Revision Date: 7/8/2024; 10/1/2021; 7/14/2020; 7/8/2020; 12/7/2018; 7/31/2018; 2/16/2018; 1/17/2018; 12/29/2017; 10/1/2017; 09/17/2015; 07/15/2014

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.

NOTE: A provider or any agent or representative of the provider shall not offer or give any form of gift, compensation, or reward or engage in any behavior or activity that may be reasonably construed as coercive to an AHCCCS eligible and enrolled member, to induce or procure the right to render and request reimbursement for an AHCCCS covered item or service.

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 hospital program (PHP)
- Intensive Outpatient Program (IOP)
- 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

DEFINITIONS

For definitions regarding behavioral health services and practitioners, please see the AHCCCS Contract and Policy Dictionary.

INTEGRATED HEALTH PLANS FOR PHYSICAL AND BEHAVIORAL HEALTH SERVICES

AHCCS COMPLETE CARE PLANS AND THE AMERICAN INDIAN HEALTH PROGRAM (AIHP)

AHCCCS Complete Care (ACC) plans are the integrated health plans for AHCCCS members that provide coverage and reimbursement for acute physical and behavioral health services, including Children's Rehabilitative Services (CRS) (effective 10/1/18) and services for individuals determined to have a Serious Mental Illness (SMI) (effective 10/1/22).

AIHP is the integrated Fee-for-Service (FFS) program administered by AHCCCS' Division of Fee-for-Service Management (DFSM) for eligible American Indian/Alaska Native (AI/AN) members that reimburses for both acute physical and behavioral health services, including CRS and SMI services, provided by and through the Indian Health Services (IHS), tribal health programs operated under 638, or any other AHCCCS registered provider.

AI/AN members may choose to enroll in AIHP; or AIHP and a Tribal Regional Behavioral Health Authority (TRBHA), if a TRBHA is available in their area through their tribe; or an ACC health plan. AI/AN members who enroll with AIHP for their physical health services will also receive their behavioral health services through AIHP or may choose to receive assistance with the coordination of their behavioral health services through a TRBHA, if a TRBHA is available in their area through their tribe.

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

ALTCS DES/DDD

Arizona Long Term Care System (ALTCS) Department of Economic Security (DES)/Division of Developmental Disability (DDD) administers integrated long term care services programs that provide coverage and reimbursement of both physical and behavioral health services, including CRS and SMI services, for members enrolled in DES/DDD's Health Plans or DDD's FFS option, the DDD Tribal Health Program (DDD-THP). For DDD-THP members, a TRBHA may also be an option for assistance with coordination of their behavioral health services if available in their area through their tribe.

Effective April 1, 2022, AHCCCS DFSM manages acute physical and behavioral health service authorizations and claim reimbursement for DDD-THP enrolled members via an inter-agency subcontract with DES/DDD. DES/DDD retains responsibility for management and reimbursement of LTC services and supports (LTSS) for DDD-THP enrolled members.

ALTCS/TRIBAL ALTCS EPD

ALTCS and Tribal ALTCS-Elderly and Physically Disabled (EPD) are integrated long term care services programs that reimburse for both physical and behavioral health services, including CRS and SMI services. Tribal ALTCS is a FFS program administered by AHCCCS DFSM.

Tribal ALTCS Programs provide case management services to American Indians who reside on reservation, or who resided on reservation prior to being placed in an off-reservation facility. 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.

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

CLAIMS PAYMENT

Title XIX and Title XXI (KidsCare) members are eligible to receive behavioral health services through their integrated health plan.

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

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

- DES/DDD health plans and DDD-THP, and
- ALTCS and Tribal ALTCS health plans.

Claims for AIHP, Tribal ALTCS, and AIHP/TRBHA members should be sent to AHCCCS DFSM.

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.

Claims for ALTCS health plans should be sent to the enrolled health plan.

Claims for DES/DDD health plans should be sent to the enrolled health plan.

Claims for DDD-THP for acute physical or behavioral health services should be sent to AHCCCS DFSM. Claims for DDD-THP for LTSS services should be sent to DES/DDD.

Claims for services provided to 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 health plan, or to AHCCCS DFSM for FFS enrolled members.

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 consist of foster care children enrolled with the Comprehensive Health Plan (CHP).

American Indian/Alaskan Native (AI/AN) foster care children enrolled with CHP may choose to receive assistance with the coordination of their behavioral health services through a TRBHA, if a TRBHA is available through their tribe.

For members enrolled with different entities for their physical and behavioral health services, payment is determined by the principal diagnosis appearing on the claim.

CARE COORDINATION

For members enrolled in different entities for physical and behavioral health services, providers are responsible for coordinating services with all entities rendering services to the members.

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 entity 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 entity authorized and/or determined medical necessity of the stay, such as when the admitting diagnosis is a physical health diagnosis.

4. The enrolled entity 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 entity 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 entity 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.

The enrolled entity 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.

TRANSPORTATION PAYMENT RESPONSIBILITY

The enrolled entity 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.

