



Welcome to the IHS/638 Fourth Quarter Forum

November 06, 2019

Attendance: WebEx Only

2:00 P.M. – 3:30 P.M.

Agenda

- Electronic Visit Verification (E.V.V.)
- Medicare Secondary Payer Claims
- American Indian Medical Homes
- 638 FQHC Billing
- AHCCCS Provider Enrollment Portal (APEP)
- Telehealth
- Behavioral Health Services Updates
- Reminders: Behavioral Health Residential Facilities (BHRFs)
- Claims Disputes
- Vaccine Administration and Point of Sale System Billing to Optum
- Naturopathic Physicians
- AHCCCS Resources

Electronic Visit Verification (EVV)



Electronic Visit Verification (EVV)

Beginning in 2020 and in response to a Federal Mandate known as the [21st Century Cures Act](#),

AHCCCS will require providers of in-home non-skilled and skilled nursing services to use Electronic Visit Verification (EVV).

EVV is an electronic-based system that verifies when provider visits occur and documents the precise time services begin and end and the location of service delivery. AHCCCS is using EVV to make sure that members get the services that they need when they need them.

EVV LIVE DEMONSTRATION !!

WEBINAR - Thursday, November 7th from 9:30am to 12pm.

To support providers in making an informed decision about an EVV system, AHCCCS will host a provider agency webinar (demonstration) of the Sandata system.

Providers will be able to see the flow of the Sandata system from authorization to billing along with a high level description of forthcoming Arizona-specific configuration to track and monitor timely service de

Providers will need to register for the webinar using the following link: **[AHCCCS Sandata Provider Webinar](#)** delivery and access to care.

Electronic Visit Verification (EVV)

In addition to monitoring access to care for members, the benefits of an EVV system include:

- Capturing the individual worker's activity (i.e. check-in, check-out and service performed) which reduces the likelihood of errors or fraud.
- Increasing efficiency because reporting is automated and claims submission is cleaner.
- Reducing provider administrative burden with scheduling and hard copy timesheet processing.

What is your plan for EVV

- AHCCCS is employing the system as an Open Vendor Model with one statewide EVV contractor, Sandata Technologies (Sandata).
- Providers have multiple options for complying with the EVV mandate including using the state's Sandata EVV system, continuing to use their existing EVV systems or choosing an alternate EVV vendor at the providers expense.
- AHCCCS is funding the development and initial implementation of the Sandata EVV system and additional funding options are being explored to compensate for ongoing maintenance costs.
- Providers choosing not to use the states procured, Sandata EVV system, will need to obtain approval of the alternate EVV system to ensure compliance with general and Arizona specific requirements for EVV.

JOINING THE WEBINAR

The webinar will be hosted using Zoom. To test your system with Zoom [click here](#). To learn how to join the Zoom webinar, [click here](#). Both links provide step by step video instruction.

Information and updates about EVV are available on the AHCCCS website (www.azahcccs.gov/EVV).

Please sign up for any and all EVV communications and notices under the **Stay Informed tab**.

JOINING THE WEBINAR

- To register for the meeting please go to:
[The Meeting Registration Link](#)

The following AHCCCS Provider Types are required to use EVV.

Provider Description	Provider Types
Attendant Care Agency	40
Behavioral Outpatient Clinic	77
Community Service Agency	A3
Fiscal Intermediary	FI
Habilitation Provider	39
Home Health Agency	23
Integrated Clinic	IC
Non-Medicare Certified Home Health Agency	95
Private Nurse	46

Medicare/Secondary Payer



MEDICARE / MEDICAID SECONDARY PAYER CLAIMS

MEDICARE

MEDICAID

Member Information

AHCCCS maintains a record of each member's coverage by Medicare and other coverages.

If a member's record indicates that First- or Third-party coverage is available, but there has been no previous payment made on the claim by either Medicare and/or another insurance, then the claim will be denied.

Secondary Claims must be received by AHCCCS within the following time frames:

Title XIX Members – claims must be received with 12 months of the date of service.

Title XXI KidsCare Members – claims must be received within 6 months of the date of service.

Retro-Eligibility – claims must be received within 12 months of the eligibility posting date and 6 months of the eligibility posting date for KidsCare members.

First and Third Party / Other Coverage

AHCCCS is the payer of last resort unless specifically prohibited by **State or Federal** law.

This means AHCCCS shall be used as a source of payment for covered services only after all other sources of payment have been exhausted, per Arizona Revised Statutes (A.R.S) title §36-2946 (section).

The AHCCCS Administration's reimbursement responsibility is limited to no more than the **difference between the Capped Fee-For-Service schedule and the amount of the first- or third-party liability.**

NOTE: AHCCCS is not the payer of last resort when the payer is Indian Health Services contract health (**IHS/638 tribal plan**).

First and Third Party / Other Coverage

AHCCCS has liability for payment of benefits after Medicare and all other first- and third-party payer benefits have been paid.

The only way for Medicaid to determine its liability for services is to submit the claim to the member's primary insurer for a formal decision for payment.

First and Third Party / Other Coverage

Per (A.A.C.) R9-22-1002, AHCCCS is not the payer of last resort (AHCSS will be the primary payer) when the following entities are the third-party:

1. The payer is Indian Health Services contract health (IHS/638 tribal plan); or
2. Title IV-E; (Federal Payments for Foster Care and Adoption Assistance) or
3. Arizona Early Intervention Program (AZEIP); or
4. Medical services provided through schools under the federal Individuals with Disabilities Education Act under 34 CFR Part 300; or
5. Entities and contractors of entities providing services under grants awarded as part of the HIV Health Care Services Program under 42 USC 300ff et. seq.

Primary Payer Denials

If the first- or third-party payer denies a covered service the provider must:

- Follow the plan's *appeal process* and exhaust all remedies before AHCCCS can consider the covered service.
- The provider must submit a copy of plan's final appeal decision to AHCCCS with the claim resubmission or the claim may be denied as incomplete.

Providers of Service

Providers who qualify for Medicare payment, but have not applied to Medicare, must:

- ✓ Register their National Provider Identifier (NPI) with Medicare, and
- ✓ Must bill Medicare before billing Medicaid for all Medicare covered services.

Medicare Crossover Claims

AHCCCS has established an *automated crossover process* for Fee-For-Service claims.

When Medicare issues a payment for a claim for an AHCCCS member the claim is automatically crossed over to AHCCCS.

Providers should not submit claims to AHCCCS for paid Medicare claims for Dual eligible AHCCCS members or QMB members.

For information on the FQHC/RHC exception, refer to FFS Chapter 10 Addendum – FQHC/RHC.

All Medicare Crossover claims are identified on the provider's Medicare Remittance Advice (RA).

AMERICAN INDIAN MEDICAL HOME (AIMH)



WHAT IS THE AIMH

- The American Indian Medical Home is a care management model that puts AHCCCS American Indian Health Program (AIHP) members at the forefront of care.
- AIMHs help address health disparities between American Indians and Alaskan Natives in Arizona by enhancing case management and care.

Member AIMH Enrollment

- AIHP enrolled members can select an AIMH when they access a participating AIMH provider or by contacting the AHCCCS Division of Member Services at 602-417-7100 or 800-334-5283.
- Members who join the AIMH can do so voluntarily and will have the choice to decline participation, dis-enroll or switch AIMHs at any time.

AIMH Eligible Provider Types

02 – Hospital

05 – Clinic (excluding Dental Providers)

IC – Integrated Clinic

C2 – Federally Qualified Health Center (FQHC)

C5 – 638 Federally Qualified Health Center (FQHC)

29 – Community/Rural Health Center (RHC)

AIMH Service and Reimbursement Per Tier Level

First Tier Level

- PCCM Services
- 24 hour telephone access to the Care Team

Second Tier Level

- PCCM services
- 24 hour telephonic access to the care team
- Diabetes Education

Third Tier Level

- PCCM services
- 24 hour telephonic access to the care team
- Participates bi-directionally in State HIE

Fourth Tier Level

- PCCM services
- 24 hour telephonic access to the care team
- Diabetes Education
- Participates bi-directionally in State HIE

Reimbursement

- Facilities who choose to become an AIMH will receive a Prospective Per Member Per Month (PMPM) rate for services provided by their medical home.
- Payments are dependent upon the AIMH tier level selected.
- Tier levels include annual rate increases.

AIMH 4.6% rate increase calculation – 10 year forecast

Calendar Year	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	CY 2025	CY 2026	CY 2027
Level 1	13.26	13.87	14.51	15.18	15.87	16.60	17.37	18.17	19.00	19.88	20.79
Level 2	15.26	15.96	16.70	17.46	18.27	19.11	19.99	20.91	21.87	22.87	23.93
Level 3	20.76	21.71	22.71	23.76	24.85	25.99	27.19	28.44	29.75	31.12	32.55
Level 4	22.76	23.81	24.90	26.05	27.25	28.50	29.81	31.18	32.62	34.12	35.69

Active AIMH's

- **Phoenix Indian Medical Center (PIMC) – Tier 2**
- **Chinle Comprehensive Health Care Facility – Tier 4**
- **Winslow Indian Health Care Center – Tier 3**
- **Whiteriver Indian Hospital – Tier 2**
- **San Carlos Apache Healthcare – Tier 2**
- **Fort Yuma – In progress**

AIMH Provider Requirements

- Be an IHS or Tribal 638 facility
- Enter into an AIMH IGA
- Primary Care Case Management (PCMH) accreditation
- Provide 24 hour telephonic access to the care team
- Dependent on selected tier level
 - Provide diabetes education
 - Participate bi-directionally in the State Health Information Exchange (HIE)

Resources

- IHS/638 Providers can send questions to AIMH@azahcccs.gov
- Review AIMH information at <https://www.azahcccs.gov/AmericanIndians/AmericanIndianMedicalHome/>
- State Plan Amendment (SPA) <https://www.azahcccs.gov/Resources/StatePlans/StatePlanAmendments.html>

BILLING 638 TRIBAL FEDERAL QUALIFIED HEALTH CENTER (FQHC)



Billing Overview

638 TRIBAL FQHC FACILITY

Who can become a 638 FQHC ?

- Tribal 638 clinic that is assigned the provider type 05 (clinic) or 77 (BH Outpatient clinic).

What requirement must the Tribal 638 clinic meet to be recognized as a FQHC by Medicaid?

- The clinic must be operated by a Tribe or tribal organization under Public Law (P.L.) 93-638.

Four Walls

The “4 Walls” of a 638 Clinic refer to the physical building the clinic operates within. The CMS interpretation of section 1905(a)(8) of the Social Security Act, in 42 CFR 440.90, specifies that “clinic services” do not include any services delivered outside of the “four walls” of the clinic, except if services are provided to a homeless individual.

Due to this interpretation, even if a Tribal 638 Clinic has a written care coordination agreement in place with a non-Tribal provider, if the service takes place outside of the clinic’s physical building then the clinic is unable to be reimbursed at the facility rate for clinic services. The reimbursement is instead based on the non-Tribal provider and service(s) rendered.

638 FQHC 4 Walls Exemption

FQHC facilities are exempt from the “4 Walls” requirement. An FQHC may bill the facility rate for services rendered to its patients outside of its “4 Walls” by a non-Tribal provider.

