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 Web site at www.azahcccs.gov.

This policy applies to Fee-For-Service (FFS) providers for the purpose of benefit coordination and determining financial responsibility for AHCCCS covered behavioral health services provided to Fee-For-Service (FFS) members.

This policy also prescribe payment responsibility for physical health services that are provided to the members, who are also receiving behavioral health services.

Payment for AHCCCS covered behavioral health and physical health services 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.

This policy does not apply to services provided through the Indian Health Services (IHS) or Tribal owned and/or operated facilities (638).

AHCCCS covered behavioral health services include:

- Inpatient hospital services
- Inpatient psychiatric facilities (Level I residential treatment centers and Level I sub-acute facilities)
- 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

Acute Care Services
The enrolled health plan provides acute care physical health services to AHCCCS members in the acute care program who are Title XIX or Title XXI eligible.

The enrolled health plan is also responsible for providing behavioral health services for its enrolled members who are treated by a Primary Care Provider (PCP) for anxiety, depression, Attention Deficit Disorder (ADD)/Attention Deficit Hyperactivity Disorder (ADHD), and/or Opioid Use Disorders (OUD).

Acute Care Hospital
A general hospital that provides surgical services and emergency services.

American Indian Health Program (AIHP)
An acute care Fee-For-Service (FFS) program administered by AHCCCS for eligible American Indians, which reimburses for services provided by and through the Indian Health Services (IHS), tribal health programs operated under 638, or any other AHCCCS registered provider.

Behavioral Health Diagnosis
Behavioral health diagnoses can be located in the Covered Behavioral Health Services Guide available at: https://www.azahcccs.gov/PlansProviders/GuidesManualsPolicies-guidesandmanuals.html

Behavioral Health Entity
The entity to which the member is assigned for the provision of Behavioral Health services.

Behavioral Health Entities can be one of the following:
- Acute care enrolled health plan for adult members dually enrolled in Medicaid and Medicare with General Mental Health and Substance Abuse (GMH/SA) needs, except for members who elect a Tribal Regional Behavioral Health Authority (TRBHA) or Regional Behavioral Health Authority (RBHA) for behavioral health services;
- Regional Behavioral Health Authority (RBHA);
- Tribal Regional Behavioral Health Authority (TRBHA);
- Children’s Rehabilitative Services (CRS) Fully Integrated;
- CRS Partially Integrated Behavioral Health; and
- Tribal ALTCS.

**Court-Ordered Evaluation**
The proceedings and related services described in A.R.S. 36-520 et seq.
A professional multidisciplinary analysis based on data describing the person’s identity, biography, and medical, psychological and social conditions carried out by a group of persons consisting of not less than the following:

1. Two licensed physicians, who shall be qualified psychiatrists, if possible, or at least experienced in psychiatric matters, and who shall examine and report their findings independently. The person against whom a petition has been filed shall be notified that they may select one of the physicians. A psychiatric resident in a training program approved by the American Medical Association or by the American Osteopathic Association may examine the person in place of one of the psychiatrists if they are supervised in the examination and preparation of the affidavit and testimony in court by a qualified psychiatrist appointed to assist in their training, and if the supervising psychiatrist is available for discussion with the attorneys for all parties and for court appearance and testimony if requested by the court or any of the attorneys.

2. Two other individuals, one of whom, if available, shall be a psychologist and in any event a social worker familiar with mental health and human services, which may be available placement alternatives appropriate for treatment. An evaluation may be conducted on an inpatient basis, an outpatient basis, or a combination of both and every reasonable attempt shall be made to conduct the evaluation in any language preferred by the person.

**Court-Ordered Treatment**
In accordance with the A.A.C. R9-21-101 and A.R.S. § 36-533 in Arizona, an individual can be ordered by the court to undergo mental health treatment if found to fit one of the following categories due to a mental disorder:

1. A Danger to Self;
2. A Danger to Others;
3. Gravely Disabled, which means that the individual is unable to take care of his/her basic physical needs; or
4. Persistently or Acutely Disabled, which means that the individual is more likely to suffer severe mental or physical harm that impairs his/her judgment such that the person is not able to make treatment decisions for himself/herself.

