



Section 6.2

Submitting Claims and Encounters to the RBHA

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6.2.1 Introduction

The purpose of this policy is to describe requirements for the submission of claims or encounters to a Regional Behavioral Health Authority (RBHA) and requirements for the submission of Tribal Regional Behavioral Health Authority (TRBHA) and TRBHA provider claims. This policy covers general requirements for submitting encounter data, procedures for submitting encounter data, procedures for submitting claims, and timelines for submitting billing information.

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 bases (these providers submit “claims”) and others are paid on a capitated basis or contract under a block purchase arrangement (these provider submit “encounters”). Although the providers submitting claims data utilize standardized forms, submission of claim and encounter data follow the procedure required by NARBHA.

6.2.2 Terms

Definitions for terms are located online at <http://www.azdhs.gov/bhs/definitions/index.php> or <http://www.narbha.org/for-providers/provider-resources/provider-policy-manual/definitions>. The following terms are referenced in this section:

[Claim](#)

[Clean Claim](#)

[Encounter](#)

[Fee-for-Service](#)

[Integrated RBHA](#)

[Retro-eligibility Claim](#)

[Sanction](#)



6.2.3 Procedures

- NARBHA must submit all encounters including resubmissions or corrections to ADHS/DBHS within 210 days from the end date of service.
 - NARBHA 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. NARBHA will also perform data validation studies.
 - A Trading Partner Agreement for Electronic Data Interchange (EDI) transactions must be in place between NARBHA and provider before a provider can submit electronic claim or encounter data to NARBHA.
 - 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 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 [NARBHA PM Attachment 6.0.2, Billing Instructions Used to Identify Crisis Services](#) for guidance).
- a. Providers submit either claims or encounters to a RBHA. TRBHAs and TRBHA providers submit claims (see Attachment 501.2 for further information on where behavioral health service or physical health care service claims/encounters are to be submitted).
- i. All paper claims:
 - 1. Must be legible and submitted on the correct form; and
 - 2. May be returned to the provider without processing if they are illegible; incomplete, or not submitted on the correct form.
 - 3. Are entered as received – NARBHA staff cannot make changes.
 - ii. Health Insurance Portability and Accountability Act (HIPAA) regulations specify the format for the submission of all electronic claims and encounters.
 - 1. HIPAA Format 837P is used to bill or encounter non-facility services, including professional services, transportation and independent laboratories.
 - 2. HIPAA Format 837I is used to bill or encounter hospital inpatient, outpatient, emergency room, hospital-based clinic and residential treatment center services.
 - 3. HIPAA Format NCPDP is used by pharmacies to bill or encounter pharmacy services using NDC codes
 - iii. Specific billing instructions on Medicare Part A and B, and Medicare Part D Prescription Drug Plan are outlined in the [Client Information System \(CIS\) File Layout and Specifications Manual](#) and the [ADHS/DBHS Office of Program Support Procedures Manual](#).



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- b. Claims or encounters submitted to a RBHA:
 - i. The RBHA must submit all encounters including resubmissions or corrections to the Arizona Health Care Cost Containment System (AHCCCS) within 210 days from the end date of service.
 - ii. The RBHA may be assessed sanctions for non-compliance with encounter submission requirements.
 - iii. 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](#)).
 - iv. 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.
 - v. RBHAs must have policies that outline requirements for providers for the submission of claims and encounters, including where claims and encounters are to be submitted and the required timeframes for the submission of claims and encounters.
 - vi. Submitted encounters for services delivered to eligible persons will result in one of the following dispositions:
 - 1. Rejected encounters: Encounters are typically rejected because of a discrepancy between submitted form field(s) and the RBHA's or AHCCCS' edit tables. A rejected encounter may be resubmitted as long as the encounter is submitted within the RBHA's established timeframe.
 - 2. Pended encounters: Encounters may pend at AHCCCS. NARBHA must resolve all pended encounters within 120 days of the original processing date. NARBHA must not delete pended encounters as a means to avoid sanctions for failure to correct encounters within the specified number of days.
 - 3. Adjudicated encounters: Adjudicated encounters have passed the timeliness, accuracy and completeness standards and have been successfully processed by AHCCCS.
 - vii. 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.
 - 1. Rejected encounters for services delivered to Non-Title XIX/XXI enrolled persons will be returned to the RBHA with an explanation of the disallowance.
 - 2. A RBHA may resubmit the encounter within 210 days from the end date of service.
 - viii. Encounters must be submitted to the RBHA within timeframes established in the RBHA's policy or as stipulated in the provider contract. Encounters received beyond the RBHA's timeframe may be subject to timeliness sanctions. Dates of service must not span a contract year. 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.
 - ix. Pseudo identification numbers are only applicable to behavioral health providers under contract with a RBHA.



