDC NOT COVERED ON DOS	462	46	29	54	53	121	159
2014-02	D255	RECIPIENT AGE EXCEEDS TERTIARY DIAGNOSIS ALLOWABLE MAX	418	155	94	35	64	70	
2014-02	D003	BHS PRIMARY DX NEEDED FOR INPATIENT PLACEMENT	111	62	13	4	3	24	5
2014-02	S385	SERVICE UNITS EXCEED MAXIMUM ALLOWED	111	15	43	23	6	21	3
2014-02	S445	PROCEDURE MODIFIER INVALID FOR PROCEDURE ON DATE OF SERVICE	85	71	3	1	4	6	
2014-02	Z220	PRESCRIBING PROVIDER ID IS MISSING OR INVALID	36	4	23				9
2014-02	R470	RECIPIENT ENROLLED IN FEE FOR SERVICE NETWORK ON SERVICE DATES	17	17					
		TOTAL ENCOUNTERS PENDING	130556						

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Monitoring Encounters Pended Over 120 Days

To be proactive in reducing and/or eliminating sanctions due to aging encounters, the Office of Program Support will work with RBHAs to address encounters pended more than 120 days. The Office of Program Support will take the following steps to monitor pended encounter corrections:

1. Access “M:\Program Support Staff\yyyy OPS RESEARCH\PENDS OVER 120 DAYS – RBHA RPTS. (yyyy being the current year), and locate the current month file for each RBHA, titled, “yyyymmdd PENDS OVER 120 DAYS – RBHA XX” (XX being the RBHA identifier). This file is created by the Office of Program Support from the AHCCCS pend files received monthly from AHCCCS. A copy of the file is placed in the RBHA’s folder on the opsftp server and an e-mail is sent to the RBHA notifying them that the file is available.
2. This report contains a list of all encounters currently pended for more than 120 days. It includes the CRN, ICN, Error Code, Form Type and Days Pended information for each pended encounter, as well as blank columns for Action Taken and Comments.
3. The RBHA is required to provide the action taken to resolve each pended encounter and their comments on any pends that are unresolved. The RBHA must complete and return the file to the RBHA’s folder on the opsftp by the first of the following month, using the same file name that was sent to the RBHA with the word **response** at the end. Example: yyyymmdd PENDS OVER 120 DAYS – RBHA XX response. The RBHA must send an e-mail to ops@azdhs.gov when it has been placed on the server.
4. The Office of Program Support will review the report and follow up with the RBHA to ensure they understand how to correct those pended encounters that remain unresolved.

[illegible]

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Aged Pends/Pend Sanctions (AP)

Introduction

ADHS produces a Pended Encounter File at the conclusion of each AHCCCS encounter processing cycle containing all encounters pending in the AHCCCS PMMIS system. The RBHAs must resolve all pended encounters from the AHCCCS PMMIS system within 120 calendar days of the original AHCCCS processing date. Failure to resolve AHCCCS pended encounters within 120 days is known as an aged pended encounter and is subject to sanction per contract. The exceptions are encounters that pended due to an AHCCCS error.

AHCCCS Pended Encounters Cycle

The AHCCCS encounter cycle takes approximately one week to complete. The output from the encounter cycle includes the Pended Encounters file produced by AHCCCS at the conclusion of each encounter processing cycle. As soon as ADHS receives the file, it is reviewed for errors, placed into manageable file formats and promptly placed on the RBHA's respective FTP server.

The Office of Program Support will immediately send a notification by e-mail to all the RBHAs stating that AHCCCS Pend files are available in the RBHAS respective folders on the rbhaftp server (AP Attachment 1). The e-mail will include the due dates to ADHS for each step of the pend correction process. RBHAs are to begin working pends to meet all deadlines. The RBHAs have the ability to work on correcting pended encounters throughout the month. All questions regarding the AHCCCS pended encounters should be directed to the Office of Program Support (OPS@azdhs.gov).

Monitoring Pended Encounters

To be proactive in reducing and/or eliminating sanctions due to aging pended encounters, the Office of Program Support will work with the RBHAs to address encounters pended more than 90 days. The Office of Program Support will take the following steps to monitor pended encounter corrections:

Access "M:\Program Support Staff\2011 OPS RESEARCH database. OPS uses the AHCCCS pend file, DETLAGIN, to update the Pended Records_5010 table in the database.

1. Create a report of encounters pended over 90 days and advise the RBHAs that the file is on the Office of Program Support FTP server.

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2. RBHAs must address all pended encounters that have been pended 90 days and resolve the pends or explain why the pend error is unresolved.
3. Follow up with the RBHA throughout the month to ensure the RBHA has been able to correct aging pends and/or understand how to correct them.
4. Ensure ITS has researched errors that have been identified through the pend reports and provided RBHAs with resolutions and/or updated system as necessary.
5. Communicate with the AHCCCS Technical Assistant Representative to clarify error resolutions. Ensure issues identified through pend report research by Office of Program Support staff are completed in a timely fashion.

Voiding and Overriding of Encounters

A RBHA may void or override a pended encounter; however, pended encounters must not be voided or overridden in order to avoid sanctions for failure to correct pended encounters within 120 days. The RBHA must document all encounters voided or overridden and maintain a record of the CRNs with appropriate reasons for the actions. See Quarterly AHCCCS Void Log and Quarterly AHCCCS Override Log sections of this manual.

Preliminary Sanctioning Process

AHCCCS on a quarterly basis distributes to ADHS Office of Program Support through the AHCCCS FTP server their preliminary findings of sanctionable aged pended encounters (AP Attachment 2). The preliminary findings are divided into aged pended encounters that are excluded from sanction (AP Attachment 3) and those that are being sanctioned (AP Attachment 4). A summary of all sanctionable pended encounters are also placed on the FTP server by AHCCCS in the form of an Excel spreadsheet. The Office of Program Support is responsible for moving these files to the M:\Program Support Staff\2011 OPS RESEARCH\Sanctions – Encounter Pend\mmm yyyy folder. The Encounter Manager then provides each RBHA with a letter defining the preliminary results and places a spreadsheet of the sanctionable aged pended encounters specific to the RBHA on the opsftp server for review and comment (AP Attachment 5).

Challenge Preliminary Findings

The RBHA is responsible for identifying any pends they want to challenge in the preliminary report. Each challenge must be supported by additional documentation. The types of additional documentation include, but are not limited to PMMIS screen prints and screen prints from the RBHA's internal system.

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The Office of Program Support will review all challenges from the RBHA and determine the documentation that will be forwarded to AHCCCS for consideration of reducing sanctions.

Final Sanction Determination

Once AHCCCS reviews all challenges and/or additional documentation, a final decision is made as to which pending encounters are sanctionable (AP Attachment 6). The sanctions are then calculated (AP Attachment 7) according to age category. The Office of Business Operations is notified of the final sanction amounts and funds are withheld from the RBHA's capitation payment the following month. The Office of Program Support will send a letter to each RBHA advising them of any final sanction amounts (AP Attachment 8). Whether sanctions are waived or not, a RBHA is still responsible for correcting all pending encounters unless the error is attributed to AHCCCS.

Sanctions are imposed per encounter per month according to the following schedule:

<u>0 – 120 Days</u>	<u>121 – 180 Days</u>	<u>181 – 240 Days</u>	<u>241 – 360 Days</u>	<u>361 + Days</u>
No Sanction	\$5 per month	\$10 per month	\$15 per month	\$20 per month

Administrative Review Scoring

Aged pending encounters will be monitored and may be scored as part of the RBHA's yearly Administrative Review.

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AP Attachment 1

AHCCCS Pends Availability and Correction due Dates E-mail

IMPORTANT INFORMATION - Concerning [Month 20XX] Pend Data

1) Pend Files are Available

The following AHCCCS pended encounter files for Month yyyy have been placed in the respective RBHA directories on the ADHS Sherman server *rbhaftp):

RBHA_PROD_PEND_XX_mmdyy.txt
RBHA_PROD_PEND_DETLAgin_XX_mmdyy.txt
RBHA_PROD_PEND_DUPECRN_XX_mmdyy.txt

2) Pend Processing Deadlines

A) DelDup File (AHCCCS Pend Overrides & Deletions) **Due By: Noon on Tuesday Month DD, YYYY.**

Use only the following combinations of Error and Reason Codes.

Error	Reason Code
Z305	A001 Per RBHA review; not a duplicate encounter
Z575	A001 Per RBHA review; not a duplicate encounter
Z620	A001 Per RBHA review; not a duplicate encounter
Z630	A001 Per RBHA review; not a duplicate encounter
Z640	A001 Per RBHA review; not a duplicate encounter
A905	A002 Enc review completed; override at request of Contractor

B) All other AHCCCS errors should be adjudicated through submission of a void or replacement transaction in the normal nightly process. **Voids or replacements not successfully submitted to AHCCCS before Month, DD YYYY will result in the encounter continuing to pend in the Month adjudication cycle.**

4) Pend Error Questions

Please contact the Office of Program Support at OPS@azdhs.gov should you have any questions, or if any other assistance is needed.

Note:

This communication, generated by the Office of Program Support on a monthly basis, is entered into the OPS e-mail Database, and is sent to the RBHA from the OPS mailbox, OPS@azdhs.gov. The original, as well as any subsequent incoming or outgoing communications related to the original, is saved in the OPS Microsoft Outlook database.

AP Attachment 2

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Preliminary Sanction Summary

Preliminary Sanction Summary			
Quarter Ending:			
Plan ID:	079999	Plan Name:	ADHSBHS
TSN:	79		
	Age Category	Total Encounters	Sanction Amount
	181-240 Days	2	\$20
	241-360 Days	4	\$80
TSN:	80		
	Age Category	Total Encounters	Sanction Amount
	121-180 Days	1	\$5
	241-360 Days	4	\$80
TSN:	81		
	Age Category	Total Encounters	Sanction Amount
	121-180 Days	4	\$20
	181-240 Days	3	\$30
TSN:	84		
	Age Category	Total Encounters	Sanction Amount
	121-180 Days	1	\$5
Plan Total		Total Encounters	Sanction Amount
		19	\$200

Pended Encounters Excluded from Preliminary Sanctions

Summary of Encounters Excluded From Preliminary Sanctions

Quarter Ending: Month, Year

Plan ID: 079999 Plan Name: ADHSBHS

<i>Error Code</i>	<i>Error Description</i>	<i>Form Type</i>	<i>TSN</i>	<i>Total</i>
A951	FORCE PEND FOR CONTRACTOR CORRECTIONS	A	79	6
A951	FORCE PEND FOR CONTRACTOR CORRECTIONS	A	80	90
A951	FORCE PEND FOR CONTRACTOR CORRECTIONS	I	93	12
A951	FORCE PEND FOR CONTRACTOR CORRECTIONS	I	79	28
P210	IHS SERVICE PROVIDERS ARE FEE FOR SERVICE ONLY	A	81	78
P210	IHS SERVICE PROVIDERS ARE FEE FOR SERVICE ONLY	A	80	295
P340	PROVIDER SPECIFIC RATE NOT ON FILE FOR DOS	I	79	2
P340	PROVIDER SPECIFIC RATE NOT ON FILE FOR DOS	I	93	3
P353	RATE NOT FOUND ON PROV TYP TBL	I	79	6
R410	RECIPIENT NOT ELIGIBLE FOR AHCCCS SERVICES ON SERVICE DATES	A	80	1
R480	RECIPIENT NOT ENROLLED ON SERVICE DATES	C	81	6
R600	MEDICARE COVERAGE INDICATED BUT NOT BILLED	A	81	12
R600	MEDICARE COVERAGE INDICATED BUT NOT BILLED	A	83	36
R632	MEDICARE APPROVED AND PAID NOT BOTH PRESENT	A	83	2
V151	OR RM BILL-ICD9 AND/OR HCPCS MUST = SURGICAL	I	79	6
V152	OR RM BILL-NO SURG ICD9 AND/OR HCPCS CODE PRESENT	I	79	3
Z610	EXACT DUPLICATE FOUND	I	79	6
Z615	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	I	80	1
Z615	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	I	79	6
Z620	NEAR DUPLICATE FOUND	I	93	2
Z720	EXACT DUPLICATE FOUND	A	81	4
Z720	EXACT DUPLICATE FOUND	A	83	8
Z720	EXACT DUPLICATE FOUND	A	79	12
Z725	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	A	83	1
Z725	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	A	79	58
Z725	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	A	93	210
Z725	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	A	80	272
Z745	NEAR DUPLICATE FROM DIFFERENT HEALTH PLANS	A	80	3
Z745	NEAR DUPLICATE FROM DIFFERENT HEALTH PLANS	A	93	12
Z760	NEAR DUPLICATE FOUND - FROM-THROUGH DATES OVERLAP	A	81	1
Z805	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	C	94	8
Z805	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	C	84	47
Z805	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	C	83	129
Z805	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	C	93	352
Z805	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	C	79	510
Z805	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	C	80	6,505
<i>Plan Total</i>				8,733

Preliminary Encounter Sanctions Error Summary

Preliminary Encounter Sanctions Error Summary

Quarter Ending: *Month, Year*

Plan ID: 079999 ***Plan Name:*** ADHSBHS

<i>Error Code</i>	<i>Error Description</i>	<i>Form Type</i>	<i>Total</i>
D010	PRIMARY DIAGNOSIS NOT ON FILE (FOR DOS)	A	1
D305	INAPPROPRIATE DIAGNOSIS SEQUENCE	A	1
D305	INAPPROPRIATE DIAGNOSIS SEQUENCE	A	1
N004	NDC CODE NOT ON FILE	C	1
N004	NDC CODE NOT ON FILE	C	5
R660	DHS MHS ENC RCP MUST BE ON MHS ENROLL	A	4
T005	PSYCH BED W/OUT PSYCH DX-INVALID	I	1
V020	REVENUE CODE NOT ON FILE FOR DOS	I	1
V045	NO ACCOMMODATION BILLING - BILL IS I/P OR LTC	I	4
<i>Plan Total</i>			19

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AP Attachment 5

Preliminary Sanction Letter Sent to RBHAs

[Date]

[Recipient]

[RBHA]

[Address]

[City, State Zip]

Dear [Mr. / Ms.] [Recipient]:

The purpose of this letter is to inform you of the preliminary results of sanctionable pended encounters for the quarter ending [month, year]. According to your contract, [RBHA] is required to resolve all pended encounters within 120 calendar days of the original processing date.

All error codes identified as due to Arizona Health Care Cost Containment System (AHCCCS) errors or error codes under review by AHCCCS were waived for quarter-ending [Month Year].

Please note, even when sanctions are waived, the Contractor is liable for addressing all pended encounters (except those errors which have been identified as due to AHCCCS error or as being under review by AHCCCS). When error codes are identified as an AHCCCS error and are corrected, or are identified as being under AHCCCS review and then released, the Contractor is responsible for addressing any remaining error codes and will be afforded a new 120 day clock for resolution. However, the true age for these pended encounters will continue to appear on the Aging Reports.