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.

GENERAL BILLING INFORMATION

The following sections provide billing information pertaining to covered behavioral health services. The billing information applies to FFS providers. Services should be billed according

to the appropriate rate as outlined in the FFS Fee Schedule posted on the AHCCCS website.

For additional information about these services, refer to AMPM 310-B, Behavioral Health Services, AMPM 320-O, Behavioral Health Assessments and Treatment Service Planning, AMPM 320-P, Serious Mental Illness Eligibility Determination, AMPM 320-S, Behavior Analysis Services, AMPM 570 Provider Case Management, AMPM 590, Behavioral Health Crisis Services and Care Coordination.

BEHAVIORAL HEALTH SERVICES MATRIX

The AHCCCS Behavioral Health Services 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.

The Behavioral Health Services 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.

Providers shall have the correct COS according to their Provider Type when submitting codes.

NOTE: All applicable coding standards and requirements, including scope of practice guidelines, supersede the Behavioral Health Services Matrix. The Behavioral Health Services 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 Healthcare Common Procedure Coding System (HCPCS), Current Procedural Terminology (CPT), and Uniform Billing (UB) revenue codes.

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.

For additional information on applicable CPT, HCPCS, and UB revenue codes in each of these categories/subcategories, and for additional information on modifiers please reference the Behavioral Health Services Matrix.

To recommend a change or update to coding in the Behavioral Health Services Matrix please submit a request to codingpolicyquestions@azahcccs.gov.

Inpatient per diem behavioral health codes are priced to include all of the non-professional behavioral health services the member will receive in a day. Additional behavioral health

services shall not be unbundled from the per diem code.

ICD DIAGNOSTIC CODES

Covered behavioral health services may be initiated regardless of a member's diagnosis with or even in the absence of any behavioral health diagnosis at the time of services, so long as there are documented behaviors or symptoms that require treatment. Likewise, the provision of covered services is not limited by a person's diagnosis (e.g., any of the covered services may be provided to address both mental illness and substance use disorders, at-risk behaviors/conditions or family members impacted by the person's disorder). While a diagnosis is not needed to receive treatment, a diagnostic code is needed for service code billing.

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.

PLACE OF SERVICE

A Place of Service (POS) code indicates where a service is provided. POS codes shall be submitted on claims.

To determine which place of service codes are available with specific service codes, please reference the Behavioral Health Services Matrix at:

https://www.azahcccs.gov/PlansProviders/Downloads/MedicalCodingResources/BehavioralHe

BILLING FOR INPATIENT SERVICES

For general guidance on Behavioral Health Service procedure codes by provider type refer to the Behavioral Health Services matrix available on the Medical Coding Resources web page.

INPATIENT FACILITY SERVICES

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

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 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 stay, the provider will bill for the inpatient psychiatric per diem rate.

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

Billing Limitations

The following services are included in the inpatient 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.

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.

See Crisis Services section of this chapter for additional billing requirements and code specific information. See AMPM 590 for crisis provider requirements.

BED HOLDS AND THERAPEUTIC LEAVE

Bed Hold/Therapeutic Leave (i.e. Home Pass) **-** Nursing Homes (Provider Type 22) and Residential Treatment Provider Types 78, B1, B2, and B3 may bill for bed hold or home pass.

- A Bed Hold (0189, 0185) or Home pass (0183) 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.
- For members aged 21 and older, therapeutic leave may not exceed nine days, and bed hold days may not exceed 12 days, per contract year,
- For members under 21 years of age, total therapeutic leave and/or bed hold days may not exceed 21 days per contract year.

Prior authorization is required with limitations to the amount covered for the benefit year.

BILLING FOR OUTPATIENT SERVICES

All outpatient and 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 (LISAC)

BC Board Certified Behavioral Analyst (BCBA)

IC Integrated Clinic

CN Clinical Nurse Specialist

Not all provider types can bill for all services. For general guidance on behavioral health service procedure codes by provider type refer to the Behavioral Health Services Matrix available on the Medical Coding Resources web page:

https://www.azahcccs.gov/PlansProviders/MedicalCodingResources.html

Providers can bill for services permitted within the scope of their licensure and AHCCCS provider type registration.

Outpatient behavioral health 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.

Provider types 77 and ICs services must be billed using a CMS 1500. Services provided by PT 77 and ICs cannot be billed using a UB claim form. Claim submitted by PT 77 and ICs using a UB claim form will be denied.

Services are reimbursed at the AHCCCS capped Fee-for-Service rate for the provider type.

For information on billing for behavioral health services provided by Behavioral Health Technicians (BHT), Behavioral Health Paraprofessionals (BHPP), or other provider types, please refer to the individual provider type section in this chapter.

Effective for dates of service 7/1/2023 and after, when the 77 or IC is reported as the rendering/servicing provider, the participating provider must be listed on the claim.

All participating providers reported must be affiliated with a licensed behavioral health agency/facility, clinic, alternative residential facility or outpatient hospital.

