



AHCCCS Third Quarter 2020 Indian Health Services and Tribal 638 Provider Forum

DFSM Provider Training

August 11, 2020

2:00pm – 3:30pm

Agenda

- **AHCCCS Provider Enrollment Portal (APEP) and Provider Enrollment Updates**
- **Referring, Ordering, Prescribing, and Attending (ROPA) Provider Updates**
- **Dental Services (Exceptions for inpatient dental services and dental therapy)**
- **COVID-19 Resources**
- **COVID-19 Billing Information**
- **General Telehealth Information**
- **Crisis Services for Federal Emergency Services Program (FESP)**
- **AIMH**
- **BHRF Updates**



The AHCCCS Provider Enrollment Portal (APEP) and Provider Enrollment Updates

AHCCCS Provider Enrollment Portal (APEP) Launches on August 31st, 2020

The implementation of the AHCCCS Provider Enrollment Portal (APEP), is set to launch August 31st, 2020.

APEP will offer a secure web-based enrollment process. APEP is designed to ease the provider enrollment process by decreasing processing time and allowing the provider to submit a new enrollment or modification to an existing provider ID effectively any time of the day.

AHCCCS Provider Enrollment Portal (APEP) Launches on August 31st, 2020

The new online system will allow providers to:

- Enroll as an AHCCCS provider.
- Update information (such phone and addresses).
- Upload and/or update licenses and certifications.

If you have questions please contact AHCCCS Provider Enrollment at:

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

APEP Site: <https://www.azahcccs.gov/APEP>

COVID -19 Temporary Provider Enrollment Flexibilities

- **AHCCCS has temporarily suspended the provider revalidation process during the emergency time frame.**
- **The provider enrollment application fee is currently waived at this time, including for Out-of-State provider applications.**
- **Provider site visits are waived at this time.**



Referring, Ordering, Prescribing and Attending (ROPA) Providers

Referring, Ordering, Prescribing and Attending (ROPA) Providers

Per 42 CFR 455.410 of the Affordable Care Act, the State Medicaid agency (AHCCCS) **must require all ordering or referring physicians, or other professionals providing services** under the State plan or under a waiver of the plan, to be enrolled as participating providers.

- This means that referring, ordering, prescribing and attending (ROPA) providers must be AHCCCS-registered providers. Providers must be registered with AHCCCS to ensure payment of items and/or services.

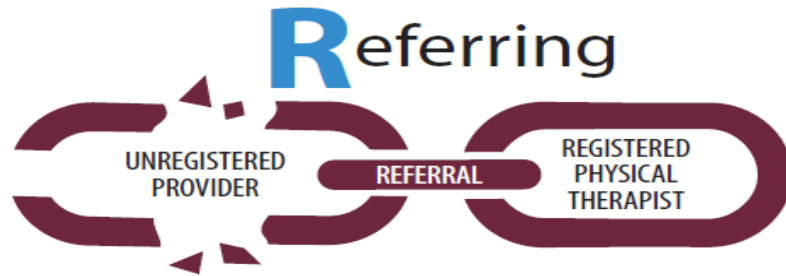
Referring, Ordering, Prescribing and Attending (ROPA) Providers

Even if a provider does not intend to submit claims to Medicaid, providers who are not registered with AHCCCS, but who may be the Referring, Ordering, Prescribing, or Attending (ROPA) provider, ***may keep members from getting needed health care, unless they enroll with AHCCCS by January 1, 2021.***

Enroll with AHCCCS to become a Referring, Ordering, Prescribing or Attending provider by **January 1, 2021.**

Referring, Ordering, Prescribing and Attending (ROPA) Providers

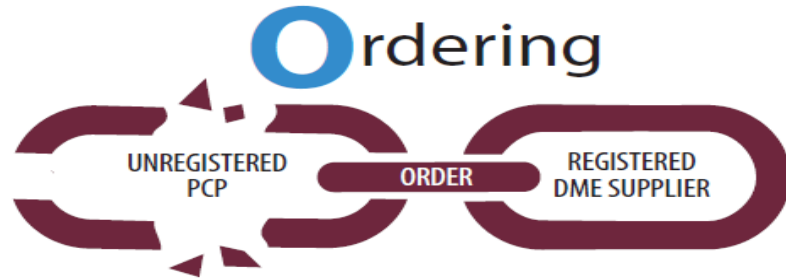
Enroll with AHCCCS to become a Referring, Ordering, Prescribing or Attending provider by January 1, 2021.



REFERRAL NOT ACCEPTED AND
CLAIM FROM PHYSICAL THERAPIST NOT PAID OR
MEMBER GOES WITHOUT NEEDED CARE

Referring, Ordering, Prescribing and Attending (ROPA) Providers

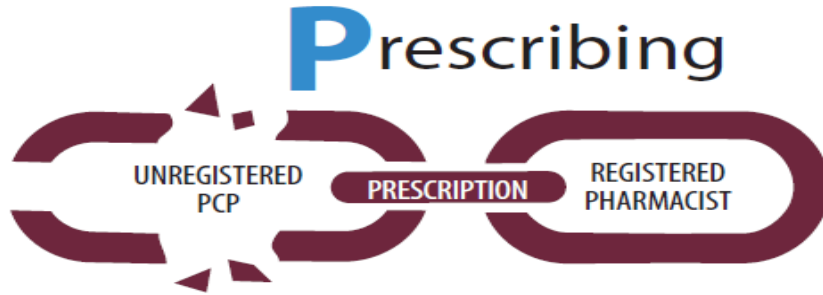
Enroll with AHCCCS to become a Referring, Ordering, Prescribing or Attending provider by January 1, 2021.



**ORDER NOT ACCEPTED AND
CLAIM FROM DME SUPPLIER NOT PAID OR
MEMBER GOES WITHOUT DME**

Referring, Ordering, Prescribing and Attending (ROPA) Providers

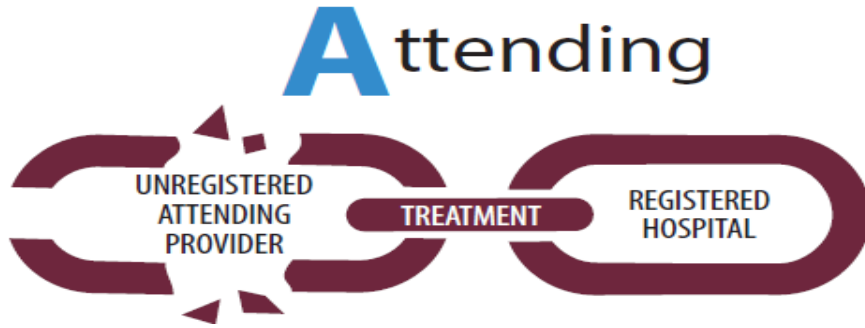
Enroll with AHCCCS to become a Referring, Ordering, Prescribing or Attending provider by January 1, 2021.