Please retrieve the spreadsheet listing your sanctionable pended encounters for the quarter ending [month, year] which includes preliminary sanction amounts from ADHS' OPS FTP server. Please enter your responses to any items believed not to be sanctionable into the designated area of the spreadsheet. Return the spreadsheet by placing it on ADHS' OPS FTP server with any supporting documentation being mailed to the Office of Program Support Encounter Unit, attention [Encounter and Claims Manager].

Clear specific justifications are expected and should not include responses such as "encounter is now adjudicated"; "encounter is in 31/78"; "resubmitted encounter"; "encounter reprocessed"; etc. . . . If the justifications are vague and/or unspecific, ADHS will not accept the challenge and the encounters will remain eligible for sanctions.

Sanction dates cover encounters pended over 120 days in [Qtr month 1, Qtr month 2 or Qtr month 3, Year]. If the encounters are voided or resubmitted after the 3rd month of the

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quarter, ADHS will not accept the challenge and the encounters will remain eligible for sanctions.

If we do not hear from you by [Month Day, Year], we will use the preliminary results as the final sanction amount. The Arizona Department of Health Services/Office of Program Support's Encounter Unit will evaluate and, if appropriate, submit a challenge to AHCCCS for final review.

Should you have any questions regarding this matter, please feel free to contact me at (602) xxx-xxxx.

Sincerely,

[Name], Claims and Encounters Office Chief
Bureau of Program Operations

Enclosures

c: [Name], Chief Financial Officer, RBHA
[Name], Deputy Director, ADHS
[Name], Chief Financial Officer, ADHS
Contract Compliance File

Error Summary Final

Error Summary Final

Quarter Ending: June, 2006

Plan ID: 079999 ***Plan Name:*** ADHS/BHS

<i>Error Code</i>	<i>Error Description</i>	<i>Form Type</i>	<i>Total</i>
D010	PRIMARY DIAGNOSIS NOT ON FILE (FOR DOS)	A	1
D305	INAPPROPRIATE DIAGNOSIS SEQUENCE	A	2
N004	NDC CODE NOT ON FILE	C	6
R660	DHS MHS ENC RCP MUST BE ON MHS ENROLL	A	2
T005	PSYCH BED W/OUT PSYCH DX-INVALID	I	1
<i>Plan Total</i>			12

Final Sanction Summary

Final Sanction Summary Quarter Ending: Month, Year

Plan ID: 079999 **Plan Name:** ADHS/BHS

TSN: 79

Age Category	Total Encounters	Sanction Amount
181-240 Days	1	\$10

TSN: 80

Age Category	Total Encounters	Sanction Amount
121-180 Days	1	\$5
241-360 Days	2	\$30

TSN: 81

Age Category	Total Encounters	Sanction Amount
121-180 Days	4	\$20
181-240 Days	3	\$30

TSN: 84

Age Category	Total Encounters	Sanction Amount
121-180 Days	1	\$5

Plan Total	Total Encounters	Sanction Amount
	12	\$100

Final Sanction Letter Sent to RBHAs

[Month Day, Year]

[Recipient]
Chief Executive Officer
[RBHA]
[Address]
[City, State, Zip]

Dear [Mr./Ms. Recipient]:

The purpose of this letter is to inform you of the final results of sanctionable pended encounters for the quarter ending [Month, year]. According to your contract, NARBHA is required to resolve all pended encounters within 120 calendar days of the original processing date.

Please retrieve the spreadsheet listing your sanctionable pended encounters for the quarter ending [Month, year], which includes final sanction amounts, from ADHS' OPS FTP server.

The spreadsheet includes all encounters determined to be sanctionable after review of the challenges submitted by the RBHA. The challenges that were not considered valid either did not apply to the month being sanctioned or did not have sufficient supporting documentation.

ADHS will withhold [\$xxx.xx] from the [RBHA] Title XIX capitation payment in [Month year].

If you disagree with the imposition of this sanction, you may file a claims dispute pursuant to the requirements in ADHS/DBHS Policy and Procedure Manual Section GA 3.2, Contractor and Provider Claims Disputes. Your claim dispute must be filed within 60 days, specify the factual and legal basis for the dispute and the relief requested.

Should you have any questions regarding this matter, please feel free to contact me at (602) XXX-XXXX.

Sincerely,

[Name], Claims and Encounters Office Chief
Bureau of Program Operations

Enclosures

c: Chief Financial Officer, [RBHA]
Deputy Director, ADHS
Chief Financial Officer, ADHS
Contract Compliance File, ADHS

Office of Program Support
Operations and Procedures Manual

Quarterly BHS Void Log (BVL)

Introduction

The Office of Program Support requires each RBHA to justify all encounters that have been voided from the AHCCCS PMMIS system quarterly.

Submitting the Quarterly BHS Void Log

Within one week following the end of each quarter the Office of Program Support will generate a log of all encounters that have been voided from the AHCCCS PMMIS system in the previous quarter and provide it to the RBHA. The Office of Program Support will send an email to each RBHA stating the quarterly void log has been placed in the RBHA's folder in the OPSFTP directory of the ADHS Sherman server. The RBHA is required to provide a detailed reason for each voided encounter and submit the log back to the ADHS Sherman server no later than 15 business days after receipt. The RBHA will send an email to the Office of Program Support copying the BHS Contract Compliance Office and the Office of Program Support Encounter Manager when the logs have been returned to the ADHS Sherman Server. Once the Office of Program Support receives the email from the RBHA stating the log is available it will be reviewed for validation of the void reasons submitted.

Findings

Upon completion of review the Office of Program Support will send an e-mail to the RBHA identifying any errors discovered in the quarterly void log, or notifying the RBHA no errors have been found and the log has been accepted. Any identified errors must be corrected immediately and the log resubmitted within 48 hours.

Utilization for the Quarterly AHCCCS Void Log

The RBHA's quarterly void log will be combined with all other RBHA void logs and submitted to AHCCCS, as required, on the Quarterly AHCCCS Void Log no later than 45 days following the end of the quarter.

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BVL Attachment 1

BHS Quarterly Void Log
Filename: Quarterly_Void_LogMMDDYYY_XX
Format: File is an Excel Spreadsheet

Record Layout

Field Name	Type	Size	Supplied/Required	Comment/Changes
RBHA_ID	Char	2	Supplied by DBHS	Value: Contractor ID
FORM_TYPE	Char	1	Supplied by DBHS	Value: Form Type Code (A = CMS 1500, B = UB, C = NCPDP)
ENC_STATUS	Char	2	Supplied by DBHS	Value: Encounter Status (AV = Approved Void)
ENC_LOCATION	Char	10	Supplied by DBHS	Value: Encounter Location (AHCCCS = AHCCCS BH enrolled client, STATE-ONLY = State BH enrolled client)
ICN-NUMBER	Char	30	Supplied by DBHS	Value: ICN-NBR
CRN-NUMBER	Char	14	**	Value: AHCCCS CRN-NBR
DATE_OF_VOID	Date	10	Supplied by DBHS	Value: Approved void status date
DETAILED_REASON_FOR_VOID	Char	200	Required from RBHA	Value: RBHA detailed void reason

** Supplied by DBHS when applicable

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Claims Dashboard

The RBHA shall submit a monthly Claims Dashboard as specified in the AHCCCS Claims Dashboard Reporting Guide and Attachment F3, AHCCCS Contractor Chart of Deliverables. The report tracks open Episodes of Care and Encounter Processing. It includes specific details on encounters received, paid, denied, pended and special projects. A separate Dashboard is required for each form type except NCPDP which is exempt. The report is due on the 30th day of the month following the reporting period.

Check Register Review (CR)

Formatted: Normal

Introduction

The Office of Program Support (OPS) requires all RBHAs to submit check registers for all Fee-For-Service (FFS) paid claims on a quarterly basis to ensure the RBHA is submitting timely and accurate encounter data.

Timeframes To Be Followed

The first business day of the month following the end of the fiscal year quarter to be reviewed, OPS will send a courtesy reminder e-mail to the RBHA(s) requesting the check register for the appropriate contract year quarter.

The RBHA must provide the check register for the prior quarter by the tenth (10th) business day to the OPS e-mail box.

Within five (5) business days from receipt of RBHA's check register, OPS will submit a request to the RBHA for copies of either the first paid claim on the checks where a single claim was paid or the third paid claim on the checks where multiple claims were paid.

The RBHA will be given ten (10) business days to submit the requested documents, in hardcopy form to OPS at:

**Arizona Department of Health Services
Division of Behavioral Health Services
Office of Program Support
150 N. 18th Avenue, Suite 280
Phoenix, Arizona -85007**

OPS will review the submitted documents and provide the RBHA with the outcome within ten (10) business days from the day the second request was received. The RBHAs will be sent a preliminary letter summarizing the findings along with a spreadsheet of the

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claims reviewed. If preliminary review is 100% (full compliance) the preliminary letter becomes a final letter

The RBHA will have ten (10) business days from the date of the preliminary letter to review the preliminary outcome and submit any challenges of the decision to OPS.

OPS will have five (5) business days from the date that the challenge is received to notify the RBHA of their final score for the review period.

Check Register Request

On the first business day of the quarter, OPS will send a courtesy reminder to each RBHA by e-mail stating that the RBHA's check register from the previous quarter is due to OPS (CR Attachment 1). The RBHA is given ten (10) business days from the date of the e-mail to submit their check register.

Check Register Received

On receipt of the RBHA's check register, OPS will begin the check register review with the sample selection process. OPS will randomly select 75 checks (to include checks for each form type) from the RBHA's Check Register. OPS will list the checks chosen via the sample selection process for the check register review on the Check Register Claim Request spreadsheet (CR Attachment 2).

Within five (5) business days of receiving the check register OPS will submit a second request (CR Attachment 3) and the Check Register Claim Request spreadsheet by e-mail to the RBHA. The RBHA will have ten (10) business days from the date of the second e-mail request to submit copies of either the first paid claim on the checks where a single claim was paid or the third paid claim on the checks where multiple claims were paid.

Due to the Protected Health Information (PHI) included on the claims, the RBHA should submit the requested documents in hard copy form delivered directly to:

**Arizona Department of Health Services
Division of Behavioral Health Services
Office of Program Support
150 N. 18th Avenue, Suite 280
Phoenix, Arizona 85007**

Requested Documents Received

Upon receipt of the copied claims, OPS will verify all claim copies requested have been provided by the RBHA. After verifying that all documents are received, OPS will sequentially number the claim copy documents.

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Document Review Process

A Check Register Review Encounter Summary spreadsheet (CR Attachment 4) will be created by OPS. In the spreadsheet, OPS will include specific information obtained from the claim document and the corresponding information found in the ADHS system for each of the claims.

The information obtained from each of the selected claims will be:

- Client ID
- Provider NPI
- Begin Date of Service or Fill Date for NCPDP claims
- End Date of Service
- Service Code (Revenue Code, CPT/HCPCS, or NDC)
- Modifier
- Units
- Billed Amount
- Diagnosis Code
- Date RBHA rcvd claim (added 4th Qtr. FY11)
- Date RBHA paid claim (added 4th Qtr. FY11)
- Day Count (Claims) – Definition explained under “Timeless” (Claims)

The information obtained from the AHCCCS system for each of the claims is as follows:

- Claim Number
- Begin Date of Service or Fill Date for NCPDP claims
- End Date of Service
- Service Code (Revenue Code, CPT/HCPCS, or NDC)
- Modifier
- Units
- Billed Amount
- Diagnosis Code
- ADHS System Add Date – Definition explained under “Timeliness” (ADHS System)
- TPL / Other Ins.

Encounter Errors

Each selected claim is reviewed for correctness, timeliness, and omission errors (AHCCCS System). Determinations for each of these categories are defined as follows:

Omissions: Any encounter for a clean paid claim that has not been received by AHCCCS at the time of the Check Register review is

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considered an omission. If any omissions are identified during the course of the review, the score will automatically default to a Non-Compliance 0% rating.

RBHAs must submit all omitted claims to AHCCCS within thirty (30) days from the date the final letter was sent to the RBHAs. This submission will have the effect of changing the omission error to a timeliness error.

Correctness: Any clean claim paid by the RBHA that has been submitted and accepted by AHCCCS where the AHCCCS system information does not match the corresponding claim information is considered a correctness error.

The AHCCCS system information keyed into the encounter summary spreadsheet is matched to the corresponding claim information keyed into the encounter summary spreadsheet. If an error is found, the claim will be flagged as a correctness error in the appropriate "Error Found" column of the encounter summary spreadsheet.

The RBHAs must adjust all correctness errors found and resubmit to AHCCCS within thirty (30) days from the date the final letter was sent to the RBHAs.

Timeliness (ADHS System):

Any encounter for a clean paid claim that is not submitted to AHCCCS within 240 calendar days after the end of the month in which the service was rendered is considered a timeliness (AHCCCS System) error.

The number of days is calculated by subtracting the last day of the month in which the service was rendered from the AHCCCS system add date and the result of this calculation is auto-populated into the "Day Count (AHCCCS System)" column on the encounter summary spreadsheet.

Any reviewed claim that has been accepted into the AHCCCS system with a "Day Count (AHCCCS System)" greater than 240 days after the end of the month in which the service was rendered will be flagged with a Timeliness error in the appropriate "Error Found" column of the encounter summary spreadsheet.

If both a correctness and timeliness (AHCCCS System) error are found on a single encounter, only the correctness error is calculated into the score.

RBHAs must submit all clean paid claims to AHCCCS within 240 days after the end of the month in which the service was rendered.

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Timeliness (Claim Payment):

Any claim that is not paid to the provider, by the RBHA, within 90 calendar days from the date RBHA receives claim from provider is considered a timeliness (Claim Payment) error.

The number of days from the “Date RBHA received claim” to the “Date RBHA paid claim” date is calculated by subtracting the “Date RBHA received claim” from the “Date RBHA paid claim” date and the result of this calculation is auto-populated into the ‘Day Count (Claim Payment)’ column on the encounter summary spreadsheet.

Any claim that has been received by the RBHA with a “Day Count (Claim Payment)” greater than 90 days will be flagged with a Timeliness error in the appropriate ‘Error Found’ column of the encounter summary spreadsheet.

RBHAs must provide payment to providers for claims received within 90 days from the date RBHA receives claim from provider.

Scoring the Check Register Review

The RBHA’s Check Register Review score is calculated by dividing the number of correct claims by the total number of claims reviewed. If any omissions are identified during the course of the review, the score will automatically default to a Non Compliance 0% rating. Score and compliance ratings are based on the Score Rating table below. Corrective action will be requested as applicable.