If an FQHC has a care coordination agreement with a non-Tribal provider, such as a neurologist, and the service is provided offsite (outside of the FQHC’s building), the FQHC may still bill the facility rate for the service. However, the FQHC would need to bill for the service, not the offsite provider.

A Tribal 638 Clinic that elects to become a 638 FQHC will have the same exemption from the limitations of the “4 Walls” requirement that current FQHCs receive. A 638 FQHC will be able to bill for reimbursement at the facility rate, also called the Alternative Payment Methodology (APM). Services provided in the member’s home or at a facility acting as the member’s home, such as an assisted living or skilled nursing facility, would also be eligible for reimbursement at the APM facility rate.

Reimbursement

The Alternative Payment Methodology (APM) is the reimbursement methodology for 638 FQHCs, for authorized categories of service. THE APM is the equivalent of the AIR (the OMB outpatient rate for all FQHC services).

Up to 5 encounters/visits may be billed at the AIR per member, per day, for distinct visits.

Note: The system is set up to automatically deny any claims submitted for reimbursement at the APM rate in excess of 5 per member, per day.

The encounters/visits will be differentiated based on the patient account numbers that are assigned for each encounter/visit. Encounters/visits include covered telemedicine services.

Tribal 638 FQHC Claims Submission

For qualifying 638 FQHC services, billing occurs as follows:

Claim Form Type: CMS 1500

Reimbursement Rate: APM

Provider Type: C5

- FQHC clinic visits must be billed under the new provider type C5 and corresponding NPI number.

Tribal 638 FQHC Claims Submission

Rate

The APM is entered on the first service line of the claim and HCPC code T1015 (FQHC visit/encounter, all inclusive) is used. The APM is put in the Total Charges field (Field 28).

HCPC Codes & Charges

Claims must include all HCPC codes (including E&M codes) describing the services rendered as a part of the visit.

These individual services will be billed with a \$0.00 charge in the \$ Charges column (Column F) of the CMS 1500 claim form.

Modifiers

Multiple visits on the same day that are distinct and separate visits must be identified by billing the T1015 HCPC code with modifier 25. The modifier will be entered under the Modifier column in section D, Procedures, Services, or Supplies on the CMS 1500 claim form.

Provider Types

The 638 FQHC Provider Type is C5.

638 FQHCs that provide pharmacy services or NEMT services may have two provider types: A C5 provider type and their previous provider type (05 or 77).

Depending upon what service is being billed, the provider may need to use either their C5 *or* their 05/77 provider type when submitting claims.

What is not considered a 638 FQHC service?

Pharmacy, NEMT Services, and Group Therapy are **not** FQHC services.

- These services should continue to be billed as a part of the provider's clinic ID. These services cannot be billed under the 638 FQHC provider type.

To note, there are items to consider when billing for dental visits, group therapy, case management, and professional services. These are also detailed in the upcoming slides.

What is not a 638 FQHC service?

Pharmacy Services

Pharmacy services will not be billed under the new 638 FQHC provider type, and will continue to be billed for under the provider's previous designation (05).

The reimbursement methodology for pharmacy services will not change and shall continue to be reimbursed at the All Inclusive Rate (AIR).

- Note: Only 1 AIR per member, per day, per pharmacy may be reimbursed. The AIR limits for pharmacy will not change.

What is not a 638 FQHC service?

Pharmacy Services

Claim Form Type: UB-04 Claim Form

Reimbursement Rate: AIR

Provider Type: 05

Notes: The UB-04 Claim Form must include the NDC codes for all prescriptions filled that day. Only 1 AIR will be reimbursed.

The outpatient AIR should be entered on the first service line of the claim and revenue code 0519 (Other Clinic) should be used.

- Include the AIR in the Total Charges field (Field 47), on the 0001 line.

Claims should be submitted with the facility's NPI as the attending provider, since AHCCCS does not register pharmacists.

What is not a 638 FQHC service?

Non-Emergency Medical Transportation (NEMT) Services

NEMT services will not be billed under the new 638 FQHC provider type, and will continue to be billed for under the provider's previous designation (05 or 77).

The reimbursement methodology for NEMT services will not change and shall continue to be reimbursed at the capped FFS fee schedule. NEMT will not be reimbursed at the APM rate.

What is not a 638 FQHC service?

NEMT Services

Claim Form Type: CMS 1500 Claim Form

Reimbursement Rate: Capped FFS Fee Schedule

Provider Type: 05/77

What is not a 638 FQHC service?

Group Therapy

Group therapy and/or any other services provided to a group do not qualify as an FQHC service, since it is not a face-to-face encounter.

For a visit to qualify as a face-to-face encounter the visit must be one-on-one, disqualifying group therapy and/or any other service provided to a group from being a PPS-eligible service.

What is not a 638 FQHC service?

Group Therapy

Claim Form Type: CMS 1500 Claim Form

Reimbursement Rate: Capped FFS Fee Schedule

Provider Type: 05/77

What is not a 638 FQHC service?

Case Management Services

Case Management is not an FQHC service.

Note: A 638 FQHC that is also an American Indian Medical Home (AIMH) will not be eligible for reimbursement of T1016 Code.

Case Management Services for Medical & Behavioral Health

Claim Form Type: CMS 1500 Claim Form

Reimbursement Rate: Capped FFS Fee Schedule

Provider Type: C5

What is not a 638 FQHC service?

Professional Services

Claim Form Type: CMS 1500 Claim Form

Reimbursement Rate: Capped FFS Fee Schedule

Provider Type: Individual Practitioner's Provider Type

AHCCCS PROVIDER Enrollment Portal (APEP)

Coming Spring 2020 !



AHCCCS Provider Enrollment Portal (APEP) Launch Date 2020 !

In the Spring of 2020, the AHCCCS provider enrollment process will move from a manual, paper-based system to a new, online system (the AHCCCS Provider Enrollment Portal) that will allow providers to:

- Enroll as an AHCCCS provider;
- Report changes to update their provider profile (such as phone and addresses, etc.);
- Upload and/or update licenses and certifications;
- Track submission and status of an application or update;
- And more, all online anytime of the day!

If you have questions please contact Provider Enrollment at:

- 1-800-794-6862 (In State - Outside of Maricopa County)
 - 1-800-523-0231 (Out of State)

AHCCCS Provider Enrollment Portal (APEP) Launch Date 2020 !

This change, from a 100% manual process to the new, automated system will streamline the provider enrollment process. Initial applications and updates to existing provider profiles will be processed more quickly and online.

In preparation for the APEP implementation, AHCCCS announces an Application Cut-Off Timeline to support the provider data conversion process. It is imperative to read all forthcoming APEP-related communication.

More information about new system training will be released in the next few months.

AHCCCS Provider Enrollment Portal (APEP) Launch Date 2020 !

Time Lines

Application Cut Off

- All new, reactivating and changes to existing provider applications must be received by AHCCCS no later than **December 12th, 2019**. This will guarantee timely processing of the application or requested change through the current paper-based process.
- Provider conversion into APEP begins **January 16th, 2020**. The new, fully operational system will be available to providers on **March 2nd, 2020**.
- During the conversation into APEP, AHCCCS cannot accept any new or reactivation provider applications, or applications requesting a change to an existing provider. **This temporary hold on applications will last from December 12th, 2019 until March 2nd, 2020!**



Telehealth Services and Billing Guidelines

FFS Presentation

October 2019

Telehealth Services

AHCCCS recently updated its telehealth policies. Updates can be found in:

- [The AHCCCS Medical Policy Manual \(AMPM\) 320-I, Telehealth Services;](#)
- [Chapter 10, Individual Practitioner Services, of the Fee-for-Service Provider Billing Manual;](#) and
- [Chapter 8, Individual Practitioner Services, of the IHS/Tribal Provider Billing Manuals.](#)

In light of these updates, the Telehealth Training Manual will be removed, as it contains outdated information (our policies have expanded telehealth services).

Telehealth Services

AHCCCS covers medically necessary, non-experimental, cost-effective telehealth services provided by an AHCCCS registered provider. There are no geographic restrictions for telehealth; services delivered via telehealth are covered by AHCCCS in rural and urban regions.

Telehealth may include healthcare services delivered via teledentistry, telemedicine, or asynchronous (store and forward).

Telehealth Services

What services are covered via telehealth?

- The first thing to know is that there is a difference between *real time telehealth (synchronous)* and *store and forward (asynchronous)*, and the types of services that that are covered.
 - **Asynchronous** provides access to data after it has been collected, and involves communication tools such as secure email or telehealth software solutions.
 - **Synchronous** is the “real time” two-way interaction between the patient and provider, using interactive audio and video.

Synchronous Telehealth Services

The following list is not comprehensive, but here are examples of services covered by real time telehealth:

Real Time (Synchronous) Telehealth Service Examples

*Not all inclusive list.

Behavioral Health	Cardiology	Dentistry	Endocrinology
Hematology / Oncology	Home Health	Infectious Diseases	Inpatient Consultations
Medical Nutrition Therapy (MNT)	Neurology	Obstetrics/Gynecology	Oncology / Radiation
Ophthalmology	Orthopedics	Office Visits (adults & pediatrics)	Outpatient Consultations
Pain Clinic	Pathology & Radiology	Pediatrics & Pediatric Subspecialties	Pharmacy Management
Rheumatology	Surgery Follow-Up	Surgery Consultations	

Asynchronous Telehealth Services

The following services are covered via asynchronous telehealth (store & forward):

Asynchronous (Store & Forward) Telehealth Services *All inclusive list.			
Behavioral Health	Cardiology	Dermatology	Neurology
Ophthalmology	Pathology	Radiology	Infectious Disease

Telehealth Services

What services are covered via telehealth?

- In order for a service to be covered via telehealth, it must be an AHCCCS covered service rendered by an AHCCCS registered provider, and it must meet the requirements as outlined in AHCCCS Medical Policy and within AMPM 320-I, Telehealth Services.



Telehealth Definitions



Telehealth Services

Modes of Service Delivery

Service delivery via telehealth can be done via teledentistry, telemedicine, or asynchronous (store and forward).

1. ***Asynchronous or "Store and Forward"*** means the transmission of recorded health history (e.g. pre-recorded videos and digital images, such as x-rays and photos) through a secure electronic communications system to a practitioner, usually a specialist, who uses the information to evaluate the case or render consultative services outside of a synchronous (real-time) interaction. As compared to a real-time visit, this service provides access to data after it has been collected, and involves communication tools such as secure email or telehealth software solutions.

Telehealth Services

Modes of Service Delivery (Continued...)

- 2. *Teledentistry*** is the acquisition and transmission of all necessary subjective and objective diagnostic data through interactive audio, video or data communications by an AHCCCS registered dental provider to a dentist at a distant site for triage, dental treatment planning, and referral.
- 3. *Telemedicine*** is the practice of health care delivery, diagnosis, consultation and treatment and the transfer of medical data through interactive audio, video or data communications that occur in the physical presence of the patient, including audio or video communications sent to a health care provider for diagnostic or treatment consultation.

Telehealth Services

Service delivery via telemedicine can occur in one of two ways:

- ***Real time (synchronous)*** means the two-way interaction between a person (patient, caregiver, or provider) and a provider using interactive audio and video. The patient is at the originating site and the provider is at the distant site. It includes the transfer of information and medical data between two sites simultaneously: the distant site and the originating site.
- ***Remote patient monitoring*** is the personal health and medical data collection from an individual in one location via electronic communication technologies, which is transmitted to a provider (sometimes via a data processing service) in a different location for use in providing improved chronic disease management care and related support.

