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10/1/2017; 09/17/2015; 07/15/2014

Important Notice:

In 2019, information contained within the AHCCCS Covered Behavioral Health Services Guide (CBHSG) will be transitioned into the following areas:

- AHCCCS Medical Policy Manual ([AMPM Policy 310-B, Behavioral Health Services Benefit](#))
 - Title XIX/XXI benefit information.
- [AMPM Policy 320-T, Non-Title XIX/XXI Behavioral Health Services](#)
 - Non-Title XIX/XXI service information.
- Appropriate AMPM Policies as necessary, including:
 - [AMPM Policy 310-BB, Transportation](#); and
 - [AMPM Policy 320-V, Behavioral Health Residential Facilities \(BHRFs\)](#).
- The Fee-For-Service (FFS) and IHS/Tribal Provider Billing Manuals
 - [Chapter 19, Behavioral Health Services, FFS Provider Billing Manual](#)
 - Behavioral Health services billing information for FFS Providers
 - **Note:** Billing information in the FFS Provider manual is primarily directed to FFS providers; however, the general billing information not identified as specific to FFS providers may also be referred to by ACC (MCO) providers. For FFS Providers, any billing information noted as specific to ACC (MCO) only does not apply to FFS.
 - [Chapter 12, Behavioral Health Services, IHS/Tribal Provider Billing Manual](#)
 - Behavioral Health services billing information for IHS/Tribal Providers.

For providers serving AIHP/FFS members, the DFSM Provider Training team can be reached at ProviderTrainingFFS@azahcccs.gov.¹ If there are claims questions regarding TRBHA or Tribal ALTCS, please contact DFSM.

Providers serving MCO plan members should refer to the enrolled MCO plan billing manual, and/or contact the MCO plan directly for billing related questions.

The above resources are designed to guide a provider through the following questions:

¹ Adding for clarification regarding the transition of information from the CBHSG.

- Who can provide covered behavioral health services?
- What behavioral health services are covered?
- When can covered behavioral health services be provided and for how long (duration)?
- Where can covered behavioral health services be provided?
- Why behavioral health services are necessary (medical necessity)?

Behavioral Health Services

The covered services, limitations, and exclusions described are global in nature and are listed in this chapter to offer general guidance to providers. Specific information regarding covered services, limitations, and exclusions can be found in the AHCCCS Medical Policy Manual (AMPM), AHCCCS Administrative Code A.A.C. R9-28-201 et seq., and R9-22-201 et seq. The AHCCCS Medical Policy Manual (AMPM) is available on the AHCCCS website at www.azahcccs.gov.

AHCCCS covered behavioral health services include, but are not limited to:

- Inpatient hospital services
- Behavioral Health Inpatient Facilities (BHIF)
- Behavioral Health Residential Facilities (BHRF)
- Partial care (supervised day program, therapeutic day program, medical day program)
- Individual therapy and counseling
- Group and/or family therapy and counseling
- Emergency/crisis behavioral health services
- Behavior management (behavioral health personal assistance, family support, peer support)
- Evaluation and diagnosis
- Psychotropic medication, including adjustment and monitoring of medication
- Psychosocial Rehabilitation (living skills training; health promotion; pre-job training, education and development; job coaching; and employment support)
- Laboratory and Radiology Services for medication regulation and diagnosis
- Screening
- Case Management Services

- Emergency Transportation
- Non-Emergency Transportation
- Respite Care (with limitations)
- Therapeutic foster care services

Additional information can be found out about the following covered behavioral health services in [AMPM 310-B, Title XIX/XXI Behavioral Health Services Benefit](#):

- Treatment Services
 - Assessment, Evaluation and Screening Services
 - Behavioral Health Counseling and Therapy
 - Other Professional Services
- Rehabilitation Services
 - Skills Training & Development and Psychosocial Rehabilitation Living Skills Training
 - Cognitive Rehabilitation
 - Behavioral Health Prevention/Promotion Education and Medication Training and Support Services (Health Promotion)
 - Psychoeducational Services and Ongoing Support to Maintain Employment
- Medical Services
 - Medication Services
 - Laboratory, Radiology, and Medical Imaging
 - Medical Management
 - Interventional Psychiatry
- Support Services
 - Case Management
 - Personal Care Services
 - Home Care Training Family (Family Support)
 - Self-Help/Peer Services (Peer Support)
 - Therapeutic Foster Care (TFC)
 - Unskilled Respite Care
- Behavioral Health Day Programs
 - Supervised
 - Therapeutic
 - Community Psychiatric Supportive Treatment
- Behavioral Health Residential Services

- Crisis Intervention Services
 - Telephonic Crisis Intervention Services
 - Mobile Crisis Intervention Services
 - Facility-Based Crisis Intervention Services
- Inpatient Services
 - Hospital
 - Behavioral Health Inpatient Facilities (BHIF)²

Members Enrolled in an Integrated Health Plan for Physical and Behavioral Health Services

On October 1, 2018, AHCCCS integrated acute physical and behavioral health services for most members. This is referred to as AHCCCS Complete Care (ACC).

Title XIX and Title XXI (KidsCare) members are eligible to receive behavioral health services through their integrated health plan. American Indian/Alaskan Native (AI/AN) members may choose the American Indian Health Program (AIHP); or AIHP and a Tribal Regional Behavioral Health Authority (TRBHA), if a TRBHA is available in their area; or an AHCCCS Complete Care (ACC) Health Plan.

AIHP is an integrated Fee-For-Service (FFS) program administered by AHCCCS for eligible American Indians, which reimburses for both physical and behavioral health services, including Children's Rehabilitative Services (CRS), provided by and through the Indian Health Services (IHS), tribal health programs operated under 638, or any other AHCCCS registered provider.

AI/AN members who enroll with AIHP for their physical health services also receive their behavioral health services through AIHP, or may choose to receive their behavioral health services through a TRBHA, if a TRBHA is available in their area.

The ACC plan, AIHP or AIHP/TRBHA is responsible for the payment of *both* physical and behavioral health services, including CRS services. (For exceptions, see Benefit Coordination for Members Enrolled with Different Entities for Physical and Behavioral Health Services, below.)

Claims for *both* physical and behavioral health services, including CRS services, should be sent to the member's integrated health plan*. Integrated health plans include:

^{2 2} Transitioned from CBHSG/310-B.

- ACC health plans,
- AIHP, and
- AIHP/TRBHA.

Claims for AIHP and TRBHA members should be sent to AHCCCS DFSM.

* Claims for services provided for Title XIX members through IHS or Tribal 638 facilities should be sent to AHCCCS DFSM.

Claims for services provided for Title XXI (KidsCare) members through IHS/638 facilities should be sent to the enrolled ACC plan, or to AHCCCS DFSM for AIHP enrolled members.

ALTCS/Tribal ALTCS EPD

MCO ALTCS and Tribal ALTCS Elderly and Physically Disabled (EPD) plans are integrated long term care services plans that reimburse for both physical and behavioral health services, including CRS services.

Tribal ALTCS Programs provide case management services to American Indians who reside on reservation. Members enrolled with Tribal ALTCS Programs may receive behavioral health services on a Fee-For-Service basis from any AHCCCS registered Fee-For-Service provider, with prior authorization from the tribal case manager.

Claims for Tribal ALTCS members should be sent to AHCCCS DFSM.

Additional information on behavioral health services for Tribal ALTCS members can be found in AMPM 1620-G, Behavioral Health Standards.

Note: For Tribal ALTCS members with an AHCCCS ID card, the member ID card may state the Tribal ALTCS Program the member is enrolled in, however, claims should still be submitted to AHCCCS DFSM.

Benefit Coordination for Members Enrolled with Different Entities for Physical and Behavioral Health Services

This section assists Fee-for-Service providers in benefit coordination and in determining financial responsibility for AHCCCS covered physical and behavioral health services for members enrolled with **different entities** for their physical and behavioral health services. These members include:

- ALTCS members enrolled with DES/DDD;
- Foster care children enrolled with the Comprehensive Medical Dental Program (CMDP); and

- Adults with a Serious Mental Illness (SMI) designation.

Behavioral Health services for the above members are provided through the RBHAs or TRBHAs.

For the above members enrolled with different entities for their physical and behavioral health services, payment is determined by the principal diagnosis appearing on the claim, except in limited circumstances as described in ACOM Policy 432, Attachment A - Matrix of Financial Responsibility.

Definitions

For definitions regarding behavioral health services and practitioners, please see AMPM 310-B, Behavioral Health Services Benefit.

