CUTE/CRS RFP YH14-0001 IT SYSTEMS DEMONSTRATION QUESTIONS AND RESPONSES TEMPLATE

AHCCCS Response #	Date Question Received	Related Exchange	Date Exchange Rcvd or Due	Question	Date Response Provided	Response
Example	1/29/2013	Initial Daily 834	1/29/2013	Should the file contain my assigned AHCCCS Health Plan Id?	1/29/2013	No, as this is "mock data" for purposes of the exercise only a "mock" health plan ID is used in the file.
Example	1/29/2013	Initial Daily 834 Summary Response	1/29/2013	Do I need to fill in all 40 blanks on the Response Document for 2a. *Recipient ID #'s for Recipients whose enrollment is Prospective*?	1/29/2013	No, fill in the appropriate number of spaces for each response.
1	1/29/2013	Encounters 837	1/29/2013	What receive date do we use for claims?	1/29/2013	For the purposes of this exercise, the date of receipt is equal to the date AHCCCS made the specific claims scenarios available to the Offerors per the published IT Systems Demonstration calendar.
2	1/29/2013	Initial 837	01/28/2013	If the Offeror bid specific GSAs and the claims scenarios given to us by AHCCCS include claims outside the GSAs we bid, do we process the claims scenarios as we would in accordance with our bid, or as if we bid statewide?	1/29/2013	All scenarios provided by AHCCCS must be processed regardless of the GSA's bid or not bid by the Offeror.
3	1/29/2013	Initial 837	01/28/2013	Do we assume that all services indicated on any claim were rendered by and/or referred by the PCP assigned to the member and process claims according to that assumption?	1/29/2013	Yes.
4	1/29/2013	Initial 837	01/28/2013	Do we assume that all claims are prior authorized?	1/29/2013	Yes.
5	1/29/2013	Initial 837	01/28/2013	Do we assume that all claims are medically indicated (medical necessary)?	1/29/2013	Yes.
6	1/29/2013	Initial 837	01/28/2013	Is it correct to validate provider TAX ID, if improperly submitted on a claim, via any other indicators, such as facility/provider name, address. Likewise are we allowed to do the same with an incorrectly submitted NPI?	1/29/2013	AHCCCS does not anticipate issues related to the Tax Id or NPI information utilized in the claims scenarios as all scenarios have been internally tested by AHCCCS with no issues identified.
7	1/29/2013	Initial 834	01/28/2013	Is it correct to validate member enrollment, if the	1/29/2013	Assume question is in relation to Initial

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		Enrollment		member identification number submitted on a claim does not match the AHCCCS assigned ID number, via any other indicators on the claim?		837/Paper Claims exchange rather than the noted Initial 834 Enrollment exchange. AHCCCS does not anticipate issues related to the AHCCCS Id information utilized in the claims scenarios as all scenarios have been internally tested by AHCCCS with no issues identified.
8	1/29/2013	Initial Paper Claims	01/28/2013	Do we assume there are no typographical errors on ALL claims provided as part of this IT Demo?	1/29/2013	AHCCCS does not anticipate issues related to the key data elements which are required to process the claims as all scenarios have been internally tested by AHCCCS with no issues identified.
9	1/29/2013	Initial Paper Claims	01/28/2013	Is it correct to reduce the level of service ("Downcoding") and thus affect level of reimbursement on a claim based upon prior claim history received as part of this IT Demo?	1/29/2013	No, downcoding should not be applied to the provided claims scenarios.
10	1/29/2013	Initial 834 Enrollment	01/28/2013	Is it correct to assume that if a single 834 file contains conflicting add/change records for a single member, do we load the member's eligibility based upon the final disposition?	1/29/2013	Information must be loaded as received.
11	1/29/2013	Reference Data Extract – Initial Extract	Rcvd: 01/29/2013	When processing claims and submitting the corresponding encounters, is the expectation that all of the claim pricing will come from the rate files provided as detailed in REFER01 – H2 and REFER02 – M3 or will they come from REFER06 – M1/M2?	1/29/2013	At this time there is no difference between these rate files so either may be utilized.
12	1/29/2013	837 – Encounters – Initial 837	Due: 02/01/2013	If the Offeror has the capability of producing an 837 Encounter file, would this be allowed to be submitted in lieu of the AZ 837P/837I/837D ENC Template First Submission?	1/29/2013	No, AHCCCS expects that the 837 Encounter templates as provided will be utilized by all Offerors.

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		Encounter Submission				
13	1/29/2013	Encounters Submission 1 Encounters 837 Template and Layout for Expected Summary Response	1/29/2013	What specific data elements are being requested for the Encounters Initial Summary Response? There are no column headings on the Response Template. What data elements do you want in each field? Are you just looking for the file name of the individual claim scenario?	1/29/2013	There are no column headings on any Response Templates, the items for which we are expecting a response are noted in column A and appropriate responses are to be provided in columns B, C and D. Specific expectations for each response are clearly outlined in the template.
14	1/29/2013	Claims Scenario – Group 1	1/29/2013	Should claims be priced at 100% and ignore AHCCCS protocol for mid-level pricing?	1/29/2013	Per the IT Systems Demonstration Provisions "Contracted rates, discounts and penalties should not be applied; only the AHCCCS Fee Schedule provided in the Reference File extract should be used." to the extent a mid-level provider type discount applies per the Reference extracts it should be utilized.
15	1/29/2013	Initial Daily 834 Summary Response	1/29/2013	Should we ignore the fact that we are the current contractor when processing members outside of our currently contracted counties?	1/29/2013	All scenarios provided by AHCCCS must be processed regardless of the GSA's bid or not bid by the Offeror. Current contracts are not a consideration.
16	1/29/2013	Claims Scenario – Group 1	1/29/2013	What Action should be taken if your AHCCCS file is not HIPAA Compliant?	1/29/2013	For purposes of this exercise, AHCCCS does not expect validation of HIPAA compliance of provided files.
17	1/29/2013	Claims Scenario – Group 1	1/29/2013	Did AHCCCS give any thought to the correlation of the provider type, the type of service and the members when they sent us the claims data?	1/29/2013	AHCCCS does not anticipate issues related to the key data elements which are required to process the claims as all

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						scenarios have been internally tested by AHCCCS with no issues identified.
18	1/29/2013	Claims Scenario – Group 1	1/29/2013	How should 837 files be handled without segment delimiters? Currently, the segments are followed by hard returns.	1/29/2013	For ease of manual processing as needed by Offerors, hard returns were utilized in the 837 claims scenario files. For automated processing, the Offeror will need to replace the hard returns with the delimiter specified in the file ISA segment.
19	1/29/2013	All		If an Offeror entity is bidding under two names – once for themselves, and once on behalf of another health plan that they manage – and all processes are managed within the same IT system - will the demo exchanges need to be completed once for all, or once for each Offeror? (e.g. UFC and MHP)	1/29/2013	All IT Systems Demonstration exchanges must be completed for each entity bidding.
20	1/29/2013	Reference, Provider & Profile Files		Do the reference, provider and profile files provided to the Offeror by AHCCCS contain the same information as used by the current production reference files in use by current contractors?	1/29/2013	Production reference files are not a consideration of this exercise; per the IT Systems Demonstration Provisions "All scenarios will be based upon and will require the offeror to utilize member, provider and reference data supplied to the Offeror by AHCCCS."
21	1/29/2013	Encounters		Is the expectation that the Offeror submit a completed Encounter Response, as well as provide the 837 outbound files for each claim form type? Or, is submission of an electronic 837 Encounter sufficient?	1/29/2013	It is expected that both the Encounter Expected Response as well as the completed 837 I/P/D Encounter Template be provided by each Offeror.
22	1/29/2013	Claims Processing		There is reference to a "Scenario #" in the Claims response template. What is the scenario # that AHCCCS is expecting? Is it the AHCCCS Member identifier, or another data element?	1/29/2013	Assigned Scenario #'s for each claims scenario are reflected in the Patient Account/Patient Control Number field on each paper or electronic claim.

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23	1/29/2013	Claims Processing		Are both the paper and EDI claims expected to be processed?	1/29/2013	Yes.
24	1/29/2013	834 Initial Daily	1/29/2013	Is the "Recipient ID #", referenced in the 834 response template, the AHCCCS member ID # or another data element?	1/29/2013	AHCCCS member ID#.
25	1/29/2013	834 Initial Daily Enrollment	1/29/2013	Is it is safe to assume that one member could be identified with Prospective Enrollment and Medicare (or multiple combinations of the "types" listed on the template – in other words, they are not mutually exclusive, correct?	1/29/2013	Yes.
26	1/29/2013	834 Initial Daily	1/29/2013	Should the Offeror assign a PCP to each member?	1/29/2013	For purposes of this exercise, PCP assignment is not expected.
27	1/29/2013	Claims Processing		Should the Offeror take a quick pay discount on inpatient hospital claims?	1/29/2013	Per the IT Systems Demonstration Provisions, "All scenarios will be based upon and will require the offeror to utilize member, provider and reference data supplied to the Offeror by AHCCCS. Contracted rates, discounts and penalties should not be applied; only the AHCCCS Fee Schedule provided in the Reference File extract should be used."
28	1/29/2013	UB Cycle 1		The room/board lines are indicating units on the 837i file. Should the Offeror substitute the units for days, as units are incorrect for those claim lines and would normally be denied. Please advise.	1/29/2013	Yes, for purposes of this exercise, the Offeror should substitute the units for days on room/board lines.
29	1/29/2013	Overall		In the IT Systems Demo INTRODUCTION. It states I will have access to User Guides and Manuals. I do not see anything similar in my secure FTP portal.	1/29/2013	All referenced User Guides and Manuals are available in the Bidders Library. Only materials related to the actual IT Systems Demonstration itself are made available through the secure FTP portal.

