Responsible Party	Type of Service	Billing	Valid Denial Reasons	Dispute Filed With*****
TRBHA or RBHA (Behavioral Health Services Only)	▪ Psychiatric or psychological evaluations provided in emergency room settings ▪ Non-inpatient emergency behavioral health services ▪ Inpatient emergency behavioral health services ▪ Inpatient psychiatric services ▪ Psychiatric or psychological evaluations provided in an inpatient setting ▪ Ambulance transportation and/or other medically necessary transportation provided to a member who requires behavioral services after the member has been medically stabilized ▪ Behavioral health services provided to American Indians not provided in a 638 or IHS facility ▪ Other medically	▪ Principal behavioral health diagnosis ▪ Applicable CPT codes for professional behavioral health services ▪ Applicable accommodation revenue codes for inpatient stays ▪ See ADHS/DBHS Covered Behavioral Health Services Guide for further guidance	▪ 11 day rule** ▪ Service not medically necessary ▪ Not a clean claim**** ▪ Prior authorization not obtained for non-emergency admission/continued stay in a Level I facility	▪ RBHA for RBHA enrolled individuals ▪ ADHS/DBHS for TRBHA enrolled individuals*

	necessary behavioral health services (see ADHS/DBHS Covered Behavioral Health Services Guide)			
Integrated RBHA (for physical health care) and Acute Care Health Plans	▪ Emergency medical services (triage, physician assessment, diagnostic tests) ▪ Emergency transportation to the emergency department, which includes transportation to the same or higher level of care for immediate medically necessary treatment ▪ Transportation to an initial behavioral health intake appointment ▪ Behavioral health services received during prior period coverage*** ▪ Non-behavioral health professional fees related to co-morbid conditions such as treatment for diabetes, asthma, hypertension, etc. ▪ Reimbursement of all facility covered services, including	▪ Applicable CPT codes for professional services ▪ Applicable accommodation revenue codes for inpatient stays ▪ See PMMIS for further guidance	▪ Service not medically necessary ▪ Not a clean claim ▪ Prior authorization not obtained ▪ See 9 A.A.C. 22, Article 7 for further guidance	▪ Acute Care Plan ▪ Integrated RBHA (for SMI enrolled members receiving physical health care services through the RBHA)

	triage and diagnostic tests, regardless of primary diagnosis, in an emergency department when there is no admission to the facility. ▪ Reimbursement of non-behavioral health professional claims, regardless of the presenting problem or diagnosis. ▪ Reimbursement of primary care provider visits, prescriptions, laboratory and other diagnostic tests necessary for diagnosis and treatment of depression, anxiety and/or attention deficit hyperactive disorder. ▪ Medication management from primary care providers.			
AHCCCS Administration	▪ Behavioral health services provided to IHS clients by IHS or 638 facilities even if the client is enrolled with a TRBHA or RBHA ▪ Emergency behavioral	See PMMIS	See the following: ▪ AHCCCS Medical Policy Manual (AMPM) ▪ AHCCCS Behavioral Health Services Guide ▪ AHCCCS Fee-For-Service Provider	AHCCCS Administration

	health services provided to (FESP) Federal Emergency Services Program clients R9-22-217 ▪ ALTCS clients (there is no TRBHA/RBHA enrollment for members who are elderly/physically disabled) ▪ Payment of medically necessary transportation (emergent and non-emergent) for TRBHA enrolled AIHP members and the diagnosis code on the claims is unspecified (799.9)		Manual ▪ AHCCCS IHS/Tribal Provider Billing Manual	
County (except for Pima and Maricopa counties)	▪ Court Ordered Evaluation (COE) ▪ Prepetition Screening	Contact applicable county	Contact applicable county	Contact applicable county

*<u>TRBHA Claim Disputes/Grievances are filed with</u>:

ADHS/DBHS Office of Grievance and Appeals
150 N. 18th Avenue
Phoenix, AZ 85007

**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.

***Prior Period Coverage:

Prior Period Coverage‖ means the period of time prior to the Title XIX member's enrollment during which the member is eligible for covered services, which is from the effective date of eligibility to the day the member is enrolled with the Contractor. ADHS will retroactively backdate the date of effective eligibility based on 834 data supplied by AHCCCS. For technical details on 834 Files, please see the CIS File Layout and Specifications Manual.

****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.

*****Grievance Timeliness (A.R.S.§ 36-2903.01.B4):

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.