Telehealth Services

What is the difference between the Distant Site (Hub) and Originating Site (Spoke)?

- **Distant site** means the site at which the provider delivering the service is located at the time the service is provided via telehealth. (Formerly hub site.)
- **Originating site** means the location of the AHCCCS member at the time the service is being furnished via telehealth or where the asynchronous service originates. (Formerly spoke site.) This is considered the place of service.



Policy Information – Limitations & Exclusions



Telehealth Services

Things to know:

- Synchronous (Real Time) Telemedicine and Remote Patient Monitoring will not replace provider and member choice for healthcare delivery modality.
- All telehealth services shall be provided by an AHCCCS registered provider.
- Confidentiality standards for Telehealth services should adhere to all applicable statutes and policies governing Telehealth.
- Informed consent standards for Telehealth services shall adhere to all statutes and policies governing telehealth, including A.R.S. §36-3602.

Telehealth Services

Things to know:

- Medical records for telehealth visits must be maintained by any provider receiving reimbursement. This includes documentation showing the procedure code and appropriate modifier.
- Telehealth and telemedicine may qualify as an FQHC/RHC visit if it meets the requirements specified in AMPM 320-I, Telehealth.

A.R.S. §36-3602 & Telehealth Services

36-3602. Delivery of health care through telemedicine; requirements; exceptions

- A. Except as provided in subsection E of this section, before a health care provider delivers health care through telemedicine, the treating health care provider shall obtain verbal or written informed consent from the patient or the patient's health care decision maker. If the informed consent is obtained verbally, the health care provider shall document the consent on the patient's medical record.
- B. The patient is entitled to all existing confidentiality protections pursuant to section 12-2292.
- C. All medical reports resulting from a telemedicine consultation are part of a patient's medical record as defined in section 12-2291.
- D. Dissemination of any images or information identifiable to a specific patient for research or educational purposes shall not occur without the patient's consent, unless authorized by state or federal law.
- E. The consent requirements of this section do not apply:
1. If the telemedicine interaction does not take place in the physical presence of the patient.
 2. In an emergency situation in which the patient or the patient's health care decision maker is unable to give informed consent.
 3. To the transmission of diagnostic images to a health care provider serving as a consultant or the reporting of diagnostic test results by that consultant.



Specific Telehealth Services



Telehealth Services

Behavioral Health

Behavioral health telehealth services are covered for Title XIX (Medicaid) and Title XXI (KidsCare) members.

Covered behavioral health services can include, but are not limited to:

- Diagnostic consultation and evaluation,
- Psychotropic medication adjustment and monitoring,
- Individual and family counseling, and
- Case management.

This includes Naturalistic Observation Diagnostic Assessment (NODA).

Telehealth Services

Teledentistry

AHCCCS covers Teledentistry for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) aged members when provided by an AHCCCS registered dental provider.

Teledentistry does not replace the dental examination by the dentist; limited periodic and comprehensive examinations cannot be billed through the use of Teledentistry alone.

Teledentistry includes the provision of preventative and other approved therapeutic services by the AHCCCS registered Affiliated Practice Dental Hygienist, who provides dental hygiene services under an affiliated practice relationship with a dentist.

- For additional information on [Affiliated Practice Dental Hygienists](#), see [AMPM 431](#).

Telehealth Services

Non-Emergency Medical Transportation (NEMT)

Non-emergency medical transportation is covered to transport a Title XIX or Title XXI member to and from the originating site, in order to receive an AHCCCS covered medically necessary consultation or treatment.

Telehealth Services

Office Setting Services

Office visits (adults & pediatrics) are covered for Title XIX and Title XXI members via telehealth.

This includes prolonged preventive services beyond the typical service of the primary procedure. These may require direct patient contact and may occur in either the office or another outpatient setting. The following codes are examples:

G0513	G0514
Prolonged preventive service(s) (beyond the typical service of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; first 30 minutes (listed separately in addition to code for preventive service).	Prolonged preventive service(s) (beyond the typical service of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes (listed separately in addition to code for preventive service).



Billing for Telehealth Services



Telehealth Billing

What has changed?

- Previously the distant site (hub) was used as the Place of Service (POS) on claims for telehealth services.
- Now the originating site (spoke) is used as the POS on claims for telehealth services.

Telehealth Billing

What has changed?

The Place of Service listed on the Claim

- Previously the distant site (hub) was used as the Place of Service (POS) on claims for telehealth services.
- Now the originating site (spoke) is used as the POS on claims for telehealth services.

Telehealth Billing

What has changed?

POS Example

- A member is located at a Rural Health Clinic (originating site) and the consulting provider (who will submit the claim) is located in their office (distant site).
- The POS listed on the claim (submitted by the consulting provider at the distant site) will be POS 72 (Rural Health Clinic).
- The POS will *not* be the provider's office (distant site).

Telehealth Billing

What has changed?

Geographic Restrictions

- There are no geographic restrictions for telehealth services.
- Telehealth services may be rendered to members both in rural and urban/metropolitan areas.

Telehealth Billing

What has changed?

Providers and Facilities Permitted to Serve as Originating and/or Distant Sites

- There are no longer restrictions for the provider types & facilities that can serve as the originating and distant sites.
- They simply need to be AHCCCS registered providers.

Telehealth Billing

What has changed?

Provider Types

There are no longer restrictions for the provider types that can bill for telehealth services.

Telepresenter

What is a Telepresenter?

At the time of service delivery via **real time** telehealth an individual who is familiar with the member's condition *may* be present with the member.

- This person is called a **Telepresenter**.
- **Telepresenter services are not billable .**

Telehealth Billing – FFS Providers

Claim Form

- FFS Providers billing for reimbursement at the FFS Rate should bill using the CMS 1500 Claim Form.



Telehealth Billing – FFS Providers

Claim Form

- IHS/638 Providers billing for reimbursement at the All-Inclusive Rate (AIR) should bill using the UB-04 Claim Form.
 - Please note that a separate telehealth training will be scheduled for IHS/638 providers for a discussion surrounding telehealth services and the All Inclusive Rate.
 - Date & Time: TBD

Telehealth Billing – FFS Providers

Coding

Providers should follow national coding standards when using HCPCS, CPT and UB-04 Revenue Codes.

For a complete code set of services, along with their eligible place of service and modifiers, that can be billed as telehealth please visit the AHCCCS Medical Coding Resources web page at:

<https://www.azahcccs.gov/PlansProviders/MedicalCodingResources.html>



Telehealth Billing – FFS Providers

Place of Service (POS)

The POS listed on the claim form shall be the **originating site** (where the AHCCCS member is located).

- i.e. A member is located at a Rural Health Clinic (originating site) and the consulting provider (who will submit the claim) is located in their office (distant site). The POS listed on the claim (submitted by the consulting provider) will be POS 72 (Rural Health Clinic).



Telehealth Billing – FFS Providers

Modifiers

For a full list of available POS and appropriate modifiers, refer to the AHCCCS Medical Coding Resources webpage at:

<https://www.azahcccs.gov/PlansProviders/MedicalCodingResources.html>



Telehealth Billing – FFS Providers

Modifiers

MODIFIER	DESCRIPTION
GQ	Asynchronous (“store and forward”) telehealth services must be billed using the “GQ” modifier to designate the service being billed as a telehealth service.
GT	Real time (interactive audio and video) telehealth services must be billed using the “GT” modifier to designate the service being billed as a telehealth service.

Telehealth Billing – FFS Providers

Medicare Dual Claims

For Medicare Dual members, claims may be submitted with the POS listed as 02 (Telemedicine) to comply with Medicare guidelines.

The POS 02 (Telemedicine) will designate the service being provided as a telehealth service.

- i.e. A member is located at Rural Health Clinic (originating site) and the consulting provider (who will submit the claim) is located in their office (distant site). The POS listed on the claim (submitted by the consulting provider) will not be POS 72 (Rural Health Clinic), but will instead be listed as POS 02.

Telehealth Billing – FFS Providers

Place of Service Note

The POS on a claim should be the originating site, however AHCCCS will also accept **POS 02 (Telemedicine)**.

However, POS 02 should *only* be used on Medicare claims that are crossing over to AHCCCS.

Telehealth Questions

The DFSM Provider Training Team

Please outreach providertrainingffs@azahcccs.gov with telehealth questions.





Behavioral Health Services Update



Behavioral Health Services Updates

Transition of the Covered Behavioral Health Services Guide (CBHSG)

In 2019, information contained within the AHCCCS Covered Behavioral Health Services Guide (CBHSG) will be transitioned into the following manuals:

- [AHCCCS Medical Policy Manual](#),
- [Fee-for-Service-Provider Billing Manual](#), and
- [IHS/Tribal Provider Billing Manual](#).

Behavioral Health Services Updates

Transition of the Covered Behavioral Health Services Guide (CBHSG)

Information from the CBHSG shall be transitioned into these specific areas within the AHCCCS Medical Policy Manual (AMPM) :

- AHCCCS Medical Policy Manual ([AMPM](#)) [Policy 310-B, Behavioral Health Services Benefit](#)
 - Title XIX/XXI benefit information.
- [AMPM Policy 320-T, Non-Title XIX/XXI Behavioral Health Services](#)
 - Non-Title XIX/XXI service information.
- Appropriate AMPM Policies as necessary, including:
 - [AMPM Policy 310-BB, Transportation](#); and
 - [AMPM Policy 320-V, Behavioral Health Residential Facilities \(BHRFs\)](#).

Behavioral Health Services Updates

Transition of the Covered Behavioral Health Services Guide (CBHSG)

Billing information from the CBHSG shall be transitioned into the following areas:

- [Chapter 19, Behavioral Health Services, FFS Provider Billing Manual](#)
 - *Transition in progress.
- [Chapter 12, Behavioral Health Services, IHS/Tribal Provider Billing Manual](#)
 - *Transition in progress.
 - Behavioral Health services billing information for IHS/Tribal Providers.
- [The Medical Coding Resources Web Page](#)
 - [The Behavioral Health Services Matrix](#) (formerly known as the B2 Matrix)

Behavioral Health Services Updates

Transition of the Covered Behavioral Health Services Guide (CBHSG)

Please note that the billing manual updates are underway and shall be posted in November of 2019. A constant contact email will be sent out when these updates are published.

The AMPM policies will be posted under the Approved Not Yet Effective tab as of 9/25/2019. Their effective date will be 10/1/2019.

AHCCCS Covered Behavioral Health Services

AHCCCS Covered Behavioral Health Services include, but are not limited to:

- Inpatient hospital services
- Behavioral Health Inpatient Facilities (BHIF)
- Behavioral Health Residential Facilities (BHRF)
- Partial care (supervised day program, therapeutic day program, medical day program)
- Individual therapy and counseling
- Group and/or family therapy and counseling
- Emergency/crisis behavioral health services
- Behavior management (behavioral health personal assistance, family support, peer support)

AHCCCS Covered Behavioral Health Services

AHCCCS Covered Behavioral Health Services include, but are not limited to (continued):

- Evaluation and diagnosis
- Psychotropic medication, including adjustment and monitoring of medication
- Psychosocial Rehabilitation (living skills training; health promotion; pre-job training, education and development; job coaching; and employment support)
- Laboratory and Radiology Services for medication regulation and diagnosis
- Screening
- Case Management Services
- Emergency Transportation
- Non-Emergency Transportation
- Respite Care (with limitations)
- Therapeutic foster care services



Billing for Behavioral Health Services



Where Should Claims Be Sent? (By Facility Type and Enrollment)

Title XIX and Title XXI (KidsCare) members are eligible to receive behavioral health services through their integrated health plan.