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30	1/29/2013	Overall		Can you confirm that our submissions of the required documents through the IT Demo period are to be placed in the Information Technology(IT)Systems Demonstration Review Submission folder on this FTP	1/29/2013	Yes. All IT Systems Demonstration "mock" data files, scenarios and Expected Response documents from AHCCCS will be posted to the Information Technology (IT) Systems Demonstration Review Files folder; and all submissions from the Offeror of required documentation should be posted to the Information Technology (IT) System Demonstration Review Submission folder.
31	1/30/2013	834 Initial	1/28/2013	Where there is a rate code on an 834 file related to a member that specifies non-Medicare but the enrollment file indicates the member has Medicare coverage in the COB field, we are assuming the rate code the COB information prevails?	1/30/2013	Rate code is not intended to reflect current status as of today; it will only reflect the information in effect when the enrollment is created. Rate code is not a reliable indicator of benefits.
32	1/30/2013	Claims – Group 1	1/29/2013	Is there a preferred naming convention for the encounter files?	1/30/2013	Returned completed Template (one file per encounter and one tab per line) should be named using the same naming convention of the file from AHCCCS to the Offeror followed by an incremental number for each encounter. I.e. AZ 837D ENC Template First Submission Encounter 1.xls, AZ 837D ENC Template First Submission Encounter 2.xls, etc…
33	1/30/2013	Initial Daily	1/29/2013	In the 834 summary Layout please clarify what goes in section #5 "Number of Recipients with TPL records added"- Is it all other non-Medicare COB information?. You continue to use COB and TPL interchangeably which causes some	1/30/2013	Represents a count of members with non-Medicare TPL/COB information.

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				confusion. Could this #5 also read 'number of Recipients with COB/TPL records added'?		
34	1/30/2013	Encounter Submission 1	1/29/2013	Please provide nomenclature for the Encounter template submission. How are we to name the template responses for each encounter submitted?	1/30/2013	Returned completed Encounter Template (one file per encounter and one tab per line) should be named using the same naming convention as the file from AHCCCS to the Offeror, followed by an incremental number for each encounter. I.e. AZ 837D ENC Template First Submission Encounter 1.xls, AZ 837D ENC Template First Submission Encounter 2.xls, etc…
35	1/30/2013	Claims Scenarios Group 1	1/29/2013	Do we need to edit for NDC required for Physician Administered Drugs in outpatient settings?	1/30/2013	For purposes of this exercise, this editing is not anticipated to be required.
36	1/30/2013	Encounter Submission 1	1/29/2013	Will there be any response (824,999,277CA) or result files (Pend correction, 277U/S) from AHCCCS for the encounter submissions?	1/30/2013	Encounter submissions are in the form a Template and Response file only. Per the IT Demonstration Calendar, there are no resulting exchanges from AHCCCS to Offeror as a result of these submissions.
37	1/30/2013	Claims Scenarios Group 1	1/29/2013	Outpatient claims – Should they be priced per the IT Demo reference file N2 records?	1/30/2013	Yes, appropriate methodology and provided Reference extracts should be utilized by the Offeror.
38	1/30/2013	Claims Scenarios Group 1	1/29/2013	Is the processing of outpatient claims to be done under the normal AHCCCS OPFS processing guidelines for the Date of service NCCI editing and date span of the claim for Rev Code bundling and observation of ER Services?	1/30/2013	Yes, appropriate methodology and provided Reference extracts should be utilized by the Offeror.
39	1/30/2013	Initial Daily 834	1/29/2013	Two claims were received for newborns – is it safe to assume that the required communication to	1/30/2013	AHCCCS expects that Claims Scenarios should be processed based upon the data

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		Claims 837i		AHCCCS has already occurred, and that the enrollment may be forthcoming? Or, following AHCCCS guidelines, should the offeror, during this demo, "notify" AHCCCS of the newborn claim/delivery?		provided to the Offeror. If a claim is received for a recipient you have not yet received a recipient record for in the 834 exchanges the Offeror is expected to process accordingly. Plan newborn notification processes are not included as a component of the IT Systems Demonstration.
40	1/30/2013	Claims	1/29/2013	For the purposes of this demo, is it safe to assume that the billing address noted on a claim (although different than the address associated with the provider TIN in the reference files) is simply another billing location for the provider?	1/30/2013	Yes.
41	1/30/2013	Claims	1/29/2013	Should the offeror assume that the value for units represents minutes for any anesthesia claim received?	1/30/2013	Yes.
42	1/30/2013	Summary of Claims Processing	1/30/2013	What is the source of truth for inpatient claims? Are inpatient $ rates included in the REFER tables, including per diem rates? cost-to-charge ratios? Peer group multipliers? Or should we use the inpatient data from the bidder's library?	1/30/2013	Per the IT Systems Demonstration Provisions, "All scenarios will be based upon and will require the offeror to utilize member, provider and reference data supplied to the Offeror by AHCCCS." Inpatient rates are provided as a component of the aforementioned provider data and therefore the Offeror should not use inpatient data from the bidder's library.
43	1/30/2013	Summary of Claims Processing	1/31/2013	The state had previously indicated that on all claims we should assume that medical necessity has been met. Does this guidance override age limitation for children's dental procedures.	1/30/2013	Dental services for adults are not a covered AHCCCS benefit, therefore medical necessity is not an overriding consideration.

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44	1/30/2013	837 Claims Scenario Grp 1	Due : 01/31/2013	UB-34: Primary diagnosis of 583.83 is invalid. Per the answers received yesterday, we did not expect to see invalid codes. "AHCCCS does not anticipate issues related to the key data elements which are required to process the claims as all scenarios have been internally tested by AHCCCS with no issues identified. " Per our internal claims processing rules, we do not allow claims with invalid codes into our system, but instead rejects these claims back to the provider. This is how we will handle it for this testing process. Are we interpreting this correctly?	1/30/2013	AHCCCS expects that Claims Scenarios should be processed based upon the data provided to the Offeror. If a claim is received for an invalid code the Offeror is expected to process accordingly.
45	1/30/2013 (after noon deadline)	Initial Daily 834 Summary Response	Due 1/30/13	In the Q&A 'ACUTE_CRS_RFP_IT_DEMO_Responses 01 29 13.pdf', it mentions the 'SystemsDemonstrationReviewSubmission' folder for offeror submissions/response. However, there is a subfolder named 'Acute-CRS-RFP *Health Plan Name* IT group'. We attempted to submit the 834 response to the ReviewSubmissions folder, but it looks like this is a read only folder. (it gave an error when uploading—SFTP: No Such File)/. As a result, we submitted the 834 summary to the subfolder that includes our health plan name and it went through without a problem.	1/31/2013	AHCCCS confirmed that file was found and retrieved from the correct folder.

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				May we please confirm with AHCCCS that subfolder: '/AcuteCare-CRS-RFP14/InformationTechnology(IT)SystemsDemonstration ReviewSubmission/Acute-CRS-RFP Health Plan Name IT group' is where we should place our responses?		
46	1/30/2013 (after noon deadline)	Encounter Submission Response 1	1/30/2013	AHCCCS responded to the question regarding encounter template submission nomenclature [AHCCCS response numbers 32 and 34] with: "Returned completed Encounter Template (one file per encounter and one tab per line) should be named using the same naming convention as the file from AHCCCS to the Offeror, followed by an incremental number for each encounter. I.e. AZ 837D ENC Template First Submission Encounter 1.xls, AZ 837D ENC Template First Submission Encounter 2.xls, etc…" Would it be easier for AHCCCS to track the paid encounters to claims using the test claim scenario in the file name instead of an incremental count? For example assuming the test scenarios included Claim ADA-22 and Claim ADA-36 and that these claims were paid, the encounter templates would be labeled "AZ 837D ENC Template First Submission Encounter ADA-22.xls and AZ 837D ENC Template First Submission Encounter ADA-	1/31/2013	Either the nomenclature/naming convention noted in AHCCCS' Response #32, or the suggested nomenclature/naming convention (i.e. AZ 837D ENC Template First Submission Encounter ADA-22.xls , AZ 837D ENC Template First Submission Encounter ADA-36.xls) will be acceptable to AHCCCS for the naming of Encounter Template submissions.

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				36.xls". Otherwise AHCCCS will need to identify and link each incrementally named template to the test scenario. In addition, test scenarios may be labeled differently if using the incremental method. One Offeror may label Claim ADA-22 as AZ 837D ENC Template First Submission Encounter 5.xls while another Offeror may label that claim as AZ 837D ENC Template First Submission Encounter 8.xls.		
47	1/31/2013	Initial Daily 834	1/30/2013	Based on the Correct 834 Response file posted, there were '0' recipients with TPL on the file. However, we saw they had both open Medicare segments and open COB segments. Are we supposed to interpret the COB records as a replacement for Medicare, rather than additional TPL?	1/31/2013	Refer to AHCCCS Response #33.
48	1/31/2013	Encounters 837	1/29/2013	We are receiving a PO Box address on paper claims which translates into the billing provider loop (2010AA) on the 837 encounter. In this case, should we then pull the street address from our claim processing system to populate the billing provider address or place the PO Box address we receive in this loop?	1/31/2013	For purposes of this exercise, AHCCCS will support the submission of P.O Box data as indicated on the claims scenarios for the submission of the 837 Encounter Templates.
49	1/31/2013	Encounters Submission 1	01/29/2013	Required segments/elements: Does 'Expected', mean required on the Encounter template. For example the PRV03 element, taxonomy codes.	1/31/2013	AHCCCS expects that the fields within the Template will be populated if required by the TR3 guidelines for the type of encounter being submitted.
50	1/31/2013	Claims Scenarios – Group 1	01/29/2013	Should a "Description" or a "Reason Code" be used to convey the 'Reason Not Paid' on the Expected Response Claims Processing 1 template?	1/31/2013	AHCCCS expects a short narrative description of the reason for denial of the claim scenario.

