ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Behavioral Health Claim and Documentation Technical Errors Workshop

3-25-2025

About This Course

The materials in this presentation are designed for behavioral health providers in the AHCCCS Fee-For-Service (FFS) programs only.

The presentation pertains to FFS and IHS/638 providers. The FFS programs include the American Indian Health Program (AIHP), Tribal Regional Behavioral Health Authority (TRBHA) and Tribal Arizona Long Term Care Services (ALTCS).

Information contained in this presentation may not adhere to requirements set forth by an AHCCCS Complete Care (ACC) or MCO plan. For questions related to claims submitted to an ACC/MCO plan, please reach out to the ACC/MCO plan directly.

Agenda

- Internal Audit
- Reminder: Documentation Must Support All Services
- Common Behavioral Health Documentation Errors
  - Examples/scenarios
- Edit Denial Resolution Guide
- Resources

Internal Audit

It is the provider's responsibility to make sure that all claims are billed appropriately and accurately prior to submission for reimbursement.

Providers should conduct an internal audit of their documentation before submission to AHCCCS. Providers may consider the following when auditing claims and documentation:

- Establish a quality management department
- Assign staff to conduct audits of claim documentation
- Have a checklist that staff members can refer to when conducting internal audits

Reminder: Documentation Must Support All Services Billed

Providers must document all services billed on the claim. If a billed service is not documented, then AHCCCS will not be able to verify that the service occurred. The claim may deny for edit **MD038 (Charges/Services Do not Match Documentation)** or another similar edit code.

Action Step: Documentation that supports all services billed must be included with the claim. Providers must indicate begin and end times on all progress notes and all documentation of services rendered by the provider. The beginning and end time must be accurate to the time each member participated in the service.

Additional information can be found in the Core Billing Limitations of the Covered Behavioral Health Services Guide

Patient Identifiers

Patient Identifiers must be included on every page of the documentation to verify the member who received the service. Documentation must conform to the requirements of AMPM 940-Medical Records and Communication of Clinical Information, and must include:

- Members first and last name, and
- AHCCCS ID number, or
- Date of Birth

Clinical documentation that does not include patient identifiers will deny with edit **MD405 (Invalid Member Info AMPM 940 (III) (A) (1) (B)**.

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HCPCS Codes On Billed Claim Must Match Progress Notes (cont.)

Progress notes must document the type of services provided and include the HCPCS used for the service. The HCPCS code on the documentation **must** match what is billed on the claim including any applicable modifiers.

Example: Behavioral health counseling was provided to a member in a group setting. The progress note details what occurred during the session and documents the HCPCS code H0004 (Behavioral Health Counseling and Therapy) with the HQ (Group) modifier. The claim must also be billed with H0004 with the HQ modifier for the same date of service.

HCPCS Codes On Billed Claim Must Match Progress Notes

Example 2: Using the previous scenario, the member received services for behavioral health counseling (H0004) in a group setting (HQ modifier) per the progress note.

However, this time the claim was billed with H2014 (Skills Training and Development) with the HQ modifier. In this case if the service code on the claim does not match the service provided in the documentation, the claim will deny with edit **MD418 (Claim Mismatch Units/Code Documented)**.

Number of Units Must Match Billed Claim

Providers must indicate begin and end times on all progress notes and all documentation of services rendered by the provider.

The beginning and end time must also be accurate to the time each member participated in the service.

The number of units indicated on the documentation for a service must match what is billed on the claim.

Providers/billers should be aware of the of number of minutes/time that is associated for a unit of specific CPT or HCPCS code to ensure accurate billing.

Number of Units Must Match Billed Claim (cont.)

Example: A member received group behavioral health and counseling therapy (H0004) on 2-12-2025. The provider documented on the progress note the HCPCS code H0004 with the HQ modifier. The progress note also indicated the duration of the service from 9:00 a.m. to 1:00 p.m.