- Claims for Title XIX and XXI members provided by a FFS provider (not an IHS or 638 facility) should be sent to the member's enrolled ACC plan.
 - **Note: AHCCCS DFSM is the ACC plan for members enrolled in the American Indian Health Plan (AIHP).**
- Claims for services provided for Title XIX AI/AN members through IHS/638 facilities should be sent to AHCCCS DFSM.
- Claims for services provided for Title XXI (Kidscare) members through IHS/638 facilities should be sent to the enrolled ACC plan, or to AHCCCS DFSM for AIHP enrolled members.

Where Should Claims Be Sent? (By Enrollment Type)

Claims for *both* physical and behavioral health services, including CRS services, should be sent to the member's integrated health plan. Integrated health plans include:

- **ACC Health Plans**
 - **Note: Claims for ACC enrolled members should be sent to the member's enrolled ACC health plan, except when the member is a Title XIX American Indian/Alaskan Native receiving services through an IHS/638 facility. In these cases, the claim should be sent to AHCCCS DFSM.**
- **AIHP**
 - **Note: Claims for AIHP members should be sent to AHCCCS DFSM.**
- **AIHP/TRBHA**
 - **Note: Claims for AIHP and TRBHA members should be sent to AHCCCS DFSM.**

National Coding Standards

Providers are required to utilize national coding standards when utilizing HCPCS, CPT, and UB-04 revenue codes.

Providers are required to use the applicable modifier(s). For HCPCS and coding modifiers that contain additional AHCCCS policy requirements, they are described in each applicable section throughout this Policy.

Diagnosis Codes – ICD-10-CM

For outpatient behavioral health services, services are considered medically necessary regardless of a member's diagnosis, so long as there are documented behaviors and/or symptoms that will benefit from behavioral health services and a valid ICD-10-CM diagnostic code is utilized.

For a complete list of ICD-10-CM codes that can be utilized, refer to the AHCCCS Behavioral Health Diagnosis List on the AHCCCS website.

For inpatient and residential (BHRF) treatment services, a valid ICD-10-CM Mental, Behavioral, or Neurodevelopmental Disorder (F01-F99) diagnosis is required.

Behavioral Health Services Matrix

What is the Behavioral Health Services Matrix?

The AHCCCS Behavioral Health Matrix is a searchable crosswalk of behavioral health service codes. It can be searched by Provider Type, Code, and Modifier. Each searchable category has an individual tab.

Once a search has been done under one of the Provider Type, Code, or Modifier tabs, the list of available behavioral health-related codes will be viewable. The user can further narrow the selection by Code, Description, Category of Service (COS), Modifier, and Place of Service (POS)/Bill Type. This is done by using the filter option at the top of each column.

Behavioral Health Services Matrix

What is the Behavioral Health Services Matrix?

i.e. An MD clicks on the Provider Type tab. They may select (in the upper right hand corner within the gold box) their Provider Type (08 MD-Physician).

The spreadsheet will populate a list of Codes that can be potentially billed by this Provider Type, along with the corresponding descriptions of the Codes. The COS and Modifiers, along with the POS/Bill Types, where these Codes can potentially be used, will also auto-populate. The provider can then filter within these columns as needed.

Behavioral Health Services Matrix

What is the Behavioral Health Services Matrix?

The Behavioral Health Matrix also offers a Definitions tab, which lists the available Bill Types, Categories of Service (COS), Places of Service (POS) and Modifiers that can be used when billing for behavioral health services.

NOTE: All applicable coding standards and requirements, including scope of practice guidelines, supersede the Behavioral Health Matrix. The Behavioral Health Matrix is intended to be a reference document and is subject to change.

Behavioral Health Services Matrix

Using the Behavioral Health Services Matrix

Step 1: Determine if you want to search by Provider, by Code, or by Modifier.

Step 2: Go to the appropriate tab on the bottom of the Matrix.

Step 3: In the upper right hand corner click on the Gold Box for drop down options.

Behavioral Health Services Matrix

BehavioralHealthServicesMatrix.xlsx [Read-Only] - Microsoft Excel

Provider Type	Code	Description	Modifier	Places of Service
19	G0482	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (eg, IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (eg, alcohol dehydrogenase)); qualitative or quantitative, all sources, includes specimen validity testing, per day, 15-21 drug class(es), including metabolite(s) if performed.)	U8	05 06 07 08 11 19 21
19	G0483	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (eg, IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (eg, alcohol dehydrogenase)); qualitative or quantitative, all sources, includes specimen validity testing, per day, 22 or more drug class(es), including metabolite(s) if performed.	U8	05 06 07 08 11 19 21
19	G0511	Rural health clinic or federally qualified health center (rhc or fqhc) only, general care management, 20 minutes or more of clinical staff time for chronic care management services or behavioral health integration services directed by an rhc or fqhc practitioner	(OPFS): CR GA XE XP XS XU 59 (FFS): AQ, CR GA GC PO Q5 Q6	05 06 07 08 11 19 21

Provider Type 19 Click in gold box for drop down options

19 22 23 27 28 29 30 31

Modifier U8

Places of Service 05 06 07 08 11 19 21

Ready | Type here to search | 11:46 AM 9/23/2019

Behavioral Health Services Matrix

Using the Behavioral Health Services Matrix

Once you have made your selection in the Gold Box drop down, the rest of the spreadsheet will populate to show the following:

- What Provider Type can bill....
 - ✓ With what Codes...
 - ✓ With what Modifiers...
 - ✓ In what Places of Service

General Billing Guidance

AHCCCS can offer *general* billing guidance through its policies and billing manuals, however AHCCCS does not instruct providers on how to code or bill for a particular service. We may only offer general guidance.

It is up to each provider to determine what they can and cannot bill for under their individual licensures.

For additional information on rates, coding, or the submission of claims to an ACC Health Plan please follow the below guidelines:

- Rates - Questions on AHCCCS FFS rates should be directed to the rates team at FFSRates@azahcccs.gov.
- Coding - Questions on AHCCCS Coding should be directed to the coding team at CodingPolicyQuestions@azahcccs.gov.

NOTE: The Coding team cannot instruct providers on *how* to code or bill for a particular service. Those questions should be directed to the provider's professional coder/biller.

AMPM 310-B, Title XIX/XXI Behavioral Health Service Benefit Updates



Definitions



AMPM 310-B Definition Updates

Behavioral Health definitions have been updated throughout AHCCCS policy, including the definitions of:

- **Behavioral Health Professionals (BHPs)**
 - i.e. A registered nurse practitioner licensed as an adult psychiatric and mental health nurse; a physician; a psychiatrist; etc.
- **Behavioral Health Paraprofessionals (BHPPs)**
- **Behavioral Health Technicians (BHTs)**

Behavioral Health Professionals (BHPs)

BHPs are:

1. Individuals licensed under Arizona Revised Statute (A.R.S.) Title 32, Chapter 33, whose scope of practice allows the individual to:
 - a. Independently engage in the practice of behavioral health as defined in A.R.S. §32-3251; or
 - b. Except for a licensed substance abuse technician (LSAT), engage in the practice of behavioral health as defined in A.R.S. §32-3251 under direct supervision as defined in AAC. R4-6-101;
2. A psychiatrist as defined in A.R.S. §36-501;
3. A psychologist as defined in A.R.S. §32-2061;
4. A physician;
5. A behavior analyst as defined in A.R.S. §32-2091;
6. A registered nurse practitioner licensed as an adult psychiatric and mental health nurse; or
7. A registered nurse with:
 - a. A psychiatric-mental health nursing certification, or
 - b. One year of experience providing behavioral health services.

Behavioral Health Paraprofessional (BHPPs)

Per A.A.C. R9-10-101(27) a BHPP is an individual, who is not a behavioral health professional (i.e. not a physician, psychiatrist, registered nurse practitioner licensed as an adult psychiatric and mental health nurse, etc.), who provides behavioral health services at or for a health care institution according to the health care institution's policies and procedures, that:

- a. If the behavioral health services were provided in a setting other than a licensed health care institution, the individual would be required to be licensed as a behavioral professional under A.R.S, Title 32, Chapter 33; and**
- b. Are provided under supervision by a behavioral health professional.**

Behavioral Health Technician (BHT)

Per A.A.C. R9-10-1010, a BHT is an individual, who is not a BHP (i.e. not a physician, psychiatrist, registered nurse practitioner licensed as an adult psychiatric and mental health nurse, etc.), who provides behavioral health services at or for a health care institution according to the health care institution's policies and procedures that:

- 1. If the behavioral health services were provided in a setting other than a licensed health care institution, the individual would be required to be licensed as a behavioral professional under A.R.S. Title 32, Chapter 33; and**
- 2. Are provided with clinical oversight by a behavioral health professional.**

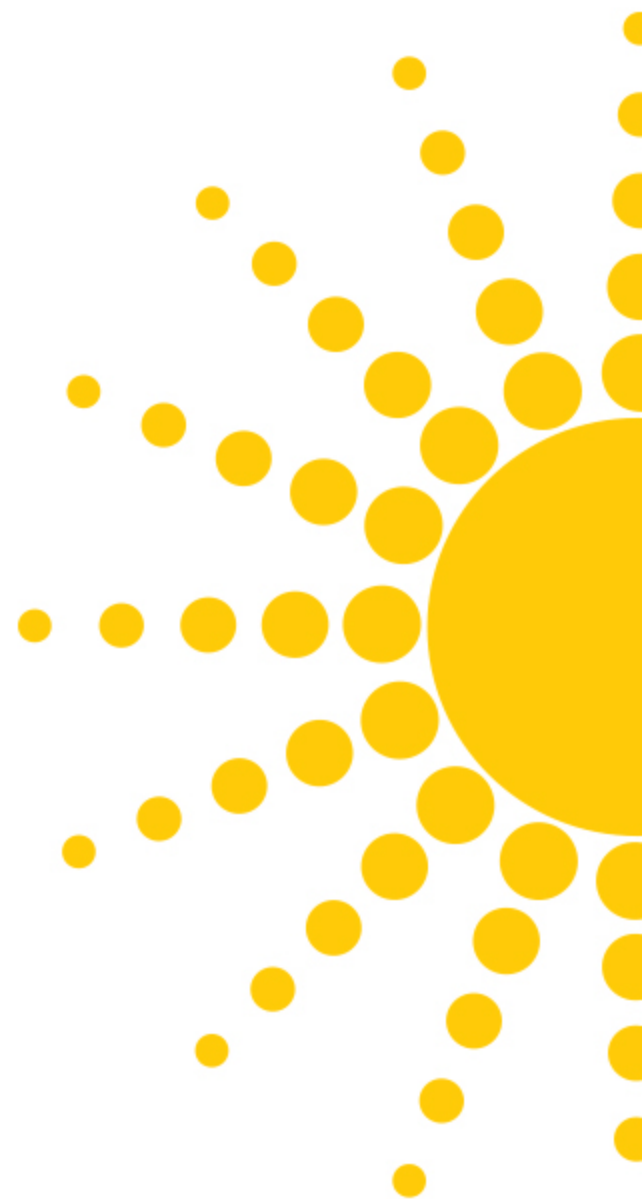
Behavioral Health Technician (BHT)

Any Behavioral Health Technician providing services in the public behavioral health system shall have clinical oversight done by a Behavioral Health Professional.