The participating provider information entered in the additional information field (field 19) shall identify the individual who performed the service and not the billing group NPI. Claims submitted with the billing group NPI shall be denied.

Refer to Exhibit 10-1 Participating Provider for details on reporting requirements.

CLAIM DATE SPAN REQUIREMENT

Effective with dates of service beginning February 17, 2023 and forward, Provider Types (77) Behavioral Health Outpatient Clinic and (IC) Integrated Clinics submitting claims to AHCCCS Division of Fee for Service Management must list a single claim line for each date of service equal to one (1) day of service, CPT/ HCPCS code and the total units for each line of service. This requirement applies to all forms of claims submission including, paper claim, 837P, and Provider Portal submissions.

AHCCCS DFSM shall deny any claim line submitted by a provider type 77 or IC when the billed claim line date span is greater than one (1) day of service.

Example of a Correct Claim Submission:

	24. A. DATES OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	02	13	23	02	13	23	11		H0004	HQ		95 00	4		NPI	1234567890
2	02	14	23	02	14	23	11		H0004	HQ		95 00	4		NPI	1234567890
3	02	15	23	02	15	23	11		H0004	HQ		95 00	4		NPI	1234567890

Example of an Incorrect Claim Submission:

	24. A. DATES OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	02	13	23	02	28	23	11		H0004	HQ		1500 00	480		NPI	1234567890
2															NPI	
3															NPI	

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

  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.

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. Only one per diem code shall be billed in a single day. Behavioral health day programs may include services such as therapeutic nursery, in-home stabilization, after school programs, and specialized outpatient substance abuse programs.

These programs can be provided to a person, group of individuals and/or families in a variety of settings and shall be provided based on licensure requirements as specified in A.A.C. R9-10-1000 and may include services as specified in AMPM 310-B. The staff who delivers the specific services within the behavioral health day program shall meet the individual provider qualifications associated with those services.

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.

There are three types of behavioral health day programs:

- **Supervised**
  - Supervised behavioral health day programs consist of a regularly scheduled program of individual, group and/or family services related to the member's treatment plan designed to improve the ability of the person to function in the community and may include rehabilitative and support services.
  - Supervised behavioral health day programs may be provided by either ADHS DLS licensed behavioral health agencies or Title XIX certified Community Service Agencies (CSA). Supervised behavioral health treatment and day programs provided by a CSA shall be supervised by a BHT.
- **Therapeutic**
  - Therapeutic behavioral health day programs are regularly scheduled program of active treatment modalities which may include services such as individual, group and/or family behavioral health counseling and therapy, medication monitoring, medical monitoring, plus rehabilitative and support services.
  - Therapeutic behavioral health day programs shall be provided by an appropriately licensed DLS Outpatient Treatment Center and as specified with applicable service requirements set forth in A.A.C. R9-10-1000.
- **Community Psychiatric Support Treatment**
  - Community Psychiatric Supportive Treatment Programs are a regularly scheduled program of active treatment modalities, including medical interventions, in a group setting and may include individual, group and/or family behavioral health counseling and therapy, nursing services such as medication monitoring, methadone administration, and medical/nursing assessments, plus rehabilitative and support services.
  - Community Psychiatric Supportive Treatment Programs shall be provided by an appropriately licensed ADHS DLS behavioral health agency and as specified with applicable service requirements set forth in A.A.C. R9-10-1000. These programs shall be under the direction of a licensed physician, nurse practitioner, or physician assistant.

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, H2015. H0018, H0014, H0035, H2020, H2018, H2016, H2026, H0037, S109, T1020, S5151, S9480, or H0015

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

- Billing Unit: 15 minutes
- Greater than 5 hours, up to 10 hours in duration

- H2015 shall not be billed with H2012, H2016, H0036, H0018, H0014, H0035, H2020, H2018, H2016, H2026, H0037, S109, T1020, S5151, S9480, or H0015

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 H0036, H0018, H0014, H0035, H2018, H2016, H2026, H0037, S109, T1020, S5151, or S9480

H2020 – Therapeutic Behavioral Services:

- Billing Unit: Per Diem
- H2020 shall not be billed with H2015, H0036, H0001, H0002, H0004, H0006, H0025, H0034, H0036, H2012, H2014, H2015, H2017, H2019, H2025, H2027, H2033, S5150. T1019. H0031, H0038, or H0030

NOTE: A professional 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, H0018, H0014, H0035, H2020, H2018, H2016, H2026, H0037, S109, T1020, S5151, or S9480,

H0037– Community Psychiatric Supportive Treatment Program:

- Billing Unit: Per Diem
- H0037 may not be billed with H0036, H2015, H0001, H0002, H0004, H0006, H0025, H0034, H0036, H2012, H2014, H2015, H2017, H2019, H2025, H2027, H2033, S5150. T1019. H0031, H0038, or H0030

Refer to AMPM 310-B for additional information on Behavioral health day programs services. Refer to the AHCCCS Medical Coding Resource page for information on Behavioral health day programs coding requirements.