On the claim submission the provider billed 4 units of H0004 with the HQ modifier. The claim denied with edit code **MD418 (Claim Mismatch Units/Code Documented)**.

The HCPCS code H0004 is a timed code in which each unit is 15 minutes. In this scenario the provider made an error in which they thought that a unit of H0004 equaled one hour. The progress note in this example would equate to 16 units (four hours) of H0004 therefore, MD418 would be a valid claim denial.

Diagnosis Codes

A diagnostic code is needed for service code billing. International Classification of Disease (ICD)-10 codes are the industry standard and are required for all Medicaid/Medicare billing purposes.

- At least one valid ICD-10 diagnosis code describing the member's condition must be included on the claim.
- Reported to its highest specificity.

Documentation in the comprehensive assessment must include justification for establishing the diagnosis and include but not limited to:

- Patient report or parent/guardian direct observations of presenting problem(s), and
- Diagnostic impression from the clinician including measures of current severity on the claim.

Diagnosis Codes Must Match Documentation and Claim Submission

Services are based on the member's diagnosis codes established in the behavioral health assessment. Diagnosis codes must be included in the clinical documentation (i.e., Treatment Plan and Progress Notes).

The diagnosis code on the claim must match the established diagnosis on Behavioral Health Assessment and other clinical documentation.

Gender Indicators

Identifying demographics on clinical documentation must include the member's gender.

[AMPM 940 Medical Records and Communication of Clinical Information]

Legibility of Scanned Documentation

Medical records documented on paper format shall be written legibly in blue or black ink. Documentation that is electronically scanned must also be clear, legible and aligned properly.

Example: Document is illegible:

IDENTIFIED NEEDS and SPECIFIC OBJECTIVES (to address these needs)	[illegible]	INTERVENTIONS to MEET OBJECTIVES		[illegible]	[illegible]	[illegible] (Y/N)
		[illegible]	[illegible]			

Progress Notes Must be Individualized

Services for members must individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the member's needs.

Scenario: A behavioral health outpatient clinic submits claims for three different members. The progress notes submitted for each member does not provide details of the interventions provided to each member based on their diagnosis and treatment plans. Each progress note is generic, the provider uses the same verbiage for each member. The claim would deny with edit **MD435-Not individualized to services provided.**

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Date Span Billing Requirement

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.

Date Span Billing Requirement (cont.)

Example of a correct claim submission:

24. A. DATE(S) OF SERVICE From MM	From DD	From YY	To MM	To DD	To YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS
1 02	12	25	02	12	25	11		H0004	HQ		44.84	4
2 02	13	25	02	13	25	11		H0004	HQ		44.84	4
3 02	14	25	02	14	25	11		H0004	HQ		44.84	4

Example of an incorrect claim submission:

24. A. DATE(S) OF SERVICE From MM	From DD	From YY	To MM	To DD	To YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 02	12	25	02	14	25	11		H0004	HQ		134.52	12		NPI	
2														NPI	

Recipient Name/DOB Do Not Match Documentation (Cont.)

Action Steps:

If the date of birth or name is incorrect on the documentation, the provider will need to correct the recipient identifiers on the documentation. Providers should do the following when completing documentation:

- Confirm a member's demographic information on the portal.
- If member information is inaccurate in the portal, the member must contact member services to update their demographic details.
- Prior to the submission of the claim, submitters should ensure the key elements of behavioral health documentation are present and correct.

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Missing/Invalid Behavioral Health Assessment /Treatment Plan for DOS

Behavior Health Assessments and Treatment plans are valid within one year of the date of service. These must be completed annually based on the signed date of the previous assessment or Treatment plan.

Scenario: A provider submits a claim for services rendered on December 12, 2024. The treatment plan submitted with the claim is dated December 1, 2023. The claim denied with edit **MD466 (Missing/Invalid TX Plan for DOS)** as the treatment plan is greater than one year from the date of service on the claim.

In this scenario services cannot be rendered until a new treatment plan is completed.