Who can provide that oversight?

- Physicians;
- Psychiatrists;
- Psychologists;
- Behavioral Analysts;
- A registered nurse practitioner licensed as an adult psychiatric and mental health nurse;
- A registered nurse with either a psychiatric-mental health nursing certification, or one year of experience providing behavioral health services; or
- Individuals licensed under [A.R.S. Title 32, Chapter 33.](#)

Emergency Behavioral Health & Crisis Intervention Services



Emergency Behavioral Health Services

Prior authorization is not required for emergency behavioral health services (A.A.C. R9-22-210.01), including Crisis Intervention Services.

Crisis Intervention Services

Crisis intervention services are provided to stabilize or prevent a sudden, unanticipated, or potentially dangerous behavioral health condition, episode or behavior. These intensive and time-limited services may include:

- Screening (e.g. triage and arranging for the provision of additional crisis services);
- Counseling to stabilize the situation;
- Medication stabilization and monitoring;
- Observation and/or follow-up to ensure stabilization; and/or
- Other therapeutic and supportive services to prevent, reduce, or eliminate a crisis situation.

Crisis Intervention Services

Crisis Service Responsibility

The RBHA is responsible for the delivery of timely crisis services.

This includes telephonic, community-based mobile, and facility-based stabilization (including observation not to exceed 24 hours), along with any associated covered services delivered by the crisis provider in these settings during the first 24 hours.

Crisis Intervention Services

Crisis Service Responsibility

While RBHAs are contracted with AHCCCS to provide crisis services, this does not preclude a FFS provider or an IHS/638 provider from providing crisis services to a member in need.

- **NOTE:** However, the RBHA is responsible for providing crisis services and is contracted with AHCCCS to provide these services.

Crisis Intervention Services

Crisis Service Responsibility & Care Coordination

The RBHAs are responsible for notifying the Contractor of enrollment (ACC Health Plan), or AHCCCS DFSM for FFS Members, within 24 hours of a member engaging in crisis services so subsequent services can be initiated.

The crisis providers have an ongoing obligation to serve the member and coordinate with the member's health plan beyond the initial 24 hours.

The Contractor (ACC Health Plan) or DFSM for FFS members is responsible for care coordination and covered services (which may include follow up stabilization services) post-24 hours, the RBHA will remain responsible for any costs associated with follow up phone calls related to the crisis episode post-24 hours.

Crisis Intervention Services

Crisis Services provided by the RBHA:

For members enrolled with an ACC plan, AIHP, or Tribal ALTCS, for the first 24 hours, crisis services provided by non-IHS/638 crisis providers should be billed to the RBHA. This means that the RBHA is responsible for crisis services for the first 24 hours.

If the member is enrolled in AIHP or Tribal ALTCS, and crisis services are provided beyond the 24 hour mark, *then* the claim (for services provided after the 24th hour) would be submitted to AHCCCS.

Crisis Intervention Services

Crisis Services provided by an IHS/638 Provider

Again, while RBHAs are contracted with AHCCCS to provide crisis services, this does not preclude a FFS provider or an IHS/638 provider from providing crisis services to a member in need.

In the event that a Title XIX member enrolled with an ACC plan, AIHP, or Tribal ALTCS received a crisis service from an IHS/638 provider and *not* from the RBHA contractor the crisis services would be billed to AHCCCS DFSM.

Crisis Intervention Services

Crisis Services provided by an IHS/638 Provider

For IHS/638 providers, how would billing work?

Depending on the physical location of where the crisis services were provided, either the AIR or the capped FFS rate (to be billed with the specific crisis service CPT or HCPCS codes) could be billed.

Crisis Intervention Services

Crisis Services provided by an IHS/638 Provider

If the service was provided within the 4 walls of the clinic, then the revenue code would be billed for reimbursement at the AIR.

If the service was provided outside of the 4 walls of the clinic it would not be billable at the AIR. In this case the CPT/HCPCS code would be billed for reimbursement at the capped FFS rate.

NOTE: In these cases (where the crisis service was provided by the IHS/638 provider), the claim would not be sent to the RBHA located in the RBHA's GSA, where the crisis occurred. It would be sent to AHCCCS DFSM for Title XIX Members.

Crisis Intervention Services

How can Crisis Intervention Services be provided?

- **Telephonically**
- **Mobile Teams in the Community**
- **Facility-Based Settings**

Crisis Intervention Services

Crisis Services FAQs are available on the AHCCCS website at:

- https://www.azahcccs.gov/AHCCCS/Downloads/ACC/View_Crisis_System_FAQs.pdf

Crisis Intervention Services

Telephonic Crisis Intervention Services (Telephone Response)

Telephonic crisis intervention services provides:

- Triage,
- Referral, and
- Telephone-based support.

They may also include:

- Follow-up phone calls to ensure stabilization of the member undergoing crisis.

Telephonic crisis intervention services shall be provided by BHPs or BHTs supervised by a BHP.

Crisis Intervention Services

Mobile Crisis Intervention Services (Mobile Crisis Team)

Mobile teams travel to where a member is experiencing a crisis (i.e. their home, emergency room, jail, community setting, etc.)

Mobile crisis intervention services shall be provided by BHPs or BHTs supervised by a BHP. If a BHT is providing the service, a BHP must be directly available to the BHT for consultation. If a mobile team responds and consists of two people, then one individual may be a BHPP.

Crisis Intervention Services

Mobile Crisis Intervention Services (Mobile Crisis Team)

Mobile crisis team requirements include training in:

- First Aid
- Cardiopulmonary Resuscitation (CPR)
- Non-Violent Crisis Resolution

Crisis Intervention Services

Mobile Crisis Intervention Services (Mobile Crisis Team)

Call Response Times

Mobile crisis teams must be able to transport a member to a more appropriate facility for care when clinically indicated.

- Mobile crisis teams in Greater AZ RBHAs must respond “on site” within an average of 90 minutes of the crisis calls.
- Mobile crisis teams in the Maricopa County RBHA’s area must respond “on site” within an average of 60 minutes of the crisis call.

Crisis Intervention Services

Facility-Based Crisis Intervention Services

They are an immediate and unscheduled behavioral health service provided:

- (a) in response to an individual's behavioral health condition to prevent imminent harm, to stabilize or resolve an acute behavioral health issue; and
- (b) (b) at an ADHS licensed inpatient facility or outpatient treatment center in accordance with 9 A.A.C. 10. Individuals may walk-in or be referred/ transported to these settings.

Facility-based crisis intervention services shall be provided by BHPs and/or BHTs/BHPPs supervised by a BHP.

Self Referrals



Self-Referrals

Members, guardians, and designated representatives may initiate their own requests for behavioral health services.

This is to ensure timely access to medically necessary behavioral health services.

These shall comply with the Rules set forth in A.A.C. Title 9, Chapters 10 and 21.

Medical Services



Medical Services

Medical services are provided and ordered within the scope of practice of the licensed physician, nurse practitioner, physician assistant, or nurse to reduce a member's symptoms and improve or maintain functioning.

These services include:

- Medication;
- Laboratory, radiology and medical imaging services;
- Medical management services, including the review of medication(s) and their side effects and the adjustment of the type and dosage of prescribed medications; and/or
- Electroconvulsive therapy and trans-magnetic stimulation on an outpatient basis.

Medical Services

Laboratory, radiology and medical imaging services may include, but are not limited to:

- Blood tests
- Urine tests
- CT scans
- MRI
- EKG
- EEG

Specimens may be collected in a medical practitioner's office. Otherwise, laboratory services must be provided in a Clinical Laboratory Improvement Act (CLIA) approved hospital, medical laboratory or other health care facility.

Behavioral Health Services to Family Members



Services to Family Members

Behavioral health services can be provided, in certain circumstances, to a Title XIX/XXI member's family member(s).

- This can be done *regardless* of the family member's Title XIX/XXI entitlement status, so long as the member's Service Plan reflects that these services are aimed at accomplishing the member's Service Plan goals.
- The member does not have to be present when these services are provided to a family member.

Room & Board



Room & Board

Room and board means the provision of lodging and meals to a person residing in a residential facility or supported independent living setting which may include but is not limited to: services such as food and food preparation, personal laundry, and housekeeping.

Room & Board

Room and Board is covered only for the following:

- **Inpatient Hospitals,**
- **Intermediate Care Facilities for individuals with Intellectual Disability (ICF/ID), and**
- **Nursing Facilities.**

Behavioral Health Support Services



Support Services

Support services are provided to facilitate the delivery of or enhance the benefit received from other behavioral health services.

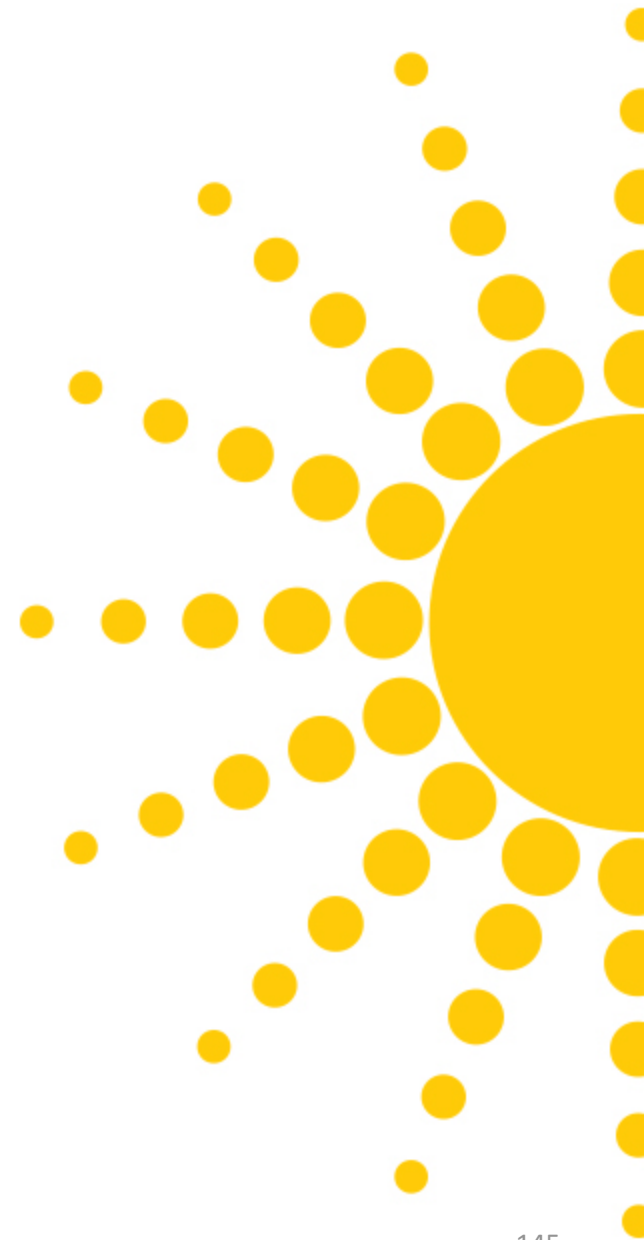
Support services shall be provided by individuals who are qualified BHPs or BHTs/BHPPs supervised by BHPs.