BEHAVIORAL HEALTH PROFESSIONALS & INDEPENDENT BILLERS

AHCCCS *does* register Behavioral Health Professional Independent Billers.

For additional information regarding BHPs, including the definition of a BHP, refer to the AHCCCS Contract And Policy Dictionary.

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) registered with AHCCCS.

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

A BHT and BHPP must be affiliated with a licensed behavioral health agency/facility, clinic, alternative residential facility or outpatient hospital.

- **NOTE**: Affiliated settings must be AHCCCS registered providers.

For services provided by a BHT or BHPP supervised by a BHP, claims are submitted as follows: Rendering Provider (when using a CMS-1500 Claim Form) – Use the Facility's NPI.

Effective for dates of service 7/1/2023 and after, when the 77 or IC is reported as the rendering/servicing provider, the participating provider must be listed on the claim.
All participating providers reported must be affiliated with a licensed behavioral health agency/facility, clinic, alternative residential facility or outpatient hospital.

The participating provider information entered in the additional information field (field 19) shall identify the individual who performed the service and not the billing group NPI. Claims submitted with the billing group NPI shall be denied.

Refer to **Exhibit 10-1 Participating Provider** for details on reporting requirements.

Claims submitted for services performed by a BHT or BHPP must include the appropriate modifier:

- (HM) Less than bachelor's degree level
- (HN) Bachelor's degree level
- (HO) Master's degree level
- (HP) Doctoral Level

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.

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

BEHAVIORAL HEALTH RESIDENTIAL FACILITY (BHRF)

Care and services provided in a Behavioral Health Residential Facility (BHRF) (Provider Type B8) are based on a per diem rate (24-hour day) **and do not include room and board**. All admissions and continued stays at a BHRF require prior authorization.

Information about BHRF criteria for admission, expected treatment outcomes, exclusionary criteria, criteria for continued stay, discharge readiness, admissions, assessments and treatment plans, personal care services, and medication assisted treatment can be found in the AHCCCS Medical Policy Manual (AMPM) Policy 320-V, Behavioral Health Residential Facilities.

For services that are included in the per diem rate (that cannot be billed separately) please review AMPM 320-V, Behavioral Health Residential Facilities.

The BHRF per diem rate is billed with HCPCS H0018.

BHRF admission is based upon the behavioral health assessment and treatment plan that recommends the member for BHRF level of care as evidenced by meeting the criteria for admission per AMPM 320-V. Since all members shall be placed at the lowest level of care that is required to achieve treatment goals, members cannot be placed in the BHRF level of care at the same time as receiving services at another level of care. For example, members cannot receive services at a BHRF and receive nonprofessional outpatient services at a Behavior Health Outpatient Clinic or Integrated Clinic (provider type 77 or IC) at the same time.

The exception to this rule is when the member is assessed to require professional specialized services as defined below and those services are included in the current comprehensive treatment/service plan. In addition to the daily BHRF full day treatment, professional specialized services that cannot be met in the BHRF and by the BHRF shall be included in the current comprehensive treatment/service plan detailing all treatment needs and the names, license/credentials of the treating providers.

Specialized services are defined as specialized behavioral health counseling and therapy provided directly by a BHP, who is an independent licensed practitioner, unaffiliated with the facility, and billed under the BHP's NPI with an appropriate CPT code. BHPs who are independent practitioners are licensed to practice without supervision, and are AHCCCS registered providers such as Physicians, Advanced Practice Nurses, Licensed Clinical Social Workers, Licensed Professional Counselors and Board-Certified Behavior Analysts.

Note: Behavioral health counseling and therapy that is provided directly by a BHT does not meet the criteria for specialized behavioral health counseling and therapy and is not billable. Behavioral health counseling and therapy shall not be provided by BHPPs.

The service frequency and duration should be described in the members' comprehensive service plan. The Frequency and duration of specialized services shall be appropriate and not provided instead of BHRF level of care. When billing for specialized services, if provided during the same day as BHRF services, may require additional prior authorization review and continued authorization to assess the appropriate level of care.

Example:
A Member receives assessment prior to BHRF admission at their outpatient clinic. BHRF BHP must assess that the treatment goals can be fully achieved at the BHRF. If it is determined that the member may likely achieve their treatment goals at another level of care, then the member cannot be placed at BHRF and should be referred to a medically appropriate level of care.

The BHRF's BHP oversight is part of the per diem and is not a separate billable service. When submitting a BHRF claim the name of the BHP, NPI, and company affiliation shall be documented in field 19 of the claim form.

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.

BHRFS AND PERSONAL CARE SERVICES

BHRFs who are also licensed through the Arizona Department of Health Services (ADHS) to provide personal care services may bill for H0018 (Behavioral health; short term residential, without room and board, per diem) with the TF modifier for personal care services.

This billing combination is only to be used by BHRFs licensed with ADHS to provide personal care services. Any member receiving such services must have had an assessment by a Physician, Physician Assistant or Advanced Practice Registered Nurse indicating that the member's condition requires assistance with personal care.