**CRS Fully Integrated**
A coverage type which includes members who receive all services from the CRS Contractor, including acute health care, behavioral health and CRS-related services.

**CRS Only**
A coverage type, which includes members who receive all CRS-related services from the CRS Contractor, who receive acute health services from the enrolled health plan, and who receive behavioral health services as follows:

- CMDP and DDD American Indian (AI) members from a TRBHA
- AIHP members from a TRBHA or RBHA

CRS Only also includes Tribal ALTCS, ALTCS/EPD American Indian Fee-For-Service (FFS) members.

**CRS Partially Integrated – Acute**
A coverage type, which includes American Indian (AI) members, who receive all acute health and CRS-related services from the CRS Contractor and who receive behavioral health services from a TRBHA.

**CRS Partially Integrated – Behavioral Health (BH)**
A coverage type, which includes CMDP or DDD members, who receive all behavioral health and CRS-related services from the CRS Contractor and who receive acute health services from the enrolled health plan.

**Enrolled Health Plan**
The entity, which may be a Contractor or AHCCCS FFS, with which the member is enrolled for the provision of acute care services.

- For members enrolled in Acute Care, the enrolled health plan is the Acute Care Contractor or AHCCCS FFS.
- For members enrolled in DDD, with or without CRS coverage and/or BH coverage, the enrolled health plan is DDD.
- For members enrolled in CMDP, with or without CRS coverage and/or BH coverage, the enrolled health plan is CMDP.
- For members with Serious Mental Illness (SMI) with CRS coverage, who did not elect the American Indian Health Program (AIHP), the enrolled health plan is CRS under the CRS Fully Integrated coverage type.
• For members with Serious Mental Illness (SMI) with CRS coverage, who elect a TRBHA for behavioral health services, the enrolled health plan is CRS under the CRS Partially Integrated-Acute coverage type.

• For members with SMI without CRS coverage, who do not elect the AIHP, the enrolled health plan is a RBHA.

• For members with SMI without CRS coverage, who elect a TRBHA or RBHA for behavioral health services, the enrolled health plan is either the Acute Care Contractor (MCO) or AIHP.

• For members who elect the AIHP the enrolled health plan is AIHP.

• For members receiving all services from the CRS Contractor including acute health, behavioral health and CRS-related services, the enrolled health plan is CRS under the Fully Integrated CRS coverage type.

• For members receiving all services from Tribal ALTCS, including acute services and behavioral health services, the enrolled health plan is Tribal ALTCS.

Medication Assisted Treatment (MAT)
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.

Primary Care Provider
An individual who meets the requirements of A.R.S. §36-2901 and who is responsible for the management of the member’s health care. A primary care provider may be:

• A physician defined as a person licensed as an allopathic or osteopathic physician according to A.R.S. Title 32, Chapter 13 or Chapter 17; or

• A practitioner defined as a Physician Assistant licensed under A.R.S. Title 32, Chapter 25; or

• A certified nurse practitioner licensed under A.R.S. Title 32, Chapter 15.

The primary care provider must be an individual, not a group or association of persons, such as a clinic.

Principal Diagnosis
The condition established after study to be chiefly responsible for occasioning the admission or care for the member, as indicated by the principal diagnosis on a UB-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.

Pre-Petition Screening
The review of each application requesting court-ordered evaluation, including an investigation of facts alleged in such application, an interview with each applicant and an interview, if possible, with the proposed member. The purpose of the interview with the proposed member is to assess the problem, explain the application and, when indicated, attempt to persuade the proposed member to receive, on a voluntary basis, evaluation or other services.

Regional Behavioral Health Authority (RBHA)
An organization that provides behavioral health services to AHCCCS members who are Title XIX or Title XXI eligible.