Support Services

Support services are classified into the following subcategories:

- **Case Management**
- **Personal Care Services**
- **Unskilled Respite Care**
- **Home Care Training (Family Support)**
- **Therapeutic Foster Care (TFC)**
- **Self-Help/Peer Services (Peer & Recovery Support)**

Case Management



Case Management

What is Case Management?

Case management (provider level) is a supportive service provided to improve treatment outcomes. Case management activities help a member meet their Service Plan goals.

Case management may be provided by BHPs, or BHTs/BHPPs supervised by BHPs.

Case Management

Examples of Case Management Services:

- Assistance in maintaining, monitoring, and modifying behavioral health services;
- Assistance in finding necessary resources;
- Coordination of care with the member's healthcare providers;
- Assistance in applying for Social Security benefits using the SSI/SSDI Outreach, Access and Recovery (SOAR) approach;
- Outreach and follow-up regarding crisis contacts and missed appointments; and/or
- Participation in staffing, case conferences or other meetings with or without the member or their family participating.

Case Management

Case management can include Indirect Contact.

Indirect contact with a member includes:

- Email;
- Phone Calls (excluding leaving voice mails);
- Obtaining collateral information; and/or
- Picking up and delivering medications.

For case management assessments the provider may bill all time spent in direct contact or indirect contact, that is involved with implementing the member's Treatment/Service Plan.

Case Management – Billing

Claim Form

- **Case Management services must be billed on a CMS 1500 Claim Form.**

Case Management – Billing

Reimbursement

FFS Providers & IHS/638 Providers:

- a. Case Management is reimbursed at the FFS rate, for both FFS providers and IHS/638 providers.
- b. CMS has designated case management as not being a clinic service, so it is not eligible for reimbursement at the AIR.

638 FQHCs:

- a. Case Management is reimbursed at the FFS rate, not the APM.
- b. To be billed under the C5 provider type.

American Indian Medical Homes

- a. AIMHs receive a Per Member Per Month (PMPM) rate for case management services, so cannot bill for Case Management Separately.

Case Management – Billing

Coding Units

For case management services (T1016), with billing units of 15 minutes, the first unit of service can be encountered/billed when 1 or more minutes are spent providing the service.

To encounter/bill an additional unit of the service, the provider must provide service for at least one half of the billing unit's time frame for the additional unit to be encountered/billed. If less than one half of the additional billing unit is spent providing the service, then only the initial unit of service can be encountered/billed.

Case Management – Billing

Modifiers

For provider case management used to facilitate a Child and Family Team (CFT), the modifier U1 is required.

For provider case management utilized when assisting members in applying for Social Security benefits (using the SSI/SSDI Outreach, Access, and Recovery (SOAR) approach) the modifier HK is required. Billing T1016 with an HK modifier indicates the specific usage of the SOAR approach and it cannot be used for any other service.

For additional information on modifiers review the [Behavioral Health Services Matrix](#).

Personal Care Services



Personal Care Services

Personal Care Services help an individual with their activities of daily living, such as bathing, shopping, dressing, cooking and other activities essential for living in a community.

Personal care services may be provided in an unlicensed setting such as a member's own home or community setting.

They may be provided by the member's parents (including natural parent, adoptive parent and stepparent) if the member receiving services is 21 years or older and the parent is not the member's legal guardian.

They may not be provided by a member's spouse.

Personal Care Services

Personal care services provided by a licensed inpatient, Supervised Behavioral Health Treatment and Day Program, or in Therapeutic Foster Care (TFC) are included in the rate for these settings and cannot be billed separately.

Personal Care Services & BHRFs

Some Behavioral Health Residential Facilities (BHRFs) may be licensed through the Arizona Department of Health Services (ADHS) to provide personal care services.

As of 10/1/2019 these licensed BHRFs may bill for H0018 (Behavioral health; short term residential, without room and board, per diem) with the TF modifier for personal care services.

- This billing combination is only to be used by BHRFs licensed with ADHS to provide personal care services.

Please note that a BHRF that is licensed to provide personal care services should only bill H0018 with the TF modifier for members that require personal care services, as documented in their assessment and service/treatment plan.

Any member receiving such services must have had an assessment by a medical provider indicating that the member's condition requires assistance with personal care.

Unskilled Respite Care



Unskilled Respite Care

Unskilled Respite Care (Respite) is short term behavioral health services or general supervision that provides an interval of rest or relief to a Family member or other individual caring for the member receiving behavioral health services.

- The availability and use of informal supports and other community resources to meet the caregiver's respite needs shall be evaluated in addition to formal respite services.

Respite may include a range of activities to meet the social, emotional, and physical needs of the member during the respite period. These services may be provided on a short-term basis (i.e. few hours during the day) or for longer periods of time involving overnight stays.

Unskilled Respite Care

Respite services can be planned or unplanned.

- If unplanned respite is needed, behavioral health provider will assess the situation with the caregiver and recommend the appropriate setting for respite. Community Service Agencies cannot provide respite services.

Who is eligible for respite?

- Parents receiving behavioral health services may receive necessary respite services for their non-enrolled children as indicated in their Service Plan.
- Non-enrolled siblings of a child receiving respite services are not eligible for behavioral health respite benefits.

Unskilled Respite Care

Respite services may be provided in a variety of settings including but not limited to:

- 1) **Habilitation Provider (A.A.C. R6-6-1523);**
- 2) **Outpatient Clinic (A.A.C. R9-10-1025);**
- 3) **Adult Therapeutic Foster Care – with collaboration health care institution (A.A.C. R9-10-1803);**
- 4) **Behavioral Health Respite Homes (A.A.C. R9-10 Article 16);**
and
- 5) **Behavioral Health Residential Facilities.**

Unskilled Respite Care

Respite services are limited to 600 hours per benefit year (October 1 through September 30) per person and are inclusive of both behavioral health and ALTCS respite care.

S5150 – Unskilled respite care: - not hospice: Unskilled respite services provided to a person for a short period of time (up to 12 hours in duration).

- Billing Unit: 15 minute intervals

S5151 – Unskilled respite care: - not hospice: Unskilled respite services provided to a person for more than 12 hours in duration.

- Billing Unit: Per Diem

Home Care Training Family (Family Support)



Home Care Training Family (Family Support)

Home Care Training Family (Family Support) support services are directed toward restoration, enhancement, or maintenance of the Family functioning to increase the Family's ability to effectively interact and care for the member in the home and community.

Home Care Training Family (Family Support)

Family support services may involve activities such as:

- **Assisting the member's family in adjusting to the members illness;**
- **Developing skills to effectively interact and/or guide the member;**
- **Understanding the causes and treatment of behavioral health issues; and**
- **Understanding and effectively utilizing the healthcare system.**

Therapeutic Foster Care (TFC)



Therapeutic Foster Care (TFC)

Therapeutic Foster Care (TFC) services are provided by a behavioral health therapeutic home to a member residing in the TFC provider's home.

The purpose of TFC is to implement the in-home portion of the member's behavioral health Service Plan.

TFC services help a member to remain in the community, avoiding institutional care.

Therapeutic Foster Care (TFC)

Behavioral health therapeutic home providers who provide TFC shall:

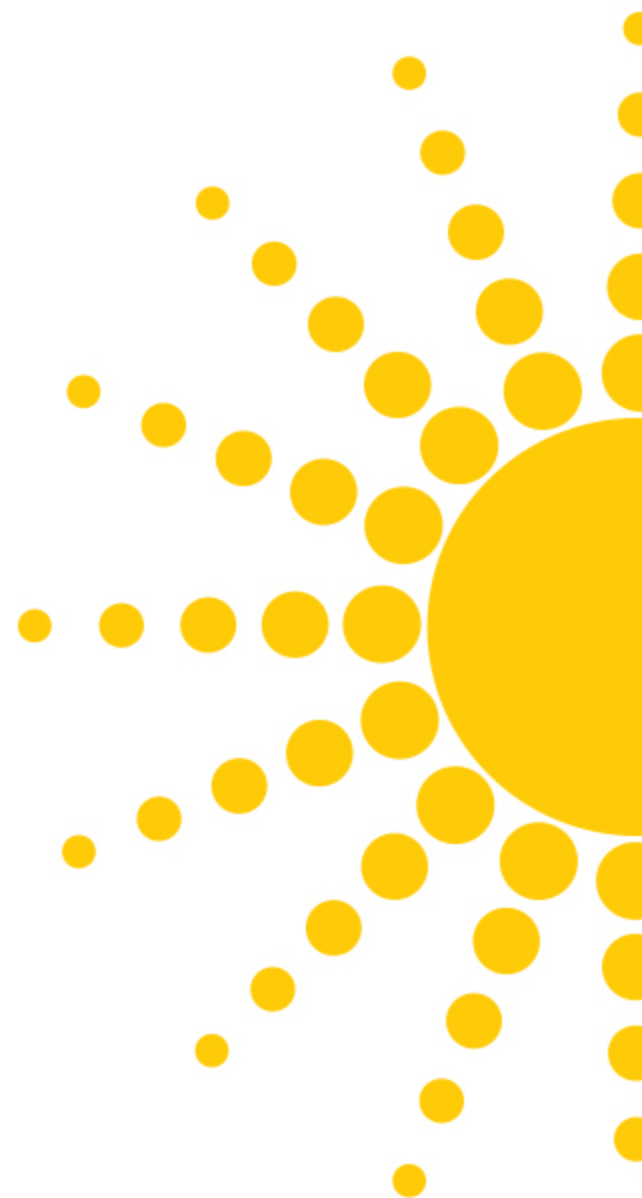
- 1) Have access to crisis intervention and emergency services,
- 2) Have a BHP as a clinical supervisor assigned to provide oversight of services, and
- 3) Complete pre-service training specific to the type of care and services required for the member being placed in the home.

Therapeutic Foster Care (TFC)

The following components are included in the TFC per diem rate:

- Personal care services,
- Psychosocial rehabilitation,
- Skills training and development,
- Family support,
- Pre-training activities,
- Clinical supervision and training,
- Over-the-counter drugs and non-customized medical supplies,
- Non-emergency medical transportation, and
- Participation in treatment and discharge planning.

Peer & Recovery Support Services



Self-Help/Peer Services (Peer & Recovery Support)

Self-Help/Peer Services (Peer & Recovery Support) are intentional partnerships based on shared lived experiences to provide social and personal support.

Peer and Recovery Support assists members with accessing services and community supports, partnering with professionals, overcoming service barriers, and/or understanding and coping with the stressors of the member's behavioral health condition.

These services are aimed at assisting in the creation of skills to promote long-term sustainable recovery.

Self-Help/Peer Services (Peer & Recovery Support)

This support is coupled with specific, skill-based training, coaching, or assistance to bring about social or personal change at the individual, Family or community level.

Peer and Recovery Support is intended for enrolled members and their families who require greater structure and intensity of services than those available through informal community-based support groups (e.g. 12 Step Programs, SMART Recovery).

