AHCCCS
Arizona Health Care Cost Containment System
DIVISION OF FEE FOR SERVICE MANAGEMENT

CLAIMS CLUES
A Publication of the AHCCCS DFSM Claims Department

April 2019

Behavioral Health Residential Facility (BHRF) Notification

Effective 4/1/2019, all admissions and continued stays at Behavioral Health Residential Facilities (BHRF) (Provider Type B8) for AIHP and TRBHA members will require authorization.

NOTE: Authorization is NOT required for IHS/638 BHRF Facilities.

All new BHRF admissions will require notification of admission to AHCCCS for initial coverage of up to 5 days of care. During this initial 5 day time frame, the BHRF will be responsible for submitting an Authorization request and ensuring compliance with criteria listed in AMPM Policy 320-V – Behavioral Health Residential Facilities and 9 A.A.C.10.

- If the Authorization request and the supporting admission documentation are not received within the initial 5 day time frame, claims may be denied.

Admission documentation that is required for the Authorization request includes:

1. Behavioral health assessment in compliance with 9 A.A.C. 10, to determine Behavioral Health Condition and Diagnosis. Assessment should be recent, and not older than 1 year. Done by a BHP, or by BHT cosigned by a BHP, utilizing standardized instrument that is able to determine the appropriate level of care.
2. Treatment Plan – completed in compliance with 9 A.A.C.10 by the Inpatient/Outpatient or TRBHA Treatment Team. Included in the plan should be an intervention specifying the BHRF level of care as necessary for the member as a least restrictive level of care required to treat the Behavioral Health Condition, identified in the Assessment. This plan shall not be older than 3 months from the request submission date.

NOTE: All criteria for admission still must be met from the date of admission.

For members currently in a BHRF, the facility must submit an authorization request to get the continued stay authorized by 5/31/2019. Criteria for admission and continued stay will be

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The DFSM Provider Training Schedule for the 2nd Quarter has been posted: https://www.azahcccs.gov/Resources/Downloads/DFMSTraining/2019/TrainingSchedule2019_2ndQuarter.pdf

Please note that the One on One Provider Trainings are by appointment only. To request an appointment, please email ProviderTrainingFFs@azahcccs.gov. Appointments are not finalized until the provider has received an email confirmation from AHCCCS confirming the date and time of the appointment from the Provider Training Unit. Please note there is often a wait list for one on one provider trainings and the provider's requested time and date may not always be available.

PROVIDER EDUCATION DATES:

- Behavioral Health Residential Facility (BHRF) Prior Authorization Training
  April 9th, 2019 - Tuesday
  10:00 AM to 12:00 PM
- General Direct Care Agency (DCA) Worker Training: Audit Tool
  April 19th, 2019 – Friday
  10:00 AM to 11:00 AM
- One on One Provider Training, By Appointment Only
  April 23rd, 2019
  9:00 am to 10:00 am
  10:15 am to 11:15 am
- Non-Emergency Medical Transportation
  April 24th, 2019 - Wednesday
  9:00 AM to 10:00 AM
- IHS/638 Quarterly Forum
  May 2nd, 2019 – Thursday

ELECTRONIC PAYMENT SIGN UP

Contact: ISDCustomerSupport@azahcccs.gov -OR-
Call 602-417-4451

CONTACTS

Prior Authorization Questions FFS PA Line (602) 417-4400

Claims Customer Service Billing Questions
(602) 417-7670

Provider Registration Process Questions - (602) 417-7670
Fax Applications (602) 256-1474

Technical Assistance with Online Web Portal Please email ProviderTrainingFFS@azahcccs.gov

Behavioral Health Residential Facility (BHRF) Notification Continued

detailed in the new AMPM Policy 320-V – Behavioral Health Residential Facilities. Specific authorization submission and documentation procedures will be available on the FFS web page on the AHCCCS web site. Please look for upcoming notifications on training opportunities that will be available on the FFS web page.

Prior Authorization Requests shall be submitted on the AHCCCS Online Provider Portal.