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				You provided no reason code table in your test reference information; please clarify your expectations for our responses in section #3- column "reason not paid".		
51	1/31/2013	Encounters Submission 1	01/29/2013	Can the encounter response values be populated in segment format as demonstrated in your encounter template or do the values need to be populated in the designated element record? Response example, 1000B, the segment is 'NM1*40*2*AHCCCS*****46*866004791~', can this value be populated in NM1 or NM101 box, or is the expected value '40' and NM102's expected value '2', etc. ?	1/31/2013	Must be populated as outlined in the Encounter Template by filling in the appropriate box for each response.
52	1/31/2013	Encounters Submission 1	01/29/2013	Is data required in 2300 CR101 and CR102. If required and the patient weight is not known, can zero be sent in CR102?	1/31/2013	For purposes of this exercise AHCCCS will not require submission of the patient weight information in the 837 Encounter Templates.
53	1/31/2013	Encounters Submission 1	01/29/2013	The encounter templates contain some sections open for data where they are marked as not used by AHCCCS in the Companion Guide. For instance, 2010BA, REF Property and Casualty claim number is open for REF01 and REF02 data. There are many others like this. In the 837 encounter templates will AHCCCS require data passed in the 837 claims that are not listed as required in the Companion Guide?	1/31/2013	AHCCCS expects that the fields within the Template will be populated if required by the TR3 guidelines for the type of encounter being submitted.
54	1/31/2013	2nd 834 file	02/01/2013	If there is an invalid rate code sent on a member record, should that record be rejected or should the record be treated as if that is a valid rate code?	1/31/2013	As noted in the Information Technology (IT) Systems Demonstration Provisions, All data provided to the Offeror either for response or processing will be

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						"mock" data created by AHCCCS. For purposes of this exercise, please treat all rate codes provided as valid.
55	1/31/2013	Second Daily	1/31/2013	If the IT Demo 834 enrollment file data contains an invalid rate code is the expectation to load this member in anticipation of other transactions that might follow and would indicate an error? We would normally contract AHCCS to have rate code corrected, what is your expectation?	1/31/2013	As noted in the Information Technology (IT) Systems Demonstration Provisions, All data provided to the Offeror either for response or processing will be "mock" data created by AHCCCS. For purposes of this exercise, please treat all rate codes provided as valid. Rate code information provided should not impact subsequent responses.
56	1/31/2013	Summary of Claims Processing	1/31/2013	In a previous question to AHCCCS (#41) "Should the offeror assume that the value for units represents minutes for any anesthesia claim received?" the response given was "Yes.". If offerror assumes the values submitted for anesthesia claims is minutes; then 6 minutes = 1 time unit, and 8 minutes also equals 1 time unit, correct?	1/31/2013	Refer to the Fee-for-Service Provider Manual in the AHCCCS Bidder's Library.
57	1/31/2013	Summary of Claims Processing	1/31/2013	If there is an industry standard edits or AHCCCS standard policy that isn't in bidder's library are we to include that edit in our claims processing?	1/31/2013	All Guides, Manuals and Policies are posted the AHCCCS Bidder's Library.
58	1/31/2013	Summary of Claims Processing	1/31/2013	Question 3 on the response asks requests "Reason Not Paid". What is expected response in this field? Standard HIPAA compliant denial reason codes? Standard HIPAA compliant denial reason explanations that would appear on a remit? Free form text? Other?	1/31/2013	AHCCCS expects a short narrative description of the reason for denial of the claim scenario.
59	1/31/2013	Second Daily 834	1/30/2013	A member was provided on the Day 2 file with a rate code that was not provided in the Bidder's	1/31/2013	As noted in the Information Technology (IT) Systems Demonstration Provisions,

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				library: Should we ignore loading this member or will AHCCCS provide a valid rate code to load the member?		All data provided to the Offeror either for response or processing will be "mock" data created by AHCCCS. For purposes of this exercise, please treat all rate codes provided as valid.
60	1/31/2013	Claims Scenarios – Group 1	1/29/2013	Is it safe to assume that the exact format/verbiage of the claims adjustment reason (for claims not paid) is not a factor in the scoring of the IT Demo? Or, for example, is the expectation that only X12 standard verbiage is to be used?	1/31/2013	For purposes of this exercise, AHCCCS will not consider this a factor for submission of the 837 Encounter Templates.
61	1/31/2013	Claims Scenarios – Group 1	1/29/2013	Is it safe to assume that the claims response template section for "claims not paid" should include both claims denials as well as rejections?	1/31/2013	AHCCCS expects inclusion as noted of any claims scenarios which are "not paid".
62	1/31/2013	Claims Scenarios – Group 1	1/29/2013	For members with dual Medicare and AHCCCS eligibility, is it safe to assume that the Medicare carrier assigned by AHCCCS is for demonstration purposes only? If not, is there an expectation, during this demo, that benefits will be coordinated with the Medicare payers received on the enrollment record?	1/31/2013	AHCCCS does not expect any coordination with Medicare payers related to this exercise. As noted in the Information Technology (IT) Systems Demonstration Provisions: All data provided to the Offeror either for response or processing will be "mock" data created by AHCCCS.
63	1/31/2013	837 Claims Scenario Grp 1	Due : 02/01/2013	We received Claims Scenarios – Group 1 on 1/29. We assume those claims are to be included in the Initial 837 Encounter Submission that is due on 2/1. We are set to receive Claims Scenarios – Group 2 on 2/1. These will be submitted in the Second 837 Encounter Submission due on 2/7. We are set to receive Claims Scenarios – Group 3 on 2/6. We note that there is a Summary for Claims Scenarios Group 3, but there is not an Encounter Submission on the schedule for Group 3 Claim	1/31/2013	Per the Information Technology (IT) Systems Demonstration Calendar, there are only two iterations of Encounter exchanges.

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				Scenario. Are these to be included in an Encounter Submission for testing purposes? If yes, when is that 837 Encounter Submission due?		
64	1/31/2013	Encounters Submissions 1	Due 02/01/2013	On the AZ 837P ENC Template First Submission, AZ 837D ENC Template First Submission and AZ 837I ENC Template First Submission, on the first tab it looks like the header information is already filled in. Do we need to change this information or can we keep what is in there already?	1/31/2013	AHCCCS expects that the fields within the Template will be populated if required by the TR3 guidelines for the type of encounter being submitted. AHCCCS does not expect that shaded or "greyed out" boxes will be completed.
65	1/31/2013	Encounters Submissions 1	Due 02/01/2013	There are also fields that are greyed out (column E, row 69-74) on the AZ 837P ENC Template First Submission, are you expecting the Offeror to fill out these fields, or should the Offeror only fill out the white fields?	1/31/2013	AHCCCS expects that the fields within the Template will be populated if required by the TR3 guidelines for the type of encounter being submitted. AHCCCS does not expect that shaded or "greyed out" boxes will be completed.
66	1/31/2013	834 First Daily	1/29/2013	Do we have the opportunity to discuss an incorrect answer, and what is the appropriate process to clarify incorrect answer results, if such a process exists?	1/31/2013	The sole purpose for providing the correct responses is to ensure that all Offerors start the next interdependent exchange on an equal basis and so that no Offeror is penalized for incorrect responses from a preceding exchange. AHCCCS will not entertain any input into correct or incorrect responses and will not amend scoring based on justification provided by any Offeror.
67	1/31/2013	834 First Daily	1/29/2013	Should we define "recipient" for the purposes of this IT Demo as a unique member/person or unique AHCCCS ID number?	1/31/2013	For purposes of this exercise unique Recipients are unique AHCCCS Id's.
68	1/31/2013	834 Second Daily	1/30	Please define the term "demographics" as used in the expected scenario templates?	1/31/2013	For purposes of this exercise "demographics" is defined as Recipient Name, gender and date of birth.

AHCCCS Response #	Date Question Received	Related Exchange	Date Exchange Rcvd or Due	Question	Date Response Provided	Response
69	1/31/2013	837 First Round	1/30	Do we assume when we have transportation claims for Behavioral Health, that the transportation being billed is for the first transportation service being provided to the member by the offeror?	1/31/2013	For purposes of this exercise, yes, assume this is the first transportation service being provided to the member.
70	1/31/2013	837 First Round	1/30	Do we assume Yuma, AZ is designated as rural for the purposes of this IT Demo?	1/31/2013	Urban or Rural designation occurs at the hospital level and is reflected in assigned fee schedule. Additional information may be obtained in the Guides, Manuals and Policies as posted the AHCCCS Bidder's Library.
71	1/31/2013		1/30	Are we to adjudicate as the primary carrier if on the 834 Enrollment there is COB/TPL indicated, but there is no EOB attached to the claim?	1/31/2013	For purposes of this exercise it should be assumed that necessary COB has occurred and no EOB should be required.
72	1/31/2013	834 Second Daily	1/30	On the template "IT_Demo_Expected_Responses_834_-_Second_Daily.xlsx" the Q1 answer cell is "greyed" out – do we answer the question?	1/31/2013	AHCCCS does not expect that shaded or "blacked/greyed out" boxes as outlined in any Response template will be completed.
73	1/31/2013	837 First Round	1/30	For purposes of this demonstration should the offerer assume that that absence of EOB attachments for purposes of processing COB is intentional and should be processed as missing?	1/31/2013	For purposes of this exercise it should be assumed that necessary COB has occurred and no EOB should be required.
74	1/31/2013	837 First Round	1/30	If an allowable is greater than the billed charges should the reimbursement be limited to only an amount up to the billed charges?	1/31/2013	Refer to the Fee-for-Service Provider Manual in the AHCCCS Bidder's Library.
75	1/31/2013	834 Second Daily	1/30	For the purposes of this IT Demo, is the term "address" considered part of "demographics" or are the two terms mutually exclusive?	1/31/2013	For purposes of this exercise "demographics" is defined as Recipient Name, gender and date of birth.
76	1/31/2013	837 First Daily	1/30	Services for newborns billed under the mother's AHCCCS ID will be identified as service code "invalid" for the age of the member; do we bypass	1/31/2013	Newborns receive separate AHCCCS ID numbers, and services for them must be billed separately using the newborn's ID.