Behavioral health diagnoses can be located in the AHCCCS Outpatient Behavioral Health Diagnosis List available on the AHCCCS website.

Behavioral Health Entity

For members enrolled with different entities for their physical and behavioral health services, the Behavioral Health Entity is the payer of behavioral health services.

Behavioral Health Entities can be one of the following:

- Regional Behavioral Health Authority (RBHA); or
- Tribal Regional Behavioral Health Authority (TRBHA)

Enrolled Health Plan

For members enrolled with different entities for their physical and behavioral health services, the Enrolled Health Plan is the payer of physical health services.

- For members who elect AIHP, the enrolled health plan is AIHP. This includes AIHP members with or without a CRS designation.
- For members who elect an ACC plan, the enrolled health plan is the [ACC plan](#).
- For members enrolled in DDD, the enrolled health plan is DDD. This includes DDD members with or without a CRS designation.
- For members enrolled in CMDP, the enrolled health plan is CMDP. This includes CMDP members with or without a CRS designation.
- For members with an SMI designation who elect a TRBHA or non-integrated RBHA for behavioral health services, the enrolled health plan is the elected ACC plan or AIHP.

Principal Diagnosis

The condition established to be chiefly responsible for occasioning the admission or care for the member, as indicated by the principal diagnosis on a UB-04 claim form from a facility, or the first-listed diagnosis on a CMS 1500 claim form.

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

Payment Responsibility for Members Enrolled with Different Entities for their Physical and Behavioral Health Services

Payment for AHCCCS covered services for members enrolled with different entities for their physical and behavioral health services is determined by the principal diagnosis appearing on the claim, except in limited circumstances. Benefit coordination and financial responsibilities for AHCCCS covered behavioral health services can be found in the AHCCCS Contractor Operations Manual (ACOM) Policy 432, Attachment A, Matrix of Financial Responsibility. ACOM is available online at:

<https://www.azahcccs.gov/shared/ACOM/>

For further information on requirements for providers in determining payment responsibility and a member's eligibility, please refer to AMPM Chapter 650, Behavioral Health Provider Requirements for Assisting Individuals with Eligibility Verification and Screening/Application for Public Health Benefits.

Inpatient Facility Payment Responsibility

Facility Claims

1. If the principal diagnosis on the claim is a behavioral health diagnosis, then payment of the facility claim is the responsibility of the behavioral health entity for both behavioral and physical health services.
2. If the principal diagnosis on the claim is a physical health diagnosis, then payment of the facility claim is the responsibility of the enrolled health plan for both behavioral and physical health services.
3. When the principal diagnosis on an inpatient claim is a behavioral health diagnosis, the assigned behavioral health entity shall not deny payment of the inpatient facility claim for lack of authorization or medical necessity when the member's enrolled health plan authorized and/or determined medical necessity of the stay, such as when the admitting diagnosis is a physical health diagnosis.

4. The enrolled health plan must coordinate with the assigned behavioral health entity when both physical and behavioral health services are rendered during an inpatient stay. The enrolled health plan must be notified of the stay. Such coordination shall include, but is not limited to, communication/collaboration of authorizations and determinations of medical necessity.

Professional Claims

1. Payment responsibility for professional services associated with an inpatient stay is determined by the principal diagnosis on the professional claim.
2. Payment responsibility for the inpatient facility claim and payment responsibility for the associated professional services is not necessarily the same entity.
3. Payment of the professional claim shall not be denied by the responsible entity due to lack of authorization/notification of the inpatient stay regardless of the entity that authorized the inpatient stay.

Emergency Department Payment Responsibility

Facility Claims

1. Payment of a facility claim for an emergency department visit, not resulting in an inpatient admission, is the responsibility of the enrolled health plan regardless of the principal diagnosis on the facility claim.

Professional Fees

1. Payment responsibility for professional services associated with the emergency department visit is determined by the principal diagnosis on the professional claim.
2. Payment responsibility for the emergency department visit and professional services may not necessarily be the same entity.
3. Payment of the professional claim shall not be denied by the responsible entity due to lack of authorization/notification of the emergency department visit.

Primary Care Provider Payment Responsibility

The enrolled health plan is responsible for reimbursement of services associated with a primary care provider visit, when behavioral health services are provided by a PCP within their scope of practice, including professional fees, related prescriptions, laboratory and other diagnostic tests.

The primary care providers who treat members with these behavioral health conditions may provide medication management services including prescriptions, laboratory, and other diagnostic tools necessary for diagnosis and treatment.

Clinical tool kits for the treatment of anxiety, depression, postpartum depression, and ADHD are available in Appendix F, Adult Behavioral Health Tool Kits of the AMPM.

The enrolled health plan is responsible for payment of medication management services provided by the primary care provider, while the member may simultaneously be receiving counseling and other medically necessary rehabilitative services from the assigned behavioral health entity.

Note: For Tribal ALTCS members with an AHCCCS ID card, the member ID card may state the Tribal ALTCS Program the member is enrolled in, however, claims should still be submitted to AHCCCS DFSM.

Transportation Payment Responsibility

When the enrolled health plan is ACC or AIHP and the member is assigned to a RBHA, the enrolled health plan is responsible for payment of medically necessary transportation services (emergent and non-emergent) when the diagnosis code on the claim is for physical health, regardless of which entity scheduled the appointment.

There are unspecified diagnoses designated for physical health (R68.89) and behavioral health (F99).

These unspecified diagnoses, when permitted, will tell the system who is the responsible payer. If a member is enrolled with a RBHA and submits a claim to AHCCCS with the unspecified diagnosis code F99, the claim may deny since the claim would need to be sent to the RBHA.

Additional Information

For further information regarding payment responsibility for transportation, outpatient services, physician services, and therapies associated with behavioral health, or for additional information on inpatient and emergency department payment responsibilities, please see ACOM Policy 432 Attachment A, the Matrix of Financial Responsibility by Responsible Party Matrix.

https://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/400/432_Attachment_A_Matrix_of_Financial_Responsibility_by_Responsible_Party.pdf

All AHCCCS services must be medically necessary, cost effective, and federally and state reimbursable. For specific information on inpatient reimbursement rates refer to A.A.C. R9-22-712 et seq.

For additional information on Tribal ALTCS Members see Chapter 12, Behavioral Health Services, of the IHS/Tribal Provider Billing Manual.³

General Billing Information

The following sections detail general and specific billing information pertaining to behavioral health service categories and subcategories. The billing information applies to both FFS programs and to plans administered by a Contractor, such as the AHCCCS Complete Care (ACC) health plans.

For additional information about these services, refer to AMPM 310-B, Behavioral Health Services.⁴

What is the Behavioral Health Matrix?

The AHCCCS Behavioral Health Matrix is a searchable crosswalk of behavioral health service codes. It can be searched by Provider Type, Code, and Modifier. Each searchable category has an individual tab.

Once a search has been done under one of the Provider Type, Code, or Modifier tabs, the list of available behavioral health-related codes will be viewable. The user can further narrow the selection by Code, Description, Category of Service (COS), Modifier, and Place of Service (POS)/Bill Type. This is done by using the filter option at the top of each column.

- i.e. An MD clicks on the Provider Type tab. They may select (in the upper right hand corner within the gold box) their Provider Type (08 MD-Physician).

The spreadsheet will populate a list of Codes that can be potentially billed by this Provider Type, along with the corresponding descriptions of the Codes. The COS and Modifiers, along with the POS/Bill Types, where these Codes can potentially be used, will also auto-populate. The provider can then filter within these columns as needed.

The Behavioral Health Matrix also offers a Definitions tab, which lists the available Bill Types, Categories of Service (COS), Places of Service (POS) and Modifiers that can be used when billing for behavioral health services.

³ Referencing where information is contained.

⁴ Adding for clarity

NOTE: All applicable coding standards and requirements, including scope of practice guidelines, supersede the Behavioral Health Matrix. The Behavioral Health Matrix is intended to be a reference document and is subject to change.

Coding & Common Modifiers for the Billing of Behavioral Health Services

Providers are required to utilize national coding standards when utilizing HCPCS, CPT, and UB-04 revenue codes.⁵

Providers are required to use the applicable modifier(s). For HCPCS and coding modifiers that contain additional AHCCCS policy requirements, they are described in each applicable section throughout this Policy.⁶

For additional information on all applicable Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), and Uniform Billing Revenue codes in each of these categories/subcategories, and for additional information on⁷ modifiers please reference the Behavioral Health Services Matrix at:

[https://www.azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/Appendix B2.xls](https://www.azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/AppendixB2.xls).