Mismatch Rendering and Billing Providers

Providers who are registered under their own NPI number can bill for AHCCCS covered services that are permitted within the scope of the practitioner's licensure and AHCCCS provider type.

AHCCCS providers registered under their own NPI can:

- Bill as the rendering/servicing provider on the claim.
- Can bill under the facility's NPI as the servicing/rendering and billing provider on the claim.
    - In this case they must be listed as a participating provider (field 19 on the CMS 1500) on the claim submission.

Mismatch Rendering and Billing Providers (cont.)

Behavioral health professionals, technicians, and paraprofessionals may **not** bill for services under the NPI of another individual provider.

For example:

- Claim was submitted under the NPI of a Registered Nurse Practitioner (provider type 19) as the servicing/rendering provider.
- The documentation shows that the services were performed by a BHT or a different provider.

In this example, the claim denied with edit **MD319 (Mismatch Providers Rendering and Billing).**

Mismatch Rendering and Billing Providers (cont.)

In the previous example:

- If practitioner who performed the service meets the qualifications to register under their own NPI, they must be billed as the servicing/rendering provider, or
- They must be listed as a participating provider in the Additional Claim information field (field 19) on the CMS 1500.

Provider Signatures

The provider signature in medical record documentation must be in electronic or in legible written form in blue or black ink. Provider signature must be followed by their approved credential (e.g., LPC, BHT, BHPP) and indicate the exact date and time of the signature.

Correct

Ryan Bell LCSW

Digitally signed by Ryan Bell
Date: 2025 . 01. 15 at 3:25 pm
172.56.80.162

Incorrect

Ryan Bell

Invalid Provider Signatures

Based on the review of the claim, if the claim denied with edit **AD281 Invalid Provider Signature AMPM 940 (III)(A)(3); ARS18-106**, the required Provider signature requirements have not been met as outlined in the AHCCCS Medical Policy 940 Medical Records and Communication of Clinical Information.

This may mean that the electronic signature used does not meet the specific requirements or standards per AMPM 940 are not met.

Per ARS 18-106, “An electronic signature shall be unique to the person using it, shall be capable of reliable verification and shall be linked to a record in a manner so that if the record is changed the electronic signature is invalidated.”

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Invalid Provider/BHP Signature on Behavioral Health Assessment or Treatment Plan

The Behavioral Health Assessment and Treatment Plan must be signed by a BHP within 72 hours per AMPM 320-0.

The example below is **incorrect**. The BHP signature occurs more than 72 hours after the BHT signed the Behavioral Health Assessment and/or Treatment Plan.

Mary Poppins BHT
Digitally Signed by Mary Poppins
Date: 2025. 03. 10 at 9:52 a.m.
172.56.80.162

Ryan Bell LCSW
Digitally signed by Ryan Bell
Date 2025. 03. 15. at 12:37 p.m.
172.56.80.162

INVALID PROVIDER/BHP Signature Example

Scenario: A Behavioral Health Assessment was completed for an AHCCCS member by a Behavioral Health Technician on March 10, 2025. Per the AMPM 320-O-Behavioral Health Assessments and Treatment Service Planning, the behavioral health assessment must be co-signed by an AHCCCS registered Behavioral Health Professional (BHP) within 72 hours of the BHT signature.

However, the BHP signs the Behavioral Health Assessment on March 15, 2025, which is outside the 72 hour timeframe of when the BHT signed the assessment. The claim denied with edit code **MD462 (Invalid Provider/BHP Signature on BHA).**

Invalid Provider/BHP Signature Example (Cont.)

A BHP must sign the Behavioral Health Assessment and Treatment Plan within 72 hours that the document is signed by the BHT. Date and timestamps are required for electronic signatures.

