

July 2021

Transaction Insight Portal – Important Information for Users Who Select Non-Person Entity

Attention All Transaction Insight (TI/TIBCO) Portal / Web Upload Attachment Users

This is an important notice for providers who log onto the Transaction Insight Portal (also known as TIBCO or the TI Portal) to upload attachments, such as medical records and the Daily Trip Report

If you select Non-Person Entity (2) and then enter in information into the Provider First Name field, this will cause an error and your attachments will not link to the claim.

This will cause your claim to be denied for missing documentation.

AHCCCS has been seeing multiple errors amongst providers who are submitting documentation as a Non-Person Entity (2). Do not enter any values in the Provider First Name when submitting documentation as a Non-Person Entity.

INCORRECT

Provider Entity Type Qualifier: Person (1) **Non-Person Entity (2)**

Provider Last or Organization Name: Organization Name

Provider First Name: **Organization Name (If you put something here, the documentation may not attach and the claim could deny.)**

CORRECT (Provider First Name must be blank/empty)

Provider Entity Type Qualifier Person: (1) **Non-Person Entity (2)**

Provider Last or Organization Name: Organization Name

Provider First Name:

The Provider First Name field **must** be left blank when a Non-Person Entity is chosen. The below image shows the correct way to do this in the portal.



The screenshot shows a web form with the following fields and values:

- Transaction Set Purpose Code: 02 - Add
- Submitter Last or Organization Name: EDI TEAM
- Provider Entity Type Qualifier: Person (1) Non-Person Entity (2)
- Provider Last or Organization Name: COMPANY
- Provider First Name: (empty)

Please also review Page 8 (Submitter Last or Organization Name) in the guide: [Transaction Insight Web Upload Attachment Guide](#)

If you encounter problems logging on to the TI Portal, please contact EDI Customer Support at servicedesk@azahcccs.gov.

[Download the latest training](#) on the new web upload attachment layout.

Any additional questions regarding training on the TI portal, please contact: ProviderTrainingFFS@azahcccs.gov

ANNOUNCEMENTS

IMPORTANT: For Transaction Insight Portal (TIBCO/TI) users, if you select Non-Person Entity (2) when submitting documentation:

- DO NOT enter information into the Provider First Name field. If you do this as a Non-Person Entity, then your attachments will not link to the claim.

This will cause your claim to be denied for missing documentation.

Please read the article in this edition of Claims Clues for more detailed information and images showing the issue we have been seeing.

TRAINING AND CONTACTS

For provider training questions and technical assistance with the online web portal please outreach the Provider Training Division of DFSM through email at ProviderTrainingFFS@azahcccs.gov

- Training materials for FFS Providers and upcoming Provider Training Sessions can be found on the DFSM Provider Training Web Page on the AHCCCS website.
- Prior Authorization Questions FFS PA Line (602) 417-4400
- Claims Customer Service Billing Questions (602) 417-7670 - Option 4
- Provider Registration Process Questions (602) 417-7670 - Option 5

ELECTRONIC PAYMENT SIGN UP

Electronic Payment Sign Up (Remittance Advice Sign Up/835)

ISDCustomerSupport@azahcccs.gov

OR call 602-417-4451

COVID FAQ

The AHCCCS Prior Authorization (PA) and Concurrent Review (CR) Standards during the COVID-19 Emergency for Fee-for-Service Programs was updated on July 2nd, 2021. It can be found in the [COVID FAQs on the AHCCCS website](#).

Court Ordered Treatment FAQ Update

AHCCCS has established an Information Center to remedy the lack of information concerning the unique jurisdictional, legal and coordination of care issues related to American Indians and the state's behavioral health system.

This web page can be found on the AHCCCS website at:
<https://www.azahcccs.gov/AmericanIndians/TribalCourtProceduresForInvoluntaryCommitment/>

On this web page AHCCCS has also posted a [Frequently Asked Question \(FAQ\)](#) document, pertaining to the American Indian Health Program (AIHP) and Court Ordered Treatment (COT). The FAQs can be found under the 'Additional Resources' menu towards the bottom of the page.