The AHCCCS Behavioral Health Services Matrix is searchable by Provider Type, Code and Modifier. The AHCCCS Behavioral Health Services Matrix does not take the place of the requirements within the AHCCCS PMMIS system.⁸

ICD Diagnostic Codes

For outpatient behavioral health services, services are considered medically necessary regardless of a member's diagnosis, so long as there are documented behaviors and/or symptoms that will benefit from behavioral health services and a valid ICD-10-CM diagnostic code is utilized. For a complete list of ICD-10-CM codes that can be utilized, refer to the AHCCCS Behavioral Health Diagnosis List on the AHCCCS website. For inpatient and residential (BHRF) treatment services, a valid ICD-10-CM Mental, Behavioral, or Neurodevelopmental Disorder (F01-F99) diagnosis is required.⁹

Place of Service

⁵ Transitioned from CBHSG/310-B.

⁶ Transitioned from CBHSG/310-B.

⁷ Transitioned from CBHSG/310-B.

⁸ Adding for clarity and transitioned from CBHSG/310-B.

⁹ Transitioned from CBHSG/310-B..

A Place of Service (POS) code indicates where a service is provided. POS codes must be submitted on both claims and encounters.¹⁰

To determine which places of service codes are available with specific service codes, please reference the Behavioral Health Services Matrix at:
<https://www.azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/AppendixB2.xls>

Behavioral Health Day Program

Behavioral health day programs provide services scheduled on a regular basis and are billed hourly, as a half day, or a full day.

School attendance and education hours are not included as part of this service and may not be provided simultaneously with this service. Meals are included in the rate and should not be billed separately.¹¹¹²

Three types of behavioral health day programs are discussed below:

- Supervised
- Therapeutic
- Community Psychiatric Support Treatment

Supervised

H2012 -- Behavioral Health Day Treatment (Supervised):

- Billing Unit: Per hour
- Per hour, up to 5 hours in duration
- H2012 shall not be billed with H0036 or H2015

H2015 – Comprehensive Community Support Services (Supervised Day Program):

- Billing Unit: Per 15 minutes
- Greater than 5 hours, up to 10 hours in duration
- H2015 shall not be billed with H2012, H2016, or H0036

H2016 – Comprehensive Community Support Services (peer support).

- Billing Unit: Per Diem

¹⁰ Adding from CBHSG.

¹¹ Transitioned from CBHSG/310-B.

¹² Added disallows for day programs (bullets below provides disallow info)

- H2016 shall not be billed with H0038

Therapeutic

H2019 – Therapeutic Behavioral Services: See general definition above.

- Billing Unit: 15 minutes
- Up to 5 ¾ hours in duration
- H2019 shall not be billed with H2020, H2015, H2012 or H0036

H2019 TF – Therapeutic Behavioral Services:

- Billing Unit: 15 minutes
- Up to 5 ¾ hours in duration
- The TF modifier is required for an intermediate level of care. The TF modifier is used to allow RBHAs to contract for an intermediate level of service (e.g., clients needing more intensive supervision, a sitter and/or 1:1 staffing).

H2016 – Comprehensive Community Support Services (peer support).

- Billing Unit: Per Diem
- H2016 shall not be billed with H0038

H2020 – Therapeutic Behavioral Services:

- Billing Unit: Per Diem
- H2020 shall not be billed with H2015, H2012, or H0036
- NOTE: A registered nurse who supervises therapeutic behavioral health services and day programs using the per diem codes may not bill this function separately. Employee supervision has been built into the procedure code rates.

Community Psychiatric Supportive Treatment

H0036– Community Psychiatric Supportive Treatment, face-to-face:

- Billing Unit: 15 minutes
- H0036 may not be billed with H0037, H2015, or H2012

H0036 TF– Community Psychiatric Supportive Treatment, face-to-face:

- Billing Unit: 15 minutes
- ****TF modifier required for intermediate level of care****
The TF modifier is used to allow RBHAs to contract for an intermediate level of service (e.g., clients needing more intensive supervision, a sitter and/or 1:1 staffing).

H0037– Community Psychiatric Supportive Treatment Program:

- Billing Unit: Per Diem
- H0037 may not be billed with H2012, H0036, or H2015¹³

Behavioral Health Professionals & Independent Billers

AHCCCS *does* register Behavioral Health Independent Billers¹⁴.

For additional information regarding BHPs, including the definition of a BHP, refer to AMPM Policy 310-B, Behavioral Health Services.

Behavioral Health Services provided by Behavioral Health Technicians (BHTs) or Behavioral Health Paraprofessionals (BHPPs)

Behavioral Health Technicians (BHTs) and Behavioral Health Paraprofessionals (BHPPs), who provide services in the public behavioral health system, must be clinically supervised by a Behavioral Health Professional (BHP).

For BHPs who clinically supervise BHTs/BHPPs, the service code incorporates the clinical supervision component; thus, clinical supervision is not a separately billable service.

For services provided by a BHT or BHPP supervised by a BHP, the rendering provider should be listed as the supervising BHP.

- For example, for a Provider Type 87 Licensed Professional Counselor (LPC) employed by a Provider Type Integrated Clinic (IC), and who is functioning as a BHP who supervises BHTs, the rendering provider would be listed as the LPC and the billing provider would be listed as the IC.¹⁵

For additional information on BHTs and BHPPs refer to the definitions in AMPM Policy 310-B, Behavioral Health Services. For information on BHTs and BHPPs operating at an IHS or 638 facility please refer to Chapter 12, Behavioral Health Services, of the IHS-Tribal Provider Billing Manual.

Behavioral Health Residential Facility (BHRF)

Care and services provided in a BHRF (Provider Type B8) are based on a per diem rate (24-hour day) and do not include room and board. Effective 4/1/2019, all admissions and continued stays at a BHRF require authorization.¹⁶ All new BHRF admissions will require

¹³ Transitioned from CBHSG/310-B.

¹⁴ Transitioned from Appendix A-3 of the CBHSG.

¹⁵ Transitioned from CBHSG/310-B

¹⁶ PA requirement addressed

notification of admission to AHCCCS for FFS members (AIHP, TRBHA, Tribal ALTCS), 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 320-V, Behavioral Health Residential Facilities.¹⁷ Criteria for admission and continued stay will also be detailed in AMPM 320-V, BHRF. For information on prior authorization requirements for FFS members refer to the FFS web page.

- **NOTE: Authorization is not required for IHS 638 Behavioral Health Residential Facilities.**

The BHRF per diem rate is billed with HCPCS H0018.

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):
 - i. 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

¹⁷ Referencing AMPM policy on BHRF

- vii. Personal Care Services (see additional licensing requirements in A.A.C. R9-10-702, R9-10-715, R9-10-814).

For additional information regarding BHRFs refer to [AMPM Policy 320-V, Behavioral Health Residential Facilities](#).¹⁸

Case Management

Case Management (provider level) is a supportive service provided to improve treatment outcomes.¹⁹

Coding Units

For case management services (T1016), with billing units of 15 minutes, the first unit of service can be encountered/billed when 1 or more minutes are spent providing the service.

To encounter/bill an additional unit of the service, the provider must provide service for at least one half of the billing unit's time frame for the additional unit to be encountered/billed. If less than one half of the additional billing unit is spent providing the service, then only the initial unit of service can be encountered/billed.²⁰

Modifiers

For provider case management used to facilitate a Child and Family Team (CFT), the modifier U1 is required.²¹

For provider case management utilized when assisting members in applying for Social Security benefits (using the SSI/SSDI Outreach, Access, and Recovery (SOAR) approach) the modifier HK is required.²² Billing T1016 with an HK modifier indicates the specific usage of the SOAR approach and it cannot be used for any other service.²³

Case Management Limitations:

- i. Billing for case management is limited to providers who are directly involved with providing services to the member.
- ii. Provider Case Management is not a reimbursable service for ALTCS E/PD, including Tribal ALTCS. Case Management is provided through the ALTCS E/PD Contractors or Tribal ALTCS Program.
- iii. Provider Case management services provided by licensed inpatient, residential (BHRF) or day program providers are included in the rate for

¹⁸ Transitioned from CBHSG/310-B.

¹⁹ Adding from 310-B and CBHSG Appendix A-3 to provide additional clarity.

²⁰ Transitioned from CBHSG/310-B.