If the Behavioral Health Assessment or Treatment Plan is not signed by BHP within 72 hours of the BHT signature, the claim will deny with one of the following denial codes:

- **MD462 (Invalid Provider/BHP Signature on BHA)**
- **MD464: Invalid Provider/BHP Signature on Individual Service Plan (ISP)**

Invalid Provider/BHP Signature Example (Cont.)

The BHT performed the assessment on 3/1/2025 and signed the assessment on the same day. The BHP reviewed and signed the assessment on 3/10/2025 which was beyond the 72 hour requirement.

Note: Electronic signatures must include a date and timestamp.

- **MD462 (Invalid Provider/BHP Signature on BHA)**
- **MD464: Invalid Provider/BHP Signature on Individual Service Plan (ISP)**

Valid Provider Signatures

Behavioral health assessment must be signed by a BHP within 72 hours per AMPM 320-0.

The example below is **correct**. The BHP signature occurs within 72 hours of BHT or BHPP signature.

Mary Poppins BHT
Signed by Mary Poppins
Date: 2025. 03. 10. at 9:52 a.m.
172.56.80.162

Ryan Bell LCSW
Signed by Ryan Bell
Date 2025. 03. 11. at 8:17 a.m.
172.56.80.162

Valid Provider/BHP Signature Example

Example: A behavioral health assessment was completed for an AHCCCS by a Behavioral Health Technician on March 10, 2025. Per the AMPM 320-O, the behavioral health assessment must be co-signed by an AHCCCS registered Behavioral Health Professional (BHP) within 72 hours of the BHT signature. The BHP signs the behavioral health assessment on March 11, 2025, which is within the 72 hours of the BHT signature.

Invalid Signature on Behavioral Health Assessment (BHA)

- Behavioral health assessment must be signed by a BHP within 72 hours per AMPM 320-0.

Assessments that are completed by an uncredentialed provider will be denied with edit **MD462 (Invalid Provider/BHP Signature on Behavioral Health Assessment).**

Incorrect: Provider credentials are missing:

Example 1:

Ryan Bell

Signed by Ryan Bell
Date: 2025. 03. 1. at 9:52 a.m.
172.56.80.162

Example 2:

Lucy Ricardo BHP

Signed by Lucy Ricardo
Date: 2025. 02. 28. at 11:27 a.m.
172.56.80.162

Recipient Name/DOB Do Not Match Documentation

If documentation submitted does not match the member's name or date of birth to what is on file with AHCCCS or what is on the claim, the claim will deny with edit code **MD423 (Recipient Name/DOB Do Not Match Documentation** or **MD405 Invalid Member ID Info AMPM 940 (III)(A)(1)(B).**

Example:

A member's date of birth on file with AHCCCS is April 12, 1980. There was a typo and the incorrect DOB was entered on the documentation submitted with the claim, which shows the member's date of birth as 4/22/1980. The claim denied with edit code **MD423**.

Uncredentialed/Unlicensed Provider Signatures

Documentation must include the appropriate signatures that include the practitioner's licensed credentials (i.e. LCSW, LMFT, LPC, etc.). Documentation that does not include the practitioner's credentials or if the Behavioral Health Assessment or Treatment Plan are not co-signed by the BHP the claim may deny with edit **MD431 (Uncredentialed/Unlicensed Provider)**

Example: A BHT signs a treatment plan with the following signature. The BHA or TX plan is not completed and co-signed by the BHP within 72 hours of the BHT signature.

Mary Poppins BHT

Signed by Mary Poppins
Date: 2025. 02. 24 at 1:23 p.m.
172.56.80.162

Member/Guardian Signatures

The member under the age of 18 must have a parent or legal guardian sign the Treatment Plan. Claims that do not contain a valid member/guardian signature will be denied.

Example:

A Treatment Plan is created for an AHCCCS member who is 17 years old. The member signs the Treatment plan. However, the member's parent (or legal guardian), does not sign the Treatment Plan. The claim denies with edit code **MD454 (Member/Guardian Signature Missing/Invalid.**

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What is the Edit Denial Resolution Guide?