PRESCRIPTION NOT COVERED AND CLAIM FROM PHARMACIST NOT PAID OR MEMBER GOES WITHOUT PRESCRIPTION

Referring, Ordering, Prescribing and Attending (ROPA) Providers

Enroll with AHCCCS to become a Referring, Ordering, Prescribing or Attending provider by January 1, 2021.



ATTENDING NOT APPROPRIATE AND CLAIM FROM HOSPITAL NOT PAID OR MEMBER GOES WITHOUT NEEDED CARE

Rev 1

Referring, Ordering, Prescribing and Attending (ROPA) Providers

Providers must be registered with AHCCCS by January 1, 2021, even if they have no intention of submitting claims to AHCCCS, if they intend to make any referrals, place any orders, prescribe any supplies/medications, or serve as an attending provider for any AHCCCS member.

If a rendering provider submits a claim to AHCCCS based on the order, referral, or prescription of a provider who is not registered with AHCCCS then that claim will be denied.

The ordering/referring/prescribing/attending provider must be both registered with AHCCCS and their NPI number shall be on the submitted claim.



Dental Services

Policy Update 310-D1

Dental Services for Members 21 Years of Age and Older

Per AMPM 310-D1, dental hygienists may also practice within an inpatient hospital setting when under the general supervision of a licensed physician, to allow for the care of patients on a ventilator or who are physically unable to perform oral hygiene.

This allows for the coverage of dental cleanings, and these services are not subject to the \$1,000 adult emergency dental limit.

These dental services shall be billed under either the inpatient hospital (for claims for facility services) or under the supervising physician (for claims for professional services).

Policy Update 310-D1

Dental Services for Members 21 Years of Age and Older

Exception for Ventilator Cases

- If services are billed under the physician, then medical codes will be submitted and are not subject to the \$1000 adult emergency dental limit.

Dental Services

Dental Therapy Services

As of February 1st, 2020, dental services provided by dental therapists within their scope of practice that are provided in practice settings or locations consistent with statute may be billed to AHCCCS by facilities or supervising dentists.

Dental Services

Dental Therapy Services

Per [A.R.S. 32-1276.01](#) a dental therapist must be a licensed dental hygienist and have graduated from a dental therapy education program accredited by (or holding an initial accreditation from) the American Dental Association Commission on Dental Accreditation.

For information on licensing requirements and scope of practice, please refer to the Board of Dental Examiners website. Per [A.R.S. 32-1231](#) *there is an exception to state licensure (but not scope of practice requirements) for dental therapists who are employed in IHS and 638 facilities or Urban Indian Health programs.*

Dental Services

Dental Therapy Services

Dental therapists may not bill as independent providers or dispense narcotics, per [A.R.S. 32-1276-03](#).

Dental Services

Dental Therapy Services

Dental therapists may practice within the following practice settings or locations, including mobile dental units that are operated or served by any of the following, per [A.R.S. 32-1276.04](#) :

1. Federally Qualified Health Center (FQHCs);
2. Health Centers that have received a Federal Look-Alike Designation;
3. Community Health Centers;
4. Private dental practices that contract with FQHCs or provides dental care for community health center patients of record who are referred by the community health center; and/or
5. Nonprofit dental practice or a nonprofit organizations that provides dental care to low-income and underserved individuals.

Dental Services

Dental Therapy Services

Facilities or clinics owned or operated by the Indian Health Service, tribes or tribal organizations with a 638 agreement, or Urban Indian Health Programs, that fall within one of the five practice settings or locations delineated in statute (A.R.S. 32-1276.04), may bill for dental therapist services, as long as the dental therapist meets the licensure requirements or exceptions to licensure requirements.



COVID-19 Resources

COVID-19 Resources - FAQs

AHCCCS has published a list of [COVID-19 Frequently Asked Questions \(FAQs\)](#), which includes information on the following topics:

* [Billing & Claims](#)

* [Clinical Delivery](#)

* [General COVID-19 Questions](#)

* [Health Plan & AHCCCS Fee-For-Service Programs Guidance](#)

* [Health Plan Requirements and Deliverables](#)

* [Pharmacy & Supplies](#)

* [Provider Enrollment and Requirements](#)

* [Rates](#)

* [Telehealth Delivery and Billing](#)

* [Uninsured Testing](#)

COVID-19 Resources – FFS Memo

The Division of Fee-for-Service Management (DFSM) also has released a memo that outlines the updated AHCCCS Prior Authorization and Concurrent Review Standards, in response to Governor Ducey's declaration of a public health emergency for COVID-19.

The memo, along with all corresponding information can be found here:

[https://azahcccs.gov/AHCCCS/Downloads/COVID19/AHCCCS PA and CR Standards COVID19.pdf](https://azahcccs.gov/AHCCCS/Downloads/COVID19/AHCCCS_PA_and_CR_Standards_COVID19.pdf)

COVID-19 Resources – Telehealth Training Materials

The DFSM Provider Training Team holds periodic trainings on telehealth services for IHS and 638 providers.

A schedule of upcoming trainings, including PDF documents of the IHS-638 Telehealth trainings that have been conducted previously can be found on the provider training web page, located here:

https://www.azahcccs.gov/Resources/Training/DFSM_Training.html



COVID-19 Coding Updates

COVID-19 Billing Updates

AHCCCS has published a list of COVID-19 Frequently Asked Questions (FAQs), which include information on coding/billing for providers.

<https://azahcccs.gov/AHCCCS/AboutUs/covid19FAQ.html>

Are IHS and 638 Providers required to report CPT/HCPCS on claims?

IHS facilities are not required to report CPT/HCPCS and modifiers on UB-04 claim forms when billing the All Inclusive Rate (AIR).

Are there billing codes available for COVID-19 testing outside of Centers for Disease Control and Prevention (CDC) testing laboratories?

For Claims Billed at the Capped Fee-for-Service Rate:

- CMS has [created a new Healthcare Common Procedure Coding System \(HCPCS\) code for COVID-19 tests](#) that are administered outside of Centers for Disease Control and Prevention (CDC) testing laboratories.

HCPCS	Description	Lab Designation
U0001	CDC 2019 NOVEL Coronavirus Real-Time	Used to report CDC Testing Laboratory
U0002	CDC 2019 NOVEL Coronavirus Real-time	Used to report Non-CDC Lab tests.

Are there billing codes available for COVID-19 testing outside of Centers for Disease Control and Prevention (CDC) testing laboratories?