²¹ U1 modifier – effective for DOS 10-1-18 and after

²² T1016 HK modifier for SOAR – effective for DOS 10-1-18 and after

²³ Transitioned from CBHSG/310-B.

- these settings and cannot be billed separately. However, providers other than the inpatient, residential (BHRF) facility or day program can bill case management services provided to the member.
- iv. A single practitioner²⁴ may not bill case management simultaneously with any other service.
 - v. For assessments,²⁵ the provider may bill all time spent in direct or indirect contact (e.g. indirect contact may include email or phone communication specific to a member's services) with the member and other involved parties involved in implementing the member's Treatment/Service Plan.²⁶
 - vi. More than one provider agency may bill for case management at the same time, as long as it is clinically necessary *and* documented within the member's Treatment/Service Plan.
 - vii. More than one individual within the same agency may bill for case management at the same time, as long as it is clinically necessary *and* documented within the member's Treatment/Service Plan.
 - viii. When a provider is picking up and dropping off medications for more than one member, the provider shall divide the time spent and bill the appropriate case management code for each involved member.
 - ix. Written electronic communication (email) is an allowable method for providing case management services with the following requirements:
 - The email must be addressing a specific member's service needs, and
 - A copy of the email communication shall be included in the member's medical record.
 - x. SOAR services shall only be provided by staff who have been certified in SOAR through the SAMHSA SOAR Technical Assistance Center. Additionally, when using the SOAR approach, billable activities do not include:
 - Completion of SOAR paperwork without member present,
 - Copying or faxing paperwork,
 - Assisting members with applying for benefits without using the SOAR approach, and
 - Email.²⁷

Indirect Contact

With the exception of case management and assessment services, the provider may not bill any time associated with indirect contact with the member (e.g. email or phone communication specific to a specific member's services²⁸, obtaining collateral information,

²⁴ Changed to practitioner to clarify that this does not mean a provider agency

²⁵ Transportation requirements are in Policy 310-BB

²⁶ Removed listing – indirect contact is described prior

²⁷ Transitioned from CBHSG/310-B.

²⁸ Clarification included on use of Indirect Contact

picking up and delivering medications) as these activities are included in the rate calculation.²⁹

Crisis Services

A crisis is any situation in which a person's behaviors put them at risk of hurting themselves and/or others, and/or when they are not able to resolve the situation with the skills and resources available to them. Persons in a crisis present with sudden, unanticipated, or potentially dangerous behavioral health conditions, episodes or behaviors.

Crisis services include mobile team services, telephone crisis response, and urgent care inpatient services including those provided at a hospital, sub-acute and/or residential treatment center. Crisis stabilization services will continue to include related transportations and facility charges.

Crisis services for American Indian/Alaskan Native (AI/AN) members enrolled in either an ACC health plan or AIHP are the responsibility of the Regional Behavioral Health Authority (RBHA).

Note: Integration began on 10/1/2018, and there was no change in crisis services for Title XIX and XXI members. RBHAs will continue to serve the same geographic service areas that they served prior to 10/1/2018.

For members enrolled with an ACC plan or AIHP, the first 24 hours of crisis services should be billed to the RBHA located in the RBHA GSA where the crisis occurred. Services up to and including the fifth hour should be billed using the hourly code S9484. Services over the fifth hour, up to and including the 24th hour, should be billed per diem using S9485.

After the first 24 hours (i.e. the 25th hour forward) crisis services should be billed to the member's health plan (ACC or AIHP). Services up to and including the fifth hour should be billed using the hourly code S9484. Services over the fifth hour, up to and including the 24th hour, should be billed per diem using S9485.

In situations where the crisis services overlap days, the per diem code can span the two dates. The crisis provider would bill the first per diem as described above the dates of service 1 and 2, and the second per diem for dates of service 2 and 3, if applicable. The crisis provider may also bill hourly as described above, if applicable, in addition to the per diem.

The Contractor or AIHP is responsible for payment of³⁰ care coordination and medically necessary covered services (which may include follow up stabilization services) post-24

²⁹ Transitioned from CBHSG/310-B

³⁰ Distinction added.

hours; the RBHA will remain responsible for any costs associated with follow up phone calls related to the crisis episode post-24 hours.³¹

For further information regarding what services are considered a crisis service and when the RBHA and ACC health plan or AIHP are responsible for payment, please see Exhibit 12-1, Matrix of Financial Responsibility for Crisis Services.

Example 1: Crisis services were initiated at 3 p.m. on October 8th (Monday – Day 1) and ended at 6 p.m. on October 9th (Tuesday – Day 2).

- Billing for Day 1 (the first 24 hours):
 - The per diem code should be billed once to the RBHA for the first 24 hour time frame. This date span is from 3 p.m. on October 8th (Monday – Day 1) to 2:59 p.m. on October 9th (Tuesday – end of the first 24 hour time frame).
- Billing for the first 3 hours of Day 2:
 - An hourly rate for 3 hours (from 3 p.m. to 6 p.m.) should be billed to AIHP. This covers the 3 hours beyond the 24th hour on October 9th (from 3 p.m. to 6 p.m.).

Example 2: Crisis services were initiated at 3 p.m. on October 8th (Monday – Day 1) and ended at 11 p.m. on October 9th (Tuesday – Day 2).

- Billing for Day 1 (the first 24 hours):
 - The per diem code should be billed once to the RBHA for the first 24 hour time period. This date span is from 3 p.m. on October 8th (Monday – Day 1) to 2:59 p.m. on October 9th (Tuesday – end of the first 24 hour time frame).
- Billing for Day 2:
 - “Day 2” started at 3 p.m. on October 9th. Since crisis services extended beyond the 5th hour of Day 2, the provider should bill the per diem to AIHP.

For mobile services, H2011 should be used and the HT modifier added for the two-person multi-disciplinary team.

Telephonic Crisis Intervention Services (Telephone Response)

- Telephonic crisis intervention services must be billed utilizing the appropriate case management service code.³²

Mobile Crisis Intervention Services (Mobile Crisis Teams)

- Mobile crisis services provided by fire, police, EMS, and/or other providers of public health and safety services or in jails are not Title XIX/XXI reimbursable.³³

³¹ Clarifying responsibility post the initial 24 hour time frame.

³² Clarifying responsibility post the initial 24 hour time frame.

³³ Clarifying responsibility post the initial 24 hour time frame.

Facility-Based Crisis Intervention Services

- Facility-based crisis intervention services are limited to up to 24 hours per episode. After 24 hours the member, depending on their discharge plan, must be transferred and/or admitted to a more appropriate setting for further treatment (e.g. inpatient hospital, BHIF, respite) or sent home with arrangements made for follow-up services, if needed (e.g. prescription for follow-up medications, in-home stabilization services).

If a member receives facility-based crisis intervention services at an inpatient hospital or through a BHIF observation/stabilization service, and the member is subsequently admitted to an inpatient hospital within the same 24 hour time frame, codes S9484 or S9485 cannot be billed within the same 24 hour time frame, as the inpatient rate is inclusive of this service.

A single provider cannot bill both codes in the first 24 hours of a crisis episode, for the same member.

S9484 – The billing unit is one hour and may only be billed if the services delivered are 5 hours or less in duration within a single crisis episode.

S9485 – The billing unit is per diem and may only be billed if the service duration is more than 5 hours in a single crisis episode. The claim should be billed to the RBHA based on the expectation that this service be limited to 24 hours in duration which supports up to one per diem unit be billed.

The ACC Plan or other Contractor of enrollment may be billed using either code for services provided to members awaiting an inpatient placement after 24 hours in the crisis stabilization.³⁴

Medical supplies and meals provided to a member while in a facility-based crisis intervention setting are included in the rate and should not be billed separately. The following services are not included in the facility-based crisis intervention services rate and can be billed separately: medications, laboratory and radiology services.³⁵

Emergent and non-emergent medical transportation from the Crisis Observation and Stabilization Unit to another level of care or other location shall be the responsibility of the ACC, CMDP, DDD, EPD Contractors or AIHP, regardless of the timing within the crisis episode.

³⁴ Added from Crisis FAQ

³⁵ Rates clarification.