DFSM Provider Training Team's Third Quarter Training Schedule Posted

The Division of Fee-for-Service Management's (DFSM) Provider Training Unit conducts periodic trainings on a variety of subjects for providers.

Training topics covered include:

- Instructing providers on how to use the [AHCCCS Online Provider Portal](#) and the [Transaction Insight Portal](#) to submit claims, prior authorization requests, and additional documentation (i.e. the AHCCCS Daily Trip report or requested medical records), as well as how to check a member's eligibility and how to check on a PA or claim's status;
- Trainings on specific topics, such as telehealth;
- Trainings designed for specific provider types, such as for Non-Emergency Medical Transportation (NEMT) providers,

Behavioral Health Residential Facilities (BHRFs), Direct Care Worker Agencies (DCWAs), and more; and

A schedule of our group training sessions for the second quarter can be found on the DFSM Provider Training web page, on the AHCCCS website, at: www.azahcccs.gov/Resources/Training/DFSM_Training.html

Scroll down to 'Training Schedules by Year' and click on the drop down to choose 2021. Select 'Training Schedule 3rd QTR 2021'.

The [Third Quarter Training Schedule for 2021](#) can be found on the website.

APEP

Providers are reminded to use the AHCCCS Provider Enrollment Portal (APEP) for all new applications to become an AHCCCS-registered provider, and for updates to current registrations.

What is the AHCCCS Provider Enrollment Portal (APEP)?

On August 31, 2020, AHCCCS launched the AHCCCS Provider Enrollment Portal (APEP), which offers a secure web-based enrollment process and a streamlined provider enrollment process that allows a provider to electronically submit an application for new enrollment or to modify an existing provider ID online.

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, at any time of the day.

This online system allows providers to:

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

For training inquiries, the Provider Enrollment Unit has established a [web page](#) with training materials for providers, regarding how to use the AHCCCS Provider Enrollment Portal. Please visit [here](#) to view the videos and training materials available online.

www.azahcccs.gov/PlansProviders/APEP/APEPTraining/Videos.html

If you have additional questions about APEP that are not addressed in those materials, please contact the APEP team at: APEPTrainingQuestions@azahcccs.gov

A list of FAQs regarding APEP can be found on the [AHCCCS website](#).

If you have any additional 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 and Adding Service Locations

If you encounter an issue trying to add a service location for your provider via the AHCCCS Provider Enrollment Portal (APEP), the Division of Member and Provider Services (DMPS) team has two other options available to assist providers with this process. Providers can contact the DMPS team at (602-417-7670, select option #5) and request to open a service ticket. A second option is to send an email to apeptraining@azahcccs.gov which will automatically generate a service ticket request as well.

Done by a BHP, or by BHT cosigned by a BHP, utilizing standardized instrument that is able to determine the appropriate level of care.

2. Treatment Plan – completed in compliance with 9 A.A.C.10

BHRF Notification

Effective 4/1/2019, all admissions and continued stays at Behavioral Health Residential Facilities (BHRF) (Provider Type B8) for AIHP and TRBHA members require authorization.

NOTE: Authorization is NOT required for IHS/638 BHRF Facilities.

- All new BHRF admissions require notification of admission to AHCCCS for initial coverage of up to 5 days of care. During this initial 5 day time frame, the BHRF will be responsible for submitting an Authorization request and ensuring compliance with criteria listed in AMPM Policy 320-V – Behavioral Health Residential Facilities and 9 A.A.C.10.
- If the Authorization request and the supporting admission documentation are not received within the initial 5 day time frame, claims may be denied.

Admission documentation that is required for the Authorization request includes:

1. Behavioral health assessment in compliance with 9 A.A.C. 10, to determine Behavioral Health Condition and Diagnosis. Assessment should be recent, and not older than 1 year.

by the Inpatient/Outpatient or TRBHA Treatment Team. 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 plan shall not be older than 3 months from the request submission date.

NOTE: All criteria for admission still must be met from the date of admission.

For members currently in a BHRF, facilities had to submit an authorization request to get the continued stay authorized by 5/31/2019. Criteria for admission and continued stay are detailed in the new AMPM Policy 320-V – Behavioral Health Residential Facilities. Specific authorization submission and documentation procedures will be available on the FFS web page on the AHCCCS web site. Please look for upcoming notifications on training opportunities that will be available on the FFS web page.