AHCCCS Response #	Date Question Received	Related Exchange	Date Exchange Rcvd or Due	Question	Date Response Provided	Response
				the edit on the reference files and process the claim?		
77	1/31/2013	837 First Daily	1/30	Do we assume the term "Medicare Changes" as used in this IT Demo only apply to a change of the COB plan?	1/31/2013	For purposes of this exercise, Medicare changes are defined as the addition or removal of Medicare data for a recipient.
78	1/31/2013	837 First Daily	1/30	The reference files provided do not address the validation of TOOTH NUMBER "primary" vs. "permanent" in relationship to member age; do we assume the TOOTH NUMBER is "primary" for the purposes?	1/31/2013	For purposes of this exercise, yes, assume the Tooth Number is "primary".
79	1/31/2013	837 First Daily	1/30	For the purposes of the demo, should the reference tables be the only source to determine the validity of a code based upon age?	1/31/2013	Yes, for purpose of this exercise; per the IT Systems Demonstration Provisions "All scenarios will be based upon and will require the offeror to utilize member, provider and reference data supplied to the Offeror by AHCCCS."
80	1/31/2013	837 First Daily	1/30/2013	Modifier SL designates a VFC immunization administration, is the SL modifier only to be used for a recipient/member under age 19?	1/31/2013	Refer to the Fee-for-Service Provider Manual in the AHCCCS Bidder's Library.
81	1/31/2013	834 Second Daily	1/31/2013	If coverage has ended and no prospective coverage is added does that fall under the definition of a "termination" for the purposes of this IT Demo?	1/31/2013	Termination is designated through the ending of coverage as indicated by a disenrollment transaction.
82	1/31/2013	837 First Daily	1/31/2013	Does a claim fall under the definition of "paid" for the purposes of this IT Demo if the payment is for zero dollars and the claim is not denied?	1/31/2013	For purposes of this exercise, yes, zero paid claims are considered paid claims.
83	1/31/2013	Summary Responses (All)	1/31/13	If we disagree with a result from a summary response may we send a question back to AHCCCS and provide our reasoning? If yes, how does AHCCCS prefer the information be sent (format, template, etc.)	1/31/2013	The sole purpose for providing the correct responses is to ensure that all Offerors start the next interdependent exchange on an equal basis and so that no Offeror is penalized for incorrect responses from a preceding exchange.

AHCCCS Response #	Date Question Received	Related Exchange	Date Exchange Rcvd or Due	Question	Date Response Provided	Response
						AHCCCS will not entertain any input into correct or incorrect responses and will not amend scoring based on justification provided by any Offeror.
84	1/31/2013	Initial 837	1/31/13	Response 41 was that the Offeror should assume that the value for units represents minutes for any anesthesia claim received. The unit values for anesthesia claims received is very small considering the billed charge amount by providers, diagnoses and procedures. Ignoring standard protocol, should the anesthesia unit values really be units instead of minutes for claim reasonability?	1/31/2013	Refer to the Fee-for-Service Provider Manual in the AHCCCS Bidder's Library.
85	1/31/2013	All	1/31/2013	Do I need to indicate my plan name in blank Offeror segment at the top of each Response document?	1/31/2013	For purpose of all Response files, yes, it is necessary to include your Offeror name in the blank Offeror segment at the top of each page.
86	2/1/2013	Second 834	1/31/2013	All these all considered 834 demographic changes? Change of location, Plan Change (Acute Health Plan or Mental Health Termination/Change), DOB, Sex and/or Name Change, and/or Pregnancy?	2/1/2013	For purposes of this exercise "demographics" changes are defined as Recipient Name, gender and date of birth.
87	2/1/2013	Second Daily	1/31/2013	In IT Demo Second Daily 834 enrollment set, you sent a co-pay code that is invalid for member county of residence. It would appear that your test data does not correlate these data elements? Are we to ignore this data relationship?	2/1/2013	For purposes of this exercise copay levels are not a consideration.
88	2/1/2013	Second Daily	1/31/2013	Number of recipients with behavioral health changes: Does that include recipients with any type of mental health transaction?	2/1/2013	Yes, includes any behavioral health change transactions, which may be one or more per recipient.
89	2/1/2013	820 Initial	2/1/2013	In our normal 820 data, we get a line for each individual month. In this mock IT demo 820 data	2/1/2013	As noted normal 820 processing does not include payments that cross-over

AHCCCS Response #	Date Question Received	Related Exchange	Date Exchange Rcvd or Due	Question	Date Response Provided	Response
				some of the time periods for eligibility cross over months. Are we to ignore this anomaly in the test data set? If not, what are your expectations for our processing results?"		multiple months. However due to the condensed nature of this exercise, the "mock" data provided allows for this. All data provided should be considered by the Offeror.
90	2/1/2013	837 Initial	1/31	Is it correct to assume we should have already received an "ANSWER" file for "Summary for Claims Scenarios Group 1"? We have not received such "ANSWER" as of the submission of these questions.	2/1/2013	The sole purpose for providing the correct responses is to ensure that all Offerors start the next interdependent exchange on an equal basis and so that no Offeror is penalized for incorrect responses from a preceding exchange. In the case of the Claims Scenarios Group 1, potential impacts to subsequent exchanges are currently under evaluation and "Correct Responses" will be provided as appropriate.
91	2/1/2013	General	2/1	For each and every submission, should we expect an "ANSWER" response from AHCCCS prior to submission of the next day's required responses to scenarios?	2/1/2013	The sole purpose for providing the correct responses is to ensure that all Offerors start the next interdependent exchange on an equal basis and so that no Offeror is penalized for incorrect responses from a preceding exchange. In the event there is not interdependency, "Correct Responses" will not be provided.
92	2/1/2013	General	2/1	What time does AHCCCS upload "ANSWER" files to the SFTP site for submissions?	2/1/2013	Per the IT Systems Demonstration Provisions, as appropriate, AHCCCS intends to provide feedback no later than 5:00 p.m. the next business day as to the actual expected results of each exchange.
93	2/1/2013	837 Initial	1/31	Do we assume that the encounter scenario	2/1/2013	For purposes of this exercise, Encounter

AHCCCS Response #	Date Question Received	Related Exchange	Date Exchange Rcvd or Due	Question	Date Response Provided	Response
				submissions will include information from AHCCCS regarding ANSWERS from the corresponding claims scenarios?		scenario submissions are intended to demonstrate the Offerors ability to correctly recognize and submit complete and accurate records for claims they have designated as paid. This exercise, is not intended to evaluate whether or not an Offeror is able to submit all claims scenarios that AHCCCS may have designates as expected to be paid.
94	2/1/2013	834 Second Daily	1/31	Do we assume for the 834 Enrollment 2nd Daily response scenarios that we include membership information/Recipient ID's from both the Initial Daily and Second Daily 834 files in response specifically to 2a-5a? Are our responses supposed to be cumulative of all member ID's or member ID's for just the 2nd Daily file?	2/1/2013	Responses should apply only to the specific data exchange in progress and are not intended to be cumulative of prior exchanges.
95	2/1/2013	834 Second Daily	1/31	When you receive both add and change records for newly added Recipients, should the change for the newly added recipient be counted in the count of changes?	2/1/2013	Yes, they are distinct transactions.
96	2/1/2013	834 Second Daily	1/31	For the purposes of this IT Demo, do we adjust previously submitted claim scenarios based upon change records or information received in the 834 Daily Enrollment files?	2/1/2013	Responses should apply only to the specific data exchange in progress and are not intended to be cumulative of prior exchanges.
97	2/1/2013	837 Second Daily	1/31	For the purposes of this IT Demo, do we create adjustments to previously submitted claims scenarios based upon information we receive in subsequent claims delivered to us?	2/1/2013	Responses should apply only to the specific data exchange in progress and are not intended to be cumulative of prior exchanges.
98	2/1/2013	837 Second Daily	2/1	For the purposes of this IT Demo, please define the term "VOID" as used in scenario 1a.(5) of the Expected Response Claims Processing Template.	2/1/2013	For purposes of this exercise, this response is intended to represent the # of claims scenarios received as a

AHCCCS Response #	Date Question Received	Related Exchange	Date Exchange Rcvd or Due	Question	Date Response Provided	Response
						component of the exchange which are coded as voids within the data provided per the applicable billing standards.
99	2/1/2013	Claims Scenarios - Group 2	2/5/13	Should the Offerer correct claims scenarios from round #1 once the correct expected results template is published, and submit them with round two claims submissions? The new claims template references # of voids and the # of replacements. We would like clarification of whether we should include claims corrections from Round #1 in these counts.	2/1/2013	Responses should apply only to the specific data exchange in progress and are not intended to be cumulative of prior exchanges. The referenced # of voids and # of replacements relates to the # of claims scenarios received as a component of the exchange, which are coded as voids or replacements within the data provided per the applicable billing standards.
100	2/1/2013	Claims Scenarios Group 3	02/06/2013	Should the Claims Scenarios in Group 3 to be provided on February 6 be included in the 2nd encounter submission due February 7?	2/1/2013	Per the Information Technology (IT) Systems Demonstration Calendar, there are only two iterations of Encounter exchanges. Therefore there is no expectation that Claims Scenarios Group 3 be considered for Encounter Submissions.
101	2/1/2013	820 Initial	Due 02/04/2013	Regarding the IT Demo Expected Response 820 Initial Template. According to the Information Technology Systems Demonstration Calendar the Summary of 820- Capitation File Processing the Summary of Initial is due Monday, February 4. Within the template itself the due date is listed as follows: Due – Friday, February 8th. Please confirm if the state is expecting us to complete the template and submit by Monday, February 4, and if we should update the date on the template; or if the state is now asking us to submit this template on	2/1/2013	Thank you for bringing this to our attention. A corrected IT Demo Expected Response 820 Initial Template reflecting the correct due date of Monday, February 4th will be posted to the SFTP site ASAP.