Guidelines related to requirements for prior authorization and its accompanying documentation

Covered Behavioral Health Services Guide – Important Update

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

- AMPM 310-B, Behavioral Health Services Benefit
  - Title XIX/XXI benefit information.
- AMPM 320-T, Non-Title XIX/XXI Behavioral Health Services Benefit
  - Non-Title XIX/XXI service information.
- The Provider Billing Manuals
  - Billing information for all providers, both FFS and MCOs, will be transferred to the Provider Billing Manuals.
    - Chapter 19, Behavioral Heath Services, of the Fee-For-Service Provider Billing Manual
    - Chapter 12, Behavioral Heath Services, of the IHS/Tribal Provider Billing Manual
- Appropriate AMPM Policies as necessary, including:
  - AMPM 310-BB, Transportation; and
  - AMPM 310-V, Behavioral Health Residential Facilities (BHRFs).

For MCO providers having additional questions, please contact the MCO directly.

For FFS providers having additional questions, the DFSM Provider Training team can be reached at ProviderTrainingFFS@azahcccs.gov.

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 formal 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 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 and steps.

Notice Of Non-Discrimination

Arizona Health Care Cost Containment System (AHCCCS) complies with applicable Federal civil rights laws, does not discriminate, and does not treat people differently on the basis of race, color, national origin, age, disability, or sex.

If you believe that AHCCCS, or an AHCCCS-registered contractor or provider, failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the AHCCCS Office of Administrative Legal Services.

You can file a grievance in person or by mail, fax, or email. Your grievance must be in writing and must be submitted within 180 days of the date that the person filing the grievance becomes aware of what is believed to be discrimination. Submit your grievance to:

General Counsel, AHCCCS Administration
Office of Administrative Legal Services, MD 6200
701 E. Jefferson, Phoenix, AZ 85034
Fax: 602 253 9115
Email: EqualAccess@azahcccs.gov

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal.

Or by mail at:
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building, Washington, D.C. 20201

Or by phone at:
1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available on the Health and Human services website.

Provider Registration (Enrollment) Updates

Automated Online Provider Enrollment System to Launch in 2019

In 2019, the AHCCCS provider enrollment process will move from a manual, paper-based system to a new, online system process that will allow providers to:

- Enroll as an AHCCCS provider;
- Update information (such as phone and addresses);
- Upload and/or update licenses and certifications;
- And more, all online and in real time!

This change, from a 100% manual process to the new, automated system will streamline the provider enrollment process. Initial applications will be processed more quickly and changes to current enrolled providers will all be completed online.

The new system is anticipated to go live in the fall of 2019. Additional information will be released closer to the implementation date.

If you have questions please contact Provider Enrollment at:

- 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)

Name Change

Did you know that the Provider Registration Unit of AHCCCS is changing its name? Moving forward Provider Registration will be called Provider Enrollment, and updates to the name will be seen across the AHCCCS website.

To access provider enrollment registration materials please visit us online.

Provider Registration Requirements for Licensed Naturopathic Physician

The Arizona Health Care Cost Containment System (AHCCCS) is accepting applications from licensed Naturopathic Physicians, who wish to serve AHCCCS members under Early Periodic Screening Diagnostic and Treatment (EPSDT). This AHCCCS provider type is active and is designated as 17-Naturopath in the AHCCCS Provider Registration system.

AHCCCS will pay retroactive claims and encounters for registered, eligible providers who provide medically necessary EPSDT services, subject to timeliness rules.

For additional information, please see the AHCCCS Provider Enrollment website.

Accessing Behavioral Health Services in Schools

Did you know that students in Arizona who receive Medicaid benefits can access behavioral health services in the school setting? AHCCCS helps school administrators and leaders connect with behavioral health providers statewide to meet their students' needs.

While schools have historically been approved settings for Medicaid-covered behavioral health services, in 2018 $3 million in state General Fund dollars were appropriated to expand behavioral health services in schools; $1 million of this funding is being used in a partnership with the Arizona Department of Education to provide mental health training to schools and school districts. The remaining dollars are matched with Federal Funds to generate $10 million in Medicaid funding to AHCCCS health plans to bring established behavioral health providers into the school setting, meet Medicaid-eligible students where they are and where they have a health needs, and pay for Medicaid-covered behavioral health services in schools.