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1. 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 provider may use a pseudo identification number to register an unidentified person. This allows an encounter to be submitted to AHCCCS, allowing the RBHA and the provider to be reimbursed for delivering certain covered services.
 2. Covered services that can be encountered/billed using pseudo identification numbers are limited to Crisis Intervention Services (Mobile), Case Management, and Transportation.
 3. 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. Pseudo identification numbers:
 - a. NR010115M0 Non-Registered GSA 1
 - b. NR010103M0 Non-Registered GSA 2
 - c. NR010127M0 Non-Registered GSA 3
 - d. NR010123M0 Non-Registered GSA 4
 - e. NR010126M0 Non-Registered GSA 5
 - f. NR010208M0 Non-Registered GSA 6
- c. TRBHA and TRBHA provider claims:
- i. Specific billing instructions for tribal claims are included in the [AHCCCS Billing Manual for IHS/Tribal Providers](#). All paper claims must be submitted using the [CMS 1500](#), [UB-04](#) or the Universal Pharmacy Form.
 1. [The CMS 1500 \(formerly HCFA 1500\) Claim Form](#) is used to bill non-facility services, including professional services, transportation and independent laboratories.
 2. The [UB 04](#) (formerly HCFA 1450) Claim Form is used to bill all hospital inpatient, outpatient, emergency room, hospital-based clinic and residential treatment center services.
 3. The Universal Pharmacy Claim Form is used by pharmacists to bill pharmacy services using NDC codes.
 4. Paper claims are not considered legible if they contain highlighter or color marks, copy overexposure marks or dark edges.
 - ii. Submitted claims for services delivered to a Title XIX or Title XXI eligible person will result in one of the following dispositions:
 1. Claims are typically denied because of a discrepancy between form field(s) and AHCCCS' edit tables. A denied claim may be resubmitted as long as the claim is submitted within 12 months of the date of service. Tribal RBHA claims will be denied in the event the claim is untimely, illegible or incomplete.
 2. Approved claims have passed the timeliness, accuracy and completeness standards and have been successfully processed by AHCCCS.
 - iii. Behavioral health providers must submit accurate, timely and complete claims data to AHCCCS for all covered behavioral health services, either on paper or electronically.



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For NARBHA's submission to ADHS/DBHS:

1. All paper claims must be mailed to AHCCCS Claims, P.O. Box 1700, Phoenix, Arizona 85002-1700.
2. For submitting electronic claims, TRBHAs and TRBHA providers must contact the AHCCCS Electronic Claims Submission Unit at (602) 417-7670 #4.

For providers' submission to NARBHA

1. All encounters or copies of paper encounters:
2. Must be legible and submitted on the correct form.
3. May be returned to the provider without processing if they are illegible, incomplete, or not submitted on the correct form.
4. Are entered as received – NARBHA staff cannot make changes.
5. Paper encounters are mailed to: NARBHA – Claims Unit
1300 S. Yale
Flagstaff, Arizona 86001

Electronic encounters are sent to: NARBHA via Secure FTP
HIPAA regulations specify the format for the submission of all electronic claims and encounters submitted to **Northern Arizona Behavioral Health Authority (NARBHA)**.

6. Encounter Submission Timeframes
All encounters must be submitted by providers to **NARBHA** within six **months** after the date of service. Encounters received beyond the **six months**, may be subject to timeliness sanctions.
7. Dates of service must not span a contract year. Contract years begin on October 1 and end on September 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.
8. 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 contracted providers no later than six months after the date of service. Claims initially received beyond the six month timeframe will be denied. If a claim is originally received within the six 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) and 835 Electronic Remittance Advice for EDI Providers. Providers must correct and resubmit claims within the 12 month clean claim timeframe.



