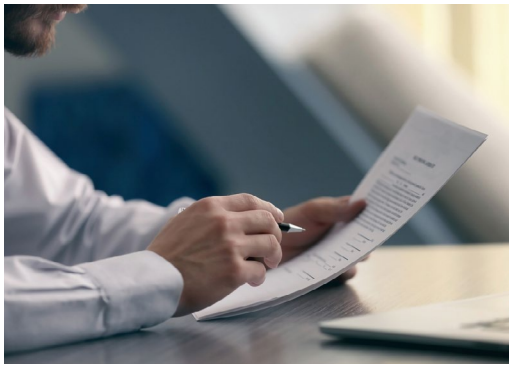
AHCCCS
Arizona Health Care Cost Containment System
DIVISION OF FEE FOR SERVICE MANAGEMENT

CLAIMS CLUES

A Publication of the AHCCCS DFSM Claims Department

July 2023

Required Documentation For Outpatient Behavioral Health Claims



To ensure proper consideration of outpatient behavioral health services provided on the same day AHCCCS Fee-for-Service effective with claims submitted on or after May 3, 2023 behavioral health providers are required to submit the following documentation with the submission of the claim; a copy of the most recent comprehensive assessment, treatment plan, and the medical record documentation for the services billed on the service date. This requirement is for but not limited to Behavioral Health Residential Facility (B8), Integrated Clinic (IC), and Behavioral Health Outpatient Clinic (77)

*Reporting same day services on separate claim submissions can result in denial of services.

Comprehensive Behavioral Assessment - is the ongoing collection and analysis of an individual's medical, psychological, psychiatric, and social conditions in order to initially determine if a health. disorder exists, if there is a need for behavioral health services, and on an ongoing basis ensure that the individual's service plan is designed to meet the individual's (and family's) current needs and long term goals.

Treatment plan - A written plan of services and therapeutic interventions based on a complete assessment of a member's developmental and health status, strengths and needs that are designed and periodically updated by the multi-specialty, interdisciplinary team.

The service and/or treatment plan shall be based on a current assessment and/or specific treatment need (e.g., out of home services, specialized behavioral health treatment for substance use). The service or treatment plan shall identify the services and supports to be provided, according to the covered, medically necessary services specified in AMPM Policy 310-BB Transportation

Medical record documentation - All communications related to a patient's physical or mental health or condition that are recorded in any form or medium and that are maintained for purposes of evaluation or treatment, including records that are prepared by a health care provider or by other providers. Records do not include materials that are prepared in connection with utilization review, peer review or quality assurance activities as specified in A.R.S. § 12- 2291.

The DFSM Claims Clues is a monthly newsletter that provides information about changes to the program, system changes/updates, billing and FFS policies.

Claims, Prior Authorization and Provider Enrollment inquires: The Division of Member and Provider Services (DMPS) manages the service calls for AHCCCS Fee-for-Service. DMPS can assist providers with prior authorizations, claim inquires and status and provider registration (APEP) questions and processes.

The hours of operation are Monday – Friday, 7:30am-5:00pm (602-417-7670).

AHCCCS Provider Enrollment Portal (APEP): Questions regarding provider-related enrollment, policy, or APEP user issues email APEPTrainingQuestions@azahcccs.gov . Your email will automatically create a service ticket to Provider Enrollment for assistance.

AHCCCS Warrents - For questions about Warrants, paper EOBs or Electronic Fund Transfers (EFT), contact the Division of Business & Finance (DBF) at (602) 417-5500.

835 Electronic Remittance Payment Sign Up (Remittance Advice Sign Up/835) Contact: ServiceDesk@azahcccs.gov or call (602) 417-4451

Transaction Insight Portal (TIBCO/ TI) users, for account creation, to add additional users, or for password resets please make sure to use the following email address: servicedesk@azahcccs.gov

Training materials for FFS Providers and upcoming Provider Training Sessions can be found on the DFSM Provider Training Web Page .

For provider training questions please outreach the Provider Training Team via email at ProviderTrainingFFS@azahcccs.gov

COVID FAQ: FAQ COVID Fact Sheet

AHCCCS Audio Only Telehealth Changes Modifier FQ

Effective May 12, 2023, the audio only modifier FQ – is used for a telehealth service furnished using real-time audio-only communication technology will no longer be valid for any Evaluation and Management codes. During the federally declared Public Health Emergency (PHE) AHCCCS sought and received approval for a waiver to allow the use of audio only delivery of the service codes identified below.