Prior Authorization Requests shall be submitted on the AHCCCS Online Provider Portal. Please see: <https://www.azahcccs.gov/PlansProviders/FeeForServiceHealthPlans/PriorAuthorization/submissionprocess.html>

For guidelines related to requirements for prior authorization and its accompanying documentation, please refer to: <https://www.azahcccs.gov/PlansProviders/FeeForServiceHealthPlans/PriorAuthorization/requirements.html>

Medicare EOB

AHCCCS maintains a record of each recipient's primary coverage by Medicare and Other primary insurance plans. If a recipient's primary payer's record indicates a first-party coverage (such as Medicare or employer's health plan) or a third-party coverage (i.e. third party liability or TPL) and the claim is filed (sent to AHCCCS for payment) without the primary payer's EOB the claim will be denied.

For more detailed information please refer to the following re-

sources:

- [Chapter 9 of the FFS Provider Billing Manual, Medicare/Other Insurance Liability.](#)
- [Chapter 7 of the IHS/Tribal Provider Billing Manual, Medicare/Other Insurance Liability.](#)

Other coverage information can be verified using the AHCCCS online eligibility verification portal.

ROPA

Referring, Ordering, Prescribing, Attending (ROPA) Providers Required to Register with AHCCCS

The [Patient Protection and Affordable Care Act \(ACA\)](#) and the [21st Century Cures Act \(Cures\)](#) require that all health care providers who refer AHCCCS members for an item or service, who order non-physician services for members, who prescribe medications to members, and who attend/certify medical necessity for services and/or who take primary responsibility for members' medical care must be registered as AHCCCS providers. AHCCCS calls this initiative, and these

providers, "ROPA", and has set a deadline of June 1, 2021 by which providers must register in order to be reimbursed.

Until these acts passed, referring, ordering, prescribing, and attending providers were required to obtain a National Provider Identifier (NPIs), but were not required to be registered as an AHCCCS provider.

Learn more at [azahcccs.gov/PlansProviders/NewProviders/ROPA.html](https://www.azahcccs.gov/PlansProviders/NewProviders/ROPA.html). One-on-One training requests, designed for a specific provider based on request.

Quality Management (QM) Housekeeping Tips

The AHCCCS/DFSM Quality Management (QM) investigates QOC Concerns, IADs, and Health and Safety Conditions for members enrolled in FFS Programs in accordance with 42 U.S.C. §1396a(a)(30)(A).

Quality Management is an important component of a member's care, and here are some tips for providers:

- Make sure to verify a Member's eligibility for Behavioral Health and Physical Health assignment when providing services to a new member.
- Please coordinate care with the member's health plan. This includes TRBHAs, who are to be considered as the member's Behavioral Health plan.
- Keep your provider contact information updated with AHCCCS Provider Enrollment. The Division of Fee-for-Service Quality Management frequently utilizes your PMMIS contact information to help with mentioning clinical documentation from your facility.
- Please include all applicable clinical documentation when reporting any incidents, accidents and deaths in the QM Portal.

The AHCCCS Medical Policy Manual chapter on 'Quality of Care Fee-for-Service provider requirements' can be found here:

- <https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/800/830.pdf>

Per AMPM 830: "The Tribal ALTCS and TRBHA programs shall participate in the investigation of QOC Concerns, IAD reports and Health and Safety Conditions related to their enrolled members, in accordance with applicable IGAs and in coordination with AHCCCS.

Reports of QOC Concerns and service issues may be raised at AHCCCS internally or externally by members/Health Care Decision Makers and designated representatives, providers, and stakeholders, from anywhere in the community. The AHCCCS Provider Participation Agreement (PPA) provides the authority for AHCCCS/DFSM to ensure that FFS providers comply with all applicable state and federal rules and regulations, including alignment with state licensure requirements, as well as AHCCCS rules and policies relating to the audit of provider records and the inspection of the provider's facilities. FFS providers are responsible for adhering to the requirements specified in all applicable AHCCCS policies, including this Policy. For specific requirements applicable to Tribal ALTCS and the TRBHAs, refer to the respective IGA."