Generally, the ACC, CMAP, DDD, EPD Contractors or AIHP is responsible for covering transportation to and from providers for services which are their responsibility. Transportation during a crisis episode to a crisis service provider will be the responsibility of the RBHA. Transportation services provided to the individual receiving the crisis intervention services is not included in the rate and should be billed separately using the appropriate transportation procedure codes.³⁶

For additional information on crisis services please visit the Crisis Services FAQs on the AHCCCS website at:

https://www.azahcccs.gov/AHCCCS/Downloads/ACC/View_Crisis_System_FAQs.pdf

COE/COT: Pre-Petition Screening, Court Ordered Evaluations, and Court Ordered Treatment

At times it may be necessary to initiate civil commitment proceedings to ensure the safety of a person, or the safety of other persons, due to a person's mental disorder when that person is unable or unwilling to participate in treatment. For specific information pertaining to the pre-petition screening that examines the person's mental status please refer to AMPM 320-U.

Financial responsibility for the cost of legal proceedings, the pre-petition screening, and the court-ordered evaluation related to civil commitment proceedings is the responsibility of the county, unless the county has an agreement with AHCCCS to provide those services. For specific information pertaining to such agreements and financial responsibility please see ACOM 437. For specific policy information pertaining to court ordered evaluations and treatments please refer to AMPM 320-U.

Services are no longer the county's responsibility after the earliest of the following events:

- The member decides to seek treatment on a voluntary basis,
- A petition for court ordered treatment is filed with the court, or
- The member is released following the evaluation.

Court ordered treatment or voluntary treatment, following one of the above events, should be billed to the entity responsible for reimbursement of the member's behavioral health services.

During the pre-petition screening and court-ordered evaluation process, the member's enrolled entity is responsible for those medically necessary, covered behavioral health services that are not associated with the pre-petition screening and court-ordered

³⁶ Clarifying transportation payment responsibility.

evaluations. Services that are Medicaid covered for an enrolled member, separate from the pre-petition screening and court-ordered evaluation services, such as case management, may also be paid with Title XIX or Title XXI funding. Physical health services provided during the court-ordered evaluation process remain with the member's enrolled entity, and are not the responsibility of the county.

Preparation of a report on the member's psychiatric status for primary use within the court is not a Title XIX or Title XXI reimbursable service. However, Title XIX or Title XXI funds may be used for a report on the member's psychiatric status if it is to be used by a treatment team or physician. The fact that the report may also be used in court, as long as it is not the primary reason for the report's creation, doesn't disqualify the service for Title XIX or Title XXI reimbursement.

Based on the results of the court-ordered evaluation and hearing, the member may be assigned to court-ordered treatment. Treatment may include a combination of inpatient and outpatient treatment. Fiscal responsibility for the court-ordered treatment will be with the member's enrolled entity.

Providers who provide court ordered treatment to Fee-for-Service members shall supply member data via AHCCCS Online (DUGless portal). This is reported by logging into the AHCCCS Online Provider Portal and choosing "Member Supplemental Data" on the left hand Menu. For additional information see the DUGless Portal Guide.³⁷

Providers, who provide court ordered treatment to Fee-for-Service members, shall follow the AHCCCS requirements for the submission of claims. For additional information see Chapter 4, General Billing Rules. Providers shall use modifier **H9** for the submission of professional and/or outpatient claims for court ordered treatment. Inpatient claims for court ordered treatment shall be submitted with **8** as the admission source.³⁸

For COE and COT proceedings that are initiated on tribal lands:

Arizona Tribes are sovereign nations and tribal courts have jurisdiction over their members residing on reservation. Tribal court jurisdiction, however, does not extend to tribal members residing off tribal lands or to state issued COE or COT due to a behavioral health crisis that has occurred off tribal lands.³⁹

Several Arizona tribes have adopted their own procedures, which may align with Title 36 and Arizona law for COE and COT. Providers shall take into account each tribe's procedures during the COE and COT process, and provide notification to the member's tribe, even for members residing off tribal lands.

³⁷ Adding for clarity

³⁸ Adding for billing clarity

³⁹ Adding for clarity

For specific information regarding Tribal Court Procedures for Involuntary Commitment, please visit the AHCCCS website at:

<https://www.azahcccs.gov/AmericanIndians/TribalCourtProceduresForInvoluntaryCommitment/>⁴⁰

Since many tribes do not have treatment facilities on reservation to provide court-ordered treatment, tribes may need to secure treatment off reservation for tribal members. To secure court ordered treatment off tribal lands, the tribal court order must be “recognized” or transferred to the jurisdiction of the state. This is done via A.R.S. 12-136, and once complete the tribal court order is carried out/enforceable off tribal lands. Treatment facilities, including the Arizona State Hospital, must then provide treatment, as identified by the tribe and recognized by the state.⁴¹

For further information pertaining to court-ordered evaluation, treatment, and fiscal responsibility please refer to ACOM 437 and AMPM 320-U.

Emergency Services

Emergency behavioral health services may include inpatient services, evaluation, crisis management counseling, psychotropic medication stabilization, and/or other therapeutic activities to reduce or eliminate the emergent/crisis situation.

Emergency behavioral health services are provided in situations where the absence of immediate medical attention could result in:

- Placing the member’s health in serious jeopardy,
- Serious impairment of bodily functions,
- Serious dysfunction of any bodily organ or part, or
- Serious physical harm to self or another person.

A behavioral health evaluation provided by a psychiatrist or a psychologist is covered as an emergency service, if required to evaluate or stabilize an acute episode of mental disorder or substance abuse.

Providers of emergency behavioral health services must verify a member’s eligibility and enrollment status to determine the need for notification for care coordination (e.g., ALTCS program, ACC plan, RBHA, TRBHA, AIHP), and to determine who is responsible for

⁴⁰ Reference

⁴¹ Adding for clarity

payment for services rendered (e.g., ACC plan, RBHA, AHCCCS DFSM for AIHP, TRBHA, Tribal ALTCS).

Claims for emergency services do not require prior authorization, but when requested, the provider must submit documentation with the claim which justifies the emergent nature of the service.

In the event of an emergency behavioral health admission for FFS members, the provider is required to coordinate care with the member's enrolled health plan and/or behavioral health entity. Contact information for RBHA/TRBHAs, ACC health plans, AIHP, and Tribal ALTCS Programs is available on the AHCCCS website.

In the case of an emergency admission for a Tribal ALTCS member, the provider should notify a Tribal ALTCS case manager within 24 hours of the emergency admission, and for MCO ALTCS, the provider should notify the ALTCS contractor within 24 hours of the emergency admission.

The provider must notify the AHCCCS Prior Authorization Unit within 72 hours of the emergency behavioral health admission of a Tribal ALTCS, AIHP or TRBHA-Assigned Fee-For-Service (FFS) member. AHCCCS may perform concurrent review to determine whether the hospitalization of a member for emergency behavioral health services is medically necessary.

Family Members Receiving Behavioral Health Services

Behavioral health services can be provided to the member's family members, regardless of the family member's Title XIX/XXI⁴² entitlement status, as long as the member's Service Plan reflects that the provision of these services is aimed at accomplishing the member's Service Plan goals (i.e. they show a direct, positive effect on the member). The member does not have to be present when the services are being provided to family members.⁴³

Health Promotion

More than one provider agency may bill for Health Promotion provided to a member at the same time if indicated by the member's clinical needs as identified in their Service Plan.⁴⁴

Home Care Training Family (Family Support)

⁴² Clarification to specify Medicaid entitlement

⁴³ Transitioned from CBHSG/310-B

⁴⁴ Transitioned from CBHSG/310-B

Family support services provided by a licensed inpatient, residential, day program or TFC are included in the rate for these settings and cannot be billed separately. However, providers other than the inpatient, residential (BHRF) facility, residential treatment facility (RTC), day program or TFC can bill family support provided to the member.

More than one provider agency may bill for family support provided to a member at the same time if indicated by the member's clinical needs as identified through their Service Plan.⁴⁵

Individual vs. Group Based Services

Group-based services apply to services provided to two or more individuals.⁴⁶ All members participating in group-based services shall be accounted for through individual member level billing of applicable code. For example, for a 15 minute code, if eight members participated in a group session for 60 minutes, the provider would bill four units for each of the eight members, for a total of 32 units (four units on eight separate claims).⁴⁷

Inpatient Services

Inpatient services include services provided in an acute care hospital or a distinct unit of an acute care hospital, inpatient psychiatric hospital, Level I residential treatment centers, and Level I sub-acute facilities.