Current projects include:

Project AWARE: In collaboration with the Arizona Department of Education, AHCCCS is working with three school districts to implement Mental Health First Aid training. This training has been shown to improve behavioral health outcomes and reduce suicides. During the next five years of this grant, approximately 12,000 students and staff at Piñon Unified School District on the Navajo Nation, Glendale Unified School District, and Sunnyside Unified School District in Tucson will receive access to mental health training.

ADE Training Partnership:

In 2018, Governor Ducey led the Safe Arizona Schools Plan which included funding for investing in mental and behavioral health resources at schools. With $1M in funding, the Arizona Department of Education and AHCCCS signed an agreement to partner efforts in expanding access to behavioral health training in schools statewide. The goal of this partnership is to implement an evidence-based curriculum focused on education school personnel and students on commonly-occurring behavioral health issues to reduce stigma and empower schools to appropriately recognize and intervene.

Arizona Medicaid School-Based Claiming Program:

Arizona participates in two Medicaid reimbursement programs for school based services, the Direct Service Claiming (DSC) program and the Medicaid Administrative Claiming (MAC) program. These two school-based programs assist participating school districts, referred to as Local Education Agencies (LEAs), including charter schools and the Arizona School for the Deaf and Blind (ASDB), by reimbursing them for their costs to provide Medicaid covered services to eligible students. The purpose of the DSC Program is to allow LEAs to receive reimbursement for the cost to provide Medicaid covered medical services to Title XIX eligible students. The purpose of the MAC program is to allow LEAs to receive reimbursement for Medicaid administrative outreach activities that are done routinely within the school setting. The Centers for Medicare and Medicaid Services (CMS) is the federal agency that oversees these two school-based programs. In Arizona, these

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Accessing Behavioral Health Services in Schools Continued

programs are overseen by the Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid agency. AHCCCS contracts with a Third Party Administrator (TPA), PCG, to administer both the DSC and MAC programs.

The Arizona Health Care Cost Containment System (AHCCCS) is Arizona's Managed Care Medicaid Program, developed as a result of Title XIX of the Social Security Act. While AHCCCS also administers other state and federal health care programs, only Title XIX members are eligible for the DSC Program.

The Medicaid Administrative Claiming (MAC) program is one of the two federally funded programs endorsed by the Arizona Department of Education (ADE) and AHCCCS. AHCCCS is the agency that develops the policies and administers the Medicaid School Based Claiming Program through PCG and in collaboration with the ADE.

AHCCCS staff is also working to improve partnerships between behavioral health providers and school administrators. A list of service billing codes approved for use in school settings may be found here.

Coordination of Care

Did you know?

- There can be confusion regarding the coordination of care responsibility for Fee for Service American Indian and Alaskan Native members who receive services at a Behavioral Health Hospital.
- For instance, members should not be discharged with 7 days of medication without a follow-up appointment for ongoing routine services to an outpatient behavioral health provider, to include coordinating transportation.
- Members who require ongoing routine outpatient behavioral health care is of the utmost importance.
- Every attempt shall be made by the treating BH hospital to avoid an unsafe discharge or a condition where a FFS member is referred to a PCP in lieu of a qualified Behavioral Health Provider for ongoing psychiatric medication monitoring.
- A FFS member's tribal affiliation should be identified to determine a possible connection with a Tribal Regional Behavioral Health Authority (TRBHA) or the member's Tribe.
- As an AHCCCS registered provider, a Behavioral Health Hospital has a Provider Participation Agreement in place with AHCCCS and has agreed to abide by that agreement which includes adherence to AHCCCS policies.

For more information regarding FFS Programs, please visit our website.

Did you know?

- For appropriate and acceptable coordination of care for a FFS member leaving the Behavioral Health Hospital, the expectation is that a follow-up appointment would be secured at a community clinic, of the member's choice prior to discharge.
- Keep in mind that a FFS member may choose Indian Health Services or a 638 clinic for ongoing care; coordination of care is expected with these organizations as well.
- As a reminder, an American Indian/Alaskan Native who is eligible for AHCCCS may be enrolled in the American Indian Health Program (AIHP) or another AHCCCS Complete Care Plan.
- Members should not be steered towards managed care; they must be afforded their federally recognized freedom of choice.

