CHAPTER 12:
Correcting Claim/Encounter Errors

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

12.0 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.

For more information on our secure provider portals, visit, www.stewardhealthchoiceaz.com under the "Provider" section of our website.
Choose the appropriate provider portal:

i. Behavioral Services Rendered = ICE Provider Portal
ii. Physical Health Services Rendered = ACC Provider Portal

Or contact our Steward Health Choice Arizona Provider Services Unit at (800) 322-8670.

12.1 UNDERSTANDING COMMON BILLING ERRORS

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

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

- **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).

- **Diagnosis code requires to the 6th/7th character level when applicable**
  This edit relates to the validity of the diagnosis code entered on the claim. The diagnosis is required to be reported to the highest applicable character level. 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.

- **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.

- **Invalid Procedure/Service Code**
  This edit relates to the validity of the procedure/service code entered on the claim form.

  For all of the procedure/service code edits, verify that the procedure/service 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.

- **Procedure/Service Modifier**
  This edit relates to the validity of the procedure/service modifiers entered on a claim form.

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

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

- **Recipient Eligibility/Enrollment**
  This edit relates to the recipient's eligibility for the services billed claim form.

  Recipient Not Eligible/Enrolled for Entire DOS; Invalid Eligibility

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

  Resubmit corrected claims/encounters containing only the dates of services the recipient was eligible with Steward Health Choice Arizona.

- **Timeliness**

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

Claim Received - Past 6 Month Limit
The initial claim for services was received by Steward 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 processed claim/encounter.

Claim Received - Past 12 Month Limit, Deny
A resubmission of a denied claim was received by Steward 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.

12.2 CLAIM RESUBMISSION/REPLACEMENT

If a clean claim was denied due to a billing error, the corrected claim must be resubmitted/replaced 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/replacement.

12.3 CLAIM DENIAL DISPUTES

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