Updates To Billing Requirements for Behavioral Health Outpatient Claims Effective July 14, 2023

DFSM Provider Training
July 2023

AHCCCS
Arizona Health Care Cost Containment System

Billing Requirements for Behavioral Health Outpatient Claims Effective July 14, 2023

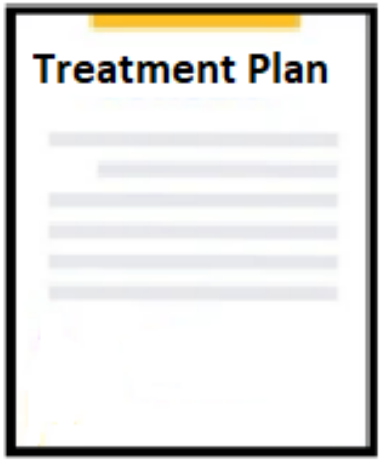
The Arizona Health Care Cost Containment (AHCCCS) is providing billing updates and clarification to billing guidelines and documentation requirements for AHCCCS registered fee-for-service providers that are billing outpatient behavioral health services. All documentation must meet the requirements of the service codes that are submitted on the claim form.

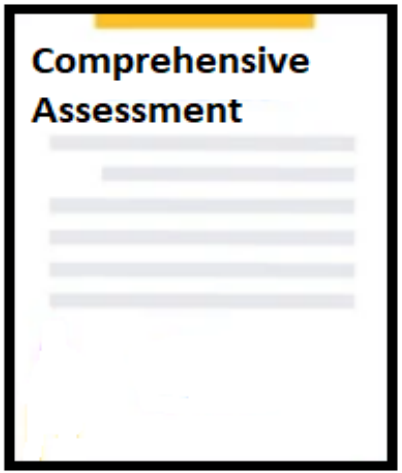
AHCCCS relies on claims edits and other tools to ensure providers are in compliance with applicable coding and billing rules and requirements through the application of coding standards outlined by the American Medical Association (AMA), Centers for Medicare and Medicaid Services (CMS), state Medicaid agencies, National Committee for Quality Assurance (NCQA), as well as other applicable regulatory and advisory agencies

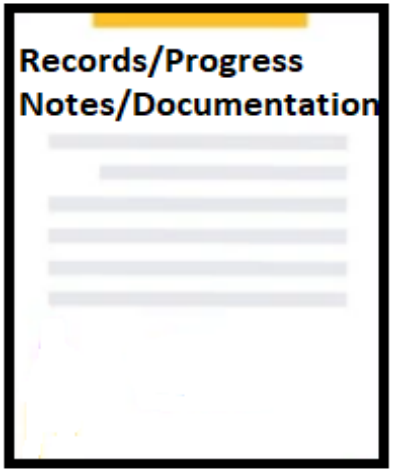
This billing update provides guidance and outlines the current documentation requirements by HCPCS code and is subject to revisions, changes and additions to the current billing codes listed in this document at any time.

Documentation Submission Using The Transaction Insight Portal

The easiest and most efficient way to attach your documentation for review is via the Transaction Insight Portal (TIBCO). For payment reviews, documentation is required and to help expedite the review process, providers can include a **"Title"** separator sheet identifying each document type that is uploaded followed by the documents. Examples:







Transaction Insight Portal Requesting Account Access

The Transaction Insight Portal is a free platform that is offered by AHCCCS FFS to providers to use to attach their documentation to the claim submission.

Providers must request a username and password to use TIBCO.

To request an Transaction Insight Portal account, providers can send a email request to **servicedesk@azahcccs.gov.**

When you request an account setup, please include the following information:

- Name of your organization and Provider Identification Number, and
- Your full name, and
- Correct email address.

Once you receive your login information you can access the Transaction Insight Portal at: **https://tiwebprd.statemedicaid.us/AHCCCS/default.aspx?ReturnUrl=%2fAHCCCS%2f**

Training Resources:
Transaction Insight Portal (TIBCO)

https://www.azahcccs.gov/Resources/Downloads/DFSMTraining/2023/TIBCOForesightTransactionInsightTIWebUploadAttachmentGuide.pdf

https://www.azahcccs.gov/Resources/Downloads/DFSMTraining/2021/TransactionInsightPortal_06112021.pdf

https://www.azahcccs.gov/Resources/Downloads/DFSMTraining/2022/TransactionInsightPortalSetPurposeCode11.pdf

AHCCCS Fee-for-Service Claim Instructions

This change is applicable to claims submitted through the Electronically Data Interchange 837P (EDI), paper submissions and via the AHCCCS Online Provider Portal.

Providers are reminded to bill procedures with the correct modifier combinations, units of service provided and correct code combinations.

If a FFS provider submits multiple claims for the same member on the same date of service, the provider will be required to submit documentation for all services provided on all claims submitted moving forward.

All of the claims from the provider will require review before payment is authorized.

AHCCCS Fee-for-Service Claim Instructions (cont.)

Prior authorization or medical review of services does not guarantee payment of a claim. Payment is contingent upon eligibility, available benefits, contractual terms, provision of a service that meets coverage criteria limitations, exclusions, coordination of benefits, submission of a clean claim, submission of all required documentation, and other terms and conditions set forth by the program.

