AHCCCS Covered Behavioral Health Services Guide (CBHSG) Effective Oct. 1, 2024

Frequently Asked Questions

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Q25: When a section of the guide uses the term "same provider" does this mean the facility, or the individual staff providing the service?

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Q29: Regarding S9480- Intensive Outpatient Psychiatric programs. "Programming operates at least three hours per day for two or more days per week." Can AHCCCS clarify whether this needs to be 3 consecutive hours or if they are in a group for 2 hours and pulled for individual sessions for an hour can they do another hour of IOP to meet the 3 hours total for the day?

Q1: What is the AHCCCS Covered Behavioral Health Services Guide (CBHSG)?

A1: The Covered Behavioral Health Services Guide (CBHSG) is provided as a resource for general information regarding behavioral health services and commonly used billing codes. The CBHSG may be accessed on the AHCCCS Medical Coding Resources web page: azahcccs.gov/PlansProviders/MedicalCodingResources.html.

Q2: What is the Purpose of the AHCCCS CBHSG?

A2: The CBHSG may be utilized as a resource regarding specific behavioral health service definitions, related clinical guidelines and related coding standards and/or limitations. The CBHSG does not contain ALL codes or service requirements.

Q3: Who does the CBHSG apply to?

A3: The CBHSG is a resource available publicly. AHCCCS Contracted MCOs and AHCCCS-registered providers may utilize the Guide as one of the reference tools for appropriate coding of behavioral health service provision.

Q4: Who do I contact if I need training or technical assistance on implementing requirements in the CBHSG and/or AHCCCS policies?

A4: Providers who are contracted with an AHCCCS contracted health plan may contact the MCO with which they are contracted for training and/or technical assistance.

For AHCCCS registered providers servicing Fee-For-Service (FFS) members, including AIHP members, refer to the AHCCCS FFS Provider Resources document located here: https://www.azahcccs.gov/Resources/Downloads/DFSMTraining/2024/FFSProviderResources.pdf.

Q5:	Are there different requirements for providers serving FFS members versus providers serving managed care members? What are the different requirements?
A5:	AHCCCS requirements apply to all AHCCCS registered providers including those serving FFS members and those serving members who are enrolled with an MCO. AHCCCS FFS and/or MCOs may impose additional requirements and standards based on its provider network and provider agreements/contracts. Providers are encouraged to work with the MCO(s) with which they are contracted to ensure they are meeting all requirements of the MCO as well as AHCCCS.

Q6:	Does AHCCCS intend to provide trainings on the CBHSG? If so, when?
A6:	Part 1 with updated content based on the active 10/1/2024 CBHSG will be held on Wednesday, October 23 from 1:00pm - 2:30pm. Part 2 will be held on Thursday, October 24 from 1:00pm – 2:30pm. Visit the Division of Fee for Service Management: Training Resources web page for updated information: www.azahcccs.gov/Resources/Training/DFSM_Training.html.

Q7:	Are all codes, services, and treatments included in the Covered Behavioral Health Service Guide (CBHSG)?
A7:	No, the CBHSG does not contain ALL codes, services, and treatments. The CBHSG is provided as a resource for general information regarding services and commonly used billing codes. There are various other resources to utilize for references of codes and services including but not limited to AHCCCS Medical Policy Manual, AHCCCS FFS Billing Manual, AHCCCS IHS/Tribal Billing Manual, and the AHCCCS Medical Coding Resources webpage.

Q8:	Will the Managed Care Organizations (MCOs) adopt all the changes in the CBHSG?
A8:	Yes. The CBHSG is applicable to all MCOs and AHCCCS registered providers.

Q9:	Can associate level therapists treat Medicaid patients without registering directly with AHCCCS since they are not independently licensed?
A9:	Currently, AHCCCS does not have an active provider type for associate level Behavioral Health Professionals (BHPs). Associate level BHPs may provide services within their scope of practice and must bill for services utilizing the service ID of the AHCCCS registered facility from which they work to provide services at this time and for IHS/638 as specified in the AHCCCS IHS/Tribal Billing Manual.

Q10:	Can associate level BHPs bill CPT codes or do they need to use HCPCS codes?
A10:	An associate level BHP (non-independent biller) would use HCPCS codes and the service ID of the facility from which they work to provide services at this time.

Q11:	Can independently licensed BHPs bill CPT codes regardless of if the BHP works for themselves or under the facility?
A11:	An independently licensed BHP must be registered with AHCCCS and list themselves as the servicing provider on the claim when billing with CPT codes. The independently licensed BHP may also need to be credentialed with the MCO(s) according to their requirements.

Q12: How often is a Behavioral Health Assessment required to be done?

A12: Behavioral health assessments, service, and treatment plans shall be completed and updated at minimum, once annually, or more often as necessary based on clinical needs and/or upon significant life events. Refer to AMPM Policy 320-O, Behavioral Health Assessments, Services, and Treatment Planning.

Q13: How often is a CALOCUS required to be done?

A13: For children ages six through 17, an age-appropriate assessment (e.g., CALOCUS, shall be completed during the initial assessment and updated at least every six months. Refer also to AMPM Policy 320-O, Behavioral Health Assessments, Services, and Treatment Planning.

Q14: Are the examples provided in billing limitation #14 the only exceptions for BHP utilization of HCPCS vs. CPT codes?

A14: No. The language in the CBHSG under Core Billing Limitations #14 are only a few common examples of allowable exceptions.