For additional information regarding provider requirements, review [AMPM 963, Peer Recovery Support Training, Credentialing and Supervision Requirements.](#)

Behavioral Health Day Programs



Behavioral Health Day Programs

Behavioral health day programs provide services on an hourly basis, or for a half day or full day. They may include services such as therapeutic nursery, in-home stabilization, after school programs, and specialized outpatient substance abuse programs.

These programs can be provided to a person, group of individuals and/or families in a variety of settings.

Behavioral health day programs are categorized into three sub-categories:

- Supervised
- Therapeutic
- Community Psychiatric Supportive Treatment

Behavioral Health Day Programs

Supervised Behavioral Health Day Programs

Supervised behavioral health day programs provide the following rehabilitative and support services:

- Skills Training and Development;
- Behavioral Health Prevention/Promotion;
- Medication training and support;
- Pre-vocational services and ongoing support to maintain employment;
- Peer and Recovery Support, and/or
- Home Care Training Family (Family Support),

Behavioral Health Day Programs

Supervised Behavioral Health Day Programs

Supervised behavioral health day programs may be provided by either DLS licensed behavioral health agencies or Title XIX certified Community Service Agencies (CSA).

Supervised behavioral health day programs provide regularly scheduled programs of individual, group and/or family services related to the member's treatment plan, designed to improve the ability of the person to function in the community. These services include rehabilitative and support services.

The supervised behavioral health day program's staff shall meet the individual provider qualifications associated with those services. Supervised behavioral health treatment and day programs provided by a CSA shall be supervised by a BHT.

Behavioral Health Day Programs

Supervised Behavioral Health Day Programs

H2012 --Behavioral Health Day Treatment (Supervised):

- Billing Unit: Per hour
- Per hour, up to 5 hours in duration
- H2012 shall not be billed with H0036 or H2015

H2015 – Comprehensive Community Support Services (Supervised Day Program):

- Billing Unit: Per 15 minutes
- Greater than 5 hours, up to 10 hours in duration
- H2015 shall not be billed with H2012, H2016, or H0036

H2016 – Comprehensive Community Support Services (peer support).

- Billing Unit: Per Diem
- H2016 shall not be billed with H0038

Behavioral Health Day Programs

Therapeutic Behavioral Health Day Programs

Therapeutic behavioral health day programs provide:

- Individual, group and/or Family behavioral health counseling and therapy;
- Skills Training and Development;
- Behavioral Health Prevention/Promotion;
- Medication Training and Support;
- Medication Monitoring;
- Medical Monitoring;
- Pre-Vocational Services and ongoing support to maintain employment;
- Home Care Training Family (Family support),
- Case Management; and/or
- Peer and Recovery Support.

Behavioral Health Day Programs

Therapeutic Behavioral Health Day Programs

Therapeutic behavioral health day programs shall be provided by an appropriately licensed DLS behavioral health agency and in accordance with applicable service requirements set forth in A.A.C. Title 9, Chapter 10.

These programs shall be under the direction of a BHP.

Behavioral Health Day Programs

Therapeutic Behavioral Health Day Programs

H2019 – Therapeutic Behavioral Services: See general definition above.

- Billing Unit: 15 minutes
- Up to 5 ¾ hours in duration
- H2019 shall not be billed with H2020, H2015, H2012 or H0036

H2019 TF – Therapeutic Behavioral Services:

- Billing Unit: 15 minutes
- Up to 5 ¾ hours in duration
- The TF modifier is required for an intermediate level of care. The TF modifier is used to allow RBHAs to contract for an intermediate level of service (e.g., clients needing more intensive supervision, a sitter and/or 1:1 staffing).

Behavioral Health Day Programs

Therapeutic Behavioral Health Day Programs

H2016 – Comprehensive Community Support Services (peer support).

- Billing Unit: Per Diem
- H2016 shall not be billed with H0038

H2020 – Therapeutic Behavioral Services:

- Billing Unit: Per Diem
- H2020 shall not be billed with H2015, H2012, or H0036
- NOTE: A registered nurse who supervises therapeutic behavioral health services and day programs using the per diem codes may not bill this function separately. Employee supervision has been built into the procedure code rates.

Behavioral Health Day Programs

Community Psychiatric Supportive Treatment Behavioral Health Day Programs

Community Psychiatric Supportive Treatment Programs provide:

- Medical Interventions;
- Medication Training and Support;
- Individual, Group and/or Family Behavioral Health Counseling and Therapy;
- Skills Training and Development;
- Behavioral Health Prevention/Promotion;
- Ongoing support to maintain employment,:
- Pre-Vocational Services;
- Home Care Training Family (Family support),
- Peer and Recovery Support; and/or
- Other nursing services, such as medication monitoring, methadone administration, and medical/nursing assessments.

Behavioral Health Day Programs

Community Psychiatric Supportive Treatment Behavioral Health Day Programs

Community Psychiatric Supportive Treatment Programs shall be provided by an appropriately licensed DLS behavioral health agency and in accordance with applicable service requirements set forth in 9 A.A.C.10.

These programs shall be under the direction of a licensed physician, nurse practitioner, or physician assistant.

Behavioral Health Day Programs

Community Psychiatric Supportive Treatment Behavioral Health Day Programs

H0036– Community Psychiatric Supportive Treatment, face-to-face:

- Billing Unit: 15 minutes
- H0036 may not be billed with H0037, H2015, or H2012

H0036 TF– Community Psychiatric Supportive Treatment, face-to-face:

- Billing Unit: 15 minutes
- ****TF modifier required for intermediate level of care****
- The TF modifier is used to allow RBHAs to contract for an intermediate level of service (e.g., clients needing more intensive supervision, a sitter and/or 1:1 staffing).

Behavioral Health Day Programs

Community Psychiatric Supportive Treatment Behavioral Health Day Programs

H0037– Community Psychiatric Supportive Treatment Program:

- Billing Unit: Per Diem
- H0037 may not be billed with H2012, H0036, or H2015

Applied Behavior Analysis (ABA)



Applied Behavior Analysis

Applied Behavior Analysis (ABA) is the design, implementation, and evaluation of instructional and environmental modifications to produce socially significant improvements in human behavior. It includes the empirical identification of functional relations between behavior and environmental factors, known as functional assessment and analysis.

ABA interventions are based on scientific research and the direct observation and measurement of behavior and the environment. Behavior analysts utilize contextual factors, motivating operations, antecedent stimuli, positive reinforcement, and other consequences to help people develop new behaviors, increase or decrease existing behaviors, and emit behaviors under specific environmental conditions.

Reminders: Behavioral Health Residential Facility (BHRF)



Behavioral Health Residential Facilities

AHCCCS has developed a policy specific to BHRFs: AMPM 320-V, Behavioral Health Residential Facilities. The policy is on the AHCCCS website at:

- <https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/320v.pdf>

Behavioral Health Residential Facilities

AHCCCS often receives questions regarding what is and what is not included in the per diem rate for Behavioral Health Residential Facilities (BHRFs).

The following information can be found in the [AHCCCS Medical Policy Manual \(AMPM\), Policy 320-V, Behavioral Health Residential Facilities.](#)

Behavioral Health Residential Facilities

Care and services provided in a BHRF are based on a per diem rate (24-hour day), require prior and continued authorization and do not include room and board.

- **NOTE: Prior Authorization is not required for IHS/638 providers.**

Behavioral Health Residential Facilities

The following services shall be made available and provided by the BHRF and cannot be billed separately, unless otherwise noted below:

a. **Counseling and Therapy (group or individual):**

Note: Group Behavioral Health Counseling and Therapy may not be billed on the same day as BHRF services unless specialized group behavioral health counseling and therapy have been identified in the Service Plan as a specific member need that cannot otherwise be met as required within the BHRF setting;

b. **Skills Training and Development: I**

i. **Independent Living Skills (e.g. self-care, household management, budgeting, avoidance of exploitation/safety education and awareness);**

ii. **Community Reintegration Skill building (e.g. use of public transportation system, understanding community resources and how to use them); and**

Behavioral Health Residential Facilities

Behavioral Health Prevention/Promotion Education and Medication Training and Support Services including but not limited to (Continued):

- vi. Treatment for Substance Use Disorder (e.g. substance use counseling, groups); and
- vii. Personal Care Services (see additional licensing requirements in A.A.C. R9- 10- 702, R9-10-715, R9-10-814).

BHRFs and Personal Care Services

Effective beginning with Dates of Service
10/01/2019 and on.

Behavioral Health Residential Facilities (BHRFs) who are also **licensed through the Arizona Department of Health Services (ADHS)** to provide personal care services may begin billing for H0018 (Behavioral health; short term residential, without room and board, per diem) with the TF modifier for personal care services.

BHRFs and Personal Care Services

BHRFS who to provide Personal Care Services must:

- **Be licensed through the Arizona Department of Health Services (ADHS) to provide Personal Care Services;**
- **Abide by ADHS Licensure Requirements;**
- **Have trained staff able to provide Personal Care Services within their scope of practice; and**
- **Be prepared to bill correctly.**

BHRFs and Personal Care Services

For BHRFS licensed by ADHS to provide Personal Care Services, the BHRF would bill as follows:

- H0018 (Behavioral health; short term residential, without room and board, per diem);
- TF Modifier (indicates Personal Care Services)

This billing combination is only to be used by BHRFs licensed with ADHS to provide personal care services. Any member receiving such services must have had an assessment by a medical provider indicating that the member's condition requires assistance with personal care.

BHRFs and Personal Care Services

Please note that a BHRF that is licensed to provide personal care services should only bill H0018 with the TF modifier for members that require personal care services, as documented in their **assessment and service/treatment plan**.

BHRF Billing Questions

There have been some questions regarding 2 HCPCS codes:

- **H0031 (Mental Health Assessment, by non-physician); and**
- **H2019 (Therapeutic Behavioral Services, per 15 minutes)**

The question was ‘can these codes be submitted by Behavioral Health Residential Facilities (Provider Type B8), in addition to the BHRF per diem code H0018?’

The answer is no.

BHRFs receive a per diem rate for the provision of behavioral health services, and per policy, the per diem rate includes Mental Health Assessment and Therapeutic Behavioral Services as part of that rate.

BHRF Billing Questions

If there are circumstances in which other medically necessary specialized services are required, that cannot be performed by the BHRF, these services are to be billed by the provider/facility who performed the service and should not be billed by the BHRF.

The specialized service type, and the name of the provider rendering these services must be included in the member's treatment/service plan.

BHRF Billing Questions

Effective 7/15/2019 AHCCCS has closed H0031 and H2019 for the B8 Provider Type (BHRF) in our system.

This is not representative of a policy or billing change, and is only a system update. For additional information please review [AMPM Policy 320-V, Behavioral Health Residential Facilities.](#)

Claim Disputes



OALS Claims Dispute Process

Effective August 16, 2018 the Office of Administrative Legal Services (OALS) implemented an online process for submission of claim disputes.

The claim dispute process however should not be used for claim denials that are a result of a provider billing or coding error, untimely submission of a claim, not submitting the appropriate documents to support the facts of the case, or a prior authorization that may require a corrective action by the provider (e.g. change in CPT code, date of service, units, etc).

A claim dispute must state in detail the factual and legal basis for the claim dispute and the relief requested (e.g. payment, specific claim denial reason(s), quick pay discount). The dispute must include any / all documents which support the facts of the case. Claim disputes that lack specificity will be denied.