The RBHA also provides physical health services for AHCCCS members determined to have a Serious Mental Illness (SMI), with the exception of American Indians who choose AIHP.

Serious Mental Illness (SMI)
A person 18 years of age or older, who has been determined to have a serious mental illness as defined in A.R.S. §36-550.

Tribal Regional Behavioral Health Authority
Tribal governments, through an agreement with the State, may operate a Tribal Regional Behavioral Health Authority for the provision of behavioral health services.

Voluntary Evaluation
An inpatient or outpatient evaluation service that is provided after a determination that a person will voluntarily receive an evaluation and is unlikely to present a danger to self or others until the voluntary evaluation is completed. A voluntary evaluation is invoked after the filing of a pre-petition screening, but before the filing of a court ordered evaluation and requires the informed consent of the person.

Acute Care Program Services
Title XIX and Title XXI (KidsCare) members enrolled with a health plan are eligible for the comprehensive package of behavioral health services through the AHCCCS subcontractors. These subcontractors are:
The Regional Behavioral Health Authorities (RBHAs), and
Tribal RBHAs (TRBHAs).

Title XIX and Title XXI (KidsCare) members enrolled with the American Indian Health Program (AIHP) may receive all available services from an IHS or a Tribal 638 facility. If a covered behavioral health service is not available through an IHS or a 638 facility, the member can receive services through their assigned TRBHA or RBHA.

The Arizona Department of Economic Security (DES) provides comprehensive medical services through the Comprehensive Medical and Dental Plan (CMDP) statewide. Behavioral health services for these members are provided through the RBHAs or TRBHAs.

**ALTCS Program Services**

ALTCS members are eligible for the comprehensive package of services through the ALTCS program contractors.

- The Elderly and Physically Disabled (EPD) program contractors provide behavioral health services through contracts with licensed behavioral health professionals and/or behavioral health agencies.
- DES/DDD has an intergovernmental agreement with ADHS/DBHS to provide comprehensive Title XIX behavioral health services to their members through the RBHAs or TRBHAs.
- Tribal contractors provide case management services to American Indians who reside on reservation. Members enrolled with Tribal Contractors 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.

**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 and to determine who is responsible (e.g., ALTCS contractor, health plan, RBHA/TRBHA, the AHCCCS Administration) for payment for services rendered.

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 acute FFS members assigned to a RBHA, the provider is required to coordinate care with the RBHA; for TRBHA assigned members, the provider is required to coordinate care with the assigned TRBHA; and for those members who are enrolled in Tribal ALTCS, the provider is required to coordinate care with the Tribal ALTCS Case Manager. The list of RBHA/TRBHA phone numbers is available at:

https://azweb.statemedicaid.us/HealthPlanLinksNet/HPLinks.aspx

The provider must notify the AHCCCS Prior Authorization Unit within 72 hours of the emergency behavioral health admission of a Tribal ALTCS 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.

**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:

The AHCCCS Behavioral Health Services Guide is available online at:

[https://www.azahcccs.gov/Shared/BehavioralHealthServicesGuide.html](https://www.azahcccs.gov/Shared/BehavioralHealthServicesGuide.html)

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.

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

**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

Not all provider types can bill for all services. For a list of allowable procedure codes by provider type refer to the Allowable Procedure Code Matrix online at:


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 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.

- Note: Non-AHCCCS registered behavioral health professionals, like BHTs, may bill for outpatient behavioral health services using revenue code 0510 for reimbursement at the AIR. However, the claim must be submitted using the facility NPI as the attending provider.

For example, a BHT may provide a behavioral health service at a behavioral health outpatient clinic (provider type 77). In this event the claim would be submitted with the behavioral health clinic listed as the attending provider on the UB-04 form.

For BCBA and BHT criteria refer to:


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 or BHT professionals. When billing for BCBA or BHT professional services, the clinic NPI is billed as the attending.

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

**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 when used to treat anxiety, depression (including postpartum depression), ADHD, and/or Opioid Use Disorder (OUD). 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.
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 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.