AHCCCS Response #	Date Question Received	Related Exchange	Date Exchange Rcvd or Due	Question	Date Response Provided	Response
				Friday, February 8th.		
102	2/1/2013	Reference Data Extract	Due 02/05/2013	Are the new reference data extract files to be released on Tuesday, February 5th, to be used for processing second encounter submissions due on Thursday, February 7?	2/1/2013	Yes, these files are intended to support processing cycles which follow their release.
103	2/1/2013	834 Daily (Adds, Changes and Terminations)	Due 02/04/2013	Do the member names, dates and IDs on the 834 need to match the names, dates and IDs on the 820 file in order to be included on the response file?	2/1/2013	Responses should apply only to the specific data exchange in progress and are not intended unless noted to require consideration of other exchanges.
104	2/1/2013	820 Initial	02/04/2013	Does the rate code in the 820 for each individual need to match the rate code on the 834 in order to be included on the response file?	2/1/2013	Responses should apply only to the specific data exchange in progress and are not intended unless noted to require consideration of other exchanges.
105	2/1/2013	Second Daily 834 Response	2/1/13	A maintenance code 001, reason 01 (divorce) was sent for a baby. Is it safe to assume that this reason code is mock data?	2/1/2013	Yes, this is "mock" data created for purposes of this exercise.
106	2/1/2013	820 Response	2/1/13	A recipient was sent via the 820 file with two different name spellings, but the same AHCCCS ID. Should this member be counted for each name spelling variation or only once?	2/1/2013	The expected response requests data related to unique AHCCCS Ids.
107	2/1/2013	Encounter Response	2/1/13	Claim scenario 1500-3 was submitted with billing provider Dr. Owen, and no rendering provider. We were advised to use the rendering provider as the billing provider for purposes of the demo, therefore the claim was paid to Dr. Owen. However, based on the reference files, Dr. Owen is affiliated with Dixie Regional Medical, and this was an ER claim. Should the encounter match the claim payment and include the NPI for Dr. Owen? Or, should the	2/1/2013	AHCCCS expects that the Offeror will reflect this scenario for Encounter processing consistent with how it was processed as a Claims Scenario.

AHCCCS Response #	Date Question Received	Related Exchange	Date Exchange Rcvd or Due	Question	Date Response Provided	Response
				encounter reflect the NPI for Dixie Regional Medical, which technically was where the service was provided?		
108	2/1/2013	Summary of Second Daily - 834	2/1/2013	If a member has an eligibility effective date prior to the file date, but without a PPC rate code should it still be considered Prior Period?	2/1/2013	Prior Period consideration should be based on the data as presented, i.e. a related contract type indicating Prior Period coverage.
109	2/1/2013	Summary of Second Daily - 834	2/1/2013	Please provide your definition of "prospective" as used on Question #2 in Summary of 834 Enrollment File Processing Summary Second Daily.	2/1/2013	Prospective enrollment is defined as enrollment without a stated end date.
110	2/1/2013	Summary of Second Daily - 834	2/1/2013	If a member is reassigned to a new RBHA but without an address change that would be appropriate for that change, should we disregard this conflict in assignment?	2/1/2013	No, ADHS determines RBHA assignment and this data should be processed as received.
111	2/1/2013	Initial 837 Encounter Submission	2/1/2013	For the 2300 CLM01 segment should the offerer submit the patient control number as received on the claim?	2/1/2013	Yes, submissions should reflect the data as provided.
112	2/1/2013	Initial 837 Encounter Submission	2/1/2013	Per guidance in question 64 AHCCCS has asked for us to prepare the response meeting TR3 Guidelines which would require changes to the header and trailer sections of template which are grayed out on the document. Please clarify if we should complete the grayed sections as per the TR3 guidelines or leave grayed out?	2/1/2013	AHCCCS does not expect that shaded or "greyed out" boxes will be completed.
113	2/1/2013	Initial 837 Encounter Submission	2/1/2013	Will feedback from Claims Scenarios Group 2 be provided prior to Initial 837 Encounter Submission; if errors are identified on any claims is it expected that encounters will reconcile to AHCCCS feedback or the offerer's initial claim submission.	2/1/2013	For purposes of this exercise, Encounter scenario submissions are intended to demonstrate the Offerors ability to correctly recognize and submit complete and accurate records for claims they have designated as paid. This specific

AHCCCS Response #	Date Question Received	Related Exchange	Date Exchange Rcvd or Due	Question	Date Response Provided	Response
						exercise is not intended to assess whether or not an Offeror is able to submit all claims scenarios that AHCCCS may designate as expected to be paid.
114	2/1/2013	Claims Scenarios - Group 2	2/1/2013	Please confirm that we should be doing UB Editing for healthcare acquired conditions, including POA indicators for inpatient claims.	2/1/2013	Yes, for purposes of this exercise, AHCCCS expects that applicable POA requirements for inpatient claims will be followed.
115	2/1/2013	Claims Scenarios - Group 2	2/1/2013	Will AHCCCS provide CRN for original claim submitted when there is an adjustment in a later claim scenario or should adjustment be treated as new day claims?	2/1/2013	For purposes of this exercise no CRN's are assigned, however the assigned scenario # is intended to be used for this function.
116	2/1/2013	Summary of Initial – 820	2/4/2013	What should be considered a unique recipient identifier? Should it be just Medicaid ID or a combination of Medicaid ID, payment dates, risk group etc.?	2/1/2013	For purposes of this exercise unique Recipients are unique AHCCCS Id's.
117	2/1/2013	Summary of Initial – 820	2/4/2013	If a unique identifier is not just a member ID the second question is: Should payments that span multiple months be considered one payment or multiple payments for each month of payment? There are 15 instances within the file where the payment spans more than one month.	2/1/2013	For purposes of this exercise unique Recipients are unique AHCCCS Id's.
118	2/1/2013	Claim Summary Response 2	2/1/13	Are we correct to assume that standard protocol should be followed if a billing error occurs on a claim such as detail line charges not matching the claim total.	2/1/2013	Yes, for purposes of this exercise, AHCCCS expects that applicable standard billing requirements be followed.
119	2/4/2013	Claims Scenarios – Group 2	2/1/2013	In regards to Encounters, if a previously paid claims needs to be replaced based on a resubmission of the claim, should we create our own CRN or assume a CRN is not required?	2/4/2013	For purposes of this exercise the scenario # of the claim being replaced or resubmitted as supplied in the related Claims Scenario should be used.

AHCCCS Response #	Date Question Received	Related Exchange	Date Exchange Rcvd or Due	Question	Date Response Provided	Response
120	2/4/2013	Claims Scenarios – Group 2	2/1/2013	Received a duplicate claim in which the member's eligibility has since been adjusted. Are we to adjust the claim and deny (since the member is terminated at this point) or would this be treated as a duplicate submission?	2/4/2013	Scenario should be processed based upon the current eligibility/enrollment of the recipient with appropriate disposition of the claim.
121	2/4/2013	Claims Scenario Group 2	02/01/2013	Does the Third Daily affect the Claims Scenario Group 2?	2/4/2013	No, since the Third Daily 834 exchange was initiated after the Claims Scenarios Group 2 exchange, it should not impact Claims Scenarios Group 2.
122	2/4/2013	Third Daily	02/01/2013	Is it AHCCCS expectation that we apply the 3rd round of enrollment data before we prepare our Eligibility Status 1 summary response?	2/4/2013	Yes, since the Third Daily 834 exchange was initiated at the same time as the Eligibility Status Inquiry 1 exchange, it should be applied.
123	2/4/2013	Claims Scenario Group 2	02/01/2013	A POA indicator requires a value and it is missing from Group Scenario 2 on the UB. As per your Response #114 you are expecting the applicable POA as required. Are you intending for us to deny these claims since the required info is missing?	2/4/2013	For purposes of this exercise, AHCCCS expects that applicable POA requirements for inpatient claims will be followed and appropriate action taken.
124	2/4/2013	Encounter Submission 2	02/01/2013	The encounter templates only have a place for one entry in a 2320 SBR/2320 AMT loop in the header tab and only have a place for one entry in 2430 SVD/2430 CAS loop in the detail tab. If there is more than one payer on a claim, how should this be reflected in the encounter template for these loops?	2/4/2013	For the purposes of this exercise AHCCCS does not expect coordination of benefits for any scenarios.
125	2/4/2013	Eligibility Status Inquiry – Inquiry 1	02/01/2013	For eligibility status 1- section C should we include members that are not eligible on date of service in status inquiry as having Medicare coverage if they have such coverage?	2/4/2013	Only members for whom eligibility is found should be included.
126	2/4/2013	Second Reference	02/01/2013	Are we to apply Feb. 5 reference extracts to Claims Scenario Group 2?	2/4/2013	No, since the second Reference and Provider exchanges will be initiated after

AHCCCS Response #	Date Question Received	Related Exchange	Date Exchange Rcvd or Due	Question	Date Response Provided	Response
		Extract				the Claims Scenarios Group 2 exchange, it should not impact Claims Scenarios Group 2.
127	2/4/2013	Third Daily	02/01/2013	Should we apply Third eligibility update file to Claims Scenario Group 2?	2/4/2013	No, since the Third Daily 834 exchange was initiated after the Claims Scenarios Group 2 exchange, it should not impact Claims Scenarios Group 2.
128	2/4/2013	Last Daily	02/07/2013	Should the Feb 7 Last daily eligibility file be applied to Claims Scenario Group 3?	2/4/2013	The Last Daily cycle is a future exchange. Per the IT Demonstration Q&A Process Provisions, "AHCCCS will not respond to any questions received outside the daily timeframes noted above, or related to exchanges already concluded or not yet in process."
129	2/4/2013	General	02/04/2013	If AHCCCS does not provide a correct response file for any submission, will AHCCCS provide a verification of receipt of files?	2/4/2013	All Offerors submit via the SFTP to their assigned folder. Offerors can confirm receipt by review of their folder, for the date and time parameters for each exchange.
130	2/4/2013	Claims Second Submission	2/5	For the purposes of this IT Demo, do we consider "VOIDS" as claims not paid?	2/4/2013	For purposes of this exercise voids are only considered under the void category within the Response Templates and are neither paid nor denied.
131	2/4/2013	Claims Second Submission	2/5	For the purposes of this IT Demo, when a claim replacement claim is received and no additional payment is made because the replacement claim only corrected the Date of Service, do we assume the claim is PAID and enter that on the summary as PAID with a payment of zero?	2/4/2013	For purposes of this exercise, zero paid claims are considered paid claims.
132	2/4/2013	Claims Second	2/5	When one claim line is paid at zero, because it was previously paid on a previous claim scenario; and	2/4/2013	For purposes of this exercise, zero paid claims are considered paid claims.