Please note that a BHRF licensed to provide personal care services shall only bill H0018 with the TF modifier for members that require personal care services, as documented in their assessment and comprehensive service plan.

For additional information regarding BHRFs refer to AMPM Policy 320-V, Behavioral Health Residential Facilities.

CASE MANAGEMENT

Case Management (provider level) is a supportive service provided to improve treatment outcomes. Case Management (CM) units of service are designed to capture significant client-specific services. Case Management services must be billed on a CMS 1500 Claim Form, and is reimbursed at the FFS rate.

CODING UNITS

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

To claim/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 claimed/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 claimed/billed.

MODIFIERS

For information on modifiers, refer to the Behavioral Health Services Matrix at:
https://www.azahcccs.gov/PlansProviders/MedicalCodingResources.html

For 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. Billing T1016 with an HK modifier indicates the specific usage of the SOAR approach and it cannot be used for any other service.

CASE MANAGEMENT LIMITATIONS:

i. Billing for case management is limited to providers who are directly involved with providing services to the member.
ii. A single practitioner may not bill case management simultaneously with any other service.
iii. Claims with T1016 must not be billed on the same day as H0018, H0014, H0035, H2020, H2018, H2016, H2026, H0037, S5109, T1020, S5151, S9480, or H0015 as case management services are included in each of the per diem rates.
iv. Case Management is not a reimbursable service for ALTCS-EPD, including Tribal ALTCS. Case Management is provided through the ALTCS-EPD Contractors or Tribal ALTCS Program.
v. Case management services provided by licensed inpatient, residential (BHRF) or day program providers are included in the rate for 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.
vi. 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.

vii. SOAR services shall only be provided by staff who have been certified in SOAR through the Substance Abuse and Mental Health Services Administration (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.

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, including but not limited to email or phone communication specific to a specific member's services and obtaining collateral information, as these activities are included in the rate calculation.

Case management does not include:

- Administrative functions such as authorization of services and utilization review;
- Outreach and communication that is not clinical in nature and directly related to the member's identified treatment needs, clinical presentation and access to services.
- Voice messages can be billed in limited circumstances. Asking for a return call or appointment reminders are not billable. There should be sufficient documentation to justify the need to bill for the voice message. Listening to voice messages cannot be billed.

T1016 shall not be used as a catch-all to bill for services not otherwise billable under other covered service codes.

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.

CARE COORDINATION

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).

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 RBHAs, 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 shall notify a Tribal ALTCS case manager within 24 hours of the emergency admission, and for MCO ALTCS, the provider shall notify the ALTCS contractor within 24 hours of the emergency admission.

BILLING INFORMATION

Although claims for emergency services do not require prior authorization, 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.

When requested, the provider must submit documentation with the claim which justifies the emergent nature of the service.

CRISIS SERVICES

Crisis services referenced in this section refer to the crisis services provided through AHCCCS' statewide behavioral health crisis services network contracted through the ACC-RBHAs.

- 24/7/365 crisis telephone lines are operated around the clock by trained crisis specialists.
- 24/7 mobile teams are staffed by behavioral health professionals who travel to the individual experiencing a crisis and provide assessment, stabilization, and, if needed, triage the individual to a higher level of care.
- Facility-based crisis stabilization centers offer crisis stabilization and observation, including access to Medication Assisted Treatment.

Crisis services are available to any Arizona resident regardless of health insurance coverage.

FIRST 24 HOURS OF CRISIS SERVICES

For Title XIX/XXI members, the first 24 hours of crisis services are the responsibility of the ACC-RBHA in the Geographical Service Area (GSA) where the crisis occurred. (For non-TXIX/XXI individuals, ACC-RBHAs are required to cover up to 72 hours per episode.)

- For Federal Emergency Services Program (FESP) members, the first 24 hours of crisis services are the responsibility of the ACC-RBHA and should be billed to the ACC-RBHA located in the GSA where the crisis occurred.

AFTER THE FIRST 24 HOURS OF CRISIS SERVICES

After the first 24 hours (i.e. the 25th hour forward) crisis services should be billed to the member's enrolled health plan.

The health plan of enrollment is responsible for payment of[1] medically necessary covered services (which may include follow up stabilization services) post-24 hours; the ACC-RBHA will remain responsible for any costs associated with follow up phone calls related to the crisis episode post-24 hours.[2]

- For FESP members, claims for crisis services after the first 24 hours (i.e. the 25th hour forward) should be billed to AHCCCS Division of Fee-for-Service Management (DFSM). Please note that only emergency services that meet FESP guidelines outlined in AMPM 1100 shall be eligible for reimbursement.

Crisis services include mobile team services, telephone crisis response, and facility-based crisis intervention services including observation, stabilization, and detoxification services. Crisis stabilization services will continue to include related transportation and facility charges.

ACC-RBHA mobile crisis teams must have right of entry from the tribe to provide services on tribal lands. If the tribe or TRBHA declines to allow right of entry to the ACC-RBHA mobile crisis team provider and instead contracts for services with a non-ACC-RBHA contracted mobile crisis provider, the claims should be sent to DFSM.