Score Rating	
90-100%	Full Compliance
75-89%	Substantial Compliance
50-74%	Partial Compliance
0-49%	Non Compliance

Preliminary Findings

Within ten (10) business days from receipt of the check and claim copies, the OPS Representative will prepare and issue the preliminary findings. OPS will mail a hard copy of the Check Register Review Preliminary Letter (CR Attachment 5) and the Check Register Review Encounter Summary spreadsheet of the claims reviewed to the RBHA. An e-mail notification will also be sent to the RBHA with the Check Register Review Preliminary Letter and Check Register Review Encounter Summary spreadsheet attached.

Challenges

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The RBHAs have ten (10) business days to challenge the preliminary findings of a Check Register Review from the date of the preliminary letter. Challenges are to be e-mailed to the OPS e-mail box within the ten (10) business days allowed.

Final Score

OPS must take into consideration any timely challenges submitted by the RBHA before calculating the final score of the quarterly Check Register Review. The final score must be determined within five (5) business days from the date the OPS receives any challenges of the decision from the RBHA.

OPS will mail a hard copy of the Final letter to the RBHA stating the number of errors and the final score (CR Attachment 6). An e-mail notification will also be sent to the RBHA with the Check Register Review Final Letter and Check Register Review Encounter Summary spreadsheet attached.

Correction of Errors

It is the expectation of the Office of Program Support that all correctness and omission errors will be corrected and/or submitted within thirty (30) days from the date of the final letter. OPS will monitor the AHCCCS system to ensure corrections are made and omitted claims are submitted in a timely manner. If corrections and/or submissions of omitted encounters do not occur, an e-mail will be forwarded to the RBHA regarding the correction.

Additionally, adjustments of an encounter must be completed and accepted into the AHCCCS system no later than 240 calendar days after the end of the month in which the service was rendered to be considered timely.

Administrative Review Scoring

The RBHA's acceptance rates will be monitored and may be scored as part of the RBHA's yearly Administrative Review.

Check Register E-mail Request Template

Good Morning,

In accordance with the following schedule, the Office of Program Support is beginning the [*1st, 2nd, 3rd, etc.*] Quarter Fiscal Year 20XX Check Register Review process. Please submit Fee-For-Service (FFS) check registers for the months of [*e.g., January, February, and March 20XX*] to OPS@azdhs.gov by close of business, [*e.g. Friday April 15, 20XX*].

Quarterly Review Month Check Register Requested

[e.g. April 20XX 3rd Quarter, Fiscal Year 20XX]

Thank you.
Arizona Department of Health Services
Office of Program Support
ops@azdhs.gov

Check Register Claim Request

Quarter Reviewing: [Qtr Yr] Check Register Month Requested: [Qtr Month]
[RBHA Name]

Please provide ADHS with a copy of the third paid claim from each of the listed checks along with the Explanation of Benefits. If the identified check contains less than three paid claims, please provide a copy of the first paid claim.									
Check Number	Check Date	Vendor	Check Amount	Date Recv	Date Paid	CRN #	Notes		
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									

FFS Claims Request Template

Good Afternoon [RBHA],

Thank you for your response to the previous check register request. OPS has reviewed the check register for the quarter ending [Month 20XX], and has randomly selected a sample of checks associated with the Fee-For-Service (FFS) paid claims. The next step in the review process will be to examine the paid FFS claims. Please submit the third paid claim from each of the checks and the corresponding Explanation of Benefits listed on the attached spreadsheet. If the identified check contains less than three paid claims, please provide a copy of the first paid claim. This information should be submitted to the attention of the Office of Program Support by close of business [Day of week Month XX, 20XX].

Please use the following address to mail hard copies of the selected claims to OPS and to ensure timely and accurate delivery is made to OPS:

**Arizona Department of Health Services
Division of Behavioral Health Services
Office of Program Support
150 N. 18th Avenue, Suite 280
Phoenix, AZ 85007**

Thank you.
Arizona Department of Health Services
Office of Program Support
ops@azdhs.gov

CR Attachment 4

Check Register Review Encounter Summary Template

[illegible]

Check Register Review Preliminary Letter Template

[Date]

[Recipient]
[RBHA]
[Street Address]
[City, State Zip]

Dear [Dr. /Mr. /Ms.] [Recipient]:

The Division of Behavioral Health Services/Office of Program Support (DBHS/OPS) has concluded its preliminary findings of the [first, second, etc.] quarter, fiscal year [20XX] Fee-For-Service (FFS) Check Register Review. The claims in the attached Check Register Review Summary have been researched to determine if omission, correctness or timeliness (AHCCCS System) and timeliness (Claim Payment) errors exist. If a claim has both a correctness and timeliness (AHCCCS System) error, only the correctness error has been calculated in the findings. If any omissions were identified during the course of the review, the score was automatically defaulted to a 0% rating.

Type of Error	Encounters Reviewed	Number of Errors	Compliance Rate
Omission			%
Correctness			%
Timeliness (AHCCCS System)			%
Timeliness (Claim Payment)			%
Total			%

Score Rating	
90-100%	Full Compliance
75-89%	Substantial Compliance
50-74%	Partial Compliance
0-49%	Non Compliance

The preliminary score of this review is [] %, which represents [Score Rating] Compliance. Any challenges must be presented to OPS within ten (10) business days from the date of this letter. If you have any questions regarding your score or the Check Register Review process, please do not hesitate to contact OPS via e-mail at ops@azdhs.gov.

Sincerely,

[Name]
Claims and Encounters Office Chief

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CR Attachment 6

Check Register Review Final Letter Template

[Date]

[Recipient]
[RBHA]
[Street Address]
[City, State Zip]

Dear [Dr. /Mr. /Ms.] [Recipient]:

The Division of Behavioral Health Services/Office of Program Support (DBHS/OPS) has completed the [first, second, etc.] quarter, fiscal year 20XX Fee-For-Service (FFS) Check Register Review. The claims in the Check Register Review Summary were reviewed to determine if omission, correctness or timeliness (AHCCCS System) and timeliness (Claim Payment) errors exist. If a claim has both a correctness and timeliness (AHCCCS System) error, only the correctness error has been calculated in the findings. If any omissions are identified during the course of the review, the score will automatically default to a 0% rating.

Type of Error	Encounters Reviewed	Number of Errors	Compliance Rate
Omission			%
Correctness			%
Timeliness (AHCCCS System)			%
Timeliness (Claim Payment)			%
Total			%

Score Rating	
90-100%	Full Compliance
75-89%	Substantial Compliance
50-74%	Partial Compliance
0-49%	Non Compliance

The final score of this review is [] %, which represents [Score Rating] Compliance. It is the expectation of OPS that all correctness errors will be corrected and submitted, in addition to all omitted claims, to AHCCCS within 30 days from the date of this letter. If you have any questions regarding your score or the Check Register Review process, please do not hesitate to contact OPS via e-mail at ops@azdhs.gov.

Sincerely,

[Name]
Claims and Encounters Office Chief

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Coordination of Benefits

Introduction

RBHAs are required to take reasonable measures to determine the legal liability of third parties who may be responsible for payment of covered services.

Policy

RBHAs shall take reasonable measures to determine all legally liable parties if it establishes the probable existence of a third party or has information that establishes that third party liability exists. However, if the probable existence of third party liability cannot be established or third party liability benefits are not available to pay the claim at the time the claim is filed, the RBHA must process the claim. If a RBHA knows that the third party insurer will not pay the claim for a covered service due to untimely claim filing or as the result of the underlying insurance coverage (e.g., the service is not a covered benefit), the RBHA shall not deny the service, deny payment of the claim based on third party liability, or require a written denial letter if the service is medically necessary. The RBHA is required to reimburse providers for previously recouped monies if the provider was subsequently denied payment by the primary insurer based on untimely filing limits or lack of prior authorization and the member failed to disclose additional insurance coverage other than AHCCCS.

Administrative Review Scoring

The Coordination of Benefits process will be monitored and may be scored as part of the RBHA's yearly Administrative Review.

Claim Audit Process

The RBHAs must have a procedure to identify and timely recoup erroneously paid claims. The RBHA must implement systems at the clinic level to audit claims processing prior to payment, e.g., the RBHA audits 5% or high dollar claims prior to check issuance.

The RBHA will submit evidence of this process with the quarterly deliverables.

Administrative Review Scoring

The Claim Audit process will be monitored and may be scored as part of the RBHA's yearly Administrative Review.

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Title XIX/XXI Recoupment Request Policy

Introduction

The RBHAs are required submit a Recoupment Request and obtain approval from ADHS prior to initiating any single recoupment, as well as any cumulative recoupment, in excess of \$50,000 per Provider Tax Identification Number per contract year. In addition, any retrospective changes to contracted rates that may result in the adjustment or voiding and replacement of encounters must be pre-approved through the Office of Program Support.

Timeframes to be followed

- The RBHA will submit a Recoupment Request to Office of Program Support's mailbox at OPS@azdhs.gov. The Recoupment Request must comply with the requirements as specified in the AHCCCS Contractor Operations Manual, Chapter 400 section 412 Claims Reprocessing Policy.
- The Office of Program Support will acknowledge receipt of the request within two (2) days.
- The Office of Program Support will review the request to determine if it meets the requirements of the policy. The Office of Program Support will notify the RBHA of any missed requirements within five days of receipt.
- The RBHA will resubmit the request along with all other required files and documentation to OPS within thirty (30) days.
- The Office of Program Support will review all requests for recoupment, evaluating such factors as validity, accuracy, and efficiency of the RBHA's process.
- Office of Program Support will also evaluate the proposed recoupment for the purposes of minimizing provider hardship and inconvenience. ADHS will acknowledge all requests in writing through electronic mail upon receipt of the completed file. A written determination will be sent to the RBHA by electronic mail no later than thirty (30) days from the date of receipt of all required information from the RBHA.
- Any request to which no response is sent within the thirty (30) day timeframe above will be deemed approved by ADHS.
- Upon receipt of approval for recoupment from ADHS, the RBHA shall have no more than 120 days to complete the project and submit additional information regarding the recouped claims.

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Preparing the Recoupment Request

A. Single Recoupment in Excess of \$50,000

To obtain advanced approval from ADHS prior to initiating any single recoupment in excess of \$50,000 for each provider Tax Identification Number (TIN), the RBHA must submit through the Office of Program Support at ops@azdhs.gov a request as detailed below:

1. A letter explaining:
 - How the need for recoupment was identified
 - The systemic causes resulting in the need for recoupment
 - The process that will be utilized to recover the funds
 - Methods to notify the affected provider(s) prior to recoupment
 - The anticipated timeline for the project
 - The corrective actions that will be implemented to avoid future occurrences
 - Total recoupment amount, total number of claims, range of dates for the claims being recouped, and the total number of providers impacted
 - Other recoupment action specific to this provider within the contract year
2. An electronic file containing the following:
 - AHCCCS Member ID
 - Date of Service
 - Original Claim Number
 - Date of Payment
 - Amount Paid
 - Amount to be recouped
3. A copy of the written communication that will serve as prior notification to the affected provider(s)

B. Cumulative Recoupment in Excess of \$50,000 per Provider per Contract Year

The RBHAs must continuously track recoupment efforts for each provider TIN. When recoupment amounts for a provider TIN have or are forecasted to cumulatively exceed \$50,000 during a contract year, the RBHA must notify the Office of Program Support at

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ops@azdhs.gov at the time total recoupment is anticipated to exceed \$50,000 with the following information:

1. A detailed letter explaining:
 - How the need for recoupment was identified
 - The process that will be utilized to recover the funds
 - Methods to notify the affected provider(s) prior to recoupment
 - Cumulative recoupment amount, total number of claims, range of dates for the claims being recouped
2. An electronic file containing the following:
 - AHCCCS Member ID
 - Date of Service
 - Original Claim Number
 - Date of Payment
 - Amount Paid
 - Amount to be recouped
3. A copy of the written communication that will serve as prior notification to the affected provider(s)

C. Recoupment of Payments Initiated More than 12 Months from the Date of the Original Payment

The RBHA is prohibited from initiating recoupment of monies from a provider more than 12 months from the date of original payment of a clean claim unless prior approval is obtained from ADHS. To request prior approval from ADHS through the Office of Program Support, the RBHA must send to ops@azdhs.gov the following information:

1. A letter explaining:
 - How the need for recoupment was identified
 - The systemic causes resulting in the need for recoupment
 - The process that will be utilized to recover the funds
 - Methods to notify the affected provider(s) prior to recoupment
 - The anticipated timeline for the project
 - The corrective actions that will be implemented to avoid future occurrences
 - Total recoupment amount, total number of claims, range of dates for the claims being recouped, and the total number of providers impacted

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2. An electronic file containing each of the following:
 - AHCCCS Member ID
 - Date of Service
 - Original Claim Number
 - Date of Payment
 - Amount Paid
 - Amount to be Recouped
3. A copy of the written communication that will serve as prior notification to the affected provider(s)

Recoupment Process

Upon receipt of approval from ADHS, the RBHA shall have no more than 120 days to complete the project and submit the following to the Office of Program Support's mailbox at ops@azdhs.gov:

- Voided or replacement encounters (which must reach adjusted status) and the appropriate associated information for all impacted encounters for recouped claims

Upon completion of the recoupment project, the RBHA shall submit an electronic file of the recouped claims containing each of the following:

1. AHCCCS Member Identification Number
2. Date of Service
3. Original AHCCCS CRN
4. New AHCCCS CRN
5. AHCCCS Allowed Amount
6. Health Plan Allowed Amount
7. Health Plan Paid Amount
8. Provider Identification Number

The RBHA must submit the above information for each adjudicated encounter. AHCCCS will validate the submission of applicable voided and replacement encounters upon completion of this project. As a result of the adjudicated encounter data, AHCCCS may adjust related reinsurance payments, Title XIX or Prior Period Coverage reconciliation payments or any other amounts paid to the RBHA that are impacted by the recoupment.

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Refunding Process

Upon receipt of a refund from a provider, the RBHA shall have 120 days to void or replace encounters (which must reach adjudicated status) and submit the appropriate associated information of all impacted encounters for refunded claims. All voided or replaced encounters must reach adjudicated status no later than 120 days from the date of the refund.

The RBHA must also be able to identify the following for all refunds received and provide this information to ADHS upon request.

- The systemic causes resulting in the need for the refund
- The corrective actions that will be implemented to avoid future occurrences

Attestation

All documentation and data submitted by the RBHA for purposes of recoupment and refund activities must be certified by the RBHA as specified in the Balanced Budget Act of 1997 42 CFR 438.600 et seq. If it is determined that after the recoupment or refund action that information provided to ADHS is inaccurate, invalid, or incomplete, or that the RBHA failed to comply with any provision of this policy, the RBHA may be subject to corrective action, up to and including sanction under the Acute Care Contract, Paragraph 72 or the ALTCS Contract, Paragraph 80.