For Coordination Of Care requirements in AHCCCS policy; please review AMPM Chapter 500 of the AHCCCS Medical Policy Manual (AMPM).

Did you know?

A Discharge Plan should be developed and planning begins upon admission and is updated periodically during the inpatient stay to ensure a safe, timely and effective discharge. It helps health care providers to coordinate outpatient treatment and helps make a smooth return to the community while fostering a regular routine. Effective discharge planning applies to short-term and long-term hospital and institutional stays and includes:

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Coordination of Care Continued

- A follow-up appointment with the primary care doctor (PCP) and/or specialist within seven (7) days;
- Safe and clinically appropriate placement, and community support services;
- Communication of the member's treatment plan and medical history across all involved providers;
- Prescription medications and medical equipment;
- Nursing services and therapies, if appropriate;
- Referral to appropriate community resources;
- Referral to a Disease Management or care management provider (if needed);
- A post-discharge follow-up call to the member within three (3) days of discharge to confirm the member's well-being and the progress of the discharge plan;
- Additional follow-up actions as needed based on the member's needs.

For more information regarding discharge planning see R9-10-209 on page 36.

What is the AIMH?

- The American Indian Medical Home is a care management model that puts 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 coordination.
- AIHP enrolled members can select an AIMH when they access a participating AIMH provider or by contacting AHCCCS Division of Member Services.
- 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.

"Becoming an American Indian Medical Home is a simple process that we are able to assist you with."

- Facilities who choose to become an American Indian Medical Home 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

First Tier Level AIMH

- PCCM Services
- 24 hour telephonic access to the care team

PMPM Rate: $14.51

Second Tier Level AIMH

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

PMPM Rate: $16.70

Third Tier Level AIMH

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

PMPM Rate: $22.71

Fourth Tier Level AIMH

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

PMPM Rate: $24.90

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What is the AIMH continued

What are the Provider Requirements?

- Be a qualified IHS or Tribal 638 facility.
- Enter into an AIMH Intergovernmental agreement (IGA).
- Provide members 24 hour telephonic access to the care team.
- Obtain Primary Care Case Management (PCCM) accreditation.
- Dependent upon AIMH tier level participation:
  - Provide diabetes education
  - Participate bi-directionally in the State Health Information Exchange (HIE)

"You can take the easy steps to become an American Indian Medical Home today, and we can assist you along the way."

Below are a few examples of organizations that provide accreditation for PCCM:

The National Committee for Quality Assurance (NCQA)

The Joint Commission PCMH Accreditation Program

National IHS Improving Patient Care (IPC) program

Or other appropriate accreditation body

Below are a few examples of organizations that provide accreditation for Diabetes Education Programs:

American Association of Diabetes Educators

American Diabetes Association

Or other appropriate accreditation body

Q & A

Q: Are Contracts Needed for FFS Members?

A: Fee-For-Service providers do not need to contract with AHCCCS AIHP, Tribal ALTCS, or a TRBHA to continue providing Medicaid Title XIX/XXI services to FFS members. A provider simply must be an AHCCCS registered provider. Providers must follow the AHCCCS Medical Policy Manual (AMPM) and Feefor-Service Provider Billing Manual. For information on providing services to an ACC Plan enrolled member (not a FFS member), please contact the ACC plan.

Q: How Do I Submit Claims to AHCCCS for FFS Members?

A: There will be no change in how providers submit claims to AHCCCS DFSM for FFS members. The process will remain the same as it is currently. However, as of October 1st, 2018 some members will undergo an enrollment change. It will be essential for providers to check a member's new enrollment, since this may effect where a provider needs to send their claim. For members enrolled with AIHP, please refer to the above section "Billing Considerations." For information on the submission of claims to an AHCCCS Complete Care (ACC) health plan, please contact the ACC plan.

Q: How Do I Submit Prior Authorization Requests for FFS Members?

A: For information on the submission of prior authorization requests for FFS members, see AMPM Chapter 800 or visit the FFS Health Plans page on the AHCCCS website. For information on the submission of prior authorization requests to an AHCCCS Complete Care (ACC) health plan, please contact the the ACC plan