AHCCCS Prior Authorization (PA) and Concurrent Review (CR) Standards during COVID-19 Emergency for Fee-for-Service Health Programs

Original Release: March 25, 2020

Last Updated: July 2, 2021

Effective Date: August 1, 2021

This memo outlines the updated AHCCCS Prior Authorization and Concurrent Review Standards for AHCCCS Division of Fee-for-Service Management (DFSM) in response to Governor Ducey's declaration of a public health emergency for COVID-19 and is effective April 1, 2020, through the duration of the emergency. These changes impact members enrolled with a Fee-for-Service Program, including the American Indian Health Program (AIHP), Tribal Regional Behavioral Health Authorities (TRBHAs), and Tribal Arizona Long Term Care Services (Tribal ALTCS).

These standards are subject to change as the emergency conditions evolve.

All services reimbursed must be medically necessary, cost-effective, federally and state reimbursable, and will be subject to post-payment review.

I. Behavioral Health Services

Initial prior authorization is still required for non-emergency Behavioral Health Inpatient, Residential Treatment Center (RTC) and Behavioral Health Residential Facility (BHRF) levels of care.

DFSM plans to extend concurrent reviews from 30 to 90 days for Residential Treatment Center (RTC) levels of care.

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.

II. Dental Services

Dental prior authorization approvals, which are within 60 days of expiration, will be extended for 6 months.

III. Pharmacy Services (Updated 4/14/2021)

Effective June 15, 2021, Sections III. A and B will no longer be in effect.

Note: This change was originally announced during Special Tribal Consultations on 4/13/2021 to be effective on 6/1/2021. OptumRx will be ending these flexibilities and reinstating utilization management edits and prior authorization requirements that were in effect with the previous plan set-ups, effective June 15, 2021. Agents that are designated as preferred on the AHCCCS Drug List will be in effect and non-preferred medications that were not grandfathered by the AHCCCS Pharmacy and Therapeutics (P&T) process are to be transitioned to the preferred agent(s) of the therapeutic class.

IHS and 638 Pharmacies may:

- a. **Continue to fill 90-day supplies of maintenance medications when billing the All-Inclusive Rate; and**
- b. **The allowance for billing for 60-days of specialty medications will be changing back to 30-day prescription fills.**

The following Section III. A & B changes, as referenced above, will be ending on June 15, 2021. Please see notations in Sections C and D.

A. Refill-too-soon edits and 90-day fills

1. All health plans must remove the refill-too-soon edit on all non-controlled medications.
 - a) Members may continue to fill prescriptions for up to a 30-day supply or they may fill a 90-day supply of maintenance medications, both of which may be done early once the edit is lifted.
 - b) Specialty medications which are filled for a 30-day supply and delivered to the member's home may be filled early for the same day's supply as previously filled.

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AHCCCS Prior Authorization (PA) and Concurrent Review (CR) Standards during COVID-19 Emergency for Fee-for -Service Health Programs

- c) When the refill-too-soon edit is lifted, Pharmacy Benefit Managers (PBMs) must check to ensure that quantity limits and duplicate therapy edits currently in place will not cause a rejection when the prescription is refilled early.
2. Controlled Substances may be refilled early when the pharmacy staff has checked with the prescribing clinician and the clinician has agreed to the early refill. The pharmacy staff or the prescribing clinician shall contact the health plan's PBM help desk for an immediate override. Please ensure that quantity limits and duplicate therapy edits will not cause a rejection when these claims are provided an override.
 3. Removal of prior authorization for specific therapeutic classes
 - a) Health plans must remove all prior authorization requirements for the following Therapeutic Classes:
 - Antibiotics,
 - Antimalarials,
 - Antivirals,
 - Beta2 Agonist Inhalers and Inhalant Solutions,
 - Long-acting Beta2 Agonist-Corticosteroid Combination Inhalers,
 - Long-acting Beta2 Agonist-Anticholinergic Combination Inhalers,
 - Corticosteroid Inhalers and Inhalant Solutions,
 - Corticosteroid Oral Agents,
 - Nebulizers (must be available through pharmacies),
 - Cough and Cold products, such as:
 - Antihistamines,
 - Nasal Decongestants,
 - Combination products of antihistamines and nasal decongestants,
 - Cough suppression products including guaifenesin and combination products,
 - Guaifenesin oral tablets and combination products, and
 - Analgesics / Anti-febrile products (aspirin, ibuprofen, acetaminophen, acetaminophen suppositories, etc.)
 - Mast Cell Stabilizers, and
 - Methylxanthines (aminophylline and theophylline).