Claims for mobile crisis team services provided by an IHS or tribal 638 provider should be sent to DFSM.

Telephonic Crisis Intervention Services (Telephone Response) (H0030)

H0030 can only be utilized by a provider that is part of the state crisis system and contracted with an ACC-RBHA to provide telephonic crisis intervention services. Claims submitted to DFSM will be denied with instructions to bill to the ACC-RBHA.

Mobile Crisis Intervention Services (Mobile Crisis Teams) (H2011)

- For mobile crisis services, H2011 shall be used and the HT modifier added for the two-person multi-disciplinary team.
- H2011 shall only be billed for mobile crisis intervention services and only when provided by crisis providers. All other providers shall use standard outpatient codes for the services provided when working with a member.
- 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.[3]

Facility-Based Crisis Intervention Services (S9484, S9485)

Codes S9484 and S9485 shall only be billed for behavioral health observation/stabilization services provided by crisis stabilization facilities.

A crisis stabilization facility is an inpatient facility or outpatient treatment center licensed as specified in 9 A.A.C. 10 that provides crisis intervention services (stabilization).

Behavioral health observation/stabilization services (A.A.C. R9-10-101 (33)) means crisis services provided, in an outpatient setting, to an individual whose behavior or condition indicates that the individual:

a. Requires nursing services,

b. May require medical services, and

c. May be a danger to others or a danger to self.

Facility-based crisis intervention services are limited to up to 24 hours per episode. After 24 hours the member, depending on their discharge plan, should 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 inpatient 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.

Crisis stabilization 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.

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 facility.

In situations where the crisis services overlap days, the per diem code can span the two dates. Please see below for crisis billing examples.

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.

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.

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 enrolled health plan, regardless of the timing within the crisis episode.

The enrolled health plan 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.

For additional information on crisis services please visit the Crisis Services FAQs on the AHCCCS website and AMPM 590.

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

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.

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 four, 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.

FOR COURT ORDERED EVALUATION (COE) AND COURT ORDERED TREATMENT (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.

Several Arizona tribes have adopted their own procedures, which may align with Title 36 of the Arizona Revised Statutes 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.

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

https://www.azahcccs.gov/AmericanIndians/TribalCourtProceduresForInvoluntaryCom

mitment/

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. Licensed COT treatment facilities, including the Arizona State Hospital, must then provide treatment, as identified by the tribe and recognized by the state.

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

HOME CARE TRAINING FAMILY (FAMILY SUPPORT)

Home care training family (family support) support services are directed toward restoration, enhancement, or maintenance of the family functioning to increase the family's ability to effectively interact and care for the member in the home and community. Family support services may involve activities such as assisting the family to adjust to the members illness, developing skills to effectively interact and/or guide the member, understanding the causes and treatment of behavioral health issues, and understanding and effectively utilizing the healthcare system. Refer to AMPM Policy 964 for training and credentialing standards for credentialed parent/family support individuals providing parent/family support services.

Family support services provided by a licensed Behavioral Health Inpatient Facility (BHIF), Residential Treatment Center (RTC), Behavioral Health Residential Facility (BHRF), day program or Therapeutic Foster Care (TFC) are included in the rate for these settings and cannot be billed separately. However, providers other than the BHIF, RTC, BHRF, 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.

Code: S5110 Home care training, family; per 15 minutes

INDIVIDUAL VS. GROUP BASED SERVICES

Group-based services apply to services provided to two or more individuals. All members participating in group-based services shall be identified individually, and have claims submitted under their individual AHCCCS member ID with the applicable CPT/HCPCS code with the accompanying group modifier, and each member shall have their own treatment/ service plan.

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). Group based counseling services may not be provided in a member's private home, unless provided via telehealth (POS 10) and billed with modifier GT or FQ in addition to the applicable group modifier.

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.

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.

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
- 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

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 included within the higher level of service.

Nursing services provided in a licensed BHIF, RTC, BHRF, or medical day program setting are included in the rate and cannot be billed separately.

PARTIAL HOSPITALIZATION PROGRAMS (PHP)

PHPs are intended to be an alternative to inpatient psychiatric care. PHP services include intensive therapeutic treatment on an outpatient basis only and must be targeted to meet the goals of alleviating impairments and maintaining or improving functioning to prevent relapse or hospitalization.

Partial Hospitalization services must be billed with code H0035, mental health partial hospitalization, treatment less than 24 hours, only by the following approved provider types and with an approved place of service:

- The approved provider types are as follows:
- B2 Residential Treatment Center Non-Secure (1-16 Beds),
- B5 Subacute Facility (1-16 Beds),
- 02 Hospital, and
- 71 Psychiatric Hospital.