For Claims Billed at the Capped Fee-for-Service Rate:

- CMS created additional codes to be used on or after March 18, 2020 for tests performed with high throughput technologies.

CPT/HCPCS	Description
U0003 (effective 03/18/2020)	U0003 should be used to identify tests that would otherwise be identified by CPT code 87635.
U0004 (effective 03/18/2020)	U0004 should be used to identify tests that would otherwise be identified by U0002.
U0003 and U0004	U0003 and U0004 <i>should not</i> be used for tests that detect COVID-19 Antibodies.

Are there billing codes available for COVID-19 testing outside of Centers for Disease Control and Prevention (CDC) testing laboratories?

For Claims Billed at the Capped Fee-for-Service Rate:

87635	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique.
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Reporting Services Provided as a Result of COVID-19

For Claims Billed at the Capped Fee-for-Service Rate:

Modifier **CR**

- AHCCCS has designated the **CR** modifier to be used on all claims for services provided as a result of, or related to COVID-19.

Providers should be using the modifier as appropriate in order for AHCCCS to identify the costs of services attributable to this emergency.

All other guidance regarding use of modifiers continues to be applicable.

Is AHCCCS covering COVID-19 antibody testing?

Yes, as outlined in Section 6004 of the Families First Coronavirus Response Act (FFCRA). Further information is available at the [CDC](#) and on the [ADHS](#) websites

COVID-19 Testing for the Uninsured

Question: Can providers be reimbursed for COVID-19 testing for Arizonans who are uninsured?

- Yes. The Families First Coronavirus Response Act authorized federal reimbursement for COVID-19 testing and services for any uninsured individual. The US Department of Health and Human Services, Health Resources & Services Administration (HRSA), announced the COVID-19 Uninsured Program Portal. [To learn more, read this AHCCCS News post.](#)



General Telehealth Updates

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](#)
- ❖ [Chapter 8, Individual Practitioner Services, of the IHS/Tribal Provider Billing Manuals](#)

In light of these updates, the Telehealth Training Manual was retired, as it contained outdated information (our policies were provided expanded telehealth services).

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 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.

How is Telehealth defined?

- **Telehealth** may include healthcare services delivered via asynchronous (store and forward), remote patient monitoring, teledentistry, or telemedicine (interactive audio and video).

Telehealth Services

What Types of Services are Covered via Telehealth?

The first thing to know is that there is a difference between real time telemedicine (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, and can also include remote patient monitoring.

Behavioral Health Telehealth Services

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).

Teledentistry (a Telehealth Service)

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.](#)

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.



Office Setting Telehealth Services

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



Telehealth and the Four Walls

Telehealth Billing IHS and 638 Providers

Consistent with CMS guidance, AHCCCS does not intend to review claims for services furnished by IHS/Tribal clinic providers “outside the Four Walls” of the clinic prior to January 30th, 2021.

CMS released FAQs on January 18, 2017, regarding the review of services furnished by IHS/Tribal clinic providers “outside the Four Walls” of the clinic prior to January 30th, 2021.

- This response can be found in Question #13, in the FAQs at: <https://www.medicaid.gov/sites/default/files/federalpolicy-guidance/downloads/faq11817.pdf>.

AHCCCS will continue to follow the “Four Walls” issue since CMS is considering extending that timeline.

Telehealth Billing IHS and 638 Providers

The following scenarios cover telehealth billing for IHS and 638 providers under normal circumstances (a non-emergency state).

PLEASE NOTE that until January 30, 2021, that CMS will not review the “Four Walls” requirement for free-standing IHS/638 clinics.

Four Walls and the AIR

The “**Four Walls**” of an IHS/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. Under normal circumstances, the “Four Walls” applies as follows:

- The “Four Walls” provision **does** apply to free-standing IHS/638 clinics
- The “Four Walls” provision **does not** apply to IHS/638 hospitals or to their hospital-affiliated (provider-based) outpatient clinics
- The “Four Walls” provision **does not** apply to 638 FQHCs

Four Walls Applicability

IHS/638 Hospitals (four walls **do not** apply) are a permanent facility, run by either IHS or tribally owned and run, which contains inpatient beds, organized staff including physician services, continuous nursing services and that provides comprehensive health care including diagnosis and treatment.

IHS/638 Hospital-affiliated, outpatient clinics (four walls **do not** apply) are a permanent facility run by either IHS or tribally owned and run, that provide outpatient services and bill under the hospital provider type. (Also known as Provider-based clinics.)

Four Walls Applicability

IHS/638 Free-standing Clinics (four walls do apply) are a permanent clinic that provides comprehensive health care including diagnosis and treatment, but cannot bill for services provided outside of the four walls of the clinic.

638 FQHCs (four walls **do not** apply) are a permanent facility that provides comprehensive health care including diagnosis and treatment.

IHS/638 Hospitals and the AIR

The “Four Walls” do not apply to IHS and 638 hospitals.

Regardless of the originating site of the service, if the IHS/638 hospital submits a reimbursable claim to AHCCCS for a facility service, it will be reimbursed at the All Inclusive Rate (AIR). Neither the patient nor the provider need to be physically located within the four walls in order for the Hospital to bill the All Inclusive Rate for services otherwise considered to be facility services.

This is per page 691 of the State Plan, which covers Reimbursement of Indian Health Service and Tribal 638 Health Facilities, and states that “Encounters/visits include covered telemedicine services” when discussing visits qualifying for reimbursement at the AIR.

Hospital-Affiliated IHS/638 Clinics and the AIR

The “Four Walls” do not apply to hospital-affiliated IHS/638 outpatient clinics (also called provider-based clinics).

Regardless of the originating site of the service, if the IHS/638 hospital-affiliated outpatient clinic submits a reimbursable claim to AHCCCS that constitutes a facility service, it will be reimbursed at the All Inclusive Rate (AIR). Neither the patient nor the provider need to be physically located within the four walls in order for the Provider-Based Clinics to bill the All Inclusive Rate for services otherwise considered to be facility services.

This is per page 691 of the State Plan, which covers Reimbursement of Indian Health Service and Tribal 638 Health Facilities, and states that “Encounters/visits include covered telemedicine services” when discussing visits qualifying for reimbursement at the AIR.

Free-Standing IHS/638 Clinics and the AIR

The “Four Walls” does apply to free-standing IHS/638 clinics.

If either the member or the provider is located inside the four walls of the 638 clinic, and a telehealth visit is being done, and the IHS/638 clinic submits a reimbursable claim (and the service provided met the definition of a clinic visit) to AHCCCS, it will be reimbursed at the All Inclusive Rate (AIR).

