

**Arizona Department of Health Services
Division of Behavioral Health Services
PROVIDER MANUAL
NARBHA Edition**

Section 6.2 **Submitting Claims and Encounters to the RBHA**

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6.2.1 Introduction

Upon rendering a covered behavioral health service, billing information is submitted by behavioral health providers as a “claim” or as an “encounter”. Some behavioral health providers are reimbursed on a fee-for-service basis (these providers submit “claims”) and others are paid on a capitated basis or contract under a block purchase arrangement (these providers submit “encounters”). Although the providers submitting claims data utilize standardized forms, submission of claim and encounter data follow the procedure required by each Regional Behavioral Health Authority (RBHA).

The intent of this section is to:

- Identify general requirements for submitting encounter data;
- Identify procedures for submitting encounter data;
- Identify procedures for submitting claims; and
- Articulate the timelines for submitting billing information.

Procedures for submission of claims to the RBHA vary significantly among providers. RBHA specific requirements concerning claims submission by the providers shall be articulated by each RBHA (see subsection 6.2.7-C for RBHA specific requirements for claims submission).

For information on procedures for submitting Tribal claims data, see [Section 6.1, Submitting Tribal Fee-For Service Claims to AHCCCS](#).

6.2.2 References

The following citations can serve as additional resources for this content area:

[45 CFR 162.1101](#)

[45 CFR 162.1102](#)

[9 A.A.C. 34](#)

[AHCCCS/ADHS Contract](#)

[ADHS/RBHA Contract](#)

[Section 3.4, Co-Payments](#)

[Section 3.5, Third Party Liability and Coordination of Benefits](#)

[Section 6.1, Submitting Tribal Fee-for-Service Claims to AHCCCS](#)

[Section 8.1, Encounter Validation Studies](#)

[CMS 1500](#)

[UB 04](#)

[ICD-9-CM Manual](#)

[First Data Bank](#)

[Physicians' Current Procedural Terminology \(CPT\) Manual](#)

[Health Care Procedure Coding System \(HCPCS\) Manual](#)

[ADHS/DBHS Office of Program Support Procedures Manual](#)

[Client Information System \(CIS\) File Layout and Specifications Manual](#)

6.2.3 Scope

To whom does this apply?

All behavioral health providers contracted with a RBHA that submit claim or encounter data.

6.2.4 Did you know...?

- The RBHA must submit all encounters including resubmissions or corrections to ADHS/DBHS within 210 days from the end date of service.
- The RBHA may be assessed sanctions for non-compliance with encounter submission requirements.
- The Arizona Health Care Cost Containment System Administration (AHCCCSA) conducts data validation studies of Title XIX and Title XXI encounter submissions. A data validation study examines a sample of medical records to ensure that the encountered service has actually been provided. The RBHA will also perform data validation studies.
- A Trading Partner Agreement for Electronic Data Interchange (EDI) transactions must be in place between a RBHA and provider before a provider can submit electronic claim or encounter data to a RBHA.
- Behavioral health providers must not bill, nor attempt to collect payment directly or through a collection agency from a person claiming to be AHCCCS eligible without

first receiving verification from AHCCCS that the person was ineligible for AHCCCS on the date of service, or that services provided were not Title XIX/XXI covered services.

- When crisis services are encountered, these services must be identified as such (see [PM Attachment 6.0.2. Billing Instructions Used to Identify Crisis Services](#) for guidance).

6.2.5 Definitions

[Clean Claim](#)

[Encounter](#)

[Sanction](#)

6.2.6 Objectives

To ensure behavioral health providers submit timely, accurate and complete claims or encounter data.

6.2.7 Procedures

6.2.7-A. What general requirements apply to RBHA providers when submitting encounters?

All encounters or copies of paper encounters:

- Must be legible and submitted on the correct form.
- May be returned to the provider without processing if they are illegible, incomplete, or not submitted on the correct form.

HIPAA regulations specify the format for the submission of all electronic claims and encounters submitted to **Northern Arizona Behavioral Health Authority (NARBHA)**

- HIPAA Format 837P is used to bill or encounter non-facility services, including professional services, transportation and independent laboratories.
- HIPAA Format 837I is used to bill or encounter hospital inpatient, outpatient, emergency room, hospital-based clinic and residential treatment center services.
- HIPAA Format NCPDP is used by pharmacies to bill or encounter pharmacy services using NDC codes.

If more information is needed regarding electronic submission of claims and encounters to **NARBHA**, please contact NARBHA's Claims Help Desk. E-mail address is Claimsunit@narbha.org

What happens after an encounter is submitted?

Submitted encounters for services delivered to eligible persons will result in one of the following dispositions:

- Rejected;

- Pended; or
- Adjudicated.