Billing for Inpatient and Outpatient Services

For a list of allowable procedure codes by provider type, refer to the Provider Types and Allowable Procedure Codes Matrix at:

<https://www.azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/AppendixB2.xls>

Inpatient (Hospital) Services

Inpatient services are billed on the UB-04 claim form and are reimbursed on a per diem basis. Inpatient services include all services provided during the inpatient stay, except those provided by behavioral health independent providers. (Please refer to the Billing for Professional Services section below for additional information on billing for services

⁴⁵ Transitioned from CBHSG/310-B

⁴⁶ Removed HQ modifier statement – other modifiers such as ‘U’ modifiers are also used – refer to the Behavioral Health Services Matrix

⁴⁷ Transitioned from CBHSG/310-B

provided by behavioral health independent providers. Please note that these services are billed on a CMS 1500 claim form.)

Note: Outpatient hospital services are billed on a UB-04 and reimbursed at the Outpatient Prospective Fee Schedule (OPFS) rate.

If a member presents to a hospital/clinic and an outpatient visit turns into an inpatient visit, the provider will bill for the inpatient per diem rate.

Services provided in hospitals are inclusive of all services, supplies, accommodations, staffing, and equipment.

Bed Hold and Therapeutic Leave (i.e. Home Pass) - Nursing Homes (Provider Type 22) and Residential Treatment Provider Types 78, B1, B2, and B3⁴⁸ may bill for bed hold or home pass.

- A Bed Hold or Therapeutic Leave Day is a day where the facility reserves the member's bed, or the member's space in the facility where they have been residing, while the member is out of the facility overnight. The member's overnight leave shall have been authorized/planned, and it shall be for the purposes of Therapeutic leave (i.e. home pass) to enhance the member's psychosocial interactions or as a trial basis for discharge planning.⁴⁹

Hospital Limitations

The following services are included in the hospital rate and cannot be billed separately:

- Medical services, including both physical and behavioral health;
- Medical supplies;
- Medications;
- Laboratory Services; and/or
- Radiology and Medical Imaging Services.⁵⁰

Observation/Stabilization Service Limitations

The following services are included in the observation/stabilization service rate and cannot be billed separately:

- Medical services, including both physical and behavioral health; and/or
- Medical supplies.⁵¹

Outpatient Services

⁴⁸ Revised provider types and requirement per DAR and State Plan and Rule R9-28-204

⁴⁹ Transitioned from CBHSG/310-B

⁵⁰ Transitioned from CBHSG/310-B

⁵¹ Transitioned from CBHSG/310-B

Professional services are billed on a CMS 1500 Claim Form.

Billing for Professional Services

Provider types that can bill for category of service 47 (mental health) include:

- 08 MD-physician with psychiatry and/or neurology specialty code 192 or 195
- 11 Psychologist
- 18 Physician Assistant
- 19 Registered Nurse Practitioner
- 31 DO-Physician Osteopath with psychiatry and/or neurology specialty code 192 or 195
- 77 Behavioral Health Outpatient Clinic
- 85 Licensed Independent Social Worker (LISW)
- 86 Licensed Marriage and Family Therapist (LMFT)
- 87 Licensed Professional Counselor (LPC)
- A4 Licensed Independent Substance Abuse Counselor
- BC Board Certified Behavioral Analyst
- IC Integrated Clinic

Not all provider types can bill for all services.

Claims from the above-listed providers must be submitted under the individual provider ID number.

Provider type 77 must use their facility **NPI** as the **billing** and **attending** provider, unless the attending provider is a registered AHCCCS provider, in which case they must use the attending provider NPI.

All other behavioral health professionals, like a behavioral health technician (BHT), must be affiliated with a licensed behavioral health agency/facility, clinic, alternative residential facility or outpatient hospital, and those services must be billed through the affiliated setting.

For BCBA and BHT criteria refer to:

<https://www.azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/AppendixA1.pdf>

Services must be billed on a CMS 1500 claim form with appropriate ICD diagnosis codes and CPT procedure codes. AHCCCS does not accept DSM-IV codes. Claims submitted with DSM-IV codes will be denied.

The attending physician must be listed as the provider's NPI, except when billing for BCBA, BHPP, or BHT professionals. When billing for BCBA, BHPP or BHT professional services, the clinic NPI is billed as the attending.

Services are reimbursed at the AHCCCS capped Fee-For-Service rate.

Child and Adolescent Residential Treatment Services

Residential treatment services may bill for bed hold or home pass days.

Residential treatment service limitations

Residential treatment services are billed through a bundled per diem rate; the following services are included in this rate and cannot be billed separately:

- Medical services including both physical and behavioral health; and/or
- Medical supplies.⁵²

Medication

Medications provided in an inpatient general acute care or psychiatric hospital setting are included in the rate and cannot be billed separately.

The administration of opioid agonist drugs by Opioid Treatment Programs (OTPs) shall be conducted in compliance with all federal and state regulations. The administration of opioid agonists through OTPs shall be billed using H2010 HG and H0020 HG as further described below:

- **H2010 HG – Comprehensive Medication Services, per 15 minutes**
Administration of prescribed opioid agonist drugs to a person *in the office setting* in order to reduce physical dependence on heroin and other opioids.
- **H0020 HG – Alcohol and/or Drug Services; Methadone Administration and/or Services (provision of the drug by a licensed program)**
Administration of prescribed opioid agonist drugs for a person *to take at home* in order to reduce physical dependence on heroin and other opioids. The billing unit is one dose per day (includes cost associated with drug and administration). While

⁵² Transitioned from CBHSG/310-B

the billing unit is a single dose of medication per day, the take home medicine can be provided for more than one day.⁵³

Refer to AMPM Policy 660 for additional information on the processes that OTPs must follow to request Mid-Level Practitioners to provide medication services for opioid use disorder treatment within an OTP setting.

Laboratory, Radiology and Medical Imaging

Laboratory, radiology, and medical imaging services provided in an inpatient hospital setting are included in the rate and cannot be billed separately.⁵⁴

Medication Assisted Treatment (MAT)

Medication Assisted Treatment (MAT) is the use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders. A combination of medication and behavioral therapies is effective in the treatment of substance use disorders, and can help some people to sustain recovery.

To address the opioid use epidemic, the AHCCCS Administration and its Contractors shall provide coverage for medically necessary, cost-effective, and federally and state reimbursable behavioral health medications prescribed by a PCP within their scope of practice. This includes the monitoring and adjustments of behavioral health medications. For OUD the PCP must refer the member to a behavioral health provider for the psychological and/or behavioral therapy component of the MAT model and coordinate care with the behavioral health provider.

For further information regarding MAT please refer to AMPM 510, Primary Care Providers.

Billing for Methadone Administration

AHCCCS policy allows only five provider types to bill for methadone administration. Provider types 08 (MD-physician), 18 (Physician assistant), 19 (Registered nurse practitioner), 31 (DO-physician osteopath), and 77 (Clinic) may bill the AHCCCS Administration and its contracted health plans and program contractors for methadone administration. These codes are in category of service 01 – Medicine.

Methadone administration must be billed with the following codes:

- H2010 Comprehensive medication services, office, per 15 minutes; and/or

⁵³ Transitioned from CBHSG/310-B

⁵⁴ Transitioned from CBHSG/310-B

- H0020 Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program).

Both codes must be billed with the HG (Opioid addiction treatment program) modifier.

Medical Management

Medical Management services provided by a Registered Nurse (RN) or Licensed Professional Nurse (LPN) shall be billed using T1002 and T1003 as further described below:

- **T1002 – Registered Nurse (RN) Services:** Medical management services (including medication monitoring) related to the treatment of a behavioral health disorder. As allowed by the individual provider's scope of practice may include such activities as the measurement of vital signs, assessment and monitoring of physical/medical status, review of the side effects of medications and administration of medications.
- **T1003 – Licensed Practical Nurse (LPN) Services:** Medical management services (including medication monitoring) related to the treatment of a behavioral health disorder. As allowed by the individual provider's scope of practice may include such activities as the measurement of vital signs, assessment and monitoring of physical/medical status, review of the side effects of medications and administration of medications.

T1002 and T1003 provided on the same day as a higher level of service (e.g. services by a physician, nurse practitioner or physician assistant) are considered inclusive of the higher level of service. Nursing services provided in a DLS licensed inpatient, residential (BHRF), or medical day program setting, are included in the rate and cannot be billed separately.⁵⁵

Personal Care Services

Personal care services provided by a licensed inpatient, Supervised Behavioral Health Treatment and Day Program, or in Therapeutic Foster Care (TFC) are included in the rate for these settings and cannot be billed separately.