If neither the member or the provider is located inside the four walls of the IHS/638 clinic (i.e. if the member is in their home and the provider is in their home office, so neither member or provider is at the IHS/638 clinic), and the IHS/638 clinic submits a reimbursable claim (even if the service provided met the definition of a clinic visit) to AHCCCS, it cannot be reimbursed at the AIR. It would have to be billed at the capped FFS rate.

NOTE: CMS had granted a grace period extending to January 30, 2021, before CMS will review claims for services furnished by IHS/Tribal clinic providers “outside the Four Walls” of the clinic.

Clinic Service

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.

In order for an outpatient service to be reimbursed at the AIR, it must meet the definition of a clinic visit.

Clinic Service

What services count as a clinic service?

Per CFS § 440.90 Clinic services:

Clinic services means preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. The term includes the following services furnished to outpatients:

- (a) Services furnished at the clinic by or under the direction of a physician or dentist.
- (b) Services furnished outside the clinic, by clinic personnel under the direction of a physician, to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address.

Billing for Telehealth Services

Billing Guidelines

Please note the following billing differences:

Institutional Claims

- For billing at the All Inclusive Rate (AIR)

Professional Claims

- Place of Service (POS) Field
- For billing at the Capped FFS Rate

Professional Claims and the POS

The Place of Service listed on a CMS 1500 Claim Form

****This applies to claims submitted for reimbursement at the capped FFS rate. The UB-04 Claim Form does not have a POS field.**

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.

Note: This applies for claims submitted on all Claim Forms.

Professional Claims and the POS

POS Example **This applies to claims submitted for reimbursement at the capped FFS rate. The UB-04 Claim Form does not have a POS field.

A member is located in their home (originating site) and the consulting provider is located in the IHS free-standing clinic (distant site). The POS listed on the claim (submitted by the IHS free-standing clinic) will be POS 12 (Home). The POS will not be the IHS free-standing clinic (distant site).

- **NOTE:** Please note this is one example of many potential scenarios. This example is not the only way to submit claims.

Professional Claims

POS Example **This applies to claims submitted for reimbursement at the capped FFS rate. The UB-04 Claim Form does not have a POS field.

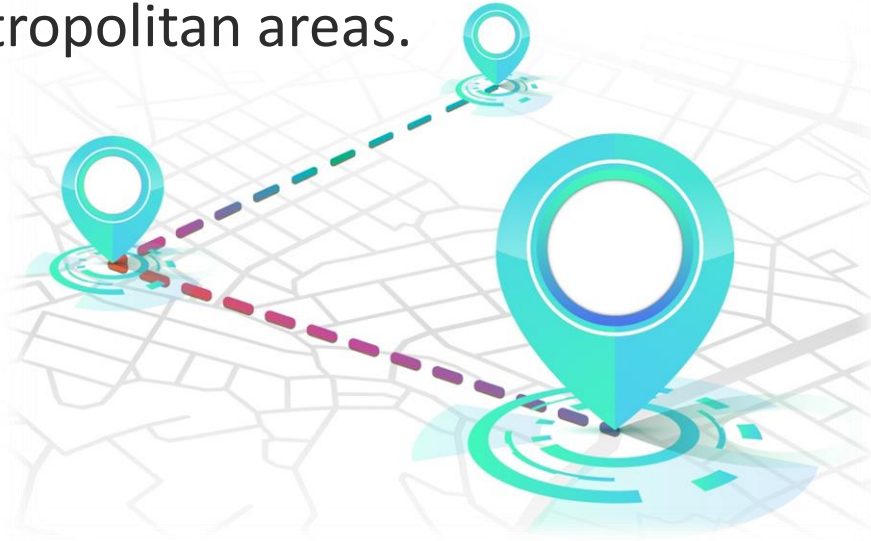
A member is located in their home (originating site) and the consulting provider is located in the IHS free-standing clinic (distant site). The POS listed on the claim (submitted by the IHS free-standing clinic) will be POS 12 (Home). The POS will not be the IHS free-standing clinic (distant site).

- **NOTE:** Please note this is one example of many potential scenarios. This example is not the only way to submit claims.

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.



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.

What Has Changed?

Provider Types

We do not prohibit certain provider types from billing for telehealth and telephonic services.

However, please note that provider types can bill for telehealth and telephonic services, only to the extent that their scope, licensure and standards of care allow.

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 IHS and 638 Providers

Claim Form:

IHS and 638 Providers billing for reimbursement at the All Inclusive Rate (AIR) should continue to bill using the UB-04 Claim Form.

IHS and 638 Providers billing for reimbursement at the Capped FFS Rate should continue to bill using the CMS 1500 Claim Form.

Telehealth Billing IHS and 638 Providers

Coding

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

When billing for reimbursement at the AIR, providers should continue to use the appropriate Revenue Code: 0510 Clinic Visit; 0512 Dental Visit; or 0516 Urgent Clinic.

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 IHS and 638 Providers

Coding & Modifiers

For IHS and 638 providers submitting for reimbursement at the All Inclusive Rate (AIR), whom are using the UB-04 Claim Form and submitting revenue codes, the submission of telehealth and telephonic modifiers is optional (not required).

For IHS and 638 providers submitting for reimbursement at the capped FFS rate, the appropriate CPT/HCPCS code must be used, along with the applicable modifier to indicate telehealth and/or telephonic services.

Telehealth Billing IHS and 638 Providers

Modifiers

*For use when billing at the Capped FFS Rate.

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.
UD	Indicates the service provided was telephonic.

Reporting Services Provided as a Result of COVID-19

Modifier **CR**

- AHCCCS has designated the **CR** modifier to be used on all claims for services provided as a result of, or related to COVID-19.

Providers should be using the modifier as appropriate in order for AHCCCS to identify the costs of services attributable to this emergency.

All other guidance regarding use of modifiers continues to be applicable.

Telehealth Billing IHS and 638 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>

*Note: For use when billing at the capped FFS rate.

Billing for Telehealth and Telephonic Services as a free-standing IHS/638 Clinic

Telehealth Billing for Free-Standing IHS and 638 Clinics

Billing Examples

The following slides present several scenarios regarding telehealth and telephonic services and discuss when the All-Inclusive Rate (AIR) is or is not appropriate to bill. These slides present billing options.

These examples vary in the following ways:

- Location of member;
- Location of provider (consulting provider) performing the telehealth/telephonic service; *and*
- Whether or not the consulting provider has an agreement in place with the IHS/638 clinic that allows the clinic to bill for them and later reimburse them (such as a CCA).