The approved places of service are as follows:

- 06 Indian Health Service - Provider Based Facility,
- 08 Tribal 638 – Provider Based Facility,
- 19 Off Campus-Outpatient Hospital,
- 22 On Campus-Outpatient Hospital,
- 52 Psychiatric Facility-Partial Hospitalization, and
- 62 Comprehensive Outpatient Rehabilitation Facility

PT 77 and ICs shall not bill for partial hospital services. Claims submitted by PT 77 and ICs will be denied.

For additional information on AHCCCS covered Behavioral Health Services refer to AMPM 310-B.

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.

Personal care services may be provided in an unlicensed setting such as a member's own home

or community setting. 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.

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.

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.

Respite services cannot be billed for members who are receiving services in an ADHS 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

Providers are prohibited from billing S5150 with the following codes: H0018, H0014, H0035, H2020, H2018, H2016, H2026, H0037, S109, T1020, S5151, and S9480.

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

- Billing Unit: Per Diem

Providers are prohibited from billing S5151 with H0001, H0002, H0004, H0006, H0018 H0025, H0034, H0036, H2012, H2014, H2015, H2017, H2019, H2025, H2027, H2033, S5150. T1019. H0031, H0038, H0030 or any other per diem code on the same day.

SELF-HELP/PEER SERVICES (PEER AND RECOVERY SUPPORT SERVICES)

Self-help/peer services (peer and recovery support services) are intentional partnerships based on shared experiences of living with behavioral health and/or substance use disorders, to provide social and emotional support as specified in AMPM Policy 963.

To receive Medicaid reimbursement for peer support services, the individual providing the service must have a Peer and Recovery Support Services (PRSS) credential from an AHCCCS-recognized Peer Support Employment Training Program (PSETP) and receive supervision as specified in Arizona Administrative Code (A.A.C. R9-10-101). Refer to AMPM Policy 310-B for additional details. AHCCCS Office of Individual and Family Affairs (OIFA) oversees the review and recognition process for Arizona's PSETPs. The PSETP credentialing the PRSS must be listed with OIFA.

FFS Providers delivering peer support services shall maintain AMPM 963 Attachment A documenting that all actively employed PRSS meet the required qualifications and credentialing for the delivery of peer support services. Attachment A shall be made available to AHCCCS DFSM upon request.

Self-help/peer services provided in an ADHS DLS licensed inpatient, residential or day program setting are included in the rate for those settings and cannot be billed separately and cannot be billed on the same day as a per diem code.

Self-help/peer services provided at a community-based organization such as Alcohol Anonymous (AA) may be a part of the member's comprehensive treatment plan but is not reimbursable by AHCCCS.

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 within the comprehensive treatment plan. Peer services shall be provided by an individual trained, credentialed, and qualified to provide peer and recovery support services within the AHCCCS programs.

- H0038 – Self-Help/Peer Services: Self-help/peer services (see general definition above) provided to an individual person for a short period of time (up to 2 ¾ hours).
  Billing Unit: 15 minutes

- H2016 – Comprehensive Community Support Services (peer support): Self- help/peer services (see general definition above) provided to a person for a period of time, 3 or more hours in duration.
  Billing Unit: Per Diem

SKILLS TRAINING AND DEVELOPMENT AND PSYCHOSOCIAL REHABILITATION

More than one provider agency may bill for skills training and development services and/or psychosocial rehabilitation living skills training services provided to a member at the same time if indicated by the member's clinical needs, as identified in their comprehensive treatment plan. H2014 (skills training and development) and H2017 (psychosocial rehabilitation services) will be denied if billed on the same day and ne the same day any per diem codes are billed.

TELEPHONIC SERVICES

Refer to the AHCCCS Telehealth Code Set for services that can be billed when providing telephonic services.

TELEHEALTH SERVICES

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

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

The POS for telehealth claims is the originating site.

Refer to the AHCCCS Telehealth Code Set, AMPM Policy 320-I Telehealth, and to Chapter 10, Individual Practitioner Services, of the Fee-for-Service Provider Billing Manual for additional information on telehealth services.

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. Psychosocial rehabilitation,
iv. Family support,
v. Pre-training activities,
vi. Clinical supervision and training,
vii. Participation in treatment and discharge planning,
viii. Over-the-counter drugs and non-customized medical supplies, and
ix. 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 comprehensive treatment plan provides justification 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 a member based on medical necessity.

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.

Refer to AMPM 310-B, Title XIX XXI Behavioral Health Service Benefit.

NON-TITLE XIX/XXI SERVICES

Claims for Non-Title XIX/XXI services are not billable to DFSM/AHCCCS.

Non-Title XIX/TXXI behavioral health services include but are not limited to:

- Auricular Acupuncture Services,
- Mental Health Services (Traditional Healing Services),
- Mental Health Services, Room and Board,
- Supportive Housing Services, and
- Crisis Services

For additional information on Non-Title XIX/XXI Services please refer to AMPM 320-T1.