AHCCCS Response #	Date Question Received	Related Exchange	Date Exchange Rcvd or Due	Question	Date Response Provided	Response
		Submission		the other claim line is not paid/denied do we enter that claim on the PAID response within the summary of claims with a payment of zero?		
133	2/4/2013	Eligibility Inquiry Response	2/6	For the purposes of responding to the Eligibility Status Inquiry scenarios, do we apply the 3rd Daily 834 and therefore use the information contained in such 834 file for the purposes of our responses to the scenarios?	2/4/2013	Yes, since the Third Daily 834 exchange was initiated at the same time as the Eligibility Status Inquiry 1 exchange, it should be applied.
134	2/4/2013	Claims Second Submission	2/5	Do VOIDED claims get counter in the NOT PAID category on the claims summary template in scenario 3 and 3(a) or only counted in 1 (a)5 and 1(b)5?	2/4/2013	For purposes of this exercise voids are only considered under the void category within the Response Templates and are neither paid nor denied.
135	2/4/2013	Claims Second Submission	2/5	Do we assume that a claim with multiple lines that have different dispositions should be reported into more than one scenario on the claim summary template?	2/4/2013	Yes, for purposes of this exercise claim lines with differing dispositions should be reported under the appropriate disposition category.
136	2/4/2013	Claims Scenarios Response Group 2	Due 2/5/13	Is the expectation that offerors should use the default "PAY-TO" information provided in the PR015 and PR045 reference files linked to the provider's NPI when adjudicating claims?	2/4/2013	Yes, for purpose of this exercise; per the IT Systems Demonstration Provisions "All scenarios will be based upon and will require the offeror to utilize member, provider and reference data supplied to the Offeror by AHCCCS."
137	2/4/2013	Second 837 Encounter Submission	2/7/2013	In Q&A # 96 AHCCCS indicated that "data exchange in progress and are not intended to be cumulative of prior exchanges." Does the guidance in Q&A #96 apply to all transactions (enrollment, claims, 820, etc.)? If not a follow up question, we have received claim scenarios in Claim Scenarios – Group 2 that requires a recoup from a prior claim in round1 (per box 22) that we denied. Does AHCCCS expect encounters to submit a void for	2/4/2013	The provided response was specific to the exchange noted. For purposes of this exercise, AHCCCS expects that the Offeror will appropriately treat subsequent scenarios based on the data provided as well as your previous processing. Encounters, as previously noted, are expected related to paid claims only.

AHCCCS Response #	Date Question Received	Related Exchange	Date Exchange Rcvd or Due	Question	Date Response Provided	Response
				the round 1 encounter, during round 2? For the purposes of round 2 encounter submission can we treat the previously denied claim as paid?		
138	2/4/2013	Summary of Claims Processing 2	2/5/2013	Please confirm, if the provider's service location is marked terminated on the state file, the dental claim with that specific address should also be denied.	2/4/2013	Scenario should be processed based upon the current Reference and Provider data supplied to the Offeror with appropriate disposition of the claim.
139	2/4/2013	Summary of Claims Processing 2	2/5/2013	Please confirm the "R" listed on the claim scenario, when present in Box 22. Does the R represent resubmission or replacement? The FFS manual in bidders library only speaks to A and V types in box 22.	2/4/2013	For purposes of this exercise "R" equates to resubmission or replacement.
140	2/4/2013	Summary of Claims Processing 2	2/5/2013	Please confirm the reference files due 2/5 will be delivered the evening of 2/4 at approximately 6pm. Will pricing updates, provider active dates, or other data received in the second extract of reference file data and second extract of provider file data be utilized in our response to claims processing 2 due 2/5?	2/4/2013	Please refer to the Information Technologies (IT) Systems Demonstration Calendar for dates specific to each exchange and the IT Systems Demonstration Provisions for delivery times. No, since the second Reference and Provider exchanges will be initiated after the Claims Scenarios Group 2 exchange, it should not impact Claims Scenarios Group 2.
141	2/4/2013	Summary of Claims Processing 2	2/5/2013	Please confirm we should be using Medicare claim payment overrides for QMB dual covered/noncovered services; it was noted previously not to coordinate benefits.	2/4/2013	AHCCCS does not expect any coordination with Medicare payers related to this exercise.
142	2/4/2013	Summary of Claims Processing 2	2/5/2013	If a claim is partially denied/partially paid in round 2 – should the claim be reported as paid or denied? Or both?	2/4/2013	For purposes of this exercise claim lines with differing dispositions should be reported under the appropriate disposition category.

AHCCCS Response #	Date Question Received	Related Exchange	Date Exchange Rcvd or Due	Question	Date Response Provided	Response
143	2/4/2013	Eligibility Status Response 1	2/5/2013	Is the Word document we received with the eligibility status inquiries meant to be the only inquiry file and should the only response to these questions be the completion of the Excel file, IT_Demo_Expected_Response_Eligibility_Status_1?	2/4/2013	Yes, for purposes of this exchange, the narrative provided is intended to be responded to in the Expected Response Eligibility Status 1.
144	2/4/2013	Third Daily 834 & Claims Scenarios Group 2	2/4/13 & 2/1/13	A member termination was received in the third daily 834 for a member with a claim in the claims scenarios Group 2. Since the claim was received PRIOR to the termination, is it safe to assume that these should be processed in the order received?	2/4/2013	Scenario should be processed based upon the current eligibility/enrollment of the recipient.
145	2/4/2013	Third Daily 834	2/4/13	A new enrollment was received for a member with Medicare Part A only. Although this does not impact the AHCCCS enrollment, typically this Medicare enrollment would reject (since there is no Part B Medicare). Should the offeror assume that this is also mock data – and that this is, in fact, a valid Medicare enrollment?	2/4/2013	Although it is possible and correct that a recipient might have Medicare Part A only, for purposes of this exercise the data provided is "mock data".
146	2/4/2013	Claims Second Submission	2/5	Previously a question was submitted regarding Correct ICD-9 coding, where AHCCCS indicated to "process claims accordingly", however in different response to a question AHCCCS indicated "all services are to be assumed medically necessary". Which standard should we apply for the purposes of this IT Demo? For example, when a gender specific ICD-9 code is submitted on a claim for the incorrect gender, do we still assume that is "medically necessary" service per previous guidance?	2/4/2013	Medical Necessity allows for the Offeror to evaluate and override age, gender and daily service limits as appropriate. For purposes of this exercise AHCCCS will support an Offeror's use of these criteria as applicable and recognize the related disposition of the scenario.
147	2/2/2013	Summary of 834	01/30/2013	In the Information Technology (IT) Systems Demonstration Provisions, it was indicated that	2/4/2013	The sole purpose for providing the correct responses is to ensure that all

AHCCCS Response #	Date Question Received	Related Exchange	Date Exchange Rcvd or Due	Question	Date Response Provided	Response
				AHCCCS intends to evaluate each Offerors "processing summaries" and responses, and provide feedback no later than 5:00 p.m. the next business day as to the actual expected results of each exchange. To date, we have not received the summary document for Claims Scenario Group 1in the files received from AHCCCS, and wondered when we might be able to receive this feedback.		Offerors start the next interdependent exchange on an equal basis and so that no Offeror is penalized for incorrect responses from a preceding exchange. In the event there is not interdependency, "Correct Responses" will not be provided.
148	2/4/2013	837	1/7/2013	Since we are adjudicating manual claims, are we required to populate the manual 837 in its entirety, i.e., fields that would only come across in on electronic submission, such as submitter EDI contact information, Identification Code Qualifier, etc?	2/5/2013	Regardless of how claims are processed, please complete the form appropriately.
149	2/5/2013	Eligibility Inquiry Response	2/5/13	In the Eligibility Inquiry, there are 4 line items however, each line poses 2 separate inquiry "questions". For the summary response file, is each "question" counted as an inquiry or is expected at the recipient/line level?	2/5/2013	To clarify, for purposes of this exercise, the Expected Response Document has categories for: Total inquiries received; # of the above for which eligibility was found and # of the above for which eligibility was not found; and for the # of the above for which eligibility was found how many of those members have Medicare for that eligibility date.
150	2/5/2013	Claims Second Daily	2/5/2013	Do we assume for the purposes of this IT Demo that only claims marked as VOID or REPLACEMENT/RESUMBIT are the only claims that we should consider as VOID or REPLACEMENT/RESUBMIT within the responses to the claims scenarios?	2/5/2013	Yes, this is a correct assumption for purposes of the demonstration.

AHCCCS Response #	Date Question Received	Related Exchange	Date Exchange Rcvd or Due	Question	Date Response Provided	Response
151	2/5/2013	Claims Second Daily	2/5/2013	Is it appropriate to VOID or REPLACE/RESUBMIT claims that have not specifically been marked as VOID or REPLACE/RESUBMIT on the original paper or EDI files delivered to us as part of this IT Demo?	2/5/2013	Please see Response 150 above.
152	2/5/2013	Claims Scenario Group 2	2/5/13	Previous Question and Answer stated that Encounters should be for Paid Claims only, please clarify whether void and adjustment requests should be included in Encounter Scenario #2, if the original question was paid.	2/5/2013	For purposes of the exercise, Encounters Second Submission Total # of encounters, number of professional, number of institutional and number of dental should be paid claims only; Number of Replacements and Number of Voids should be replaced or voided claims only.
153	2/5/2013	Claims Inquiry 1	2/5/13	For completion of the Claims inquiry template, please confirm Claims Inquiry #'s as the document only has a underlined header for claims inquiry – 1. Should we assume subsequent inquiries are sequential 2, 3, etc. And also confirm that the template should be completed with these Claims Inquiry #'a and not the actual claim scenario #'s.	2/5/2013	Yes for purposes of the exercise, subsequent inquiries should be numbered sequentially 2, 3, etc… Response document should be completed with the appropriate inquiry number(s).
154	2/5/2013	Second Encounter Submission	2/7/13	For the Encounter submissions… Since the offerors have been advised to use the billing provider and location as the rendering provider and location on the claim… Is it safe to assume that the Encounter should be submitted for the paid claim, using the billing provider name from the claim (loop 2010AA NM103/NM104), rather than attempting to determine a group affiliation and name?	2/5/2013	Encounter submissions should be consistent with the way the claim was paid.