Telehealth Billing for Free-Standing IHS and 638 Clinics

Example 1

1. A member is located in their home (originating site) and the provider is located inside the “four walls” of the free-standing IHS/638 clinic (distant site).
 - In the above scenario, if an AIR-eligible service was provided, then the clinic could bill for reimbursement at the AIR.

Telehealth Billing for Free-Standing IHS and 638 Clinics

Example 2

2. A member is located at a free-standing IHS/638 clinic (originating site) and the consulting provider is located inside a home office, or an office *not* within the “four walls” of the free-standing IHS/638 clinic (distant site).

In this scenario, the provider has an agreement in place with the IHS/638 clinic for the clinic to bill for the services provided. The clinic will submit the claim for these services, not the provider.

Telehealth Billing for Free-Standing IHS and 638 Clinics

Example 2 (Continued)

- In the example 2 scenario, if an AIR-eligible service was provided, then the clinic could bill for reimbursement at the AIR; *and*
- Since the IHS/638 clinic is doing the billing for the consulting provider, then the clinical documentation is maintained by the facility; *and*
- The clinic and the provider cannot both bill for the same service. Either the clinic bills for the AIR, or the provider bills at the capped FFS rate. It cannot be both.

Telehealth Billing for Free-Standing IHS and 638 Clinics

Example 3

3. A member is located at a free-standing IHS/638 clinic (originating site) and the consulting provider (who will submit the claim in this example) is located inside a home office, or an office *not* within the “four walls” of the free-standing IHS/638 clinic (distant site).

In this scenario the provider will submit the claim, not the clinic.

Telehealth Billing for Free-Standing IHS and 638 Clinics

Example 3 (Continued)

- In the example three scenario, *even if an AIR-eligible service was provided*, the consulting provider would submit the claim for reimbursement at the **capped FFS rate**. Please note that in this scenario the consulting provider does not have an arrangement, such as a CCA, that would permit the IHS/638 clinic to bill for the service and to later reimburse the consulting provider; *and*
- The clinic **and** the provider **cannot both bill for the same service**. Either the clinic bills for the AIR, or the provider bills at the capped FFS rate. It cannot be both. In the above scenario, due to the lack of arrangement between the provider and clinic, the consulting provider is the one to submit the claim for reimbursement at the capped FFS rate .

Telehealth Billing for Free-Standing IHS and 638 Clinics

Example 4

A member is located in their home (originating site) and the consulting provider is located inside a home office, or an office *not* within the “four walls” of the free-standing IHS/638 clinic (distant site).

In the above scenario, *even if an AIR-eligible service was provided*, then either the clinic or the consulting provider may bill for the reimbursement at the capped FFS rate. Neither clinician nor member was within the “four walls” of the free-standing clinic, so it is not an AIR eligible visit.

- NOTE: The clinic **and** the provider **cannot both bill for the same service**. Either the clinic bills for the AIR, or the provider bills at the capped FFS rate. It cannot be both.

Telehealth & School Based Behavioral Health Services

Question: For members who have been receiving behavioral health services through the AHCCCS Behavioral Health in Schools Initiative, can telephone and telehealth be leveraged to provide these services in the member's home and/or community while school is closed?

- **Answer:** Yes, AHCCCS strongly encourages Behavioral Health Providers to continue to provide behavioral health services to children and their families in their home and community while schools are closed. Please see other telehealth FAQs for additional information on telehealth and telephonic service delivery.

Provider to Patient Outreach Services

Question: Can primary care physicians and pediatricians outreach to their patients to provide preventive medicine counseling via telehealth (including telephonic) during the COVID-19 emergency?

- Yes, providers are encouraged to outreach to patients to ensure their care needs are being met during the emergency. Information on what billing codes can be used for preventive medicine counseling are listed on the [Medical Coding Resource web page](#).



Crisis Services for Federal Emergency Services Program (FESP)

Crisis Services and FESP Members

Billing for Title XIX Members for the First 24 Hours of Crisis Services

The first 24 hours of crisis services are the responsibility of the RBHA and should be billed to the RBHA located in the GSA where the crisis occurred.

- **Note:** For Federal Emergency Services Program (FESP) members, the first 24 hours of crisis services are the responsibility of the RBHA and should be billed to the RBHA located in the GSA where the crisis occurred.

Services up to and including the fifth hour should be billed using the hourly code S9484. Services over the fifth hour, up to and including the 24th hour, should be billed per diem using S9485.

Crisis Services and FESP Members

Billing for Title XIX Members After the First 24 Hours of Crisis Services

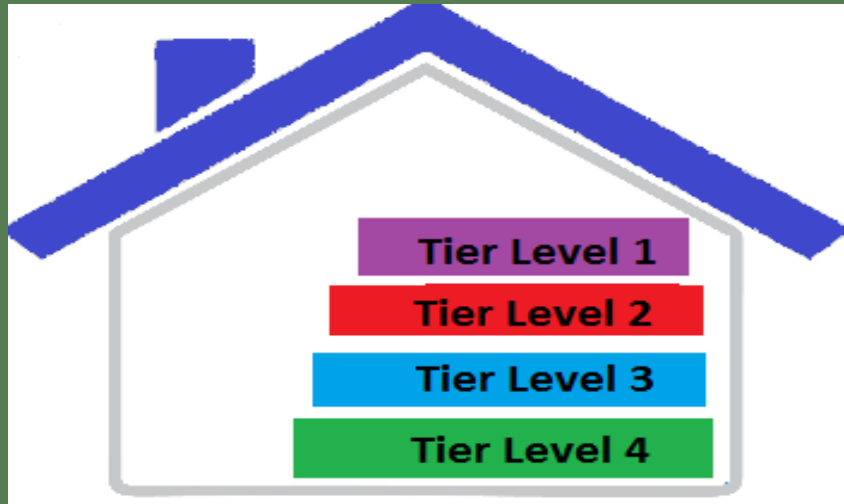
After the first 24 hours (i.e. the 25th hour forward) crisis services should be billed to the member's enrolled health plan.

- The health plan of enrollment is responsible for payment of medically necessary 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.

Note: For FESP members, claims for crisis services after the first 24 hours (i.e. the 25th hour forward) should be billed to AHCCCS Division of Fee-for-Service Management (DFSM). Please note that only emergency services that meet FESP guidelines outlined in AMPM 1100 shall be eligible for reimbursement.



American Indian Medical Homes



What is an American Indian Medical Home

- The American Indian Medical Home (AIMH) 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 coordination through the use of Primary Care Case Managers (PCCM) and 24 hour access to the care team.