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Non- Title XIX/XXI Recoupment Request Policy

Introduction

The RBHAs are required to submit a Recoupment Request to obtain advanced approval from the Arizona Department of Health Services (ADHS) prior to initiating any single recoupment, as well as any cumulative recoupment, in excess of \$50,000 per Provider Tax Identification Number per contract year. In addition any retrospective changes, to contracted rates that may result in the adjustment or voiding and replacement of encounters must be pre-approved through the Office of Program Support.

Timeframes to be followed

- The RBHA will submit a Recoupment Request to Office of Program Support's mailbox at OPS@azdhs.gov. The Recoupment Request must comply with similar requirements as specified in the AHCCCS Contractor Operations Manual, Chapter 400 section 412 Claims Reprocessing Policy.
- The Office of Program Support will acknowledge receipt of the request within two (2) days.
- The Office of Program Support will review the request to determine if it meets the requirements of the policy. The Office of Program Support will notify the RBHA of any missed requirements within five days of receipt.
- The RBHA will resubmit the request along with all other required files and documentation to OPS within thirty (30) days.
- When all the requirements of the policy are met, the Office of Program Support will forward the request to ADHS Compliance Officer.
- The Office of Program Support will review all requests for recoupment, evaluating such factors as validity, accuracy and efficiency of the RBHA's process. The Office of Program Support will also evaluate the proposed recoupment for the purposes of minimizing provider hardship and inconvenience. And will acknowledge all requests in writing through electronic mail upon receipt of the completed file. A written determination will be sent to the RBHA by electronic mail no later than thirty (30) days from the date of receipt of all required information from the RBHA.
- Any request to which no response is sent within the thirty (30) day timeframe above will be deemed approved by ADHS.
- Upon receipt of approval for recoupment from ADHS, the RBHA shall have no more than 120 days to complete the project and submit additional information regarding the recouped claims.

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Preparing the Recoupment Request

D. Single Recoupment in Excess of \$50,000

To obtain advance approval from the ADHS prior to initiating any single recoupment in excess of \$50,000 for each provider Tax Identification Number (TIN), the RBHA must submit through the Office of Program Support at ops@azdhs.gov a request as detailed below:

1. A letter explaining:
 - How the need for recoupment was identified
 - The systemic causes resulting in the need for recoupment
 - The process that will be utilized to recover the funds
 - Methods to notify the affected provider(s) prior to recoupment
 - The anticipated timeline for the project
 - The corrective actions that will be implemented to avoid future occurrences
 - Total recoupment amount, total number of claims, range of dates for the claims being recouped, and the total number of providers impacted.
 - Other recoupment action specific to this provider within the contract year
2. An electronic file containing the following:
 - CIS Member ID
 - Date of Service
 - Original Claim Number
 - Date of Payment
 - Amount Paid
 - Amount to be recouped
3. A copy of the written communication that will serve as prior notification to the affected provider(s).

E. Cumulative Recoupment in Excess of \$50,000 per Provider per Contract Year

The RBHAs must continuously track recoupment efforts for each provider TIN. When recoupment amounts for a provider TIN have or are forecasted to cumulatively exceed \$50,000 during a contract year, the RBHA must notify the assigned ADHS Operations and Compliance Officer through the Office of Program Support at ops@azdhs.gov at the time total recoupment is anticipated to exceed \$50,000 with the following information:

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1. A detailed letter explaining:
 - How the need for recoupment was identified
 - The process that will be utilized to recover the funds
 - Methods to notify the affected provider(s) prior to recoupment
 - Cumulative recoupment amount, total number of claims, range of dates for the claims being recouped
2. An electronic file containing the following:
 - CIS Member ID
 - Date of Service
 - Original Claim Number
 - Date of Payment
 - Amount Paid
 - Amount to be recouped
3. A copy of the written communication that will serve as prior notification to the affected provider(s)

F. Recoupment of Payments Initiated More than 12 Months from the Date of the Original Payment

The RBHA is prohibited from initiating recoupment of monies from a provider more than 12 months from the date of original payment of a clean claim unless prior approval is obtained from ADHS. To request prior approval from ADHS through the Office of Program Support, the RBHA must send to ops@azdhs.gov the following information:

1. A letter explaining:
 - How the need for recoupment was identified
 - The systemic causes resulting in the need for recoupment
 - The process that will be utilized to recover the funds
 - Methods to notify the affected provider(s) prior to recoupment
 - The anticipated timeline for the project
 - The corrective actions that will be implemented to avoid future occurrences
 - Total recoupment amount, total number of claims, range of dates for the claims being recouped, and the total number of providers impacted

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2. An electronic file containing each of the following:
 - CIS Member ID
 - Date of Service
 - Original Claim Number
 - Date of Payment
 - Amount Paid
 - Amount to be Recouped
3. A copy of the written communication that will serve as prior notification to the affected provider(s)

Recoupment Process

Upon receipt of approval from ADHS, the RBHA shall have no more than 120 days to complete the project and submit the following to the Office of Program Support's mailbox at ops@azdhs.gov:

- Voided or replacement encounters (which must reach adjusted status) and the appropriate associated information for all impacted encounters for recouped claims.

Upon completion of the recoupment project, the RBHA shall submit an electronic file of the recouped claims containing each of the following:

1. CIS Member Identification Number
2. Date of Service
3. Original ICN
4. New ICN
5. Health Plan Allowed Amount
6. Health Plan Paid Amount
7. Provider Identification Number

The RBHA must submit the above information for each adjudicated encounter. ADHS will validate the submission of applicable voided and replacement encounters upon completion of this project. As a result of the adjudicated encounter data, ADHS may adjust related reinsurance payments, Non-Title XIX/XXI or Prior Period Coverage reconciliation payments or any other amounts paid to the RBHA that are impacted by the recoupment.

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Refunding Process

Upon receipt of a refund from a provider, the RBHA shall have 120 days to void or replace encounters (which must reach adjudicated status) and submit the appropriate associated information of all impacted encounters for refunded claims. All voided or replaced encounters must reach adjudicated status no later than 120 days from the date of the refund.

The RBHA must also be able to identify the following for all refunds received and provide this information to ADHS upon request.

- The systemic causes resulting in the need for the refund
- The corrective actions that will be implemented to avoid future occurrences

Attestation

All documentation and data submitted by the RBHA for purposes of recoupment and refund activities must be certified by the RBHA as specified in the Balanced Budget Act of 1997 42 CFR 438.600 et seq. If it is determined that after the recoupment or refund action that information provided to ADHS is inaccurate, invalid, or incomplete, or that the RBHA failed to comply with any provision of this policy, the RBHA may be subject to corrective action including sanction determined by the sanction committee guided by Sanction Protocol.

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Miscellaneous Encounter Clarifications

Correct Reporting of Ancillary Charges

Incorrect Billing

Ancillary line should not be submitted with zero/blank units or dollars.

Line	Rev Cd	Units	Billed	NonCovChg	Paid	Description
01	0134	5	2960.00	000.00		Psych/3&4 Bed
02	0251	1	0.00	000.00		Drugs/Generic
03	0301	32	0.00	000.00		Lab/Chemistry
04	0302	1	0.00	000.00		Lab/Immunology
05	0305	1	0.00	000.00		Lab/Hematology
Total			2960.00		2960.00	

Line	Rev Cd	Units	Billed	NonCov Chg	Paid	Description
01	0134	5	3650.00			Psych/3&4 Bed
02	0251	1	450.00			Drugs/Generic
03	0301	32	400.00			Lab/Chemistry
04	0302	1	150.00			Lab/Immunology
05	0305	1	150.00			Lab/Hematology
Total			4800.00		2960.00	Total paid for entire claim

Correct Billing

The providers should bill UBs to the RBHA exactly as they would bill any private insurance carrier. Ancillary revenue codes, units, and amounts must be reported on all inpatient UBs. The rates reported should not be the contracted amount or expected to payment amount but the actual amount of the service.

Line	Rev Cd	Units	Billed	NonCov Chg	Paid	Description
01	0134	5	3650.00	690.00		Psych/3&4 Bed
02	0251	1	450.00	450.00		Drugs/Generic
03	0301	32	400.00	400.00		Lab/Chemistry
04	0302	1	150.00	150.00		Lab/Immunology
05	0305	1	150.00	150.00		Lab/Hematology
Total			4800.00		2960.00	Total paid for entire claim

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Correct Reporting of Same Day Admit/Discharge Encounters

Inpatient encounters for clients who are admitted and discharged on the same date will be allowed for ancillary services only. The bill type submitted on the claim/encounter must be an inpatient bill type and the revenue code must be reported with an appropriate HCPCS code if indicated by the AHCCCS reference screen RF774. These UB04 inpatient encounters with the same start and end date must be submitted as follows:

Line	Rev Cd	Units	Billed	NonCov Chg	Paid	Description
01	0134	1	1200.00	1200.00	0.00	Psych/3&4 Bed
02	0251	1	450.00	0.00	450.00	Drugs/Generic
03	0301	32	400.00	0.00	400.00	Lab/Chemistry
04	0302	1	150.00	0.00	150.00	Lab/Immunology
05	0305	1	150.00	0.00	150.00	Lab/Hematology
		Total	2350.00		1150.00	Total paid for claim

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Grievance and Appeals Research (GA)

Introduction

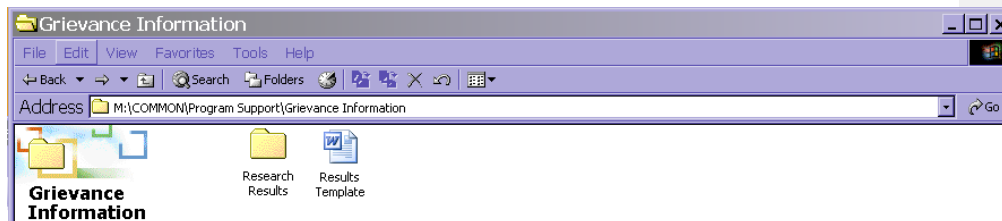
The Branch for Program Operations assists the Office of Grievance and Appeals in researching the AHCCCS claim processing of appeals filed by providers.

Referral Process

Providers submit appeals to the ADHS/DBHS Office of Grievance and Appeals where they are reviewed to determine if ADHS or the RBHA is responsible. If it is determined that ADHS is responsible, the appeal is assigned a docket number and a confirmation of receipt letter is sent to the provider. When the appeal is regarding the incorrect processing or denial of a claim a *Provider Claim Dispute Research Request* (GA Attachment 1) form is completed. A copy of the information submitted by the provider and the *Provider Claim Dispute Research Request* form is delivered to the Branch for Program Operations for research.

Research Initiated

Upon receipt of the research request, the Branch for Program Operations will utilize the AHCCCS PMMIS claim system to determine if the claim was processed correctly. Each claim submitted to AHCCCS by the provider for the service identified in the appeal must be addressed. A *Branch for Program Operations Grievance Research* form (GA Attachment 2) will be completed and screen prints from PMMIS will be attached to support findings. A template of the *Branch for Program Operations Grievance Research* form can be found at M:\COMMON\Program Support\Grievance Information\Results Template.



At a minimum the following PMMIS screen prints must be attached to the *Branch for Program Operations Grievance Research* form:

Denied Claims

- CL144 (XCLAM), Claim Browse Gateway

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Enter recipient ID, provider ID, and dates of service then filter by typing either filter or “fil” in the CMD field to display only claims related to the grievance.

- CL064 (SVTOP), Claim Service-Topics
Place the cursor on the specific claim found on the Claim Browse Gateway screen and enter “V,” this is the claim that will be displayed on CL064.
- CL180, CL181 or CL182 (CLMFA, CLMFB, CLMFC), claim view screens
The claim view can also be accessed by placing a “V” on the Condensed Claim View line of the Claim Service Topics screen.
- CL108 (SACT), Scorecard-work Actions
An explanation of the denial code can be displayed by placing the cursor on the reason code and pressing the F3 key. Each denial reason should be addressed.

The scorecard can also be accessed by placing a “V” on the Latest Work Action line of the Claim Service Topics screen.

- All PMMIS screens necessary to support the decision.

Incorrectly Paid Claims

- CL144 (XCLAM), Claim Browse Gateway
Enter AHCCCS ID, provider ID, and dates of service then filter to display only claims related to the grievance.
- CL064 (SVTOP), Claim Service-Topics
Place cursor on the specific claim found on the Claim Browse Gateway screen and enter “V”, this is the claim that will be displayed on CL064.
- CL180, CL181 or CL182 (CLMFA, CLMFB, CLMFC), claim view screens
The claim view can also be accessed by placing a “V” on the Condensed Claim View line of the Claim Service Topics screen.
- CL085 (ACACC), Claim Accounting Detail
This screen will display the actual payment and payment date.
- CL075 (ACPRC), Claim Pricing Detail
This screen will display how AHCCCS calculated the payment.
- All PMMIS screens necessary to support the decision.

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Additionally, any PMMIS screen used to make a determination about the processing of the claim should be attached. These screens may include, but are not limited to:

- CL233 (BCASE), Behavioral Health Case Browse
Enter the AHCCCS ID and dates of service then filter to display any prior authorizations issued. When the appropriate prior authorization is found enter an “E” on the line to see details.
- CL234 (BEVNT), BH Case-Event Browse
Displays all of the sequences authorized; enter an “E” to view a specific date range.
- CL235 (BACTV), BH Event-Activity Browse
The Activity will display the actual diagnosis, dates and procedure authorized. Entering a “V” in the SEL field for the line will further identify who entered the authorization and the date issued.

***Note:** All prior authorization discrepancies should be thoroughly researched including reviewing ADHS internal files.*

- CM097, Client Contact Tracking System
Screen is used to identify any phone call received by AHCCCS regarding the claim in question. Enter either “P” and the Provider ID or “R” and the Recipient (client) ID. The system will display 30 days at a time. Search back from the current date to the date of the first claim submission.
- RP216/RP285, Inquire BHS/FYI Data
Screen is used to verify client has behavioral health enrollment in a tribe on the date of service. RP285 is used to look up claims with dates of enrollment prior to 9/1/07.
- Image of the Claim
If there is a discrepancy between the keyed claim and the claim copy submitted by the provider in the grievance packet AHCCCS should be contacted to request a copy the claim submitted to AHCCCS.
- Any PMMIS screen, web-site or policy may be used to support a decision and should be included in the Office of Program Support response.

Non-Docketed Referrals

In addition to the above referrals, the Branch for Program Operations may receive non-docketed referrals. These referrals are sent to the Branch for Program Operations to determine if the grievance should be referred to the RBHA or should receive a docket number to be processed as a Tribal grievance.

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When researching non-docketed referrals, the following AHCCCS PMMIS screens should be utilized to determine responsibility for the grievance.