AHCCCS Response #	Date Question Received	Related Exchange	Date Exchange Rcvd or Due	Question	Date Response Provided	Response
155	2/5/2013	Claims Status Inquiry -1	2/4/13	For the Claims Status Inquiry 1 File, should the offeror respond based on the claims received and processed in Claims Scenario Groups 1 & 2 – or ALSO Claims Scenario Group 3, since those claims will be received prior to the due date for the Status Response 1?	2/5/2013	For purposes of this exchange, only Claims Scenarios Groups 1 & 2 should be considered. Since the Claims Scenarios Group 3 initiates after the Claims Status Inquiry 1 exchange, it should not be considered.
156	2/5/2013	Second Daily Encounters	2/7/2013	Can we assume that the paid amounts with adjustment reason codes should be documented at the line level in the 2430 SVD loop?	2/5/2013	For the purposes of this exercise, AHCCCS does not expect coordination of benefits for any scenarios.
157	2/5/2013	Summary of Third Daily - 834	2/5/2013	There is TPL data for a carrier with an H code. H codes are traditional recognized as Medicare Carriers; however the demo data seems inconsistent with that. Based on this difference should we follow the H code or the TPL indicator?	2/5/2013	For the purposes of this exercise, please follow the TPL Indicator.
158	2/5/2013	Summary of Claims Processing 2	2/5/2013	Do Replacement claims get counter in the NOT PAID category on the claims summary template in scenario 3 and 3(a), PAID on the scenario 3 and 3(a), and or only counted in 1 (a)4 and 1(b)4?	2/5/2013	For purposes of the exercise, Encounters Second Submission Total # of encounters, number of professional, number of institutional and number of dental should be paid claims only; Number of Replacements and Number of Voids should be replaced or voided claims only.
159	2/5/2013	Summary of Claims Processing 2	2/5/2013	If there is a conflict in between existing processes (e.g. 5010) and the guidance given in the bidder's library which should the offerer follow?	2/5/2013	For purposes of this exercise, guidance in the Bidder's Library should be followed.
160	2/5/2013	Claim Status Inquiry 1	2/5/13	Is it permissible to list the Claim Scenario # along with the Inquiry # when responding to a1, a2.1, and a3.1 in IT Demo Expected Response Claims Status.xls?	2/6/2013	Yes, please list both if desired. At a minimum, the Inquiry # is expected.
161	2/6/2013	Claim	02/6/2013	How should voids be reported on the Expected	2/6/2013	For purposes of this exercise, if a voided

AHCCCS Response #	Date Question Received	Related Exchange	Date Exchange Rcvd or Due	Question	Date Response Provided	Response
		Status Inquiry Response		Response Claim Status 1? And specifically should they be listed in not paid section a.3 and a.3.1?		claim is identified as applicable to the inquiry, it should be reported under the category of Approved rather than in the category of Not Paid.
162	2/6/2013	Summary of Claims Processing 3	2/7	In Q&A #158 the offerer asked a question related to Claims group #2. The answer given appears to be related to Encounter Second Submission. Could you please clarify the question as it relates to claims?	2/6/2013	To clarify this prior response, for purposes of the exercise, Claims Scenarios 2 and 3 Submissions: 1 = a + b a = a1 + a2 + a3 a4 and a5 are subsets of a b = b1 + b2 + b3 b4 and b5 are subsets of b 2 and 3 = are subsets of 1 (not including replacements and voids)
163	2/6/2013	Summary of Claims Processing 3	2/7	As a follow up to Q&A #40: For the purposes of this demo, is it safe to assume that a provider's claim is still payable when the billing address noted on the claim is not on the provider record, and that provider has no active billing address with AHCCCS.	2/6/2013	For purposes of this exercise, per the IT Systems Demonstration Provisions, "All scenarios will be based upon and will require the offeror to utilize member, provider and reference data supplied to the Offeror by AHCCCS."
164	2/6/2013	Summary of Claims Processing 3	2/7	We noted a provider record on Profile.zip where the provider record is active, but there are no active billing addresses. Should the provider be considered active?	2/6/2013	For purposes of this exercise, per the IT Systems Demonstration Provisions, "All scenarios will be based upon and will require the offeror to utilize member, provider and reference data supplied to the Offeror by AHCCCS."
165	2/6/2013	834 3rd file Correct	2/06/13	The third response for the 834 file included 3 new members with no prior enrollment. The 834 correct responses included these members as	2/6/2013	The sole purpose for providing the correct responses is to ensure that all Offerors start the next interdependent

AHCCCS Response #	Date Question Received	Related Exchange	Date Exchange Rcvd or Due	Question	Date Response Provided	Response
		Response		prospective enrollment members but also as recipients with behavior health changes. A change would be making something different from what it is. A new member to the health plan that had never been on the plan before would have the behavior health information added new, not a change. Can you verify that a new member's behavioral health information should be treated as a change?		exchange on an equal basis and so that no Offeror is penalized for incorrect responses from a preceding exchange. AHCCCS will not entertain any input into correct or incorrect responses and will not amend scoring based on justification provided by any Offeror.
166	2/6/2013	Encounter Second Submission	2/7	For the purposes of this IT Demo is it correct to assume that the paid amount and the adjustment reason code(s) are not required on Encounter files if the claim is not paid in full?	2/6/2013	Encounter submissions should be consistent with the way the claim was paid.
167	2/6/2013	Claim Status	2/6	For the purposes of this IT Demo does the term (as referenced in scenario 1(a)3) "not paid" include claims that were "denied" and/or "void"?	2/6/2013	For purposes of this exercise, if a voided claim is identified as applicable to the inquiry, it should be reported under the category of Approved, and if a denied claim is identified as applicable to the inquiry, it should be reported under the category of Not Paid.
168	2/6/2013	Encounter Second Submission	2/7	For the purposes of this IT Demo if a field is listed in the companion guide as NOT REQUIRED/NOT AVAILABLE but the scenario response template has the cell OPEN and not greyed out, do we assume that the information is being requested for the purposes of this demo and therefore fill in the cell despite guidance provided in the companion guide?	2/6/2013	AHCCCS expects that the fields within the Template will be populated if required by the TR3 and Companion guidelines for the type of encounter being submitted.
169	2/6/2013	Encounter Second Submission	2/7	If the guidance in the companion guide specifies that a specific value is required in a field, but the template states a DIFFERENT specific value is	2/6/2013	AHCCCS expects that the fields within the Template will be populated if required by the TR3 and Companion

AHCCCS Response #	Date Question Received	Related Exchange	Date Exchange Rcvd or Due	Question	Date Response Provided	Response
				required in a field, do we follow the guidance of the template or the companion guide for the purposes of this IT Demo?		guidelines for the type of encounter being submitted.
170	2/6/2013	Encounter Second Submission	2/7	For loop 2000B element SBR 01 the companion guide states to expect "P=Primary", however the expected response template states to "expect any value but not "P"", which guidance do we follow for the purposes of this IT Demo?	2/6/2013	For purposes of this exercise, AHCCCS expects that the fields within the Template will be populated if required by the TR3 and Companion guidelines for the type of encounter being submitted.
171	2/6/2013	Encounter Summary Second	2/7	On the Encounter Summary you ask for the number of Professional and Institutional and Dental Encounters that we will be submitting, as well as REPLACEMENT and VOIDS, however the REPL may count as a PROFESSIONAL and a REPLACED encounter because we are paying such claim, or do we assume it is ONLY a REPLACED claim and excluded from the count of PRO claims for the purposes of this IT Demo?	2/6/2013	For purposes of the exercise, Encounters Second Submission Expected Summary Response: 1 = Total # of paid claims submitted as encounters (a + b + c) d = Total # of replacements submitted e = Total # of voids submitted
172	2/6/2013	Encounter Second Summary	2/7	On the encounter summary – question 1 states total number of encounters submitted (PAID CLAIMS ONLY) do we assume that you are requesting a response which counts only the paid claims for professional, institutional and dental and NOT the VOIDS?	2/6/2013	See Response 171.
173	2/6/2013	Encounter Second Summary	2/7	Do we assume for the purposes of this IT Demo that we do not submit 837 encounters for "VOID" or voided claims?	2/6/2013	If an encounter was previously reported as paid and is subsequently voided, it should be submitted as a voided encounter.
174	2/6/2013	Encounter Second Summary	2/7	Do we assume that a REPLACEMENT claim which is PAID counts both as a PAID CLAIM and a REPLACEMENT CLAIM on the encounter	2/6/2013	See Response 171.