AIHM Provider Requirements

- **Must be an IHS or Tribal 638 facility**
- **Enter into an AIMH Intergovernmental Agreement (IGA)**
- **Primary Care Medical Home (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)**

AIHM Medical Provider Types

02 - Hospital

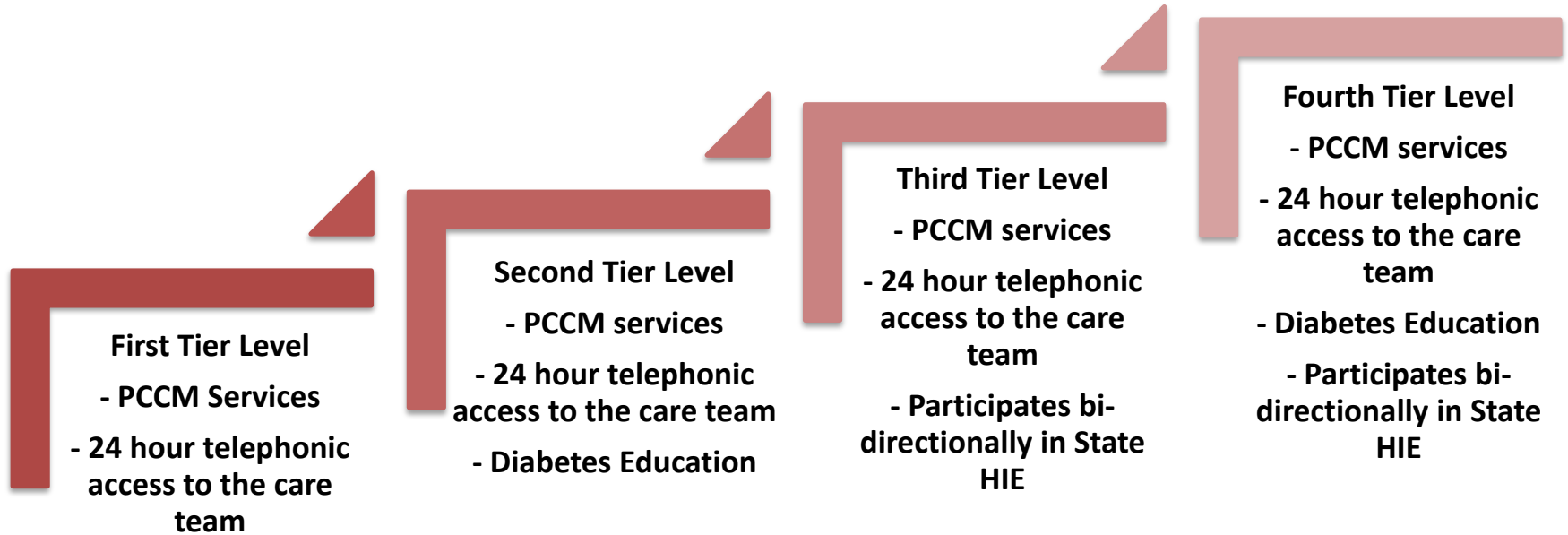
05 - Clinic – *(excluding Dental Providers)*

IC - Integrated Clinic

C2 - Federally Qualified Health Clinic (FQHC)

C5 - 638 Federally Qualified Health Clinic (FQHC)

AIMH Services Per Tier Level



AIMH Reimbursement Rates

- 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 Reimbursement Rates

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 American Indian Medical Homes

- Chinle Comprehensive Health Care Facility
 - Tier 4
 - **13,108 members**
- Phoenix Indian Medical Center (PIMC)
 - Tier 2
 - **4,485 members**
- WhiteRiver Indian Hospital
 - Tier 2
 - **5,215 members**
- Winslow Indian Health Care Center
 - Tier 3
 - **3,401 members**
- San Carlos Apache Healthcare
 - Tier 4
 - **2,236 members**
- Fort Yuma Indian Health Center
 - Tier 1
 - **3 members**

AIMH Resources and Information

- **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>



Behavioral Health Residential Facility (BHRF) General Information and Updates

Behavioral Health Residential Facility (BHRF)

- Initial prior authorization is still required for non-emergency Behavioral Health Inpatient Facility (BHIF), Residential Treatment Centers (RTC) and Behavioral Health Residential Facility (BHRF) levels of care.
- DFSSM plans to extend continued stay review timeframes from 30 to 90 days for Residential Treatment Centers (RTC).
- Clinical Staffings, Child and Family Teams (CFTs), Adult Recovery Teams (ARTs), and coordination of care between facilities and outpatient providers should continue to inform appropriate levels of care and continued stay.
- Telehealth and telephonic modalities are strongly encouraged for these staffings and coordination


Behavioral Health Residential Facility (BHRF)

As Specified in *Arizona Administrative Code* - A.A.C. R9-10-101, a BHRF is a health care institution that provides treatment to an individual experiencing a behavioral health issue that limits the individual's ability to be independent or causes the individual to require treatment to maintain or enhance independence.



Prior Authorization and Indian Health Services / Tribal 638 BHRF

Behavioral Health Residential Facilities that are designated as an Indian Health Services (IHS) facility, or a Tribal 638 facility being operated by a Tribe or Tribal organization, **do not require** prior authorization.



No Prior Authorization is required for IHS/638 facilities, for members enrolled under Title XIX.

Behavioral Health Residential Facility Mandatory Notification Process

Contractors and BHRF providers shall ensure appropriate notification is sent to the Primary Care Physician and Behavioral Health Provider/Agency/TRBHA/Tribal ALTCS program upon *intake to and discharge from the BHRF.*

BHRF Admission Guidelines

Direct Admission from BIHF Crisis System Urgent Admission

Behavioral Inpatient Health Facility (BHIF)

Direct Admissions to a BHRF

If member is admitted directly from a BHIF, the Crisis System, or the Pre-Admission Evaluation determines that the member needs an urgent admission, Prior Authorization is not required.

BHRF shall submit the Behavioral Health Residential Facility Admission Notification Form via the AHCCCS Online Provider Portal.

DFSM will authorize up to initial 5 days for this type of admission. **BHRFs shall submit all required documentation to receive Prior Authorization beyond the 5th day.**

Direct Admissions to a BHRF

From a Behavioral Inpatient Health Facility (BHIF)

Continued stay requests beyond the 5TH day will require a **prior authorization** request via the AHCCCS Online Provider Portal, and these must include all clinical documentation necessary to support the need for the BHRF stay.

Note: The Administration or a contractor may deny a claim if a provider fails to obtain prior authorization (Title 9 A.A.C. 22)

Prior Authorization information for BHRFs can be found at:

<https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/BHRFPRevisedAMPM320VGuidance.docx>

<https://www.azahcccs.gov/PlansProviders/Downloads/PriorAuthorizations/BHRFAdmissionNotificationForm.pdf>

Treatment Plan

Behavioral Health Residential Facility (BHRF) Treatment Plan

Treatment Plan – Completed in compliance with Title 9 Arizona Administrative Code (A.A.C.) Chapter 10, by the Inpatient, Outpatient or Tribal Regional Behavioral Health Authority (TRBHA) Treatment Team.