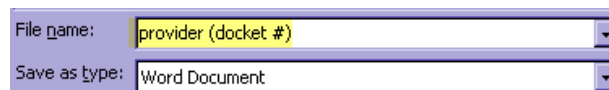
1. RP216, Inquire BHS/FYI Data
Screen is used to verify client has behavioral health enrollment and to determine the responsible T/RBHA.
2. RP285
Screen is used to verify client has TXIX eligibility and behavioral health coverage for date(s) of service.

Response Due Date

Each referral from the Grievance and Appeals Unit will include a “response is due no later than” date. The documented research must be completed by the Branch for Program Operations and returned to the Grievance and Appeals Unit on or before the indicated date. If additional time is needed coordination should take place between the Branch for Program Operations and the Office of Grievance and Appeals.

Saving Research Results

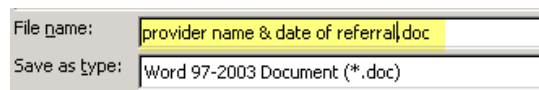
Every *Branch for Program Operations Grievance Research* form when completed should be saved in the following folder M:\COMMON\Program Support\Grievance Information\Research Results. The document should be saved by listing the provider and docket number as the file name.



File name: provider (docket #)

Save as type: Word Document

Not-docketed results should be saved in the following folder M:\COMMON\Program Support\Grievance Information\Research Results\Not docketed. The document should be saved by listing the provider and date of referral as the file name.



File name: provider name & date of referral.doc

Save as type: Word 97-2003 Document (*.doc)

Hearing

The Office of Grievance and Appeals will review the findings from the Branch for Program Operations and apply any legal statutes to determine the outcome of the Grievance. The provider will be advised of the final decision and may request a hearing

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if not pleased with the ruling. In the event the provider requests a hearing the Branch for Program Operations reviewer may be required to testify.

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GA Attachment 1



Division of Behavioral Health Services

Office of Grievance and Appeals

150 North 18th Avenue, Suite 230

Phoenix, Arizona 85007

(602) 364-4575

(602) 364-4591 FAX

Internet: www.azdhs.gov

JANICE K. BREWER, GOVERNOR

WILL HUMBLE, DIRECTOR

PROVIDER CLAIM DISPUTE RESEARCH REQUEST

TO:

FROM:

DATE: _____

RE: PROVIDER: _____

DOCKET#: _____

Patient Name: _____

Please REVIEW the following issue(s) and provide a recommendation regarding how G&A is to respond to the Provider. Anything used in formulating that decision (prior authorization screens, denial letters, policies, rules, etc.) should be referenced, and the documentation needs to be copied for the file record. Thank you.

ISSUE(S):

Non payment of claim. _____

A response is needed by no later than: _____.

Thank you.

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GA Attachment 2

Branch for Program Operations Grievance Research

The Branch for Program Operations has completed reviewing the referred grievance and the following are the results of that research. All resolutions are based solely on claims processing guidelines and do not supersede a denial of the claim for other legal issues.

Provider:
Provider ID:
Docket #:
OPS Analyst:
Phone #:
Client Name:
AHCCCS ID:
Date(s) of Service:

AHCCCS CRN:
Denial Reasons:
Last Denial Date:

Resolution:

\$ Owed: \$

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T/RBHA Monitoring

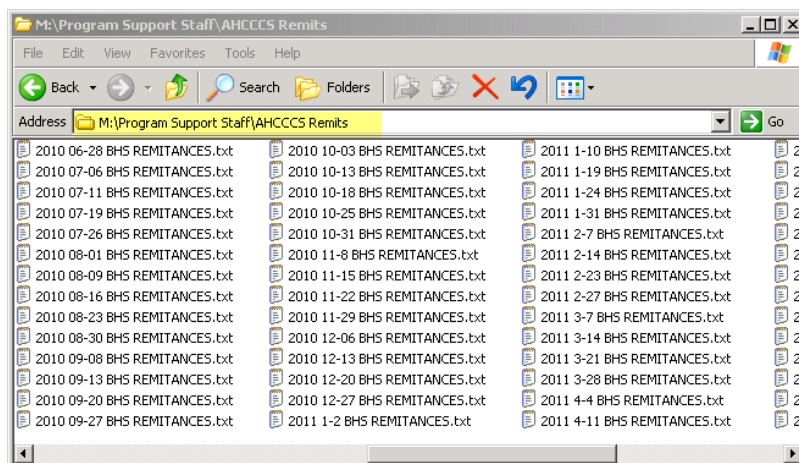
AHCCCS Remittance Advice

Weekly AHCCCS places a complete copy of the remittance advice for all Behavioral Health claims on the Control D web site. Control D is accessed at the following location. OPS staff uses the same User Name and Password that is used to access PMMIS; however, staff must have Control D security granted by AHCCCS.

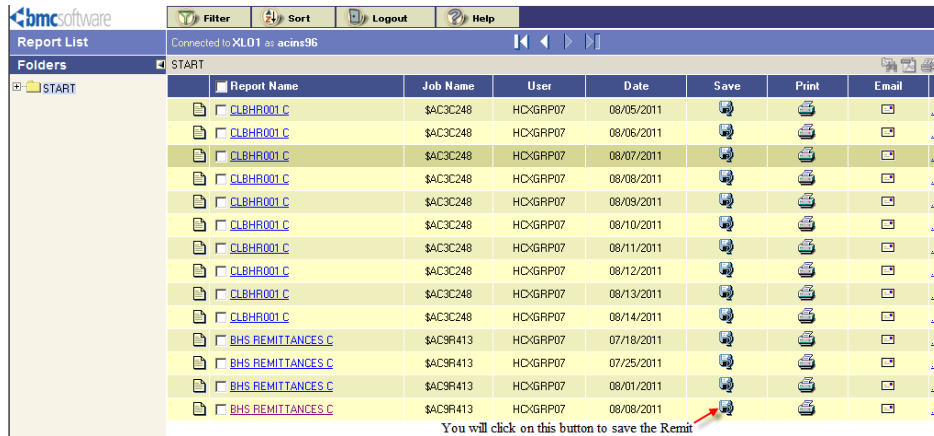
<http://azctrl01.azdoa.gov/wa/bmc-ctd-wa-cgi.exe?RequestType=LoginWindow>



The remittance advice must be saved into the Program Support Staff shared folder. All remits are named using the same naming convention.



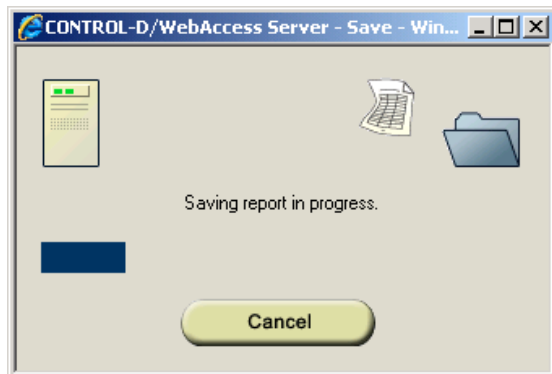
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Report Name	Job Name	User	Date	Save	Print	Email
CLBHR001 C	\$AC3C248	HCXGRP07	08/05/2011			
CLBHR001 C	\$AC3C248	HCXGRP07	08/06/2011			
CLBHR001 C	\$AC3C248	HCXGRP07	08/07/2011			
CLBHR001 C	\$AC3C248	HCXGRP07	08/08/2011			
CLBHR001 C	\$AC3C248	HCXGRP07	08/09/2011			
CLBHR001 C	\$AC3C248	HCXGRP07	08/10/2011			
CLBHR001 C	\$AC3C248	HCXGRP07	08/11/2011			
CLBHR001 C	\$AC3C248	HCXGRP07	08/12/2011			
CLBHR001 C	\$AC3C248	HCXGRP07	08/13/2011			
CLBHR001 C	\$AC3C248	HCXGRP07	08/14/2011			
BHS REMITTANCES C	\$AC9R413	HCXGRP07	07/18/2011			
BHS REMITTANCES C	\$AC9R413	HCXGRP07	07/25/2011			
BHS REMITTANCES C	\$AC9R413	HCXGRP07	08/01/2011			
BHS REMITTANCES C	\$AC9R413	HCXGRP07	08/08/2011			

You will click on this button to save the Remit

You will see the below screen while the remit is saving to the location designated.



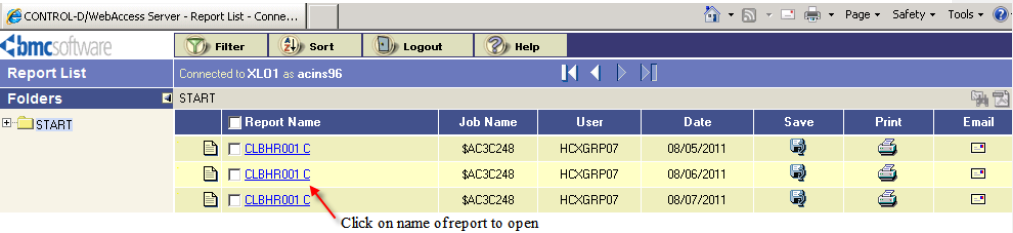
Reviewing the remittance advice will reveal services paid that are not covered by behavioral health and will also identify any unusually high denials. In the event that a potential fraud situation is identified the reviewer should discuss the findings with their supervisor or manager as appropriate.

AHCCCS Enrollment Denial Report

Daily AHCCCS places a report of all claims that have denied because the client did not have active behavioral health enrollment for the date(s) of service (RP216) on the Control D web site. Control D is accessed at the following location. You will use the same User Name and Password that you use to access PMMIS however you must have Control D security granted by AHCCCS.

<http://azctrl01.azdoa.gov/wa/bmc-ctd-wa-cgi.exe?RequestType=LoginWindow>

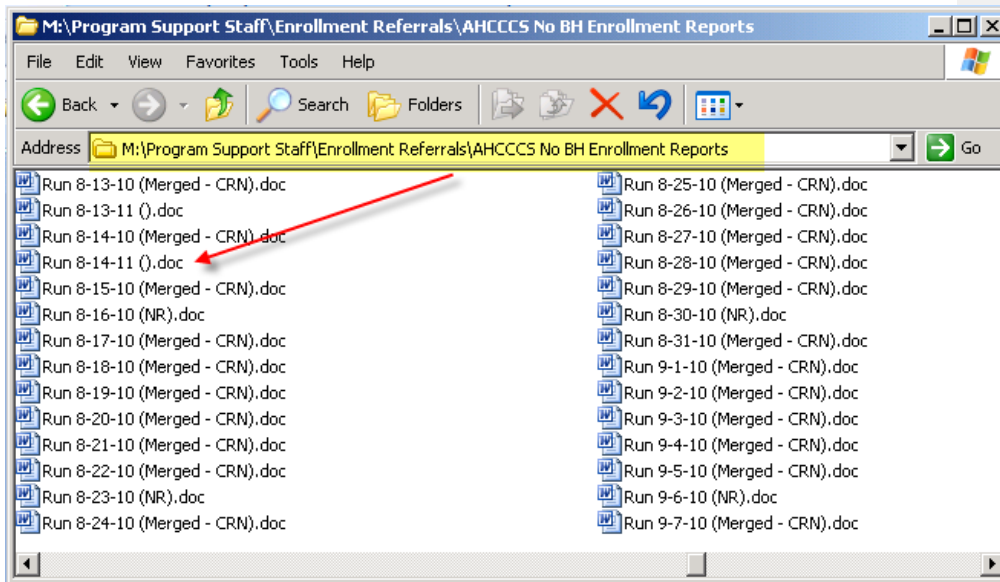
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The report appears and can be copied to a word document to be saved in the Program Support share folder.

REPORT ID: CLBHR001		ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM						PAGE: 1	
PROGRAM #: CLBHL001		CLAIMS WITH BEHAVIORAL HEALTH EDIT H210 OR L103 AND NO BHS FYI SITE CODE						RUN: 08/14/11	
		FOR 08/13/2011						17:08	
EDIT		PRIMARY		R E C I P I E N T			P R O V I D E R		
CLAIM	NUMBER	DATES OF SERVICE	DIAG	NAME	ID	DOB	NAME	ID	
11223000072801	L103.3	07/14/2011-07/14/2011	300.11		A65600442	08/26/1993	PETERSON/KAREN E.	222350	
11223500218701	L103.3	08/05/2011-08/05/2011	291.81		A51550474	07/15/1970	MANGUBAT/CHUCK G.	363226	
11223500218801	L103.3	08/06/2011-08/06/2011	291.81		A51550474	07/15/1970	MANGUBAT/CHUCK G.	363226	
11223500235201	L103.3	07/05/2011-07/05/2011	307.81		A16884237	07/03/1973	ISKYAN/KARA M.	526459	
11223500237501	L103.3	08/05/2011-08/05/2011	310.2		A65270479	12/20/1996	MURILLO/ROBERTO Q.	238916	
11224500041101	L103.5	03/02/2011-03/02/2011	295.70		A65519867	10/09/1969	LABORATORY CORP OF AMER	050154	
11224500041301	L103.5	07/11/2011-07/11/2011	295.30		A76520071	08/20/1954	LABORATORY CORP OF AMER	050154	
11224500170201	L103.5	08/01/2011-08/01/2011	309.28		A13861626	10/16/1993	FOUR DIRECTIONS LLC	308281	
11224500170202	L103.5	08/01/2011-08/01/2011	309.28		A13861626	10/16/1993	FOUR DIRECTIONS LLC	308281	
11224500170203	L103.5	08/01/2011-08/01/2011	309.28		A13861626	10/16/1993	FOUR DIRECTIONS LLC	308281	
11224500170204	L103.5	08/01/2011-08/01/2011	309.28		A13861626	10/16/1993	FOUR DIRECTIONS LLC	308281	
11224500170205	L103.5	08/01/2011-08/01/2011	309.28		A13861626	10/16/1993	FOUR DIRECTIONS LLC	308281	
11224500219101	L103.5	07/30/2011-07/30/2011	309.4		A53152512	07/21/2004	ZAREPHATH INC.	529388	
11224500223801	L103.5	07/30/2011-07/30/2011	309.4		A53152512	07/21/2004	ZAREPHATH, INC.	531658	
11224500223802	L103.5	07/30/2011-07/30/2011	309.4		A53152512	07/21/2004	ZAREPHATH, INC.	531658	
11224500223803	L103.5	07/30/2011-07/30/2011	309.4		A53152512	07/21/2004	ZAREPHATH, INC.	531658	
COUNT		16							

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Reviewing the Report

Each denied claim will be reviewed against the PMMIS screens

CL108 (Scorecard) used to determine the reasons the claim has denied. Claims that have denied correctly (only edits L103 or H210) because the client should have behavioral health enrollment with a tribe will need the enrollment added to RP216 as appropriate.

```
NOT ENTITLED TO BEHAVIORAL HEALTH SRV; SERVICE NOT INPATIENT PSYCH
TR: CL108 SACT ACT: _ SCORECARD - WORK ACTIONS USER-ID: 691 08/15/11
CMD: 10:33:08
CLED3006
```

```
CLAIM NUMBER: 112230000728 FORM: A
SCORE NUMBER: 01
CLEAN CLAIM DATE: 08/11/2011
ADJUDICATION STATUS: DENIED
```

LN	ACTION	SEL	NO	GROUP	FUNCTION	DESC	REASON	SOURCE	ORIG	DATE	PRTY	ACTION	DATE	USR	BYF	FLG
-	00	004	PAY	CLAIM/LINE	(APPRO	SA001	SA001	08/13/2011	10							
-	01	008	HOLD	CLAIM		L136.1	L136.1	08/13/2011	17						O	
-	01	003	DENY	CLAIM/LINE		L013.3	L013.3	08/13/2011	70						D	
-	01	003	DENY	CLAIM/LINE		L103.3	L103.3	08/13/2011	70							

RP216 (Inquire BHS/FYI Data) used to see if any previous or future behavioral health enrollment existed.