When the PHE ended on May 11, 2023, the 2023 CPT guidelines will go into effect, which state that these services must be delivered face-to-face.

Providers will be able to use **modifier GT** - telehealth service via interactive audio and video telecommunication systems for those services performed via synchronous telehealth (remote exchange of patient information through direct, real-time interaction between a physician and a patient.

All evaluation and management codes will be updated to reflect an end date of the FQ modifier effective for d**ates of service July 1, 2023, and after**. This will also be updated on the AHCCCS approved telehealth spreadsheet located on the AHCCCS Medical Coding Resources page,

Telehealth FQ Modifier Update

Transaction Insight Portal (TIBCO) File Size and Types

When submitting files on the Transaction Insight Portal, only one file can be uploaded at a time and any additional filles that are uploaded will replace the previously loaded file. If there are multiple pages to the document providers can scan them as a single file and then upload them to the Transaction Insight Portal.

The maximum file size is limited to **64 MB**.

The following is a list of the types of files that can be uploaded on the Transaction Insight Portal.

.TXT – text file	**.PNG –** portable networks graphic
.HTM, .HTML – hypertext markup language	**.GIF –** graphics interchange file
.JPEG, .JPG – Joint Photographic Experts Group image	**.RTF –** rich text format
.PDF – portable document file	**.TIF, .TIFF –** tagged image file format

Reminder: Non-Emergency Medical Transport Diagnosis Codes

If the diagnosis code is unknown at the time of the claim submission, NEMT providers (PT28) are allowed to use one of the following “general” diagnosis codes provided below based on the reason for the NEMT transport service:

- ICD-10 diagnosis code R68.89 can be used for NEMT physical health transports.
- ICD-10 diagnosis code F99 can be used NEMT behavioral health transports.
    - The Event Type (BT) must be selected for a behavioral health NEMT PA request.

New and Revalidating Behavioral Health Providers Subject to High-Risk Screening

Behavioral Health Residential Facility (B8), Integrated Clinic (IC), and Behavioral Health Outpatient Clinic (77) providers will be required to meet additional registration requirements.

Effective May 29, 2023, three types of behavioral health providers are required to register as a high risk provider type and meet additional requirements.

What Providers Need To Know:

At initial application and, for existing providers, at revalidation, these three provider types will be required to pay an application fee and complete additional screening criteria, including:

- Fingerprint-Based Criminal Background Check (FCBC), and
- Site visit in accordance with Section 6401 of the Affordable Care Act and 42 CFR 455, Subpart E, in addition to all other required screenings.

Providers can contact APEPTrainingQuestions@azahcccs.gov with questions.

Behavioral Health Services Billing and Coding H2016 and H0038 Same Day Billing Denial Edit L237.4

Claims billed with the HCPCS code H2016 (Comprehensive Community Support Services, per diem) H0038 (Self-Help/ Peer Services per 15 minutes) that are billed on the same date of service will automatically deny with the denial edit **L237.4 "Service Not Allowed On The Same Day".**

Arizona Health Care Cost Containment (AHCCCS) for purposes of consideration for behavioral health services, per billing and policy may use American Medical Association Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS) or other procedure coding guidelines. References to CPT or other sources are for definition purposes only and do not imply any right to reimbursement.

Provider Type 02 Hospital - Prior Authorization Submission Reminders

Hospitals must submit a complete prior authorization request and receive a provisional affirmation decision as a condition of payment. DFSM has noticed an increase in prior authorization submissions from acute care hospitals that are **Incomplete**. An incomplete PA request is one that is missing the ***Event and or Activity information or both.***

The Prior Authorization submission process has three steps that must be completed.

- **Case Creation**
- **Event Type**
- **Activity Type**

Providers must submit prior authorization requests via the AHCCCS Online Provider portal and include all relevant medical documentation that will allow the PA team to make a decision.

AHCCCS Restricts Providers' Ability to Bill on Behalf of Others

Effective May 18, 2023, AHCCCS has made system updates to the AHCCCS Online Claims Submission system that restrict a provider's ability to bill on behalf of other providers. This change increases system integrity and reduces the risk of fraudulent billing.

Providers may only submit claims for IDs associated with affiliated providers. Approved affiliated providers will display in a drop-down list. If an affiliated provider is not listed, the billing provider must create a new AHCCCS Online account for the provider they wish to bill for. Only providers registered with AHCCCS can create an AHCCCS Online account.

AHCCCS Online Provider portal is the portal that registered providers use for several types of transactions, including electronic FFS claims submission. Along with the change described above, AHCCCS has taken aggressive action to prevent fraudulent billing, including creating additional claims flags, disallowing retroactive billing, and increasing provider registration requirements for three behavioral health provider types.