For the purposes of this policy, a complete written description of all services to be provided by the BHRF. The Treatment Plan shall be based on the intake assessments and outpatient Service Plan.

- ✓ 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 treatment plan shall not be older than 3 months from the request submission date to the BHRF.

BHRF Responsibility of Care and Services

The Behavioral Health Residential Facility maintains core responsibility for the member's medically necessary services in alignment with AMPM Policy 320-V and the facility's license.

If an outpatient behavioral health clinic is also asked to provide services to a member who is receiving services from the BHRF, the BHRF must provide the member's assessment and treatment plan in order to ensure appropriate care coordination is occurring (i.e. to avoid duplication of services, as well as ensuring the behavioral health outpatient clinic is only providing the "Specialty" services, not being provided by the BHRF) as indicated in the member's assessment and treatment plan.




Behavioral Health Residential Facility Admission Overview AMPM Policy 320-V

Criteria for BHRF Admission

AMPM Policy 320-V

BHRF providers providing services to Fee for Service members are required to adhere to the elements listed in AMPM Policy 320-V Behavioral Health Residential Facility.

- 
1. Member has a diagnosed Behavioral Health Condition which reflects the symptoms and behaviors necessary for a request for residential treatment. The Behavioral Health Condition causing the significant functional and/or psychosocial impairment shall be evidenced in the **assessment** by the following:

Criteria for Admission AMPM Policy 320-V

- A. At least one area of significant risk of harm within the past three months as a result of:
- i. Suicidal/aggressive/self-harm/homicidal thoughts or behaviors without current plan or intent;
 - ii. Impulsivity with poor judgment/insight;
 - iii. Maladaptive physical or sexual behavior;
 - iv. Member's inability to remain safe within his or her environment, despite environmental supports(i.e. Natural Supports); or
 - v. Medication side effects due to toxicity or contraindications.

Criteria for Admission

AMPM Policy 320-V

B. At least one area of serious functional impairment as evidenced by:

- I.** Inability to complete developmentally appropriate self-care or self-regulation due to member's Behavioral Health Condition(s);
- II.** Neglect or disruption of ability to attend to majority of basic needs, such as personal safety, hygiene, nutrition or medical care;
- III.** Frequent inpatient psychiatric admissions or legal involvement due to lack of insight or judgment associated with psychotic or affective/mood symptoms or major psychiatric disorders;

Criteria for Admission

AMPM Policy 320-V

(continued)

- IV.** Inability to independently self-administer medically necessary psychotropic medications despite interventions such as education, regimen simplification, daily outpatient dispensing, and long-acting injectable medications; or
- V.** Impairments persisting in the absence of situational stressors that delay recovery from the presenting problem.

Criteria for Admission AMPM Policy 320-V

- C.** A need for 24 hour behavioral health care and supervision to develop adequate and effective coping skills that will allow the member to live safely in the community;
- D.** Anticipated stabilization cannot be achieved in a less restrictive setting;
- E.** Evidence that appropriate treatment in a less restrictive environment has not been successful or is not available, therefore warranting a higher level of care; and
- F.** Member agrees to participate in treatment. In the case of minors, family/guardian/designated representative also agrees to and participates as part of the treatment team.

BHRF Criteria for Continued Stay

Continued stay shall be assessed by the BHRF staff and as applicable by the

- Child and Family Team (CFT), Adult Recovery Team (ART), Tribal Regional Behavioral Health Authority (TRBHA) during the Treatment Plan review and update.

Progress towards the treatment goals and continued display of risk and functional impairment shall also be assessed.

Treatment interventions, frequency, crisis/safety planning, and targeted discharge shall be adjusted accordingly to support the need for continued stay.

BHRF Criteria for Continued Stay

The following criteria shall be considered when determining continued stay:

- 1.** The member continues to demonstrate significant risk of harm and/or functional impairment as a result of a Behavioral Health Condition.
- 2.** Providers and supports are not available to meet current behavioral and physical health needs at a less restrictive lower level of care.

BHRF Continued Stay

BHRF request for a Continued Stay should be submitted to PA at least **two weeks prior to the last approved prior authorized date of the BHRF stay.**

The Prior authorization online portal does not allow changes to a prior authorization that has been changed from a “Pend” to an “Approved” status by the PA team.

- A request to extend the current authorization can be done by using the AHCCCS Online Provider Portal. To update go to a Prior Authorization Tab along the Menu and search for the Prior Authorization Case. Select the appropriate Case/PA number and then click on the “Attachment” tab.
 - Include all documents that support the continued stay request; the dates of services, make sure all documents are *signed and dated* by the appropriate BHS professional(s) and scanned into your electronic device or computer to upload to the prior auth.

E. Discharge Readiness

BHRF services provided to Fee for Service (FFS) members are required to adhere to the minimum discharge elements below.

- Important: Discharge planning shall begin at the time of admission.

R9-10-101 Definition – “ Discharge planning” means a process of establishing goals and objectives for a patient in preparation for the patient’s discharge

Discharge readiness shall be assessed by the BHRF staff and as applicable by the Child and Family Team (CFT), Adult Recovery Team (ART), Tribal Regional Behavioral Health Authority (TRBHA) during each Treatment Plan review and update.

E. Discharge Readiness (continued)

The following criteria shall be considered when determining discharge readiness:

1. Symptom or behavior relief is reduced as evidenced by completion of Treatment Plan goals.
2. Functional capacity is improved; essential functions such as eating or hydrating necessary to sustain life has significantly improved or is able to be cared for in a less restrictive level of care.
3. Member can participate in needed monitoring or a caregiver is available to provide monitoring in a less restrictive level of care.
4. Providers and supports are available to meet current behavioral and physical health needs at a less restrictive level of care.

Admission, Assessment, Treatment and Discharge Planning Summary

F. Admission, Assessment, Treatment and Discharge Planning

BHRF Providers rendering services to FFS members shall follow the below outlined admission, assessment, treatment and discharge planning requirements.

1. Except as provided in subsection R9-10-707(A)(9), a behavioral health assessment for a member shall be completed before treatment is initiated and within 48 hours of admission.
2. The CFT/ART/TRBHA/Tribal ALTCS shall be included in the development of the Treatment Plan within 48 hours of admission for members enrolled with a Contractor.
3. All BHRFs serving TRBHA or Tribal ALTCS members shall coordinate care with the TRBHAs or Tribal ALTCS programs throughout the admission, assessment, treatment, and discharge process.