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```

3018 RECORD(S) NOT FOUND
TR: RP216 ACT: I          AHCCCS - RECIPIENT      USER-ID: 6$1      08/15/11
NTR:                     INQUIRE BHS/FYI DATA    10:36:14
                                           RP04L016

A123456789 Donald Duck          SEX M DOB 08/26/1993 DOD

TYPE   BEGIN   END   S CHG   RB   SM   DATE   LAST   MOD
ID     DATE    DATE  T RSN   HA C   I   CIS ID  ADDED  DATE  USR

```

RP285 (Inquire Eligibility and Enrollment) used to determine if TXIX eligibility and behavioral health eligibility exists for date(s) of service.

```

TR: RP285 ACT: I          AHCCCS - RECIPIENT      USER-ID: 6$1      08/15/11
NTR:                     INQUIRE ELIGIBILITY AND ENROLLMENT 10:39:35
                                           RP02L085

A123456789 Donald Duck          SEX M DOB 08/26/1993 DOD

                                ELG      COMB BEG      COMB END
                                KEY      DATE          DATE
                                900      06/01/2010    08/31/2011
                                900      01/01/2008    07/31/2009

HEALTH PLAN/      ENROLLMENT      ENROLLMENT      RATE      ENRL
CSA/CTRT TYP      BEGIN DATE      END DATE        CODE      TYP      STA
000850 13 U        08/22/2010      08/21/2010      1014      RB      A
000850 13 U        06/01/2010      07/31/2009      1014      RA      A
000850 13 U        01/29/2009      01/28/2009      1014      RA      A
000850 13 U        01/01/2009      12/31/2008      1014      RA      A
000850 13 U        01/01/2008      12/31/2008      1014      RB      A

```

RP135 (Demographic Inquire) if the client has TXIX eligibility and behavioral health eligibility for the date(s) of service this screen is used to determine if the client should be TRBHA or RBHA enrolled.

```

TR: RP135 ACT: I          AHCCCS - RECIPIENT      USER-ID: 6$1      08/15/11
NTR:                     DEMOGRAPHIC INQUIRE    10:41:55
                                           RP01L035