Rejected encounters: Encounters are typically rejected because of a discrepancy between submitted form field(s) and the RBHA's, ADHS/DBHS' or AHCCCS' edit tables. A rejected encounter may be resubmitted as long as the encounter is submitted within the RBHA's established timeframe of one year from the date of service. Pended claims/encounters do not apply to NARBHA. NARBHA does not pend claims. Claims are either paid or denied.

Pended encounters: Encounters may pend at AHCCCS. The RBHA must resolve all pended encounters within 120 days of the original processing date. The RBHA must not delete pended encounters as a means to avoid sanctions for failure to correct encounters within the specified number of days.

Adjudicated encounters: Adjudicated encounters have passed the timeliness, accuracy and completeness standards and have been successfully processed by ADHS/DBHS (and AHCCCS for Title XIX/XXI eligible persons).

What about submissions for Non-Title XIX/XXI eligible persons?

Submitted encounters for services delivered to Non-Title XIX/XXI enrolled persons must be submitted in the same manner and timeframes as described in this subsection. These encounters are not submitted to AHCCCS, but must be sent to CIS within 210 days from the end date of service.

Encounters for services delivered to Non-Title XIX/XXI enrolled persons will result in one of the following dispositions: Rejected or accepted.

Rejected encounters for services delivered to Non-Title XIX/XXI enrolled persons will be returned to the RBHA with an explanation of the disallowance. A RBHA may resubmit the encounter within 210 days from the end date of service.

6.2.7-B. What requirements apply to RBHA contracted providers when submitting encounters?

Where are encounters submitted?

Paper encounters are mailed to: NARBHA – Claims Unit
1300 S. Yale
Flagstaff, Arizona 86001

Electronic encounters are sent to: NARBHA via VPN using server
10.16.1.67
And FTPing files to directory
/c2/provinf/xxxx/claim

Encounter Submission Timeframes

All encounters must be submitted to **NARBHA** within four **months** from the date of service. Encounters received beyond the **four months**, may be subject to timeliness sanctions.

Dates of service must not span a contract year. Contract years begin on July 1 and end on June 30. If a service spans a contract year, the claim must be split and submitted in two different date segments, with the appropriate number of units for each segment so the dates of service do not span a contract year. For additional information related to encounter submission, see [PM Attachment 6.0.1, Where Do I Submit My Claim?](#)

Pseudo identification numbers for Non-Title XIX/XXI eligible persons

Pseudo identification numbers are only applicable to behavioral health providers under contract with a RBHA.

On very rare occasions, usually following a crisis episode, basic information about a behavioral health recipient may not be available. When the identity of a behavioral health recipient is unknown, a behavioral health provider may use a pseudo identification number to register an unidentified person. This allows an encounter to be submitted to ADHS/DBHS, allowing the RBHA and the provider to be reimbursed for delivering certain covered services. Covered services that can be encountered/billed using pseudo identification numbers are limited to:

- Crisis Intervention Services (Mobile);
- Case Management; and
- Transportation.

Pseudo identification numbers must only be used as a **last option** when other means to obtain the needed information have been exhausted. Inappropriate use of a pseudo identification number may be considered a fraudulent act. For a list of available pseudo identification numbers, see [Attachment 6.2.1, Pseudo Identification Numbers](#).

6.2.7-C. What requirements apply to RBHA providers when submitting claims?

Behavioral Health Providers must submit accurate, timely and complete claims to NARBHA for all covered behavioral health services either on paper or electronically.

All initial claims must be received by NARBHA no later than four months from the date of service. Claims initially received beyond the four month timeframe will be denied. If a claim is originally received within the four month timeframe and denied, the provider has up to 12 months from the date of service to resubmit a clean claim. Claims received after 12 months from the date of service will be denied.

NARBHA will deny claims with errors that are identified during adjudication. These errors will be reported back to the provider on their Explanation of Benefits (EOB). Providers must correct and resubmit claims within the 12 month clean claim timeframe.

Requirements for Medicare Part A and B, and Medicare Part D Prescription Drug Plan Coordination of Benefits for persons eligible for Medicare Part A, Part B or Part D must follow the procedures established in Provider Manual [Section 3.5, Third Party Liability and Coordination of Benefits](#).

For specific billing instructions on Medicare Part A and B, and Medicare Part D Prescription Drug Plan, see the [Client Information System \(CIS\) File Layout and](#)

[Specifications Manual](#) and the [ADHS/DBHS Office of Program Support Procedures Manual](#).

6.2.7-D What requirements apply to providers about overpayments?

As a result of changes in federal law in 2009 and 2010, any person (including a provider of Medicaid-funded services) who has received an overpayment is required to report and return the overpayment, and provide a reason for the overpayment within 60 days after the date on which the overpayment was identified. (See the Affordable Care Act of 2010 § 6402, 42 U.S.C. 1320a-7j(d)). The 2009 amendments to the federal False Claim Act now define ‘retention of overpayments’ as an ‘obligation’ under the FCA, 31 U.S.C. § 3729.

