PM Attachment 6.0.1

Behavioral Health Services

Where Do I Submit My Claim?

(TXIX/TXXI Only)

Responsible Party	Type of Service	Valid Denial Reasons	Dispute Filed With
Tribal RBHA or RBHA	○ ADHS/DBHS or Subcontractor is responsible for payment even in situations where the member is not enrolled with a Tribal RBHA/RBHA ○ Retro enrollment that is not Prior Period Coverage ○ Behavioral health services provided to American Indians not provided in a 638 or IHS facility ○ Emergency inpatient behavioral health services provided to non-behavioral health enrolled members from the 73rd hour after admission	○ 11 day rule (see attached) ○ Service not medically necessary ○ Not a clean claim	○ RBHA for RBHA clients ○ ADHS/DBHS for Tribal RBHA clients ***
Acute Care Health Plan	○ Emergency inpatient behavioral health services up to a maximum of 72 hours (R9-22-210.01) for members enrolled with a contractor but not enrolled with Behavioral Health ○ Behavioral health services received during prior period coverage	○ Health Plans rules and regulations	○ Acute Care Plan
AHCCCS Administration	○ Behavioral health services provided to IHS clients by IHS or 638 facilities even if the client is enrolled with a Tribal RBHA or RBHA ** ○ Emergency behavioral health services provided to (FESP) Federal Emergency Services Program clients R9-22-217 ○ ALTCS clients (there is no Tribal RBHA/RBHA enrollment for members who are elderly/physically disabled)	○ Behavioral Health emergency services clients are eligible for emergency services only ○ AHCCCS claim rules and regulations	○ AHCCCS Administration
County	○ Court Ordered Evaluation (COE) * ○ Prepetition Screening		○ County

TRBHA Claim Disputes/Grievances are filed with: ADHS/DBHS Office of Grievance and Appeals
150 N. 18th Avenue
Phoenix, AZ 85007

* May vary depending on County/State agreement

** Case management and non-emergency transportation are not covered services for IHS/638 facilities, services should be billed to either the Tribal RBHA or RBHA

*** Per **A.R.S.§ 36-2903.01.B4** A grievance/dispute may be denied if it is not filed timely

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Prior Period Coverage: Two elements **must** exist in order for an eligibility segment in the AHCCCS system to be considered Prior Period Coverage. When both of these conditions exist, the client will be enrolled in an Acute Health Plan and the Tribal RBHA/RBHA is not responsible for payment of services occurring during the period.

Enrollment Type=RA	Found in the enrollment type column on PMMIS screens RP285 and RP160
Contract Type=H/I/M/O	Found in the Contract Type Column on PMMIS screens RP285 and RP160

H	Acute Prior Period Coverage
I	Acute Prior Period Coverage Emergency Service
M	Long Term Care Prior Period Coverage
O	Long Term Care Prior Period Coverage Acute

When both of these conditions exist, the client will be enrolled in an Acute Health Plan. There has been some confusion when Retroactive Enrollment is posted and the client is enrolled in a FFS Health Plan (008690 or 003335). This is **not** considered Prior Period Coverage.

11 Day Rule: This rule only applies to Emergency Behavioral Health Services for Non-FES Members

R9-22-210.01 #8 Grounds for denial. A contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS may deny payment for **emergency** behavioral health services for reasons including but not limited to the following:

a) The claim was not a clean claim
b) The claim was not submitted timely, or
c) The provider failed to provide timely notification to the contractor, ADHS/DBHA, or a subcontractor of ADHS/DBHS.

R9-22-210.01 #9 Notification. A hospital, emergency room provider, or fiscal agent shall notify a contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, whichever is appropriate, no later than the 11th day from presentation of the non-FES member for **emergency inpatient** behavioral health services.

Clean Claim: A claim that may be processed without obtaining additional data from the provider of service or from a third party but does not include claims under investigation for fraud and abuse or claims under review for medical necessity.

A.R.S.§ 36-2903.01.B4: (Grievance Timeliness) A grievance that is related to a claim for payment of system covered services must be filed in writing and received by the administration or the prepaid capitated provider or program contractor within twelve months after the date that eligibility is posted or within sixty days after the date of the denial of a timely claim submission, whichever is later…