A123456789 Donald Duck          SEX M DOB 08/26/1993 DOD

HOME ADDRESS      RES CTY: MARICOPA      HEAD OF HOUSE?: N
24 W TONTO ST     FIS CTY: MARICOPA      ON RESERVATION?: N
                                SSN:
PHOENIX           CASE ID: 073           OTHER RECORDS?
AZ 85009          RACE: CAUCASIAN/WHITE SPECIAL PGMS:
                                TRIBE ID:
MAILING ADDRESS   MAR STA: UNKNOWN/UNSPECIFIED MEDICARE:
24 W TONTO ST     LANG: SPANISH          THIRD PTY CHG:
                                LANG SRC: AZTECS       ALTERNATE ID: Y
PHOENIX           CITIZEN: OT UNDOCUMENTED MEDICAL COND:
AZ 85009          CITIZEN SRC: AZ        CORRESPONDENCE: Y
                                CARE LVL:
                                FACILITY:
                                           CO-PAY: N

```

If it is determined that behavioral health enrollment needs to be updated on RP216 a referral will either be made to DBHS/ITS department or AHCCCS. If the enrollment is for the only T/RBHA that already exists on RP216 or of no other enrollment is present the referral can be sent to DBHS IT. If the enrollment needed is to be inserted prior to existing enrollment for another T/RBHA the referral must be sent to AHCCCS.

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AHCCCS or DBHS IT Manual Enrollments

AHCCCS or DBHS IT Manual Enrollments									
AHCCCS ID	Last Name	First Name	Begin Dt	End Dt	Chg Rsn	Site	Category	BHMIS ID	Additional Instructions (if necessary)

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AHCCCS Communications

Introduction

Periodically, AHCCCS sends a communication to advise health plans/providers of claim/encounter processing changes or other important information.

ADHS/DBHS Process

Upon receipt of an AHCCCS Communication the Office of Program Support reviews the content to determine any behavioral health impact on T/RBHA or their providers. If it is determined that the communication contains information that needs to be shared with the T/RBHAs, the information will be distributed through the OPS mailbox.

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Sample Selection Process

The RBHA should ultimately review all providers over time with special attention paid to poor performing providers. Providers that consistently fail their data validation audits must receive technical assistance from the RBHA and follow up audits until the provider is able to pass an audit. Provider refers to all providers under contract with a RBHA (including single case agreements) or a RBHA network that deliver services to clients (any provider that the RBHA will receive a claim/encounter from). The number of clients/charts to be reviewed must be not less than 20 or 100% of the clients for provider selected. The Data Validation Specialist will review all services in the medical record for the review quarter.

Exit Interview

The RBHA is required to perform an exit interview with each provider at the time of the review. The Data Validation Specialist(s) should be prepared to explain any error or issue discovered during the audit with the provider. In addition the RBHA must provide any technical assistance needed or requested by the Provider. The following evidence will be submitted as a quarterly deliverable:

- Sign-in sheets for any training that took place in the previous quarter
- A brief description of the training provided

OPS Data Validation Audit Program and Follow-up

Introduction

On a routine basis, the Bureau of Corporate Compliance (BCC) will perform an Encounter Data Validation Ride-Along Audit of each RBHA. The purpose of the Encounter Data Validation Ride-Along (RA) Program is to evaluate the current processes of the Contractor to ensure that they are accurately and thoroughly performing effective data validation reviews.

The RA Program also gives the ADHS/DBHS/BCC a presence in the community to routinely meet with RBHA staff, provide increased oversight, technical assistance and provide clarification, as needed to maintain the program's integrity.

The designated BCC lead will accompany the RBHA during the RBHA's regularly scheduled data validation audit. BCC will coordinate with OPS to ensure audit findings are in agreement. OPS will review audit findings for possible follow-up. If noticeable discrepancies are identified, OPS will perform a desk audit of a sample from the RBHA's recent data validation audit.

Sample Selection Process

The sample size and methodology is calculated based on the results of the Data Validation audit. The sample size indicates the number of medical records OPS intends to review for the follow-up data validation study.

Medical Record Collection Process

OPS will prepare an email to notify the RBHA about the data validation follow-up process and its requirements. The RBHA/provider/facility must comply with the request and submit records to OPS by the date specified.

Type of Errors Examined

ADHS/DBHS OPS will review the medical records to determine what services the clients received. The services received will be compared to the encounters submitted to determine what types of errors, if any, exist. To comply with CMS requirements any or all of three types of errors may be examined.

- *Correctness* is an error assessed when the dates of service, procedure code and or diagnosis code in the encounter were incorrectly coded according to the medical documentation

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- *Timeliness* is an error assessed when the encounter is received by AHCCCS more than 240 days after the end of the month in which the service was rendered, or the effective date of the enrollment
- *Omission* is an error assessed when provider documentation indicates that medical services were rendered, but an encounter was never received at AHCCCS.

Preliminary Report Distribution, Review and Challenge

A preliminary report will be prepared and will be distributed to the RBHA. This is the only opportunity that the RBHA has to challenge the errors identified by OPS. The RBHA should review the preliminary error report and perform a comparison to data from the client's medical records and/or the RBHA's system. Each challenge must be supported by additional documentation. Types of additional documentation include, but are not limited to PMMIS screen prints; CIS screen prints, and screen prints from the RBHA's internal system.

All documentation required to support the challenge must be submitted to the Office of Program Support by the date specified. If the documentation does not support the challenge, the challenge will not be considered and the error will stand.

Final Report

The OPS will review the challenges and documentation submitted. This review will result in a final report that is distributed to the appropriate RBHA. The RBHA will be required to prepare a corrective action plan to assure the problems identified will be corrected.

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AHCCCS Study

Introduction

The Centers for Medicare and Medicaid Services (CMS) requires AHCCCS to oversee and submit progress reports on the encounter data collection process. AHCCCS performs yearly data validation studies to meet this requirement. All AHCCCS T/RBHAs and subcontractors are contractually required to participate in this process. In addition to meeting the CMS requirement, the data validation studies enable AHCCCS to monitor and improve the quality of encounter data.

Sample Selection Process

The sample size and methodology is re-calculated each year. The sample size indicates the number of encounters/services AHCCCS intends to review for the data validation study.

Medical Record Collection Process

AHCCCS will prepare a letter to notify the RBHA/subcontractor about the data validation process and its requirements. The RBHA/provider/facility must comply with the request and submit records to AHCCCS by the date specified.

Type of Errors Examined

AHCCCS will review the files to determine what services the clients received. The services received will be compared to the encounters submitted to determine what types of errors, if any, exist. To comply with CMS requirements any or all of three types of errors may be examined.

- *Correctness* is an error is assessed when the dates of service, procedure code and or diagnosis code in the encounter were incorrectly coded according to the medical documentation
- *Timeliness* is an error is assessed when the encounter is received by AHCCCS more than 240 days after the end of the month in which the service was rendered, or the effective date of the enrollment
- *Omission* is an error is assessed when provider documentation indicates that medical services were rendered, but an encounter was never received at AHCCCS.

Preliminary Report Distribution, Review and Challenge

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A preliminary report will be prepared and will be distributed to each RBHA. This is the only opportunity that the RBHA/provider has to challenge the errors identified by AHCCCS. The RBHA is responsible for identifying any errors that they want to challenge in the AHCCCS preliminary report. The RBHA should review the preliminary error report and perform a comparison to data from the client's medical records and/or the RBHA's system. Each challenge must be supported by additional documentation. Types of additional documentation include, but are not limited to PMMIS screen prints; CIS screen prints, and screen prints from the RBHA's internal system.

All documentation required to support the challenge including the *Data Validation Challenge Form* (Attachment 1) must be submitted to the Branch for Program Operations by the date specified. If the documentation does not support the challenge, the challenge will not be processed and forwarded to AHCCCS.

Challenge Received

The Data Validation Unit will review the preliminary report and the challenges submitted by the RBHAs. The Data Validation Unit will create one unified challenge response containing all documented challenges noted by the RBHA. This along with all the supporting documentation submitted by the RBHA will be forwarded to AHCCCS.

Final Report

AHCCCS will review the challenges and documentation submitted. This review will result in a final report that is distributed to the appropriate RBHA. Included with the final report is the sanction assessed by AHCCCS.

Collection of Sanction

ADHS/DBHS will withhold the final sanction amount from the capitation paid to the RBHA each month. In addition to the monetary sanction the RBHA is also required to comply with a training sanction. The RBHA will be required to spend a set dollar amount for training related to reducing the data validation errors. This amount must be tracked and reported to DBHS on a quarterly basis using the following form.

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Provider Education & Training Sanction FY ____
Expenditures for Quarter ____ (dates)

Expenditure Category	Amount Spent	Describe of how amount spent relates to Education/Training
Total Expenditure for Quarter:		

In addition to the form the RBHA must maintain the sign-in sheet from each training and an overview of the training content including how the training will reduce data validation errors

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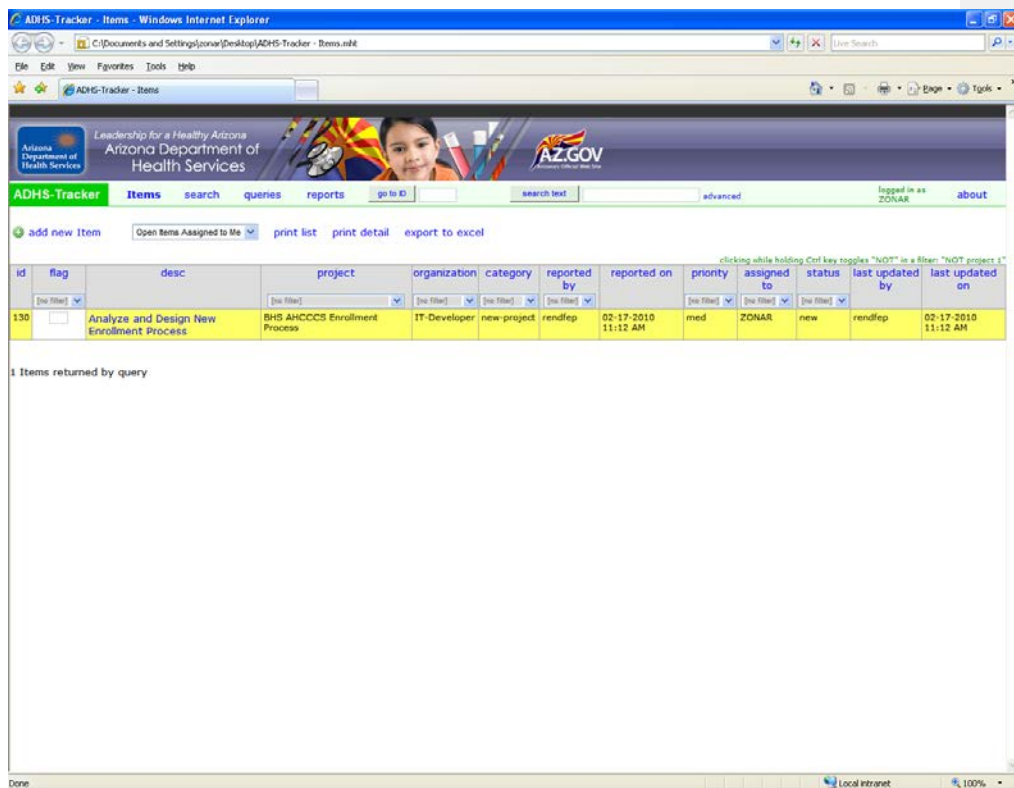
Tracker

Introduction

Tracker is the method used by the Office of Program Support to notify DBHS/ITS of system changes/modification needed in the ADHS/DBHS operating system. In addition, a Tracker can be used to request research of encounter issues or to request reports.

Create a New Tracker

The Office of Program Support staff access the Tracker database using an icon placed on their desktop when they are given user rights.



To enter a new Tracker select “add new item” on the top left of the screen under the green **ADHS-Tracker**.

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The screenshot shows a web browser window titled "ADHS-Tracker - Add New Item". The address bar shows the URL "http://hphcweb13/adstracker/jedit_item.aspx?". The browser's menu bar includes "File", "Edit", "View", "Favorites", "Tools", and "Help". The page header features the Arizona Department of Health Services logo, the text "Leadership for a Healthy Arizona", and the "AZ.GOV" logo. Below the header is a navigation bar with links: "ADHS-Tracker", "Items", "search", "queries", "reports", "go to ID", "search text", "advanced", "logged in as ZONUAR", and "about". The main content area is titled "add new item" and contains a form with the following fields: "Description:" (a text box), "Project:" (a dropdown menu with "BHS.NET" selected), "Organization:" (a dropdown menu with "BHS" selected), "Category:" (a dropdown menu with "[no category]" selected), "Priority:" (a dropdown menu with "[no priority]" selected), "Assigned to:" (a dropdown menu with "[not assigned]" selected), and "Status:" (a dropdown menu with "new" selected). To the right of the form fields are links for "Presets: use / save". Below the form fields is a "Comments:" section with a text box and a note: "Entering 'itemid=999' in comment creates link to id 999". At the bottom of the form is a "Create" button. The browser's status bar at the bottom shows "Done", "Local intranet", and "100%".

The following information must be added for the new Tracker item:

- Description - A brief description of the issue
- Project – Does the issue deal with encounters, enrollment, demographics, etc.
- Category – Is the request for an enhancement, ad-hoc report, change request, etc.
- Priority – Is the priority an emergency, high, medium, etc.
- Comment – Give details of the issue including what effects it is having on the issue

Once the above information is entered, select “Create” below the comment field.

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Item ID 1475 R415 Pends - Windows Internet Explorer

http://hphcrweb13/redstracker/red_item.aspx?id=1475

ADHS-Tracker

add new Item

create copy

print

subscriptions

stop notifications

relationships(0)

tasks/time(1)

send email

add attachment

Item ID: 1475 R415 Pends

Created by Zona, Ruth on 04-25-2011 5:15 PM, 113 days ago

Presets: use / save

Project: BHS Encounters

Organization: BHS

Category: maintenance-request

Priority: high

Assigned to: Pell, Larry

Status: closed

Comment: Entering "Itemid=999" in comment creates link to id 999

Update

show inline images

show change history

file 8699 attached by Zona, Ruth on 04-25-2011 5:16 PM, 113 days ago

R415 Pends

attachment: R415 Pends.xlsx view save

size: 142706 content-type: application/vnd.openxmlformats-officedocument.spreadsheetml.sheet

comment 8698 posted by Zona, Ruth on 04-25-2011 5:15 PM, 113 days ago

The 2484 encounters attached were sent to AHCCCS in error and pending for R415, RECIPIENT IS QMB ONLY ELIGIBLE ON DOS. Please create and send a void to AHCCCS for these encounters.

When the adjudication file is returned from AHCCCS mark the encounters with a State Only (ST) status instead of approved void (AV).

forward

Done

Local intranet

100%

The created Tracker is automatically assigned a number that can be used to easily locate the record again. The comments entered on the previous screen are moved to the bottom and additional comments may be entered in the original comments field and saved by selecting "update" at the bottom of the comments field.

Attachments may also be added by selecting "add attachment" to the left of the comments field. The added attachment is also posted at the bottom and may be viewed or saved to another location.

After a Tracker is entered the originator must contact ITS and give them the Tracker number and a brief description of the issue. ITS will add their comments and change the status to Closed when the issue has been resolved.

Note: It is the responsibility of the Tracker originator to follow-up on the progress/completion of the Tracker request.

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Training Requirements

Introduction

T/RBHAs are required to provide on-going training to their providers for submission of claim/encounter/demographic data.

Encounter Related Training

The Office of Program Support requires the Contactor to provide evidence of on-going training that has been provided to their providers. The following evidence must be submitted to the OPS mailbox the last day of each month as a deliverable i.e. December training is due January 31:

- Sign-in sheets for any training that took place in the previous month
- A brief description of the training content
- Amount spent per training event

AHCCCS Operational and Financial Review

Annually, AHCCCS will conduct an Operational and Financial Review (OFR) of DBHS in order to determine if there are organization, management and administrative systems in place capable of fulfilling all contract requirements including those areas related to encounter submission and data validation.

T/RBHAs are required to provide documentation requested as necessary to satisfy any of the OFR standards.

System Access Requests

Introduction

Some T/RBHA employees will need access to the ADHS-CIS and AHCCCS-PMMIS claim systems to perform their job duties. The procedures to obtain a CIS and/or PMMIS ID are as follows:

CIS

Three forms must be completed to request a CIS user ID. The employee requesting the login ID must complete and sign two of the forms. To obtain copies of the CIS forms, the T/RBHA should contact ADHS' Grants Management Information Systems (GMIS).

Office of Program Support Operations and Procedures Manual

1. ADHS Computer User Registration Request Form (SA Attachment 1)
2. ADHS User Affirmation Statement (SA Attachment 2)
3. ADHS Confidentiality Agreement (SA Attachment 3)

The T/RBHA should fax all signed forms to ADHS' Grants Management Information Systems to fax number (602) 364-4737 or scan them to DBHS' DataOwner@azdhs.gov . The Data Owner will review the forms to ensure they are complete and will forward the request to the ITS department. ADHS/ITS will assign an appropriate login ID and password for the new user.

PMMIS

Two forms must be completed to request a PMMIS user ID. The employee requesting the login ID must complete and sign both forms. The T/RBHA may obtain copies of the AHCCCS security forms at the following website:

<http://www.ahcccs.state.az.us/Publications/Forms/PlansProviders/02-001F.doc>
http://www.ahcccs.state.az.us/publications/forms/plansproviders/useraffirmation2008_external.pdf

1. AHCCCS User Access Request Form (SA Attachment 4)
2. AHCCCS User Affirmation Statement (SA Attachment 5)

The T/RBHA should fax both signed forms to the ADHS' Grants Management Information Systems to fax number (602) 364-4737 or scan them to DBHS' DataOwner@azdhs.gov. The Data Owner will review the forms to ensure they are complete and will forward the request to AHCCCS. AHCCCS will assign an appropriate login ID and password for the new user.

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SA Attachment 1

ADHS COMPUTER USER REGISTRATION REQUEST FORM			
MAIL TO: Data Security, ITS, 1740 W. Adams, Suite 407, Phoenix, 85007 FAX #: (602) 542-3250 E-MAIL: DataSecurity PHONE #: (602) 542-2810			
*** TO BE COMPLETED BY AUTHORIZED REQUESTOR ***			
Please	☐ Add	☐ Employee	Request Date: _____
	☐ Change	☐ Contractor	
	☐ Remove	☐ Temp	Effective Date: _____
	Company Name _____		
Transfer	☐ To: _____		
	☐ From: _____	Temp or Intern _____	
Last Name _____		First Name _____	MI _____
Office/Section _____		Physical Location _____	Employee Phone _____
On the following systems/applications:			
LAN =	☐ ACPTC	☐ DHS	☐ FLG
	☐ ALS	☐ EDC	☐ HSP
	☐ BHS	☐ FHS	☐ ITS
	☐ Internet	☐ Outlook	
DLS =	☐ AMS	☐ TAE	☐ CTS
BEMS =	☐ AMB	☐ EMP	☐ EMT
BHS =	☐ CIS	☐ OGA	☐ OHR
	☐ IRS	☐ DWH	☐ FTP(CIS)
CFHS =	☐ CRS	☐ CATS	☐ Sensory
EDC =	☐ ASIIS	☐ BDR	☐ STD
FIN SVCS =	☐ AEDW	☐ EPR	☐ POTSY
(DOA)	☐ USAS	☐ HRIS	☐ Fix asset
HSP =	☐ IRD		
HSS =	☐ HDD		
PHS =	☐ Birth	☐ Death	☐ VitalChek
SLS =	☐ CLAS	☐ RLIMS	☐ ELBIS
ITS =	☐ Unix	☐ AppWorx	☐ LITS
ORACLE:	☐ asit	☐ tw	☐ cist
	☐ asip	☐ pw	☐ cisp
		☐ crst	☐ natt
		☐ natp	☐ vrst
		☐ crsp	☐ vrsp
		☐ azht	☐ limsp
		☐ azhp	
Ad hoc Query			
	☐ IRS	☐ HR	
	☐ CIS	☐ OGA	☐ CRSG
	☐ Supply	☐ PWO	
Other Instructions: _____			
If User removal please choose:			
☐ Move F: drive contents to specific user:			
☐ Delete F: drive (Contents not needed)			
Supervisor (PRINT): _____		Phone: _____	
Supervisor Signature: _____		Phone: _____	
Data Owner Signature: _____		Phone: _____	
TO BE COMPLETED BY THE DATA SECURITY ANALYST			
Login ID _____		Completed Date: ____/____/____	
LAN _____			
ENTITY CODE _____			
Comments: _____			
Signed: _____		Form Rev. 3/04/2008	
Data Security Analyst			

**ARIZONA DEPARTMENT OF HEALTH SERVICES
USER AFFIRMATION STATEMENT**

I have been made aware and understand that all personnel who have access to the Arizona Department of Health Services (DHS) data are bound by applicable laws, rules and DHS directives and are responsible for DHS data.

I agree to abide by all applicable laws, rules and DHS directives, and I pledge to refrain from any and all of the following:

1. Revealing DHS data to any person or persons outside or within DHS who have not been specifically authorized to receive such data.
2. Attempting or achieving access to DHS data not germane to my mandated job duties.
3. Entering/altering/erasing DHS data for direct or indirect personal gain or advantage.
4. Entering/altering/erasing DHS data maliciously or in retribution for real or imagined abuse, or for personal amusement.
5. Using DHS workstations, printers, and/or other equipment for other than work related purposes.
6. Using another person(s) personal logon ID and password.
7. Revealing my personal logon ID and password to another person.
8. Asking another person to reveal his/her personal DHS logon ID and password.

In relation to my responsibilities regarding the proprietary rights of the authors of computer software utilized by DHS, I recognize that:

1. DHS licenses the use of computer software from a variety of outside companies. DHS does not own this software or its related documentation and, unless authorized by the software developer, does not have the right to reproduce it.