F. Admission, Assessment, Treatment and Discharge Planning

4. The Treatment Plan shall connect back to the member's comprehensive Service Plan for members enrolled with a Contractor.
5. A comprehensive discharge plan shall be created during the development of the initial Treatment Plan and shall be reviewed and/or updated at each review thereafter. The discharge plan shall document the following:
 - a. Clinical status for discharge,
 - b. Member/health care decision maker and designated representative and, CFT/ART/TRBHA/Tribal ALTCS understands follow-up treatment, crisis and safety plan, and
 - c. Coordination of care and transition planning are in process (e.g. reconciliation of medications, applications for lower level of care submitted, follow-up appointments made, identification of wrap around supports and potential providers).

F. Admission, Assessment, Treatment and Discharge Planning

6. The BHRF staff and the CFT/ART/TRBHA/Tribal ALTCS shall meet to review and modify the Treatment Plan at least once a month.
7. A Treatment Plan may be completed by a BHP, or by a BHT with oversight and signature by a BHP within 24 hours
8. Implementation of a system to document and report on timeliness of BHP signature/review when the Treatment Plan is completed by a BHT.
9. Implementation of a process to actively engage family/health care decision maker and designated representative in the treatment planning process as appropriate

F. Admission, Assessment, Treatment and Discharge Planning

10. Clinical practices, as applicable to services offered and population served, shall demonstrate adherence to best practices for treating specialized service needs, including but not limited to:

- a. Cognitive/intellectual disability,
- b. Cognitive disability with comorbid Behavioral Health Condition(s),
- c. Older adults, and Co-Occurring disorders (substance use and Behavioral Health Condition(s), or
- d. Comorbid physical and Behavioral Health Condition(s).

F. Admission, Assessment, Treatment and Discharge Planning

11. Services deemed medically necessary through the assessment and/or CFT/ART/ TRBHA/Tribal ALTCS which are not offered at the BHRF, shall be documented in the Service Plan and documentation shall include a description of the need, identified goals and identification of provider meeting the need.

Services Included in the BHRF Daily Per Diem

Services Included in the BHRF Per Diem Rate

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):

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;

Services Included in the BHRF Per Diem Rate

B. Skills Training and Development:

- 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
- iii. Social Communication Skills (e.g. conflict and anger management, same/opposite-sex friendships, development of social support networks, recreation).

Services Included in the BHRF Per Diem Rate

C. Behavioral Health Prevention/Promotion Education and Medication Training and Support Services including but not limited to:

- i. Symptom management (e.g. including identification of early warning signs and crisis planning/use of crisis plan);
- ii. Health and wellness education (e.g. benefits of routine medical check-ups, preventive care, communication with the PCP and other health practitioners);
- iii. Medication education and self-administration skills;
- iv. Relapse prevention;

Services Included in the BHRF Per Diem Rate

- v. Psychoeducation Services and Ongoing Support to Maintain Employment Work/ Vocational skills, educational needs assessment and skill building;
- 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).

SYSTEM UPDATE
BHRF Provider Type B8 (only)
07/15/2019 Notification

HCPCS CODES

H0031 – Mental Health Assessment by non-physician.

H2019 – Therapeutic behavioral services, per diem.

NOTE: This is not representative of a policy or billing change, and is only a system update.

Behavioral Health Residential Facilities Notification

Constant Contact Notification Release: 07/15/2019

Important: Effective 07/15/2019 AHCCCS Administration has closed HCPCS codes H0031 and H2019 for the Behavioral Health Residential Facility (BHRF), Provider Type B8 in our system.

It previously came to AHCCCS' attention that HCPCS codes H0031 (MENTAL Health Assessment, by non-physician) and H2019 (Therapeutic Behavioral Services, per 15 minutes) were being submitted by Behavioral Health Residential Facilities (Provider Type B8), in addition to the BHRF per diem HCPCS code H0018.

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.

Behavioral Health Residential Facilities Notification

Constant Contact Notification Release: 07/15/2019

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

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](#).

Behavioral Health Residential Facility Personal Care Services Policy 9 A.A.C. 10 Article 7

Behavioral Health Residential Facilities Personal Care Services

Effective for dates of service 10/1/2019 - Behavioral Health Residential Facilities (BHRFs) that 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.*

Services that may be provided under Personal Care Services may include (but are not limited to) blood sugar monitoring, bed baths, application and care of prosthetic and orthotic devices, use of pad lifts, respiration monitoring, catheter care, etc.

Providers should view AMPM Policy 320-V section H for additional information about BHRFs and Personal Care Services.

Behavioral Health Residential Facilities

Personal Care Services

R9-10-715. Physical Health Services

An administrator of a behavioral health residential facility that is authorized to provide personal care services shall ensure that:

1. Personnel members who provide personal care services have documentation of completion of a caregiver training program that complies with A.A.C. R4-33-702(A)(5);
2. Residents receive personal care services according to the requirements in R9-10-814(A), (D), (E), and (F); and
3. A resident who has a stage 3 or stage 4 pressure sore is not admitted to the behavioral health residential facility.

BHRF Personal Care Services

H. BHRF WITH PERSONAL CARE SERVICES

BHRFs licensed to provide Personal Care Services shall offer services in accordance with A.A.C R9-10-702 and A.A.C R9-10-715. Contractors and BHRF providers shall ensure that all identified needs can be met in accordance with A.A.C. R9-10-814 (A)(C)(D) and (E). Some examples of services are; blood sugar monitoring, application and care of orthotic and prosthetic devices, application of topical medications, use of pad lifts, respiration and radial pulse monitoring.

Refer to the AMPM Policy 320-V Section H for a list of examples of services that may be provided as Personal Care Services.

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

BHRF and Personal Care Services

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

Reminders:

- BHRF must be licensed by Arizona Department of Health Services (ADHS) to provide personal care services.
- The need for personal care services must be documented in the members assessment and service/treatment plan and identify the specific personal care services required by the member.
- HCPCS code H0018 with the TF modifier (intermediate level of care).

Claim Submission

Claim Submission

Care and Services provided in a BHRF are based on a per diem rate (24 hour day). Prior and continued authorization **do not include *room and board***.

Criteria for **admission and continued stay** will be detailed in the new [AMPM Policy 320-V – Behavioral Health Residential Facilities](#).

Form Type: CMS 1500 Professional Form

HCPCS Code: H0018

Modifier: TF may be billed only when the BHRF is licensed by ADHS for personal care services and the services are included in the member's service plan.

Questions?

Thank You.

This concludes the presentation.