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NARBHA is Payer of Last Resort, if member has any other coverage it must be billed first and reported on the claim when billing NARBHA.

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.

- iv. All initial claims must be received by AHCCCS no later than six months from the date of service, unless the behavioral health recipient has retro-eligibility. For hospital inpatient claims, "date of service" means the date of discharge of the behavioral health recipient. Claims initially received beyond the six-month timeframe, except retro-eligibility claims, will be denied. If a claim is originally received within the six-month timeframe, the provider has up to 12 months from the date of service to resubmit the claim in order to achieve clean claim status or to correct a previously processed claim, unless the claim is a retro-eligibility claim. If a claim does not achieve clean claim status or is not corrected within 12 months, AHCCCS is not liable for payment.
- v. A retro-eligibility claim is a claim where no eligibility was entered in the AHCCCS system on the date(s) of service but, at a later date, eligibility was posted retroactively to cover the date(s) of service. Retro-eligibility fee-for-service claims are considered timely submissions if the initial claim is received by AHCCCS no later than six months from the AHCCCS date of eligibility posting. Retro-eligibility claims must attain clean claim status no later than 12 months from the AHCCCS date of eligibility posting. Corrections to paid retro-eligibility claims must be received by AHCCCS no later than 12 months from the AHCCCS date of eligibility posting.
- vi. Denied claims:
 - 1. AHCCCS will deny claims with errors that are identified during the editing process. These errors will be reported to the provider in the AHCCCS remittance advice. Providers must correct claim errors and resubmit claims to AHCCCS for processing within the 12-month clean claim timeframe.
 - 2. When resubmitting a denied claim, the provider must submit a new claim form containing all previously submitted lines. The original AHCCCS claim reference number (CRN) must be included on the claim to enable the AHCCCS system to identify the claim being resubmitted. Otherwise, the claim will be entered as a new claim and may be denied for being received beyond the initial submission timeframe.
- vii. Paid or Denied Claims
 - 1. Paid or denied claims are reported back to the provider on their Explanation of Benefits (EOB) and 835 Electronic Remittance Advice for EDI Providers.
 - 2. Claims submitted to NARBHA that pass the timeliness, accuracy and completeness standards are paid. Claims that do not meet these standards are denied and Providers have one year from the date of service to correct and resubmit. Claims paid by NARBHA are submitted to DBHS (and AHCCCS for Title XIX/XXI eligible persons). At times encounters fail due to AHCCCS edits, providers are notified of these failures and are expected to correct and resubmit via the void/replacement process.



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viii. Quick Pay Discount/Interest Payments

1. The following procedures apply to claim payments to contracted providers with fee-for-service and single case agreements.
 - a. A quick pay discount of 1% will be applied to hospital clean claims paid within 30 days of the date of the receipt of the clean claim.
 - b. For non-hospital claims, late payments are those that are paid after 45 days of receipt of a clean claim. Interest shall be at the rate of 10% per annum unless a different rate is stated in a written contract. Interest shall accrue starting on the 46th days after receipt of a clean claim.
 - c. For all hospital clean claims, a slow payment penalty is paid in accordance with A.R.S. 2903.01. Slow payments are those that are paid more than 60 days after the receipt of a clean claim. Interest shall be at the rate of 1% per month following the sixtieth day after receipt of the clean claim until the date of payment.
 - d. In grievance situations, interest shall be paid back to the date interest would have started to accrue beyond the applicable requirement.

ix. 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:



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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.
 6. 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.
- x. Required Transaction to Adjust an Overpayment
1. Overpayment adjustments (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. All claims must have the original claim number identified within the replacement claim.
 2. Upon NARBHA's completion of an overpayment adjustment run, reversals and replacement claims will be reported back to Providers on their EOB/835. Overpayment adjustments for Fee for Service and Single Case Agreement providers are deducted from the provider's next claims run and is also reported back to providers on their EOB/835. 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.
- xi. Consequences
1. 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.
 2. Providers may need to take appropriate action, in addition to the steps listed above, to report or notify AHCCCS, ADHS-DBHS, and other agencies