AHCCCS Response #	Date Question Received	Related Exchange	Date Exchange Rcvd or Due	Question	Date Response Provided	Response
				summary?		
175	2/6/2013	Encounter Second Summary	2/7	Do we assume that Question 1 on the Encounter Scenario Summary is to only include a count of encounters listed in 1(a), 1(b) and 1(c).	2/6/2013	See Response 171.
176	2/6/2013	Second Claim Summary	2/7	Do we need to encounter VOIDS since the Encounter Summary Template states to submit only PAID encounters?	2/6/2013	See Response 171.
177	2/6/2013	Second Claim Summary	2/7	For the purpose of this IT Demo should we include voided claims as encounters?	2/6/2013	See Response 173.
178	2/6/2013	Claims Scenarios – Group 3	2/6/13	We have received EDI claims with an inappropriate NPI (belonging to a different provider). Normally, our electronic process would automatically reject these claims, ultimately informing the provider. For the purposes of this demo, is it safe to assume that these are valid rejections based on provider data found within the reference files?	2/6/2013	Yes, for purposes of this exercise, per the IT Systems Demonstration Provisions, "All scenarios will be based upon and will require the offeror to utilize member, provider and reference data supplied to the Offeror by AHCCCS."
179	2/6/2013	Claims Scenarios – Group 3	2/6/13	A claim (UB-50) was received where the AHCCCS ID# appears to have a typo for one digit – this claim would typically be denied. For the purposes of this claim, should the offeror assume that the AHCCCS ID submitted is correct and valid?	2/6/2013	Yes, for purposes of this exercise, per the IT Systems Demonstration Provisions, all processing should be based upon the data provided by AHCCCS.
180	2/6/2013	Initial 837 Encounter Submission	2/7	If an original claim was paid in cycle 1 and that claim was submitted in Encounters cycle 1 and a replacement claim was subsequently denied in claims cycle 2. Should we assume that we should not submit this claim in encounter cycle 2 since it was denied in claims cycle 2?	2/6/2013	For purposes of this exercise, Encounter scenario submissions are intended to demonstrate the Offeror's ability to correctly recognize and submit complete and accurate records for claims they have designated as paid or were previously reported as encounters and subsequently

AHCCCS Response #	Date Question Received	Related Exchange	Date Exchange Rcvd or Due	Question	Date Response Provided	Response
						voided.
181	2/7/2013	Last Daily 834	2/8/2013	If a member goes from one prospective rate code to another would it be considered a prospective enrollment "add"?	2/7/2013	AHCCCS does not consider this type of transaction to be an add, this type of record is provided as a "change" transaction on the 834.
182	2/7/2013	Last Daily 834	2/8/2013	For the purposes of this demonstration, if the prospective rate code changed from another prospective rate code and is not indicated with an effective date, do we consider it a valid change? If yes, what effective date would be used for the new rate code?	2/7/2013	The effective date for a change transaction on the 834 is in the 2700 loop per the AHCCCS Companion Guide.
183	2/7/2013	Second Encounter Submission	02/07/2013	With Reference to your response to Question #135; Does your response to report claims with varying line status (paid and denied disposition) in separate categories apply to UB Outpatient claims as well as HCFA 1500 claims?	2/7/2013	No, UB claims are adjudicated as a single record, either paid or not paid. Any lines not paid should be disallowed or non-covered.
184	2/7/2013	Claims Scenarios Group 3	02/06/2013	Since this is mock data should we ignore that the billing name does not match the billing TIN in Claims Scenario Group 3 in 837P files?	2/7/2013	Yes, for purposes of this exercise, per the IT Systems Demonstration Provisions, all processing should be based upon the data provided by AHCCCS.
185	2/7/2013	Second 837 Encounter Submission	2/7/2013	For purposes of the Demo and the second 837 encounter submission, does AHCCCS expect we submit provider data (billing address, AHCCCS ID, etc.) as the data exists on the AHCCCS claim, or do we submit provider data as received from AHCCCS on Provider.zip file?	2/7/2013	Encounter submissions should be consistent with the way the claim was paid.
186	2/7/2013	Summary of Last Daily - 834	2/8/2013	If a demographic change occurs on a term transaction should it be included as a termination on question 11 and a demographic change on question 7?	2/7/2013	If a termination transaction was provided it should be counted as a termination. If a change transaction was provided it should be counted as a change.
187	2/7/2013	Second	2/7/2013	In question #6 of the Q&A AHCCCS stated in an	2/7/2013	AHCCCS expects that related Claims

AHCCCS Response #	Date Question Received	Related Exchange	Date Exchange Rcvd or Due	Question	Date Response Provided	Response
		Encounter Submission		answer that "[you] do not anticipate issues related to Tax ID or NPI information utilized in claim scenarios…" However in question #178 AHCCCS implies that the reference data supplied should be used to validate data supplied on a claim for accuracy such as NPI and TAX ID, since they are included in such reference tables. Could you please clarify, for the purposes of this Demo, if inaccurate, mistyped, erroneous or otherwise incorrect data in relationship to Provider Identification Demographics such as NPI, AHCCCS ID, TAX ID that is presented on a claim, would be considered incorrect and thus cause for denial.		Scenarios should be processed based upon the data provided to the Offeror. If a claim is received for a Tax ID or NPI the Offeror is expected to process using the data provided.
188	2/7/2013	Second Encounter Submission	2/7/2013	If data is not included on a claim scenario, but is required per the companion guide for an encounter and reasonable inference can be made to obtain that information from another field or data element, are we for the purposes of this demo to infer we can use the data on the encounter even though it is not located in the correct area on the claim or the corresponding field on the claim for the encounter.	2/7/2013	For purposes of this exercise, AHCCCS expects that the fields within the Template will be populated if required by the TR3 and Companion guidelines for the type of encounter being submitted.
189	2/7/2013	Third Daily Claims	2/8/2013	Should the information contained in the reference tables be used to make a decision to pay the claim or not, or is it simply being provided for reference?	2/7/2013	Per the IT Systems Demonstration Provisions, "All scenarios will be based upon and will require the offeror to utilize member, provider and reference data supplied to the Offeror by AHCCCS. Contracted rates, discounts and penalties should not be applied; only the AHCCCS Fee Schedule provided in the Reference File extract should be

AHCCCS Response #	Date Question Received	Related Exchange	Date Exchange Rcvd or Due	Question	Date Response Provided	Response
						used."
190	2/7/2013	Second Encounter Submission	2/7/2013	On question # 6 the answer to invalid TIN's &NPI 's was "AHCCCS does not anticipate issues related to the TAX ID or NPI info utilized in the claims scenarios as all scenarios have been internally tested by AHCCCS with no issues identified"; however question #178 the answer to whether claims should be rejected for inappropriate NPI's was " Yes, for the purposes of the exercise, per the IT System Demonstration Provisions, "All scenarios will be based upon and will require the offeror to utilize member, provider and reference data supplied to the Offeror by AHCCCS." And then on question #179 when asked about if they should assume that the incorrect AHCCCS ID submitted on UB-50 is correct and valid the answer was "Yes, for the purpose of this exercise, per the IT System Demonstration Provisions, all processing should be based upon the data provided by AHCCCS".	2/7/2013	AHCCCS expects that Claims Scenarios should be processed based upon the data provided to the Offeror. If a claim is received for a recipient you have not received a recipient record for in the 834 exchanges the Offeror is expected to process accordingly.
191	2/8/2013	820-Capitation File	02/08/2013	The actual number of segments within the ST/SE loop does not balance with the number (20) sent in the segment 'SE{20{000000005'. As *this is a test situation*, should the offer modify the file and correct the out of balance situation to report all lines on the file, or should we ignore the remittance lines that are contained within the ST/SE loop? Typically, we would reject these two records.	2/8/2013	For the purpose of this exercise, AHCCCS expects that the Offeror will not reject any remittances because of an ST/SE balancing issue.
192	2/8/2013	Eligibility Status	02/08/2013	Should recipient ID numbers listed in 1.a.1 be a list of unique ID numbers?	2/8/2013	For purposes of this exercise, AHCCCS expects that the Offeror will list the

AHCCCS Response #	Date Question Received	Related Exchange	Date Exchange Rcvd or Due	Question	Date Response Provided	Response
		Inquiry 2				recipient ID for each inquiry.
193	2/8/2013	820 Monthly Capitation File	02/08/2013	On the monthly 820 capitation file released to plans on 2-8, the process date is 02/01/2013. That is the identical process date we received on the initial 820 file released to plans on 2-1. Should the process date on the new file be 02/08/2013?	2/8/2013	For purposes of this exercise, AHCCCS expects that the Offeror will treat the process date on this exchange as 02/08/2013.
194	2/8/2013	Eligibility Status Response 2	2/11/2103	On question a1 Eligibility Status Response – Two: if the same member has 2 different inquires and eligibility was found for both inquiries should the recipient ID be listed twice or just once for question a1 Recipient ID#'s for Recipients found with Eligibility	2/8/2013	For purposes of this exercise, AHCCCS expects that the Offeror will list the recipient ID for each inquiry.
195	2/8/2013	Eligibility Status Response - 2	2/11/2103	Is the Eligibility Status Response – 2 to take into account enrollment changes from the Monthly enrollment file received on 2/8 or are utilize eligibility information as of processing the last daily enrollment file received 2/7?	2/8/2013	No, for purposes of this exchange the Offeror should only consider 834 files received prior to 2/8/13.
196	2/8/2013	Claims Status Inquiry Response 2	2/11/2013	Should the offerer assume the claim status inquiry for member 303 is a typo? If so, should the offerer respond with matches found by that provider and date of service?	2/8/2013	AHCCCS expects that Claims Status Inquiry Scenarios should be processed based upon the data provided to the Offeror. If a claim status inquiry is received for a claim which is not found the Offeror is expected to process that inquiry appropriately.
197	2/8/2013	820 - Capitation File	2/8/2013	The 820 file received on 2/8 is not HIPAA compliant because the trailer on the last transaction set shows a segment count of 20, but the numbers of actual transactions in the set are 19. In a related issue, the DTM segment in the Transaction Set	2/8/2013	For the purpose of this exercise, AHCCCS expects that the Offeror will not reject any remittances because of an ST/SE balancing issue.

AHCCCS Response #	Date Question Received	Related Exchange	Date Exchange Rcvd or Due	Question	Date Response Provided	Response
				header is missing from the 5th transaction set (ST/SE). Should this file be rejected or should we utilize it as-is for the submission of the summary response?		
198	2/8/2013	834 Final	2/11/2013	For the purposes of this demo, is the number referred to in question 1a a count of inquiries or a count of unique recipients? If there are multiple inquiries on the same Recipient ID, should the response list them just once or proportionally to the number of inquiries?	2/8/2013	As outlined in the Claims Status Response – 2 document, 1a is the "number of claims status inquiries". For purposes of this exercise please list the recipient ID for each inquiry.