B. Addressing Drug Shortages (See note at start of Section III above for reference to changes)

1. The AHCCCS Drug List has preferred medications which the AHCCCS Medical Policy Manual (AMPM) 310-V requires to be utilized prior to a non-preferred agent. However, in the event of a shortage, a non-preferred medication must be approved. For example, ProAir is the preferred albuterol inhaler. Using ProAir as an example, if there is a shortage of ProAir, the health plans must allow all other branded and generic albuterol products to be reimbursed through the pharmacy claims system without prior authorization.
2. When there is a drug shortage and the health plans' network pharmacies are unable to obtain the medication in a timely manner, the health plans shall open up their pharmacy network to pharmacies that have the medication as long as they have an AHCCCS registered ID.
3. Please check the FDA web links daily for shortage updates:
 - <https://www.accessdata.fda.gov/scripts/drugshortages/default.cfm>
 - <https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-supplychain-update>

C. Pharmacy Copayments - This section will not be changing.

1. Title XIX Member enrolled in AHCCCS Fee-For-Service do not have copayments for prescription medications.
2. Prior authorization is not required during the Federal emergency period for compounded drugs for children under the age of ten years old.

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AHCCCS Prior Authorization (PA) and Concurrent Review (CR) Standards during COVID-19 Emergency for Fee-for -Service Health Programs

D. Signature Requirements – This section will not be changing during the Federal emergency period.

42 CFR 456.705 and the Arizona State Board of Pharmacy requires that members receive counseling when prescriptions are dispensed. While counseling is still required, the Arizona State Board of Pharmacy has waived the member's signature requirement and will instead allow the pharmacist to enter confirmation that counseling occurred. This will allow members to not have to sign a document and to keep appropriate distance from the counter.

IV. Physical Health Services (Updated 7/2/2021)

A. COVID-19 Testing and Treatment Services

DFSM will not require prior authorization or concurrent review for services related to testing, diagnosis, and/or treatment of COVID-19.

B. Facility Services

DFSM will reinstate prior authorization requirements for the following levels of care, effective 8/1/2021:

- a) Acute Inpatient Hospitalization; and
- b) Inpatient Rehabilitation Facilities (e.g. Long Term Acute Hospitals).

DFSM continues to maintain the temporary removal of prior authorization requirements for the following levels of care:

- a) Assisted Living Facilities/Centers; and
- b) Skilled Nursing Facilities (SNFs).

1. DFSM will remove prior authorization requirements for the following levels of care:

- Acute Inpatient hospitalization;
- Assisted Living Facilities/Centers;
- Skilled Nursing Facilities (SNFs); and
- Inpatient Rehabilitation Facilities (e.g., Long Term Acute Care Hospitals).

2. FFS Providers shall coordinate care management activities to ensure FFS members have safe and effective transitions between levels of care.

3. Prior Authorization approvals for elective inpatient services, which are within 60 days of expiration, may be extended for 6 months, as needed.

C. Outpatient Services

Effective 8/1/2021, DFSM will no longer automatically extend outpatient service prior authorization approvals, which are within 60 days of expiration. Providers are responsible for submitting for prior authorization, when additional prior authorization is needed.

1. DFSM may extend outpatient service prior authorization approvals, which are within 60 days of expiration, for 6 months, as needed.
2. For services related to the COVID-19 emergency, other than testing, diagnosis and treatment, the document submission period for Prior Authorization will no longer be extended to 90 days. COVID-19 testing, diagnosis and/or treatment are exempt from Prior Authorization. Please see IV A.

