437 – FINANCIAL RESPONSIBILITY FOR SERVICES AFTER THE COMPLETION OF COURT ORDERED EVALUATION

EFFECTIVE DATES: 05/01/13, 10/01/15, 07/01/16, 10/01/18, 05/20/20

APPROVAL DATES: 08/29/13, 01/16/14, 05/14/15, 08/01/15, 07/07/16, 01/07/19, 03/05/2020

I. PURPOSE

This Policy applies to ACC, ALTCS E/PD, DES/DDD (DDD), and RBHA Contractors. The purpose of this Policy is to provide clarification regarding financial responsibility for the provision of medically necessary behavioral health services rendered after the completion of a Court Ordered Evaluation (COE).

II. DEFINITIONS

COURT ORDERED EVALUATION (COE) A professional multidisciplinary analysis based on data describing the person's identity, biography, and medical, psychological, and social conditions, as specified in A.R.S. §36-501 and A.R.S. §36-520.

COURT ORDERED TREATMENT (COT) As specified in A.A.C. R9-21-101 and A.R.S. §36-533 et seq, treatment ordered by the Court for an individual to undergo mental health treatment if found to fit one of the following categories as a result of mental disorder:

1. A Danger to Self,
2. A Danger to Others,
3. Gravely Disabled, or
4. Persistently or Acutely Disabled.

EVALUATION AGENCY A health care agency licensed by the Arizona Department of Health Services (ADHS) that has been approved pursuant to A.R.S. Chapter 5 Title 36, providing those services required of such agency

PRE-PETITION SCREENING Pursuant to A.R.S. §36-501, the review of each application requesting COE, including an investigation of facts alleged in such application, an interview with each applicant, and an interview, if possible, with the proposed patient. The purpose of the interview with the proposed patient is to assess the problem, explain the application and, when indicated, attempt to persuade the proposed patient to receive, on a voluntary basis, evaluation or other services.

PRINCIPAL DIAGNOSIS The condition established after study to be chiefly responsible for occasioning the admission or care for the member, (as indicated by the Principal Diagnosis on a UB claim form from a facility or the first-listed diagnosis on a CMS 1500 claim line).

The Principal Diagnosis should not be confused with the admitting diagnosis or any other diagnoses on the claim. Neither the admitting diagnosis nor any other diagnoses on the claim should be used in the assignment of payment responsibility.

III. POLICY

A. COUNTY RESPONSIBILITY

1. Contractors subject to this Policy are responsible for providing medically necessary, covered behavioral health services to enrollees, including services provided pursuant to court ordered involuntary treatment (COT) as specified in A.R.S. §36-533 et seq.

2. AHCCCS Covered Behavioral Health Services are specified in:
   a. AMPM Policy 310-B and AMPM Exhibit 300-2A for the Title XIX/XXI benefit,
   b. AMPM Policy 320-T and AMPM Exhibit 300-2B for the Non-Title XIX/XXI benefit,
   c. AHCCCS Medical Coding Resources webpage,
   d. Behavioral Health Services Matrix (previously the B2 Matrix),
   e. Appropriate AMPM Policies as necessary (e.g. AMPM Policy 310-V, Behavioral Health Residential Facilities).

As a matter of State law A.R.S. §36-545.04, the cost of COE services provided as part of a legal proceeding under A.R.S. §36-520 et seq. (Title 36, Chapter 5, Article 4) is the financial responsibility of the county in which the individual resided or was found (i.e. the county of origin). Under A.R.S. §36-545.06, the cost of Pre-Petition Screening and COE is a county responsibility unless the county has an agreement with AHCCCS under A.R.S. §36-545.07 to provide those services for the county. If such an agreement exists, the RBHA Contract will include those services within the scope of the RBHA's responsibilities.

For RBHAs contracted directly with a county for COE services or contracted indirectly with a county through AHCCCS for COE services, the RBHA should not use Title XIX/XXI funding for COE.

B. DETERMINING WHEN COUNTY RESPONSIBILITY ENDS

1. For any member who has been admitted to an Evaluation Agency for COE, the evaluation period is deemed to end when one of the following occur:
   a. Petition for COT is filed with the court,
   b. Individual agrees to voluntary treatment, or
   c. Individual is released from COE.

Meeting any of these conditions does not always indicate that the person is no longer physically at the location at which the evaluation occurred.

2. The date on which one of the three actions occurs: petition for COT is filed with the court, the individual agrees to voluntary treatment, or the individual is released from COE is the day the member's Contractor of enrollment assumes responsibility for payment if it is a covered service. County payment responsibility ends that day, and transfers to the Title XIX/XXI Contractor of enrollment who shall pay for all Title XIX/XXI medically necessary services thereafter, including services associated with the period of time between the filing of the Petition for COT and the hearing set for the purposes of a judicial determination for the need for COT. If the member is Non-Title XIX/XXI, the Non-Title XIX/XXI Contractor of enrollment shall pay for medically necessary services if they are covered by the Contractor's available Non-Title XIX/XXI funding sources. Refer to AMPM Policy 320T-1, AMPM Policy 320T-2 and AMPM Exhibit 300-2B.

3. The fact that the member is not voluntarily participating in treatment is not, in and of itself, a factor in the determination of medical necessity. The refusal of a member to accept services is not, in and of itself, a factor in determining the medical necessity of the service, responding to a prior authorization request, or adjudicating the claim.

C. FINANCIAL RESPONSIBILITY FOR SERVICES AFTER THE COMPLETION OF COURT ORDERED EVALUATION

The Contractor of enrollment shall accept and process timely claim submissions for covered medically necessary services for all enrolled members receiving COE services in inpatient and outpatient settings for time periods that are not the county's responsibility.

For COEs that do not require an inpatient stay, any medically necessary physical health services provided to the individual shall be the responsibility of the Title XIX/XXI Contractor of enrollment.

Outpatient behavioral health services separate from the COE services, such as case management, that are covered for enrolled members shall continue to be paid by the Contractor of enrollment with Title XIX/XXI funding, or available Non-Title XIX/XXI funding if a Non-Title XIX/XXI member, during the COE time period.

Payment responsibility for a member that is determined to have an SMI during a COE/COT inpatient stay is based on the principal diagnosis. If the stay has a principal diagnosis of behavioral health, and is thus reimbursed at a daily rate, the per-diem claim shall be able to be split between the two AHCCCS payers for the time the member is designated GMH/SU and for the time the member is determined SMI, as indicated on the 834 Enrollment Notifications file sent to the Contractors. If the stay has a principal diagnosis of physical health, for a provider type 02, the APR-DRG policy rules apply and the payer for the claim is the Contractor of enrollment as of the discharge date.