BHRFs may provide personal care services within the BHRF setting, provided they have the additional level of licensure for personal care services. Refer to AMPM Policy 320-V, Behavioral Health Residential Facilities, for additional information.

⁵⁵ Transitioned from CBHSG/310-B

More than one provider agency may bill for personal care services provided to a member at the same time if indicated by the member's clinical needs as identified through their Service Plan.

Personal care services may be provided in an unlicensed setting such as a member's own home or community setting.^[1] Parents (including natural parent, adoptive parent and stepparent) may be eligible to provide personal care services if the member receiving services is 21 years or older and the parent is not the member's legal guardian. A member's spouse is not eligible to be reimbursed for personal care services.⁵⁶

Psychoeducational Services and Ongoing Support to Maintain Employment

Psychoeducational Services (pre-vocational services; H2027) and Ongoing Support to Maintain Employment (post-vocational services, or Job Coaching; H2025 and H2026) are designed to assist members to choose, acquire, and maintain employment or other meaningful community activity (e.g. volunteer work).

Service codes H2025, H2026, and H2027 cannot be billed on the same day.

More than one provider agency may bill for Psychoeducational Services and Ongoing Support to Maintain Employment services provided to a member at the same time, if indicated by the member's clinical needs as identified in their Service Plan.⁵⁷

Respite Care (Unskilled)

Respite services are limited to 600 hours per benefit year (October 1 through September 30) per person and are inclusive of both behavioral health and ALTCS respite care.⁵⁸

Respite services cannot be billed for members who are receiving services in an ADHS Level I Facility, ADES group home or nursing home. Community Service Agencies cannot provide respite services.

S5150 – Unskilled respite care: - not hospice: Unskilled respite services provided to a person for a short period of time (up to 12 hours in duration).

- Billing Unit: 15 minute intervals

S5151 – Unskilled respite care: - not hospice: Unskilled respite services provided to a person for more than 12 hours in duration.

^[1] The statement is implied, but added for clarification purposes.

⁵⁶ Transitioned from CBHSG/310-B

⁵⁷ Transitioned from CBHSG/310-B

⁵⁸ Emphasis added to ensure the 600 allowable hours are total across both BH and ALTCS programs.

- Billing Unit: Per Diem

Home Care Training to Home Care Client (HCTC) services cannot be encountered billed on the same day as Unskilled Respite (S5151).⁵⁹

Self-Help/Peer Services (Peer and Support Services)

More than one provider agency may bill for self-help/peer services provided to a member at the same time if indicated by the member's clinical needs.⁶⁰

Skills Training and Development

More than one provider agency may bill for skills training and development services provided to a member at the same time if indicated by the member's clinical needs, as identified in their Service Plan.⁶¹

Telephonic Services

The following services can be billed for when provided telephonically: 98966, 98967, 98968, 99441, 99442, 99443, H2014, H0025, H2025, T1016, S5110, and H0038.

When providing services telephonically, providers are required to list the Place of Service (POS) as 02.⁶²

Telehealth Services

When providing services via telemedicine (i.e. via interactive audio and video telecommunications), both the GT modifier and POS 02 shall be utilized.

When providing services via asynchronous telecommunications systems (i.e. store and forward), both the GQ modifier and POS 02 shall be utilized.

Refer to the AHCCCS Behavioral Health Services Matrix located on the AHCCCS website and AMPM Policy 320-I for additional information.⁶³

⁵⁹ Transitioned from CBHSG/310-B

⁶⁰ Transitioned from CBHSG/310-B

⁶¹ Transitioned from CBHSG/310-B

⁶² Transitioned from CBHSG/310-B

⁶³ Revisions for clarification of where to find the Behavioral Health Services Matrix

Therapeutic Foster Care (TFC)

The following components are included in the TFC per diem rate:

- i. Personal care services,
- ii. Skills training and development,
- iii. Family support,
- iv. Pre-training activities,
- v. Clinical supervision and training,
- vi. Over-the-counter drugs and non-customized medical supplies, and
- vii. Non-emergency medical transportation.

Personal Care Services, Skills Training and Development, and Family Support may be provided and billed on the same day that TFC services are furnished if the Service Plan provides justification in the Service Plan on why additional services outside of the per diem rate are required to meet the member's needs. All other healthcare services not included in the TFC rate component should be provided to member residing in a behavioral health therapeutic home based on medical necessity.⁶⁴

Provider Travel

Provider travel is the cost associated with certain provider types traveling to provide a covered behavioral health service. This is different than transportation, which is provided to take a member to and from a covered behavioral health service.

Certain behavioral health professionals are eligible to bill for provider travel services, as outlined below.

The mileage cost of the first 25 miles of provider travel is included in the rate calculated for each service; therefore, provider travel mileage may not be billed separately except when it exceeds 25 miles. In these circumstances providers bill the additional miles traveled in excess of 25 miles using the HCPCS code A0160.

When a provider is traveling to one destination and returns to the office, the 25 miles is assumed to be included in the round trip. If a provider is traveling to multiple out-of-office settings, each segment of the trip is assumed to include 25 miles of travel. The following examples demonstrate when to bill for additional miles:

- a. If Provider A travels a total of 15 miles (to the out-of-office setting in which the service is delivered and back to the provider's office), travel time and mileage is included in the rate and may not be billed separately.
- b. If Provider B travels a total of 40 miles (to the out-of-office setting in which the service is delivered and back to the provider's office), the first 25 miles of

⁶⁴ Transitioned from CBHSG/310-B

provider travel are included in the rate but the provider may bill 15 miles using the provider code A0160 (40 miles minus 25 miles = 15 miles).

- c. If Provider C travels to multiple out-of-office settings (in succession), he/she must calculate provider travel mileage by segment. For example:
- First segment = 15 miles; 0 travel miles are billed
 - Second segment = 35 miles; 10 travel miles are billed
 - Third segment = 30 miles; 5 travel miles are billed
 - Total travel miles billed = 15 miles (see below Note for billing instruction breakdown) are billed using provider code A0160. The provider may bill for travel miles in excess of 25 miles for the return trip to the provider office.
 - Note: In scenario C the provider would submit two claims for provider travel. One claim for 10 miles billed under the member for the second segment, and one claim for 5 miles billed under the member for the third segment.
- d. Providers may not bill for travel for missed appointments.⁶⁵

Provider Travel Limitations⁶⁶

If a behavioral health professional, behavioral health technician, or behavioral health paraprofessional travels to provide case management services, or provider type 85, 86, 87, or A4 travels to provide services to a client and the client misses the appointment, the intended service may not be billed.

Additionally, providers may not bill for travel for missed appointments.

This applies for time spent conducting outreach without successfully finding the member and for time spent driving to do a home visit and the member is not home.⁶⁷

Transportation

For information on transportation services please refer to Chapter 14, Transportation Services, of the Fee-For-Service Provider Billing Manual and AMPM 310-BB, Transportation Services.

⁶⁵ Transitioned from CBHSG/310-B

⁶⁶ Added from CBHSG Case Management Services Billing Guidelines - [A-4: Case Management Billing Guidelines](#)

⁶⁷ Transitioned from CBHSG/310-B

Non-Title XIX/XXI Services

For information on Non-Title XIX/XXI Services please refer to the Non-Title XIX/XXI Exhibit (Exhibit 19-1) of Chapter 19, Behavioral Health Services, of the Fee-for-Service Provider Billing Manual.

References

Please refer to the following chapters for additional information:

AMPM Exhibit 300-2A AHCCCS Covered Services Behavioral Health

AMPM Chapter 300, Policy 310-B Behavioral Health Services

AMPM Chapter 300, Policy 320-T, Non-Title XIX/XXI Behavioral Health Services

Non-Title XIX/XXI Services Exhibit 19-1 of the Fee-For-Service Provider Billing Manual

AMPM Chapter 310-V Prescription Medications-Pharmacy Services (the section on Behavioral Health Medication Coverage)

AMPM Chapter 510 – Primary Care Providers

AMPM Chapter 320-U Pre-Petition Screening, Court Ordered Evaluation and Court Ordered Treatment

ACOM Chapter 437 Financial Responsibility for Services After the Completion of Court-Ordered Evaluation

ACOM Chapter 432, Attachment A – Matrix of Financial Responsibility by Responsible Party

AMPM Chapter 1200 contains additional information regarding behavioral health services for members eligible for the ALTCS program.