AHCCCS Provider Services representatives are able to answer basic claims questions. C**all (602) 417-7670, Monday through Friday 7:30 a.m to 5:00 p.m. MST.**

To reset an AHCCCS Online password, click "Forgot your Password?" and follow the Password Recovery link directions or contact the master account holder. For any additional information regarding accounts, please click the FAQ link on the AHCCCS Online website.

Psychiatric Hospital Provider Type 71 Prior Authorization Diagnosis Code Mismatch

It is important when submitting the initial prior authorization (PA) request that the diagnosis code matches the documentation that is submitted to support the PA request.

For example, if the PA is submitted with the diagnosis code F39. "unspecified mood disorder" but the documentation submitted to support the PA request shows the diagnosis code F25.9 "Schizoaffective disorder" this mismatch will result in a delay finalizing the PA request and the ll PA team will request confirmation for the reason (diagnosis) for the admission.

Reminder: Non-Emergency Medical Transportation (NEMT) Policy Change for Local Community Based Support Programs

As a reminder for dates of services on or after 07/01/2022, due to the changes in AMPM Policy 310-BB Transportation transports to Local Community Based Support Programs including Driving Under the Influence (DUI) classes are not a covered NEMT transport and cannot be submitted to FFS for reimbursment.

Non-Covered Local Community-Based Support Programs:

Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Cocaine Anonymous , Crystal Meth Anonymous Dual Recovery Anonymous, Heroin Anonymous Marijuana Anonymous, Self-Management and Recovery Training (SMART Recovery), National Alliance on Mental Illness (NAMI) Programs, Living Well with a Disability and Working Well with a Disability Program.

Check out the DFSM June 2023 Claims Clues for information on Diabetes Self Management Training.

Prior Authorization Tips For Provider Type 71 Psychiatric Hospital

Prior authorization requests for Inpatient Psychiatric facility (PT71) must include the following documents:

- Completed copy of the Certificate of Need (CON) must include the date of admission, signed by DO/MD and credentials and DO/MD name must be legible on the document.
- The Certificate of Need (CON) is due within 72 hours of the admission.
- Psychiatric Evaluation.
- Multidisciplinary Treatment Plan.
- Daily MD progress notes signed and legible.
- Discharge Summary must include the date of discharge with the aftercare plan and must be signed by the attending medical provider.
- Providers should only upload the required documentation.
- All required documentation should be uploaded in one or two file uploads.

A Recertification of Need (RON) is required on the 4th covered day of the stay and must be provided weekly (7 days) thereafter until discharge. The RON can be signed by Medical Doctor (MD), Doctor of Osteopath (DO), Nurse Practitioner (NP) and Physician's Assistant (PA).

The **Event Type** must be BI **(Psychiatric Inpatient)** and the **Activity** tab must include the level of care identified by the revenue code and include the number of days.

Claim Date Span Billing Requirement

Effective with dates of service beginning February 17, 2023 and forward, Provider Types (77) Behavioral Health Outpatient Clinic and (IC) Integrated Clinics submitting claims to AHCCCS Division of Fee for Service Management must list a single claim line for each date of service equal to one (1) day of service, CPT/ HCPCS code and the total units for each line of service.

AHCCCS DFSM will deny any claim line submitted by a provider type 77 or IC when the billed claim line date span is greater than one (1) day of service.

Example of a Correct Claim Submission:

1	02	13	23	02	13	23	11		H0004	HQ				95	00	4		1234567890
2	02	14	23	02	14	23	11		H0004	HQ				95	00	4		1234567890
3	02	15	23	02	15	23	11		H0004	HQ				95	00	4		1234567890

Example of an Incorrect Claim Submission:

1	02	13	23	02	28	23	11		H0004	HQ				1500	00	480		1234567890
2																		
3																		

Electronic Visit Verification (EVV) Edit Tips
Edit Denial Code: L227.1 Claim Line Failed For Unmatched Units, Field is Missing

Edit	Description	Cause	Action Steps
• **L227.1**	**Claim Line Failed For Unmatched Units, Field is Missing.**	This edit sets when the EVV claim details must match the Aggregator visit details and the visit must be in **Verified** status. ✓ The aggregator is used to support validation against the visits during the claim's adjudication process.	• Review the visit in the Aggregator, to confirm the units match the units claimed. • If the Aggregator visit has incorrect units, confirm the In and Out times are correct. • Update the visit or claim accordingly.