Q15: If a provider has only one resident in the home and the resident's treatment plan states that this resident should receive Group Counseling can Individual Counseling be provided in place of the Group Counseling since there is only one resident in the home?

A15: Group Counseling should be offered in a BHRF. If one resident is in the facility the provider will continue to offer and provide counseling as indicated in the members BHRF treatment plan and can resume group sessions when additional residents are admitted.

Q16: For BHPs who provide oversight, review, and sign off of services, are those services not to be billed under the independent biller (e.g., an LPC)?

A16: Associate level licensees are not able to bill independently and should use the applicable HCPCS of the service provided. BHP clinical oversight and review of documentation are not billable services.

Q17: How are services billed when the rendering provider is an associate level BHP (e.g. LMSW, LAC, LASAC.)?

A17: See core billing limitations #18 in the CBHSG: Claims for services rendered by a non- independent biller (such as an associate level BHP, a BHT, or BHPP) shall be submitted utilizing the licensed behavioral health facility NPI as the rendering provider. The name of the individual providing the service shall be reported in Box 19.

Q18: If a Psychiatric Mental Health Nurse Practitioner (PMNP) renders a Psychiatric Evaluation, Prescribes Medication, and bills under Provider type 77, what is the appropriate code to use?

A18: The PMNP must use the appropriate CPT code for the service provided and list the PMNP's own NPI as the rendering/servicing provider.

Q19: Are CPT-based services excluded from the H0018 rate for Behavioral Health Residential Facilities (BHRFs)?

A19: CPT codes may be billed by a separate provider on the same day as H0018 if medical necessity is met for the specialty service and is included in the members' service plan.

Q20: Can H0046 be used to request Non-Title XIX/XXI funding for Title XIX/XXI members to cover the cost of Room and Board for residential settings if the rate does not include it already?

A20: H0046 is not a Title XIX/XXI covered service but can be billed to Non-Title XIX/XXI funding sources for Title XIX/XXI members who meet the criteria of a specific Non-Title XIX/XXI program criteria. See AMPM Policies 320-T1 and 320-T2 for additional information.

Q21: Are Service Plan and Treatment Plan used interchangeably in the CBHSG?

A21: No. AHCCCS is reviewing our definitions of Service and Treatment Plan between policy, state plan and rule. These terms should not be interchangeable but may often be stated as Service Plan or Treatment plan to indicate applicability to health homes and specialty providers.

Q22: The Behavioral Health Matrix (B2 Matrix) used to have a tab that defined Modifiers and Place of Service. Where can I find that information now?

A22: Refer to the Coding Related Exhibits and Policy Reference drop down menu on the AHCCCS Medical Coding Resources webpage. The AHCCCS Modifiers List has been made available at this link: azahcccs.gov/PlansProviders/Downloads/MedicalCodingResources/AHCCCS_ModifiersList2024.pdf and the Place of Service list has been made available at this link: https://azahcccs.gov/PlansProviders/Downloads/MedicalCodingResources/AHCCCS_PlaceOfServiceCodes2024.pdf

Q23: Where can I find information on Telehealth Place Of Service (POS) requirements?

A23: Refer to the Reference Extracts drop down menu on the AHCCCS Medical Coding Resources webpage. The Telehealth code set has been made available at this link: https://azahcccs.gov/AHCCCS/Initiatives/Telehealth/

Q24: Can AHCCCS clarify the "all-inclusive" language? Is all-inclusive language similar to a "daily rate", where all services regardless of who delivers the service is inclusive to the code? In other words, can you confirm that all CPT and HCPCS codes are included in the partial hospitalization code H0035?

A24: In the CBHSG, all-inclusive coding indicates that certain services or procedures are inherently included within another primary service or procedure, and therefore cannot be billed separately.

Q25: When a section of the guide uses the term "same provider" does this mean the facility, or the individual staff providing the service?

A25: "Same provider" in the CBHSG refers to the facility.

Q26:	**Are Respite modifiers required for respite services performed in a Behavioral Health Residential Facility?**
A26:	Yes, the required modifiers for respite services are applicable to all provider types providing Respite services.

Q27:	**For medical management for the patient, can providers bill an add on procedure code over and above IOP or is this included as a cost into calculation of the rate?**
A27:	Medical Management services are not included in the per diem rate for IOP services. Behavioral Health HCPCS and professional CPT services cannot be billed separately during the same time period on the same day as S9480 to prevent overlapping.

Q28:	**Will Prior Authorization for Intensive Outpatient Programming (IOP) MH/SUD be required starting on 10/01/2024?**
A28:	Prior Authorization (PA) is not currently required for Intensive Outpatient Programming (IOP) by AHCCCS Fee-For-Service programs. MCOs may require PA on this and any other service that is not specifically prohibited by AHCCCS. Providers are encouraged to request clarification on PA requirements from all MCOs for which they are contracted.

Q29:	**Regarding S9480- Intensive Outpatient Psychiatric programs. "Programming operates at least three hours per day for two or more days per week." Can AHCCCS clarify whether this needs to be 3 consecutive hours or if they are in a group for 2 hours and pulled for individual sessions for an hour can they do another hour of IOP to meet the 3 hours total for the day?**
A29:	S9480 – Intensive Outpatient Psychiatric Services are a comprehensive outpatient treatment program inclusive of psychiatric services, individual, group and family therapy, peer support services and educational groups. If the individual session is a service included in the per diem rate, the total 3-hour requirement would be satisfied. Behavioral health HCPCS codes and professional CPT services for other individual sessions cannot be billed separately during the same time period on the same day as S9480 to prevent overlapping.