What is an Overpayment?

An overpayment means “any funds that a person receives or retains under title XVIII (Medicare) or XIX (Medicaid) to which the person, after applicable reconciliation, is not entitled under such title.” (Affordable Care Act, § 6402, 42 U.S.C. 1320a-7j(d)).

Overpayments can occur for many reasons. Examples can include (but are not limited to) a duplicate payment for the same service, incorrect code, non-covered service, medically unnecessary service, third party pay or, billing error, member eligibility or enrollment changes, provider license or certification changes, adjustments identified through audits, encounter or data validation audits, clinical record reviews, appeals, inadequate documentation or lack of documentation, payments to an excluded party, and a host of other reasons.

Overpayments **must be reported and returned** within 60 days after they are “identified” according to federal law (see 6.2.7-E (3)(a) below).

6.2.7-E Reporting and Return of Overpayment

When an overpayment is suspected by the provider or by NARBHA, the provider is required to immediately notify NARBHA claims office of the suspected overpayment and submit the following in writing within two business days after learning of a suspected overpayment. This notification of suspected overpayment must contain:

1. An explanation which includes the reason for the suspected overpayment and how the overpayment (and/or need for adjustment) was identified.
2. The amount (or estimated amount) of the overpayment, to include the total dollars and number of encounters/claims and the range of dates for the encounters/claims.
3. A detailed timeline specifying when the provider will complete its investigation and:
 - a. **Calculate the amount and number of encounters/claims of the overpayment** and the process that the provider will utilize to return the funds (see 6.2.7-F below).
 - b. **Return the overpayment to NARBHA** (specific dates and timeline). If the adjustment is past the timelines for timely claim filing, the provider must notify the NARBHA claims office in advance or the adjustment will deny for timely filing.

- c. **Process adjustment(s)** to correct the overpayment through NARBHA claims system through a void or void/replace transaction (see 6.2.7-F)
This step **must be completed** no later than forty (40) days after the date the provider has identified the amount of the overpayment in 3(a) above:
4. Contact information for the provider's staff member who is assigned to ensure investigation and completion of these actions.

Within five (5) business days after the provider has completed the processing and successful submission of the necessary adjustments through NARBHA's claim system, the provider shall provide a Final Overpayment Return Report in writing to the NARBHA Claims Office which sets out:

1. The provider's final calculation of the amount and number of encounters/claims that the provider has certified and identified as an overpayment;
2. The steps taken and dates of completion of each of the steps required in 1, 2 and 3 above;
3. The reason for the overpayment;
4. The corrective actions, including timeline for completion, that have been/will be implemented to avoid future occurrences;
5. Any systemic cause(s) resulting in the overpayment and timeline for systems correction.

Providers should note that Provider Manual Policy 8.1 provides a shorter timeline of twenty-one (21) days to complete adjustments to encounters and claims (void or void/replace transactions) identified through NARBHA data validation audits.

6.2.7-F Required Transactions to Adjust An Overpayment

Overpayment adjustments (void and void/replace transactions) must be processed by the provider through NARBHA's claim system within the timelines specified above. For electronic submissions, the provider must e-mail the Claims Help desk when the file is in the provider's directory, identifying the specific overpayment adjustment file names, as overpayment files need to be processed separately from other submissions. Overpayment adjustments which are submitted manually (paper) must clearly identify the submission as an overpayment adjustment.

Upon NARBHA's completion of an overpayment adjustment run, block purchase and Responsible Agency contract providers will receive a report from NARBHA to reflect the adjusted encounters and amounts. Overpayment adjustments for fee for service and Single Case Agreement providers are deducted from the provider's next claims run if that next claim run occurs within 40 days of the date that the overpayment is identified. Any other claim/encounter reimbursements owed by a provider to NARBHA due to overpayment must be paid by check to NARBHA within 40 days after the overpayment is identified or upon such other timeline established by NARBHA.

6.2.7-G Consequences

NARBHA may impose sanctions and corrective actions for incurring overpayment(s). If a provider does not correct and return an overpayment to NARBHA as required within 40 days after the overpayment is identified, NARBHA *will* impose sanction(s) for each incorrect encounter/claim or delay (see also Provider Manual Policy 10.1), and take other action, up to and including provider subcontract termination. Federal law states that “any overpayment retained by a person after the deadline for reporting and returning the overpayment” [60 days after identification] is regarded as a false claim and subject to penalties and enforcement under the False Claim Act (31 U.S.C. 3729 et seq). NARBHA will notify appropriate state/federal authorities about the provider’s False Claim Act obligation.

Providers may need to take appropriate action, in addition to the steps listed above, to report or notify AHCCCS, ADHS-DBHS, and other agencies depending on the circumstances of the overpayment. [See Provider Manual Policy 7.1 Fraud and Program Abuse Reporting]