The claims dispute process cannot be used to submit claims corrections, provide documentation requested by the Prior Authorization or Medical Review teams or to file a claim Resubmission or Reconsideration request.

Providers should refer to the AHCCCS Fee for Service Provider Manual, Chapter 28 Claims Dispute, and the AHCCCS IHS/Tribal Provider Billing Manual, Chapter 19 Claims Disputes, for additional information regarding the claim dispute process.

Constant Contact Release Mar 22, 2019

Claim Dispute Process

- The claim dispute process is used to resolve disputes regarding post-service payment denials and payment disputes.
- If a claim is pending in the AHCCCS claims processing system, a claim dispute will not be investigated until the claim is paid or denied.
- A delay in processing a claim by the AHCCCS Administration may be cause for OALS to consider a claim dispute on a Pended claim, provided all claim dispute deadlines are met.

Your Remittance Notice

Claim Denials - The explanation of benefits (EOB) or remittance advice details the reason a claim is approved or denied.

The EOB will also provide “remark codes” to provide further detail in regards to the denial reason and what additional information may be required for review.

Time Limits for Filing a Dispute

The initial claim must be received by AHCCCS

- ✓ 6 months of the date of service.
- ✓ 6 months from the retro-eligibility posting date.
- ✓ 6 months from the date of discharge for an Inpatient hospital claim.
- ✓ The date that a dispute is received by OALS is considered the date the claim dispute is filed.

Time Limits for Filing a Dispute

The timeline for filing a claim dispute is:
the greater of:

- 12 months from the date of service.
- 12 months from the posting of eligibility.
- 60 days from the denial of a timely submitted claim.

Invalid Appeal/Dispute Requests

- ✓ Requests for an authorization or an update to an existing authorization.
- ✓ Submission of corrected claims.
- ✓ Submission of missing documents
- ✓ Documents requested by DFSM
- ✓ Requests to reprocess claims (provider updates (Group biller affiliation, Tax ID, etc)

Invalid Appeal / Dispute Requests

- ✓ Service(s) not covered under the plan.
- ✓ Incorrect CPT/HCPCS code for the service.
- ✓ Incomplete information for review.
- ✓ Wrong Member ID

Important: A corrected claim submission including medical documentation should be submitted to the AHCCCS Claims department for reconsideration.

Resolving Claim Disputes

If the provider has exhausted all authorized processing procedures and still has a disputed claim, the provider has the right to file a claim dispute with the Office of Administrative Legal Services.

Emergency Medical Treatment & Labor Act (EMTALA)

In 1986, Congress enacted the Emergency Medical Treatment & Labor Act (EMTALA) to ensure public access to emergency services regardless of ability to pay.

Citing EMTALA as the reason for the dispute does not override AHCCCS requirements for coverage, medical review or approval of a claim.

Services that may be deemed “**Medically Necessary**” may not meet the Federal definition for ‘Emergency’ care.

Federal Emergency Service Plan

AHCCCS provides emergency health care services through the Federal Emergency Services Program (FESP) for qualified and nonqualified aliens, as specified in 8 USC 1611 et seq., who meet all requirements for Title XIX eligibility as specified in the State Plan except for citizenship.

Federal Emergency Service Plan

- Any services billed must meet the federal definition of emergency services as defined in federal law within section 1903(v)(3) of the Social Security Act and 42 CFR 440.255 in order for a claim to be considered for reimbursement.
- “Emergency medical or behavioral health condition” for a FESP member means a medical condition (including labor and delivery) or a behavioral health condition manifesting itself by acute symptoms of sufficient severity, including extreme pain, such that the absence of immediate medical attention could reasonably be expected to result

in:

Covered Services and Limitations

- 1. Placing the member's health in serious jeopardy;
- 2. Serious impairment to bodily functions;
- 3. Serious dysfunction of any bodily organ or part; or
- 4. Serious physical harm to self or another person (for behavioral health conditions).

IMPORTANT: Only services that fully meet the federal definition of an emergency medical condition will be covered. Services may be medically necessary, but may not meet this definition for FES Program.

FES PLAN GUIDELINES

In accordance with the Balanced Budget Act, prior authorization cannot be required for emergency services.

Each time emergency services are delivered to an FES Program member, “the Federal criteria for an emergency medical condition must be met in order for the claim to be considered for payment”.

FES PLAN GUIDELINES

Services rendered through the FESP are subject to all exclusions and limitations on services in [R9-22-217](#).

This includes, but is not limited to, the limitations on inpatient hospital services as described in R9-22-204 and AMPM Chapter 300, Policy 310-K, Hospital Inpatient Services.

FES PLAN GUIDELINES

All emergency services under the FESP, in any setting, **are subject to retrospective review** to determine if an emergency did exist at the time of service. If AHCCCS determines that the service did not meet the **definition of an emergency medical or behavioral health condition then the following actions may occur:**

- 1. Denial or recoupment of payments,
- 2. Feedback and education to the provider, and/or
- 3. Referral for investigation, if there appears to be a pattern of inappropriate billing.

Claims Submission & Documentation Requirements

FESP members are not enrolled in health plans and they have no primary care physician.

Claims for services are reimbursed by the AHCCCS Administration on a Fee-For-Service basis if services meet the Federal definition of emergency services.

Claims Submission & Documentation Requirements (continued)

All claims for services provided to members eligible under the FES and FFS program will be *reviewed by the AHCCCS Administration on a case-by-case basis.*

All claims must be submitted to AHCCCS with documentation that supports the emergent nature of the services provided or AHCCCS must have remote access to the medical records.

Important Billing Rules

The appropriate emergency indicator and Admission Type code must be included on each claim submission for an FESP/FFS member.

CMS 1500 /837P	Field 24C (EMG) must be completed with a 'Y' or 'X'.
UB-04 / 837I	The Admit Type Field 14 identifies the type of visit. Per AHCCCS guidelines Admit Type "1" identifies the service as an "EMERGENCY" and must be included on the UB-04 for Inpatient and Outpatient services.

Important Billing Rules

If the fields on the claim submission are not completed correctly, it will result in a denial of the claim and the biller must submit a corrected claim with the appropriate fields completed for consideration.

- ✓ **Important: Filing an appeal for an improperly completed claim form is not accepted.**

Edit Denial Reasons

Edit Code	Description	Action
MD034	Emergency Criteria Not Met	Medical review denial. Option to contact CS for reviewer comments.
H140.3	Primary Diagnosis not covered for contract type	Review claim data, make correction if appropriate.
L028.3	Diagnosis not covered for contract type	Review claim data, make correction if appropriate.
L076.4	Claim received past 6 month limit.	Did not meet the time frame for claim submission.
H218.4	Service not covered for ESP recipient must be emergency or PA.	Review the Admit type field. (UB-04)
L101.4	Service not covered for ESP recipient; must be emergency.	Review the EMG Field 24C on the CMS 1500.

Charges To Members R9-22-702

AHCCCS (Title 9, Health Services)

The state rules about AHCCCS are found in Title 9 of the Arizona Administrative Code, and include the following link:

<https://www.azahcccs.gov/PlansProviders/CurrentProviders/State/AAC.html>

RECAP

- Review the denials on the EOB or AHCCCS Web portal.
- Make appropriate corrections and resubmit the claim (within timely) to the claims dept.
- Provide the requested documentation.
- Ensure the claim is coded correctly.
- EDI submissions reduce delay times.
- Upload Medical Records (EDI)

Vaccine Administration & Point of Sale System Billing to Optum



Vaccine Administration & POS Billing to Optum

AHCCCS has recently received questions regarding when a vaccination is billable to Optum via the Point of Sale (POS) System and when it is not.

Billable to Optum through the POS System

When an AHCCCS covered vaccine, such as a flu vaccine, is administered to an adult AHCCCS member, who is 19 years of age or older, in the pharmacy by a pharmacist in accordance with the Arizona State Board of Pharmacy regulations.

Not Billable to Optum through the POS System

When an AHCCCS covered vaccine, such as a flu vaccine, is administered to an AHCCCS member during an office visit. For instance, a physician or a medical assistant administers the medication. This would not be billable to Optum via the POS System.

Vaccine Administration & POS Billing to Optum

IHS and 638 Pharmacies

IHS and 638 Pharmacies may bill the outpatient AIR one time which includes the cost and the administration of the vaccine, when administered by a pharmacist or intern.

The AIR claim, which covers the administration and the cost of the vaccine, counts as the one pharmacy AIR that can be billed per member per day per facility, and applies to medications and vaccines.

IHS and 638 pharmacies may bill the outpatient all-inclusive rate when the pharmacist/intern administers an adult vaccine to a member at the pharmacy, as noted above. The claim shall only be submitted to the FFS PBM for the AIR claim's adjudication.

Vaccine Administration & POS Billing to Optum

AHCCCS covers vaccines and emergency medication for adults without a prescription order when administered by a pharmacist or an intern at the pharmacy, who is currently licensed and certified by the Arizona State Board of Pharmacy consistent with the limitations of this Policy and state law A.R.S §32-1974.

When billing for a vaccine or medication administered by pharmacists or interns, the facility may not submit a claim to AHCCCS for the administration of the vaccine in addition to the pharmacy billing the PBM for the cost of the vaccine/medication.

Vaccine Administration & POS Billing to Optum

For purposes of this section “Emergency Medication” means emergency epinephrine and diphenhydramine.

“Vaccines” are limited to AHCCCS covered vaccines for adults as noted in the [AHCCCS Medical Policy Manual \(AMPM\) Policy 310-M, Immunizations](#).

Naturopathic Physicians



Naturopathic Physicians

As of 3/1/2019, AHCCCS members under the Early Periodic Screening Diagnostic and Treatment (EPSDT) program may be treated by Licensed Naturopathic Physicians.

This AHCCCS provider type is active and is designated as 17-Naturopath in the AHCCCS Provider Enrollment system.

Naturopathic physicians blend natural medicine with conventional diagnosis and treatment. They treat the cause of illness, work to prevent disease whenever possible and teach patients how to live healthy lives using tools including nutrition, lifestyle medicine, physical medicine and herbal therapies.

Naturopathic Physicians

In order to submit claims for AHCCCS Fee for Service Programs, an active AHCCCS provider registration is required.

Naturopathic physicians will be paid at 100% of the physician fee schedule rate. AHCCCS will pay retroactive claims and encounters for registered, eligible providers who provide medically necessary EPSDT services subject to timeliness rules.

Resources



Claims Clues

DFSM publishes a monthly newsletter for providers. It is available online and provides information about the following:

- Claims and billing updates
- Billing policies and requirements
- System changes
- Changes to program benefits

Information on a host of Behavioral Health topics frequently appears in Claims Clues.

Past issues are available [here](#).

Constant Contacts/DFSM Email News Alerts!

Providers are invited to subscribe to DFSM email news alerts regarding changes to the program, claims and billing updates and requirements, system changes, upcoming trainings, forums and other business news.

Information on Behavioral Health Services and updates is frequently sent out through Constant Contacts.

Providers may sign up for Constant Contacts [here](#).

Upcoming Trainings

The Provider Training Schedule is available on the [DFSM Provider Training web page](#), underneath the drop down menu reading 'Training Schedules by Year.'

Attendance for trainings is always via WebEx Only (please note no room is booked and trainings can typically *only* be attended via WebEx, unless other prior arrangements are made.

Questions?



Your feedback is important to us