General Requirements Regarding Payment for Physical and Behavioral Health Services

Payment for AHCCCS covered behavioral health and physical 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 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 – B, Behavioral Health Provider Requirements for Assisting Individuals with Eligibility Verification and Screening/Application for Public Health Benefits.

MCO ALTCS and Tribal ALTCS Members

ALTCS Elderly and Physically Disabled (EPD) Enrolled Members are not assigned to a RBHA or TRBHA for behavioral health services. ALTCS EPD plans are integrated service plans that reimburse for both physical and behavioral health services.

MCO ALTCS EPD Enrolled Members
Payment for an emergency department facility claim and inpatient services for ALTCS EPD members enrolled in managed care is the responsibility of the enrolled entity.
The ALTCS contractor should be notified within 24 hours of admission.

Tribal ALTCS EPD Enrolled Members
Payment for an emergency department facility claim and/or inpatient services for Tribal ALTCS EPD members is the responsibility of the AHCCCS administration.
- A tribal case manager should be notified within 24 hours of admission.

Acute 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 health plan for both behavioral and physical health services.

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.

IHS/Tribally Owned or Operated 638 Facilities

1. AHCCCS Fee-For-Service (FFS) is responsible for payment of claims for physical and behavioral health services provided by an IHS or tribally owned and/or operated 638 facility to Title XIX members, whether enrolled in managed care or FFS.

2. If the member is a RBHA enrolled member, with a behavioral health diagnosis, the RBHA will be responsible for payment of claims for (physical and behavioral) health services that are provided by an IHS or tribally owned and/or operated 638 facility to Title XIX members.

3. KidsCare members enrolled with a MCO should have claims sent to the TRBHA.

4. KidsCare members enrolled with a RBHA should have claims sent to the RBHA.

For 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/400/432A.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.

Specific Circumstances Regarding Payment for Behavioral Health Services

1. The enrolled health plan is responsible for reimbursement of services associated with a primary care provider visit for diagnosis and treatment of depression (including postpartum depression), anxiety, Attention Deficit Hyperactivity Disorder (ADHD), and Opioid Use Disorder (OUD) 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.

2. 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 and the enrolled health plan is notified of the stay. Such coordination shall include, but is not limited to, communication/collaboration of authorizations and determinations of medical necessity.

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. When the enrolled health plan is AIHP and members are assigned to a TRBHA or a RBHA, then AHCCCS FFS is responsible for payment of medically necessary transportation services (emergent and non-emergent) when the diagnosis code on the claim is unspecified regardless of which entity scheduled the appointment.

5. Payment of pre-petition screening and court ordered evaluation services is the fiscal responsibility of a county. For payment responsibility for other court ordered services refer to AMPM Chapter 320-U for further information.

Court Ordered Evaluations & Financial Responsibility

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 RBHA/TRBHA 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.

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

References

Please refer to the Behavioral Health Services Guide for restrictions, scope and time limitations, provider requirements, and eligibility limitations for Title XIX and Title XXI behavioral health services at:
https://www.azahcccs.gov/Shared/BehavioralHealthServicesGuide.html

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 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


Revision History

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<td>Link updated on page 8 to link to the AHCCCS Behavioral Health Allowable Procedure Code Matrix</td>
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<td>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.”</td>
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<td>Definitions updated&lt;br&gt;Emergency Services section updated&lt;br&gt;Billing for Professional Services section updated&lt;br&gt;Billing for Methadone Administration section updated&lt;br&gt;Medication Assisted Treatment for Opioid Use Disorder added&lt;br&gt;General Requirements Regarding Payment for Physical and Behavioral Health section updated.&lt;br&gt;Inpatient Facility Payment Responsibility section updated&lt;br&gt;Emergency Department Payment Responsibility section updated</td>
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<td>New format Changed “ICD-9” to “ICD” in preparation for 10/1/2015 ICD-10</td>
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Behavioral Health changes effective service date 07/01/2016 and later BH Billing Matrix