REFERENCES

Please refer to the following chapters for additional information:

AMPM Exhibit 300-2A AHCCCS Covered Services Behavioral Health

AMPM 310-B Behavioral Health Services

AMPM 310-V Prescription Medications-Pharmacy Services

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

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

AMPM 650 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

Presentation: Overview of BH Services for IHS and 638 Providers

REVISION HISTORY

Date	Description of changes	Page(s)
7/8/2024	Added information regarding provider coercion to engage AHCCCS members into services.	1
	Removed definitions and redirected to AHCCCS Contract and Policy Dictionary.	2
	Revised Integrated health plans for physical and behavioral health services to include SMI and AIHP and ALTCS integration changes.	2
	Added Claims Payment section to outline where claims are to be sent based on member health plan/program. included DDD THP.	3
	Update Benefit Coordination for Members Enrolled with Different Entities for Physical and Behavioral Health Services to only include CHP members. Removed DES/DDD and SMI members based on integration.	4
	Revised General Billing Information to change how to navigate Behavioral Health Services Matrix. Added email to recommend changes to matrix.	7
	Revised Hospital services section to Inpatient Facility Services.	8
	Added Bed Holds and Therapeutic Leave section.	9
	Revised Outpatient Services section. Added reference to Exhibit 10 Participating Provider. Added Medication section to note medication in an inpatient general acute care or psychiatric hospital setting are included in the rate and cannot be billed separately. Added Provider types 77 and ICs services must be billed using a CMS 1500. Added guidance for the administration of opioid agonist drugs by Opioid Treatment Programs (OTPs).	10
	Added Behavioral Health Day Program section.	12
	Added Behavioral Health Professionals & Independent Billers section.	15
	Added Behavioral Health Services Provided by Behavioral Health Technicians (BHTs) Or Behavioral Health Paraprofessionals (BHPPs)	15
	Added Behavioral Health Residential Facility (BHRF) section.	16

	Added Case Management Section Revised Crisis Services section. Added clarification that Crisis services referenced in this section refer to the crisis services provided through AHCCCS' statewide behavioral health crisis services network contracted through the ACC-RBHAs. Removed crisis definition not aligning with AHCCCS Policy And Contract Dictionary. Added Home Care Training Family (Family Support) section. Added Individual VS. Group Based Services Section. Added Laboratory, Radiology and Medical Imaging Section Added Medical Management Section Added Partial Hospitalization Programs (PHP) section. Added Personal Care Services section. Added Psychoeducational Services and Ongoing Support to Maintain Employment Section Added Respite Care (Unskilled) section. Added Self-Help/Peer Services (Peer and Recovery Support Services) section. Added Skills Training and Development and Psychosocial Rehabilitation section. Added Therapeutic Foster Care (TFC) Section Added Provider Travel Section Added Non-Title XIX/XXI Services section.	17 20 26 26 27 27 28 28 29 29 30 31 31 32 32
	Added new section for Claim date span requirements	16
10/1/2021	Added Clinical Nurse Specialist to list of providers eligible to bill COS 47	15
7/14/2020	FESP Crisis Services information added to chapter.	10-11
7/8/2020	Link to the Behavioral Health Services Matrix updated Additional section on Crisis Service Billing for Telephonic Services added (code H0030 is replacing T1016 for telephonic crisis service billing)	8 11-12

12/7/2018	The entire chapter was restructured and formatting updated. Important Notice regarding the Covered Behavioral Health Service (CBHSG) added. List of covered behavioral health services updated. New section added called 'Members Enrolled in an Integrated Health Plan for Physical and Behavioral Health Services.' ALTCS/Tribal ALTCS EPD section updated, including an addition regarding where claims should be sent for BH services. (To AHCCCS DFSM). New section added called 'Benefit Coordination for Members Enrolled with Different Entities for Physical and Behavioral Health Services.' The referenced populations are: • 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.	1-18 1-2 2-3 3 4

	Definitions section updated for integration. The following definitions were removed (and a reference to where they can be found in AMPM has been added): 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 The following definitions were updated: Behavioral Health Entity Enrolled Health Plan	4-5
	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
	A General Billing Information section was added. A Place of Service section was added. A Common Modifiers for the Billing of Behavioral Health Services section was added. The Emergency Services section was updated for integration billing information. A Crisis Services section was added with billing examples. The Pre-Petition, Court Ordered Evaluations, and Court Ordered Treatment section was updated. 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,	8 8 8 8-9 9-10 10-11 12

	cost-effective, and federally and state reimbursable behavioral health medications prescribed by a PCP within their scope of practice." The References section was updated.	15-16
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	Definitions updated Emergency Services section updated Billing for Professional Services section updated Billing for Methadone Administration section updated Medication Assisted Treatment for Opioid Use Disorder added General Requirements Regarding Payment for Physical and Behavioral Health section updated. Inpatient Facility Payment Responsibility section updated Emergency Department Payment Responsibility section updated IHS Tribally Owned or Operated 638 Facilities section updated Specific Circumstances Regarding Payment for Behavioral Health section updated Court Ordered Evaluations & Financial Responsibility section added References updated Format changes	2-7 7-8 11 10-11 11 12-14 12 12 13 13-14 15 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