New Additions: HCPCS Codes Which Now Require Documentation for Claims Submitted In Any Unit Quantity:

HCPCS	Description
T1503	Administration of medication, other than oral and/or injectable, by a health care agency/professional, per visit.
S5131	Homemaker service NOS, per diem
T2020	Day Habilitation, waiver; per diem
T2026	Specialized childcare, waiver; per diem
S5130	Homemaker services, NOS, per 15 minutes,
S9484	Crisis intervention, mental health services, per hour

New Additions - HCPCS Codes Which Now Require Documentation When Claims Are Submitted In Excess Of 2 Hourly Units Or 4 Fifteen Minute Units:

Effective with claims *submitted* on and after July 17, 2023, Fee-For-Service providers billing more than 2 units of hourly codes or 4 units of 15 minutes codes in the following list of HCPCS codes, on a single date of service, are required to provide the following documentation with the submission of the claim.

- **Comprehensive assessment:**
  - The member's most recent comprehensive behavioral health assessment,
- **Treatment care plan:**
  - The treatment plan for the services billed,
- **Consent to treat form:**
  - A signed copy of the member's consent to treatment for the services billed, and
- **Records / Documentation:**
  - Medical record documentation for each claim line billed on the service date(s).

New Additions - HCPCS Codes Which Now Require Documentation When Claims Are Submitted In Excess Of 2 Hourly Units Or 4 Fifteen Minute Units: (cont.)

Billing Codes (claims submitted on or after July 17, 2023 will be affected)

HCPCS	Description
H0006	Alcohol and/or drug services; case management, per 15 minutes,
H0036	Community psychiatric supportive treatment, face to face, per 15 minutes,
H2010	Comprehensive medication services, per 15 minutes
H2012	Behavioral health day treatment, per hour,
T1002	RN services, per 15 minutes, and
T1003	LPN services, per 15 minutes.

HCPCS Codes Now Requiring Documentation When Billing More Than 8 Units:

HCPCS	Description
H2019	Therapeutic behavioral health services, per 15 minutes,
H2025	Ongoing support to maintain employment, per 15 minutes,

HCPCS Codes Now Requiring Documentation When Billing More Than 4 Units:

Additionally, the documentation requirement on the following codes has changed when providers are submitting claims for more than 4 units on or after July 17, 2023.

- Refer to the following slides for more code additions.

HCPCS Codes Now Requiring Documentation When Billing More Than 4 Units:

HCPCS	Description
H0004	Behavioral Health Counseling and Therapy
H0038	Self-Help/Peer Services
H2011	Crisis Intervention Service, per 15 minutes-only billable for Crisis Mobile Team services, see (AMPM Policy 590 Behavioral Health Crisis Services and Care Coordination for requirements)
H2014	Skills Training and Development
H2015	Comprehensive Community Support Services
H2017	Psychosocial Rehabilitation Services

HCPCS Codes Now Requiring Documentation When Billing More Than 4 Units (cont.)

HCPCS	Description
H2025	Behavioral Health Prevention Education Service
H2027	Psychoeducational Service
H5150	Unskilled Respite Care, Not Hospice
T1016	Case Management
T1019	Personal Care Services
H0034	Medication training and support, per 15 minutes

Behavioral Health Claim Denials

Behavioral health outpatient claims may be denied due to any of the following:

- Submission of poor quality documentation (i.e., **no letterhead,** required and/or valid signatures not present, mismatch between documented services provided and services billed, etc.) will result in denial of the claim.
- See AMPM Chapter 940 Medical Records and Communication of Clinical Information for documentation requirements.

Behavioral Health Claim Denials

Behavioral health outpatient claims may be denied due to any of the following:

- Providers shall submit all required documentation with the claim.
- Claims received without the required documentation will be denied after seven (7) calendar days unless the provider submits the required documents within that time frame.
- Failure to submit all of the required documentation for each date of service billed will result in denial.

***If you miss the 7 day timeline, you can still attach the required documentation to the claim.**

Behavioral Health Claim Denials (cont.)

Behavioral health outpatient claims may be denied due to any of the following:

- A claim line with multiple dates of services on a single line is not allowed and will result in a denial of the claim. When billing behavioral health claims, each service must be billed on a single line to include the:
  - Date of service,
  - CPT/HCPCS code and, a
  - Applicable number of units.

Behavioral Health Claim Denials (cont.)

Behavioral health outpatient claims may be denied due to any of the following:

- Some billing codes may be denied when inappropriately billed on the same date of service as a per diem service.
- H0030 Behavioral Health Hotline Services can only be utilized by a provider that is part of the state crisis system and claims *cannot be submitted to DFSM*. This code will be denied if billed to DFSM.

Behavioral Health Claim Denials (cont.)

Behavioral health outpatient claims may be denied due to any of the following:

- A claim submitted with a substance use disorder (SUD) diagnosis for a child 12 years of age or younger will be denied if it is not submitted with documentation.

- If a FFS Provider submits a behavioral health outpatient claim to DFSM that is then denied for lack of documentation, and then re-submit a claim with a lesser number of units or a different diagnosis, the provider will be required to submit documentation for all services provided. Documentation will need to be reviewed before payment is authorized for any claim submitted by the provider.

Behavioral Health Claim Denials (cont.)

Behavioral health outpatient claims may be denied due to any of the following:

- If a FFS provider is found to be submitting multiple claims for the same member on the same service day, the provider will be required to submit documentation for all services provided on any claim submitted.
- All of the claims from the provider will require documentation that will require review before payment is authorized.


Division of Fee-for-Service Management (DFSM)
Provider Education and Training Unit

AHCCCS
Arizona Health Care Cost Containment System

Thank You.