V. Non-Emergency Medical Transportation (NEMT) Services (Updated 7/2/2021)

Effective 8/1/2021, NEMT providers transporting a member over 100 miles must obtain prior authorization.

1. Prior authorization requirements have been temporarily waived for NEMT services over 100 miles.
2. AHCCCS continues to temporarily waive the requirement for NEMT drivers to collect a passenger's signature, whether on paper or electronically at this time.

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AHCCCS Prior Authorization (PA) and Concurrent Review (CR) Standards during COVID-19 Emergency for Fee-for -Service Health Programs

VI. Home Health Services and Durable Medical Equipment: Face-to-Face Requirement Change

CFR § 440.70 requires that the initiation of home health services and medical equipment and supplies be subject to face-to-face encounter requirements for the FFS population.

Pursuant to section 1135(b)(5) of the Social Security Act, CMS has temporarily approved an extension of the timeline required for completion of the face-to-face requirement.

Effective 6/8/20, through the duration of the emergency, the face-to-face encounter does not need to be completed before the start of services and may occur at the earliest time feasible for a provider, provided that the face-to-face encounter occurs within 12 months from the start of service.

This is a temporary extension of the timeline for completion of the face-to-face requirement, and all services are subject to post-payment review.

VII. COVID-19 Frequently Asked Questions (FAQs)

We encourage everyone to please continue to check the [AHCCCS COVID-19 FAQs](#). The FAQs are updated daily.

Behavioral Health Residential Facility (BHRF) Notification

Effective 4/1/2019, all admissions and continued stays at Behavioral Health Residential Facilities (BHRF) (Provider Type B8) for AIHP and TRBHA members require authorization.

- **NOTE:** Authorization is NOT required for IHS/638 BHRF Facilities.

All new BHRF admissions require notification of admission to AHCCCS for initial coverage of up to 5 days of care. During this initial 5 day time frame, the BHRF will be responsible for submitting an Authorization request and ensuring compliance with criteria listed in [AMPM Policy 320-V – Behavioral Health Residential Facilities](#) and 9 A.A.C. 10.

- If the Authorization request and the supporting admission documentation are not received within the initial 5 day time frame, claims may be denied.

Admission documentation that is required for the Authorization request includes:

1. Behavioral health assessment in compliance with 9 A.A.C. 10, to determine Behavioral Health Condition and Diagnosis. Assessment should be recent, and not older than 1 year. Done by a BHP, or by BHT cosigned by a BHP, utilizing standardized instrument that is able to determine the appropriate level of care.
2. Treatment Plan – completed in compliance with 9 A.A.C. 10 by the Inpatient/Outpatient or TRBHA Treatment Team. 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 plan shall not be older than 3 months from the request submission date.

NOTE: All criteria for admission still must be met from the date of admission.

For members currently in a BHRF, facilities had to submit an authorization request to get the continued stay authorized by 5/31/2019. Criteria for admission and continued stay are detailed in the new [AMPM Policy 320-V – Behavioral Health Residential Facilities](#). Specific authorization submission and documentation procedures will be available on the FFS web page on the AHCCCS web site. Please look for upcoming notifications on training opportunities that will be available on the FFS web page.

Prior Authorization Requests shall be submitted on the AHCCCS Online Provider Portal. Please see: <https://www.azahcccs.gov/PlansProviders/FeeForServiceHealthPlans/PriorAuthorization/submissionprocess.html>

For guidelines related to requirements for prior authorization and its accompanying documentation, please refer to: <https://www.azahcccs.gov/PlansProviders/FeeForServiceHealthPlans/PriorAuthorization/requirements.html>

Behavioral Health Residential Facility (BHRF) Per Diem Rate Information

AHCCCS has received questions regarding what is and what is not included in the per diem rate for Behavioral Health Residential Facilities (BHRFs). The following information can be found in the AHCCCS Medical Policy Manual (AMPM), [Policy 320-V, Behavioral Health Residential Facilities](#).

Care and services provided in a BHRF are based on a **per diem rate (24-hour day)**, require prior and continued authorization and **do not include room and board**.

NOTE: Prior Authorization is *not* required for IHS/638 providers.

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):

Note: 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;

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).

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;
- 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).