Section 6.2 Submitting Claims and Encounters to the RBHA

6.2.1 Introduction
6.2.2 References
6.2.3 Scope
6.2.4 Did you know…?
6.2.5 Definitions
6.2.6 Objectives
6.2.7 Procedures
6.2.7-A. What general requirements apply to RBHA providers when submitting encounters?
6.2.7-B. What requirements apply to RBHA contracted providers when submitting encounters?
6.2.7-C What requirements apply to RBHA providers when submitting claims?

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 Magellan.

- 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 Magellan, please contact the Magellan Electronic Data Interchange (EDI) Hot Line at 314-387-5890.

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 180 days from the Date of Service.

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:	Magellan Health Services of Arizona P.O. Box 67090 Phoenix, AZ 85082-7090
Electronic encounters are sent to:	Magellan Health Services of Arizona P.O. Box 67090 Phoenix, AZ 85082-7090

Encounter Submission Timeframes
All encounters must be submitted to Magellan within 180 days from the date of service. Encounters received beyond the 180 days, 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/encounter data to Magellan for all covered behavioral health services. Dates of service must not span a contract year. Contact years begin on July 1 and end on June 30. If a service spans a contract year, the claim/encounter must be split and submitted in two different date segments, so the dates of service do not span a contract year.

No claims/encounters should be submitted for dates of service after a recipient's death. Case management services completed after the date of death should be documented as non-billable services.

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.