The Edit Resolution Guide is a tool that was created to help providers understand the denial edits, descriptions, and actionable next steps.

New denial edits will be added periodically to the guide. Providers maintain the responsibility to ensure all claims are billed appropriately.

We recommend providers review the claim denial edits in the Edit Resolution Guide ***prior*** to submitting a ticket to the Service Desk.

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Where is the Edit Denial Resolution Guide Located?

The Edit Resolution Guide can be found on the DFSM Training Resources webpage and is updated regularly.

To navigate to the DFSM Training Resources webpage:

- Click on the *Resources* tab on the AHCCCS website.
- Select *Fee-for-Service Provider Training* on the right-hand side.

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  - MCO Provider Training
- State Plans
- Electronic Data Interchange (EDI)
- Community Partners (HEAplus)
- Pharmacy

Division of Fee for Service Management: Training Resources

AHCCCS Provider Training offers group and individual training to Fee-For-Service (FFS) providers on how to submit claims, prior authorization requests, additional documentation (i.e. the AHCCCS Daily Trip report or requested medical records), etc. using the AHCCCS Online Provider Portal and the new EDI Solutions portal ServiceNow to upload documents.

Users will need to have access in order to use the EDI Solutions Portal. If you do not have an account, please follow the instructions outlined in the: EDI Portal Provider Signup and Login Guide.

Additional information related to the EDI platform can be found AHCCCS EDI Portal Upload Medical Records or NEMT Trip Reports.

The AHCCCS Provider Training team also offers periodic trainings whenever there are significant changes in AHCCCS policy or to the AHCCCS billing manuals.

This web page provides information on:

- The DFSM Claims Clues Newsletter,
- How to sign up for DFSM email alerts,
- The DFSM Provider Training Schedule,
- Access to Power Point Presentations for past trainings, and
- Contact information for the Division's Training Team.

By reading the DFSM Claims Clues Newsletter and signing up for email alerts providers will be alerted to system and program changes, and claims and billing updates.

DFSM Claims Clues Newsletter

DFSM publishes a monthly newsletter for providers. It is available online and provides information about the following:

- Claims and billing updates,
- Billing policies and requirements,
- System changes, and
- Changes to program benefits.

Past issues are available on the Claims Clues webpage.

Provider Denial Resolution Guide

Provider Denial Resolution Guide *(10/25/2024)*

The Edit Resolution Guide is a tool that was created to help providers understand the denial edits, descriptions, and actionable next

The Importance of Submitting Complete Documentation For Review

Accurate and complete medical documentation is the foundation of efficient claims processing.

- Missing or incomplete documentation can result in delays and denials.
- Proper documentation encompasses only the complete written records pertaining to the claim billed with respect to member's care, services and necessity.
- Complete and legible documentation is crucial for accurate claims processing.
- Detailed records support the medical necessity of billed services.
- Documentation facilitates accurate coding of services performed.
- Incomplete claims trigger requests for additional information and delays processing.

EDI Solutions Portal

The EDI Solutions portal ServiceNow is used to upload documents to a claim submission.

Users will need to have access in order to use the EDI Solutions Portal. If you do not have an account, please follow the instructions outlined in the: EDI Portal Provider Signup and Login Guide.

Additional information related to the EDI platform, including how to upload documentation, can be found AHCCCS EDI Portal Upload Medical Records or NEMT Trip Reports.

Resources

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Resources

Denial Edit Resolution Guide

AHCCCS Covered Behavioral Health Services Guide (CBHSG)

FFS Provider Billing Manual, Chapter 19, Behavioral Health Services

IHS/Tribal Provider Billing Manual, Chapter 12, Behavioral Health Services

AMPM 310-B Title XIX XXI Behavioral Health Service Benefit

AMPM 320-O Behavioral Health Assessments and Treatment Service Planning

AMPM 940 Medical Records and Communication of Clinical Information

DFSM Training Resources webpage