2. When used on a local area network or on multiple machines, employees/contractors shall use the software in accordance with the license agreement.
3. Employees/contractors who know of any misuse of software or related documentation within the agency shall notify their manager/supervisor, or the department security administrator.
4. Employees/contractors making, acquiring or using unauthorized copies of computer software, or using personal non-DHS software are subject to punitive action in accordance with agency guidelines as appropriate to the circumstances.
5. According to U. S. Copyright Law, 17 USC Sections 101 and 506, illegal reproduction of software can be subject to criminal damages up to \$250,000 and/or up to 5 years imprisonment.
6. In the event that an employee is sued or prosecuted for the illegal reproduction of software, he/she will not be represented by the Department of the Attorney General.

Appropriate action will be taken to ensure that applicable federal and state laws, regulations, and directives governing confidentiality and security are enforced. A breach of procedures occurring pursuant to this policy or misuse of department property including computer programs, equipment, and/or data, may result in disciplinary action including dismissal, and/or prosecution in accordance with any applicable provision of law including Arizona Revised Statutes, Section 13-2316.

My signature below confirms that I have read this form and accept responsibility for adhering to all applicable laws, rules, and DHS directives. Failure to sign this statement will mean that I will be denied access to DHS data, computer equipment, and software.

NAME (Last, First, M.I.) PRINT OR TYPE	SIGNATURE	PHONE	DATE
NAME OF SUPERVISOR (Last, First, M.I.)	SIGNATURE	PHONE	DATE

Routing: Original to Security Administrator; Copy 1-Originator

Rev 9/28/2007

**ARIZONA DEPARTMENT OF HEALTH SERVICES
Confidentiality Agreement Form**

PLEDGE TO PROTECT CONFIDENTIALITY INFORMATION

I, _____, understand and agree to abide by the following statements addressing
(Please Print Name)

the creation, use and disclosure of confidential information, including information designated as protected health information ("PHI"), and all other sensitive information:

1. I understand that as a user of information at the Arizona Department of Health Services, I may develop, use, or maintain information relating to public health and welfare, direct or indirect health care, quality improvement, peer review, audit functions, education, billing, reimbursement, administration, research or other approved purposes. This information, from any source and in any form, including, but not limited to paper records, oral communications, audio recordings and electronic display, is considered confidential. Access to confidential information is permitted only on a need-to-know basis and limited to the minimum amount of confidential information necessary to accomplish the intended purpose of the use, disclosure or request.
2. I understand that it is the policy of the Arizona Department of Health Services that users (i.e. employees, medical staff, students, volunteers, contractors, vendors and others who may function in an affiliated capacity) shall respect and preserve the privacy, confidentiality, and security of confidential information.
3. I understand that persons who have access to information that contains confidential information are ethically and legally responsible for observing the federal and state statutes and rules governing confidential records. I will not alter, misuse, disclose without proper authority or the individual's authorization any confidential information.
4. I understand that confidential information may include oral communications, paper or electronic documents, databases, audio/visual tapes, and other items identified as "confidential" or "sensitive" information.
5. I understand that Arizona State Law prohibits me from using confidential information for personal gain.
6. I understand that confidential information in my control must be maintained and protected from inappropriate disclosure at all times (i.e. hard copy information when not in use will not be accessible to others, including stored or locked or other secure compartments, computer files must be password protected and closed, working documents turned face down on desk, electronic transmission of information will be encrypted according to Department policy, etc.)

ARIZONA DEPARTMENT OF HEALTH SERVICES
Confidentiality Agreement Form

7. I understand that it is the user's responsibility to protect highly sensitive Department information. As such, I am required to use good judgment in assessing what form of communication is appropriate for particular information. If I have any questions or concerns, I am to consult Department policies, my supervisor or the applicable Assistant Director for guidance.
8. I understand that confidential information may only be accessed when I am specifically authorized to do so by the appropriate program manager and I will use only the amount of information necessary within the scope of my duties. When confidential information is no longer needed, I will dispose of it in an appropriate manner to prevent inappropriate access to that information.
9. I understand that confidential information, including paper and electronic records, correspondence, documents and other forms of such information, cannot be released to or discussed with anyone other than authorized individuals. I will also violate this provision if I intentionally or negligently mishandle or destroy confidential information.
10. I understand that I am not to contact the individual(s) or other related persons to whom confidential information pertains unless I am specifically authorized to do so by law and the appropriate program manager.
11. I understand that it is a violation of Department and State of Arizona policy for me to share my sign-on code and/or password for accessing electronic confidential information or for physical access to restricted areas. I further understand that I will not use another person's sign-on code and/or password or otherwise attempt to access electronic confidential information or to gain physical access to a restricted area that is not within the scope of my work or permitted by my supervisor.
12. I understand that it is my responsibility to know and abide by any additional confidentiality provisions required by my job that may be issued by the Department, Division, Bureau, program or other work unit to which I report. If I have questions about which confidentiality rules apply to my job, I understand that it is my responsibility to ask my supervisor prior to releasing any information, even if the information request is in the form of a subpoena or other legal document.
13. I understand that it is my responsibility to report any observed or suspected breach of confidentiality by any other Department employee to my supervisor.
14. I understand that if it is determined that I have violated the Pledge or any other confidentiality requirement, I may be subject to formal disciplinary action up to and including termination of employment, loss of privileges, contractual or other rights which may be granted as a result of an affiliation in accordance with Department and/or State of Arizona procedures. Unauthorized use or release of confidential information may also subject me to personal, civil, and/or criminal liability and legal penalties.

Service Designation:

☐ Employee ☐ Contractor ☐ Volunteer ☐ Student ☐ Other

User Signature: _____

Title: _____

Date: _____

Office of Program Support
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SA Attachment 4

USER ACCESS REQUEST FORM			
ISD Security MD2800		Effective Date [REDACTED]	
All Add requests must be accompanied by a completed User Affirmation Statement (Form 02-002F)			
I. Security Access Requirements:			
Security Action:	☐ Add	☐ Change	☐ Delete
System Access:	☒ Mainframe/PMMIS	☐ Network/NT	☐ Other/Type _____
II. Mainframe Access Requirements:			
***** Long Term Care *****			
OPID	Group #	Printer Worker-ID Type Site	Group Owner's Signature:
_____	_____	_____	<u> x </u>
EC Adj Lvl: L= _____		AND/OR Health Plan ID(s): _____	
Claims Administrator Signature: <u> x </u>			
Mainframe/PMMIS Userid: _____		Last 4 numbers of SSN: [REDACTED] (for all ADDs only)	
III. Network Access Requirements:			
If required, list below any protected directories or applications to be accessed:			
Read Access	☐	Write Access	☐
Prod Access (ACE)	☐	Test Access (ACE)	☐
Directory Path(s) or Application(s): _____			
Application Group Name (ACE Only): _____			
Group Owners Signature (ACE Only): <u> x </u>			
Application Owners Signature: <u> x </u>			
Protected Directory Owner Signature: <u> x </u>			
Copy Network profile from this user: _____ Network Userid: _____			
IV. User Information Requirements:			
Name:	[REDACTED]	[REDACTED]	[REDACTED]
	(Last)	(First)	(MI)
Title:	[REDACTED]		Telephone: [REDACTED]
Division:	[REDACTED]	Dept: [REDACTED]	Location: [REDACTED]
Authorized By: <u> x </u>	Date: ____/____/____		
Title: <u>CONTRACT DEVELOPMENT ANALYST</u>	MD: _____	Phone: 602 364-4670	
V. Security Administration:			
Received: _____	Completed: _____	Notified: _____	By: _____
Comments: _____			

EXTERNAL USER AFFIRMATION STATEMENT

I understand that all users who have access to the AHCCCS computer network and data are bound by applicable laws, rules and AHCCCS directives, including but not limited to, AHCCCS Administrative Policies and Procedures, AHCCCS Privacy and Security Policies (HIPAA), ARS 13-2316, ARS 41-770, and ARS 38-448.

Use of AHCCCS Data:

- I will share (i.e., verbal, hardcopy, electronic) AHCCCS data only with people who are authorized to receive the data.
- I will only access/add/change/copy/delete AHCCCS data related to my assigned job duties.
- I will never use AHCCCS data for non-work related purposes.

Logon IDs and Passwords:

- I will never use another person's AHCCCS Logon ID and password.
- I will never ask another person to reveal his/her AHCCCS Logon ID and password.
- I will never reveal my AHCCCS Logon ID and password to anyone, at any time.
- I understand that no one else may use my AHCCCS Logon ID and password and that I am responsible for all actions taken with my Logon ID.

Use of State Resources:

- I will use state equipment in a legal and ethical manner.
- I understand that the use of equipment provided by the agency is subject to monitoring.

Use of Software:

- I will not download or install computer software. Only ISD Network Services has the authority to install and license software.
- Unless authorized, I do not have the right to copy, change or distribute computer software or its related documentation.

Misuse of Equipment, Software or Data:

- I understand that if I become aware of any misuse of AHCCCS equipment, software or data I must promptly notify AHCCCS ISD Customer Support at 602-417-4451.
- I understand that AHCCCS will take appropriate action to ensure that applicable federal and state laws, regulations, and directives governing confidentiality and security are enforced.
- I understand that the misuse of AHCCCS equipment, software or data may result in prosecution, or disciplinary action if I am an employee of another state agency.

My signature below confirms that I have read and understood this form. I accept responsibility for adhering to all applicable laws, rules, and AHCCCS directives. Failure to sign this statement will mean that I will be denied access to AHCCCS data, computer equipment, and software.

Print Legal Name of User (Last, First, M.I.)	Signature	Date

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Deliverables

The table below describes the deliverables due to AHCCCS in accordance with their contract requirements:

Name	Description	Deliverable Due
Encounter Report	Based on finalized claims data, this report indicates the number of claims and plan paid amounts finalized by the Contractors and subsequently submitted as encounters to AHCCCS.	Quarterly
Override Log	This report is the override log, which includes a list of CRNs, the date the encounter was overridden in PMMIS, and a detailed reason for the override.	Quarterly
Void Log	This report is the void log, which has a list of CRNs, the date the encounter was voided in PMMIS, and a detailed reason for the void.	Quarterly

Encounter Report

Finalized Claims Submitted to AHCCCS

This report indicates the number of claims and plan paid amounts finalized by the Contractors and subsequently submitted as encounters to AHCCCS. The data is broken down on the report monthly by claim form type.

The number of claims and plan paid amounts finalized by the Contractors are derived from the Claims Dashboard information submitted by the RBHAs monthly. The number of encounters submitted to AHCCCS is pulled from the CIS database.

Quarterly AHCCCS Override Log

The AHCCCS Quarterly Override Log must be submitted by DBHS on a quarterly basis 45 days following the end of the quarter. The log must be submitted as an Excel file and must contain the following fields: Number, AHCCCS CRN, Member ID, Edit Error Code(s), Form Type, Override Performed by AHCCCS for Contractor (Y/N), Date of Override, and Reason for Override.

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The quarterly override log is created using the table(s) “DELDUP_YYYYMM” found at M:\Program Support Staff\1-OPS Databases in the OPS database named “Master_Pend12”. This table, created by OPS on a monthly basis during the AHCCCS pended encounters cycle, is a consolidation of all pended encounter overrides submitted by each RBHA on their individual monthly deldup files.

Copy the CRN Number, Error Code, and Reason Code fields from the individual DELDUP tables relevant to that quarter’s review* and paste them on individual tabbed spreadsheets on an Excel file. This file will become the Office of Program Support’s working copy of the final file that will eventually be provided to AHCCCS. The individual tabbed spreadsheets must be named for the month and year relevant to that quarter’s review (e.g. July YYYY Overrides, August YYYY Overrides, etc.). The Number, Member ID, Form Type, Override Performed by AHCCCS for Contractor (Y/N), and Date of Override fields must be manually added to each spreadsheet later in this process.

The Reason Code column heading must be manually changed to Reason for Override, and the reason codes listed in all of this column’s fields must be manually changed to each reason code’s worded description**.

When completed and each spreadsheet’s AHCCCS CRN, Edit Error Code(s), and Reason for Override fields are populated, insert a column between the AHCCCS CRN and Edit Error Code(s) fields and manually add the heading Member ID. Next, insert three columns between the Edit Error Code(s) and Reason for Override fields and manually add the headings Form Type, Override Performed by AHCCCS for Contractor (Y/N), and Date of Override. The values for these four columns must be added for each record by accessing the PMMIS system and inputting the individual CRN on reference screen EC262 (Encounter Override Audit Trail).

When this process is completed for each month’s spreadsheet, copy all three month’s records and paste them onto one spreadsheet on an excel file that will become the quarterly override log provided to AHCCCS. Insert a column before the AHCCCS CRN field and manually add the heading Number. In this column add numbers to all records on the override log in sequential order.

When all of the above processes are completed the file should be saved to directory M:\Program Support Staff\2011 OPS Research\Qtrly AHCCCS Override Log\Qx_FYyy under the name “Qx_FYyy_Encounter_Overrides.xlsx”. The file should then be sent via email to the Encounter & Claims Manager who will ensure it is forwarded to AHCCCS, along with the Quarterly Void Log and the Quarterly Encounter Log, by the appropriate deadline.

Footnotes:

*i.e. 1st Quarter report records come from tables “DELDUP_YYYY07”, “DELDUP_YYYY08” and “DELDUP_YYYY09”; 2nd Quarter report records come from tables “DELDUP_YYYY10”, “DELDUP_YYYY11” and “DELDUP_YYYY12”

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****i.e.** Reason Code A001 must be changed to state “Per RBHA review, not a duplicate encounter” and Reason Code A002 must be changed to state “Encounter review completed; override at request of Contractor”

Quarterly AHCCCS Void Log

The AHCCCS Quarterly Void Log must be submitted by DBHS to AHCCCS on a quarterly basis 45 days following the end of the quarter. The log must be submitted as an Excel file and must contain the following fields: CRN Number, Date of Void, and Detailed Reason for Void.

A report of the approved voids will be sent to the RBHAs within one week after the end of the quarter. The RBHAs will populate the Detailed Reason for Void field and return the report DBHS. DBHS will use this data to create the AHCCCS Quarterly Void Log. The queries to pull the void data for the RBHAs are located in TOAD.

CREATE RBHA FILE

Connect to TOAD:

- Open the VOIDS – HCFAS sql query. Change the dates in the query to cover the quarter you are working on. Click on the green triangle to run the query. The answer table will appear at the bottom of the screen. Right click anywhere in the answer table and select Save On. Select Delimited, the Delimiter selected from Common Delimiters... should be Tab, Include Column Headers should be checked, and clipboard needs to be selected at the bottom. Then select OK. This saves the answer table to your clipboard.

Open an EXCEL spreadsheet. Change the format on columns A & F to text, then put the cursor in column A, line 1 and paste. This takes the information from the clipboard and pastes it to the spreadsheet. Save the spreadsheet to M:\Program Support Staff\2011 OPS RESEARCH\QTRLY AHCCCS VOID LOG\Q#_FYyy (current quarter).

- Open the VOIDS – UBS sql query. Follow the same instructions as for the HCFAS sql query.
- Open the VOIDS – DRUGS sql query. Follow the same instructions as for the HCFAS sql query.

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Combine the three spreadsheets into one spreadsheet named VOIDS-mmyyyy.

- Once the three spreadsheets have been combined and the manual voids added, the HCFA, UB and DRUG spreadsheets may be deleted.

The encounters pulled thus far are the AV encounters. You will need to add any manual voids that were done during the quarter to the spreadsheet.

Once the manual voids have been added the voids need to be split by RBHA. The RBHAs want text files.

- Import the spreadsheet into MS Access.
- Do query to pull the first RBHAs data and export as a text file named Qx_FYyy_VOIDS_RBHAxx to the RBHAs folder in the QTRLY AHCCCS VOID LOG for the current quarter.
- Repeat for each RBHA
- Place each RBHA's Quarterly_Void_Log in their RBHAs folder on the opsftp server.
- Send a notification email to the RBHAs (AVL Attachment 1):

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VL Attachment 1

NOTIFICATION EMAIL TO RBHAS

– fill in current info in yellow highlighted spaces

To: CURRENT LIST (update as needed) –
jlgray@centene.com; PMCBRIDE@CENTENE.COM; ktunis@centene.com;
ECOLLINS@CENTENE.COM; rmccaw@cenpatico.com; azclaims@cenpatico.com;
dataservices@cenpatico.com
Cheri.Burian@netsvcs.narbha.org; Tia.Martinez@netsvcs.narbha.org;
Renee.Munoz@cpsa-rbha.org; Gale.Leair-Kaiser@cpsa-rbha.org;
Augustine.Celaya@cpsa-rbha.org; MaricopaRBHAOPSEmail@magellanhealth.com;
SCODY@cenpatico.com

cc: BHSCContractCompliance; OPS; Encounter & Claims Manager

Subject: Quarterly Void Log – (month, year)

This is to notify you that the Quarterly Void Log for (month, year) is now available in your RBHA's folder on the opsftp server.

Please provide the reason that each encounter was voided in the Detailed Reason for Void column.

- A detailed reason must be provided for every void
- "Researching", "Sent to ____ for research/resolution", etc. are not acceptable reasons

This report must be updated and returned to the RBHAs folder on the opsftp server by close of business (15 business days after receipt from OPS) using the file name that was sent to the RBHA with the word **response** at the end; Example:
Quarterly_Void_Log_10012012_RBHA15-response. The RBHA must send an email to ops@azdhs.gov notifying them that the response file has been placed on the server.

If there are any problems or issues regarding this request or if you have any questions, please contact OPS.

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Arizona Department of Health Services
Division of Behavioral Health
ops@azdhs.gov

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RBHA RESPONSE FILES

Place a copy of each response file from the opsftp server into M:\Program Support Staff\2011 OPS RESEARCH\QTRLY AHCCCS VOID LOG\Q#_FYyy (current quarter)\RBHA Response Files.

- Create a spreadsheet named Q#_FYyy_Encounter_Voids for the AHCCCS Quarterly Void Log.
- When response files for the quarter have been received from all RBHAs, copy each one and paste it into Q#_FYyy_Encounter_Voids spreadsheet.
- When response files have been copied to the Q#_FYyy_Encounter_Voids spreadsheet, delete all the columns from the spreadsheet except the last three, (CRN, Date of Void, Detailed Reason for Void)
- Move the completed Q#_FYyy_Encounter_Voids spreadsheet to M:\Program Support Staff\2011 OPS RESEARCH\QTRLY AHCCCS VOID LOG\Q#_FYyy (current quarter).

When the Quarterly Void Log is complete it should be sent to the Encounter & Claims Manager who will ensure it is forwarded to AHCCCS, along with the Quarterly Override Report and the Quarterly Encounter Report, by the appropriate deadline.

Operations and Procedures Manual Updates and Revisions

The Office of Program Support Operations and Procedures Manual will be reviewed and updated as needed. The Office of Program Support Manager is responsible for maintaining this manual and should coordinate with all functional areas of the Arizona Department of Health Services when there are proposed changes. All functional areas of the Arizona Department of Health Services should coordinate with the Office of Program Support Manager regarding any changes in their policies, procedures, contracts or reference documents that may affect this manual.