AMPM Chapter 650 – B, Behavioral Health Provider Requirements for Assisting Individuals with Eligibility Verification and Screening/Application for Public Health Benefits

Chapter 12, Pharmacy, of the Fee-For-Service Provider Billing Manual

For the Case Manager Billing Guide refer to:

<https://www.azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/AppendixA4.pdf>

For additional crisis service billing examples please view the November 2018 edition of Claims Clues:

<https://www.azahcccs.gov/PlansProviders/Downloads/ClaimsClues/2018/ClaimsCluesNov2018.pdf>

In early 2019, information contained within the AHCCCS Covered Behavioral Health Services Guide (CBHSG) will be transitioned into the AHCCCS Medical Policy Manual and the FFS and IHS/Tribal Provider Billing Manuals. Please see 'Important Notice' on page 1.

Revision History

Date	Description of changes	Page(s)
5/22/2019	<p>*Billing information from the Covered Behavioral Services Guide was transitioned into this chapter. This includes information on covered services, what is included in the established rates, limitations, limited coding information, and definitions.</p> <p>Updated the Important Notice (regarding the Covered Behavioral Health Services Guide's transition) with locations and hyperlinks.</p> <p>Added a purpose section explaining what the listed resources in the chapter are meant to assist a behavioral health provider with.</p> <p>Added reference and a list of where information about other behavioral health services can be found (within AMPM 310-B, Behavioral Health Services Benefit)</p> <p>Reference to Chapter 12, Behavioral Health Services, of the IHS/Tribal Provider Billing Manual added regarding MCO ALTCS and Tribal ALTCS.</p> <p>General Billing Information introduction added.</p> <p>'What is the Behavioral Health Matrix?' section added.</p> <p>Coding and Common Modifiers for the Billing of Behavioral Health Services section updated.</p> <p>ICD Diagnostic Codes section added.</p> <p>Place of Service section added.</p> <p>Behavioral Health Day Program section added.</p> <p>Behavioral Health Professionals and Independent Billers section added.</p> <p>Behavioral Health Services provided by Behavioral Health Technicians (BHTs) or Behavioral Health Paraprofessionals (BHPPs) section added.</p> <p>Behavioral Health Residential Facility (BHRF) section added.</p>	<p>1</p> <p>1-2</p> <p>3-4</p> <p>10</p> <p>10</p> <p>10-11</p> <p>11</p> <p>11</p> <p>11-12</p> <p>12-14</p> <p>14</p> <p>14</p> <p>14-16</p>

	Case Management section added. (Including information on coding units, modifiers, limitations, and indirect contact.)	16-17
	Crisis Services section updated. (Including information on Telephonic Crisis Intervention Services, Mobile Crisis Teams and Facility-Based Crisis Intervention Services.)	17-21
	COE/COT: Pre-Petition Screening, Court Ordered Evaluations and Court Ordered Treatment section updated. (Including information about the DUGless portal, FFS members, and COE/COT proceedings initiated on tribal lands.)	21-24
	Family Members Receiving Behavioral Health Services section added.	
	Health Promotion section added.	24
	Home Care Training (Family Support) section added.	
	Individual vs. Group Based Services section added.	24
	Inpatient Services, Billing for Professional Services section updated with the following information:	25
	<ul style="list-style-type: none"> • Bed Hold and Therapeutic Leave clarification. • Hospital Limitations • Observation/Stabilization Service Limitations • Child and Adolescent Residential Treatment Services • Medication, including those used in Opioid Treatment Programs (OTP) • Laboratory, Radiology and Medical Imaging 	26-29
	Medical Management section added. (Including information on T1002 and T1003)	27
	Personal Care Services section updated.	27
	Psychoeducational Services and Ongoing Support to Maintain Employment section added.	27
	Respite Care (Unskilled) section added.	27
	Self-Help/Peer Services (Peer and Support Services) section added.	28
	Skills Training Development section added.	28
	Telephonic Services section added.	28
	Telehealth Services section added.	28
	Therapeutic Foster Care (TFC) section added.	28
	Provider Travel section added.	28
	Transportation section added.	28
	Non-Title XIX/XXI Services section added. (References newly created exhibit.)	28
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12/7/2018	The entire chapter was restructured and formatting updated.	1-18
	Important Notice regarding the Covered Behavioral Health Service (CBHSG) added.	1-2

	<p>List of covered behavioral health services updated. 2-3</p> <p>New section added called ‘Members Enrolled in an Integrated Health Plan for Physical and Behavioral Health Services.’</p> <p>ALTCS/Tribal ALTCS EPD section updated, including an addition regarding where claims should be sent for BH services. (To AHCCCS DFMSM). 3</p> <p>New section added called ‘Benefit Coordination for Members Enrolled with Different Entities for Physical and Behavioral Health Services.’ The referenced populations are: 4</p> <ul style="list-style-type: none"> • ALTCS members enrolled with DES/DDD; • Foster care children enrolled with the Comprehensive Medical Dental Program (CMDP); and • Adults with a Serious Mental Illness (SMI) designation. <p>Definitions section updated for integration. The following definitions were removed (and a reference to where they can be found in AMPM has been added): 4-5</p> <p>Acute Care Services Acute Care Hospital American Indian Health Program (AIHP) Behavioral Health Diagnosis Court Ordered Evaluation Court Ordered Treatment CRS Fully Integrated CRS Only CRS Partially Integrated – Acute CRS Partially Integrated – Behavioral Health (BH) Primary Care Provider</p> <p>The following definitions were updated:</p> <p>Behavioral Health Entity Enrolled Health Plan</p> <p>Payer responsibility section updated to read as ‘Payment Responsibility for Members Enrolled with Different Entities for their Physical and Behavioral Health Services.’ The information regarding who the payer is for inpatient facility and professional claims, ER facility and professional claims, transportation claims, and primary care provider payments has been updated. 5-8</p> <p>A General Billing Information section was added. 8</p> <p>A Place of Service section was added. 8</p>	
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	<p>A Common Modifiers for the Billing of Behavioral Health Services section was added.</p> <p>The Emergency Services section was updated for integration billing information.</p> <p>A Crisis Services section was added with billing examples.</p> <p>The Pre-Petition, Court Ordered Evaluations, and Court Ordered Treatment section was updated.</p> <p>A minor update to the Medication Assisted Treatment section was done. It was changed from: “To address the opioid use epidemic, the AHCCCS Administration and its Contractors shall provide coverage for medically necessary, cost-effective, and federally and state reimbursable behavioral health medications prescribed by a PCP when used to treat anxiety, depression (including postpartum depression), ADHD, and/or Opioid Use Disorder (OUD)” to “To address the opioid use epidemic, the AHCCCS Administration and its Contractors shall provide coverage for medically necessary, cost-effective, and federally and state reimbursable behavioral health medications prescribed by a PCP within their scope of practice.”</p> <p>The References section was updated.</p>	<p>8-9</p> <p>9-10</p> <p>10-11</p> <p>12</p> <p>15-16</p>
7/31/2018	Link updated on page 8 to link to the AHCCCS Behavioral Health Allowable Procedure Code Matrix	8
2/16/2018	Billing the AIR for BH services conducted by a non-AHCCCS registered behavioral health professional, like a BHT, clarification added.	10
1/17/2018	IHS Tribally Owned or Operated 638 Facilities section corrected to read as “KidsCare members enrolled with a MCO should have claims sent to the TRBHA.”	13
12/29/2017	<p>Definitions updated</p> <p>Emergency Services section updated</p> <p>Billing for Professional Services section updated</p> <p>Billing for Methadone Administration section updated</p> <p>Medication Assisted Treatment for Opioid Use Disorder added</p> <p>General Requirements Regarding Payment for Physical and Behavioral Health section updated.</p> <p>Inpatient Facility Payment Responsibility section updated</p> <p>Emergency Department Payment Responsibility section updated</p> <p>IHS Tribally Owned or Operated 638 Facilities section updated</p> <p>Specific Circumstances Regarding Payment for Behavioral Health section updated</p> <p>Court Ordered Evaluations & Financial Responsibility section</p>	<p>2-7</p> <p>7-8</p> <p>11</p> <p>10-11</p> <p>11</p> <p>12-14</p> <p>12</p> <p>12</p> <p>13</p> <p>13-14</p> <p>15</p>

	added References updated Format changes	15-16 All
10/1/2016	Behavioral Health changes effective service date 07/01/2016 and later BH Billing Matrix	9 – 16
09/17/2015	New format Changed “ICD-9” to “ICD” in preparation for 10/1/2015 ICD-10	All