12 Correcting Claim Errors

Providers have an opportunity to correct and resolve claim denials by following the guidelines in this chapter.

CLAIMS RESOLUTION SERVICES

Provider offices are encouraged to keep their billings timely and review every remittance advice thoroughly upon receipt. There may be occasions when a provider may request the status of a specific claim or have questions regarding payment or the denial of a claim. The Health Choice Arizona Provider Portal: https://www.healthchoicearizona.com/ProviderPortal/login/ or Health Choice Arizona Member Services Unit at (800) 322-8670 is the resource for such information.

UNDERSTANDING COMMON BILLING ERRORS

This section presents a summary of common denial or disallowance edits, including, but not limited to, the error number, error message, a brief description of the error, and a brief statement of the action required.

14 Prior Authorization

This edit relates to the validity of the authorization, from the status of the authorization to the procedure and units billed.

27 Diagnosis Code invalid or missing

This edit relates to the validity of the diagnosis code entered on the claim form. The following further describe the edits related to the diagnosis code.

For all of the diagnosis edits, determine if the primary diagnosis is a valid ICD 10 diagnosis code and entered correctly on the claim form and was valid on the date of service (date of admit for UB Claims forms).

D3 Diagnosis code requires 4th/5th digit

This edit relates to the validity of the diagnosis code entered on the claim. The diagnosis requires the 4th or 5th digit. For all of the diagnosis edits, determine if the primary diagnosis is a valid ICD 10 diagnosis code and entered in its entirety on the claim form.

AA/AG Age/Gender Diagnosis/CPT/HCPCS

This edit relates to the validity of the diagnosis code/CPT/HCPCS entered on the form as it relates to the recipient's age and/or gender. The following further describe the edits.

26 Invalid Procedure Code

This edit relates to the validity of the procedure code entered on the claim form.

For all of the procedure code edits, verify that the procedure code was entered on the claim, that the code was entered in the correct format, and that the code is a valid five-digit CPT or HCPCS code.

38 Procedure Modifier

This edit relates to the validity of the procedure modifiers entered on a claim form.

For all edits, verify that the first procedure modifier was entered on the claim line and that the modifier is valid for the procedure code billed on that line.

74 Category of Service

For category of service edits, verify that the correct procedure was billed. If there is no error in the procedure billed on the claim and the provider believes that the service was billed correctly, the provider should contact the Health Choice Arizona Claims Resolution Service Unit.

15 Recipient Eligibility/Enrollment

This edit relates to the recipient's eligibility for the services billed claim form.

15 Recipient Not Eligible/Enrolled for Entire DOS; Invalid Eligibility

For all recipient eligibility edits, the recipient is either not Health Choice Arizona eligible or not eligible for the service on the date(s) of service. Verify the recipient's Health Choice Arizona ID number and eligibility standing either through the Provider Portal of the Health Choice Arizona Website or with the Health Choice Arizona Member Services Department. Refer to Chapter 2, Member Eligibility and Member Services. Resubmit corrected claim containing only the dates of services the recipient was eligible with Health Choice Arizona

25 Timeliness

This edit relates to the timeliness requirement for submitting claims to Health Choice Arizona.

Claim Received - Past 6 Month Limit
The initial claim for services was received by Health Choice Arizona more than six months from the end date of service or the date of eligibility posting for a retro-eligibility claim. For hospital claims, the end date of service is the date of discharge. If the claim was originally submitted within the six-month time frame, resubmit the claim

with the CRN of the previously denied claim.

Claim Received - Past 12 Month Limit, Deny

A resubmission of a denied claim was received by Health Choice Arizona more than 12 months from the end date of service or date of retro-eligibility posting. For hospitals, the end date of service is the date of discharge. Verify the "from" and "through" dates of service entered on the claim.

CLAIM RESUBMISSION

If a clean claim was denied due to a billing error, the corrected claim must be resubmitted within twelve (12) months of the date of service/discharge, or of the date of eligibility posting.

If the clean claim was denied due to a request for medical documentation, please include a copy of the claim, a copy of the remittance advice, and the requested documentation with the resubmission.

Claim Denial Disputes

All Providers have the right to file a claim dispute in response to any adverse action or decision made by Health Choice Arizona. However, Health Choice Arizona encourages Providers to exhaust all other means of resolution before using the claim dispute process. See Chapter 15: Claim Disputes, Member Appeals and Member Grievances for additional information.