





AHCCCS Fee-For-Service

Covered Behavioral Health Services Guide Overview

Part 1

Revision date: August 01, 2024

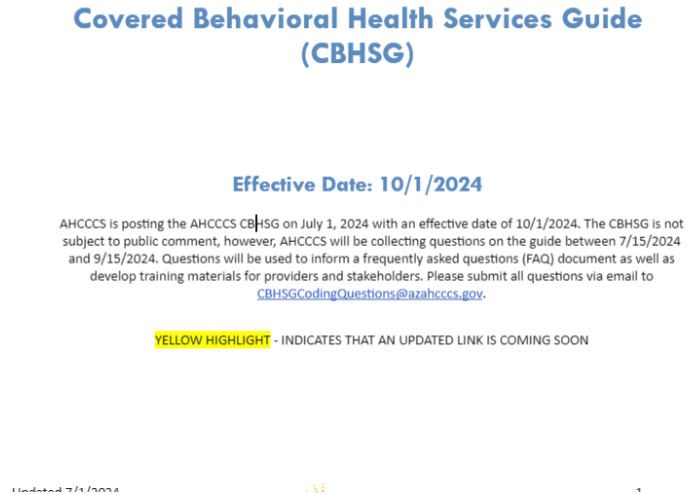
AHCCCS
Arizona Health Care Cost Containment System

Introduction
AHCCCS Covered Behavioral Health Services Guide

[Covered Behavioral Health Services Guide (CBHSG)]

The CBHSG is a resource for BH providers for basic billing and coding information. The purpose of this document is to compile billing and compliance information and clarify rules for service delivery, billing, and encounters.

These are pending changes. The CBHSG will go into effect 10/1/2024.



Covered Behavioral Health Services Guide (CBHSG)

Effective Date: 10/1/2024

AHCCCS is posting the AHCCCS CBHSG on July 1, 2024 with an effective date of 10/1/2024. The CBHSG is not subject to public comment, however, AHCCCS will be collecting questions on the guide between 7/15/2024 and 9/15/2024. Questions will be used to inform a frequently asked questions (FAQ) document as well as develop training materials for providers and stakeholders. Please submit all questions via email to CBHSGCodingQuestions@azahcccs.gov.

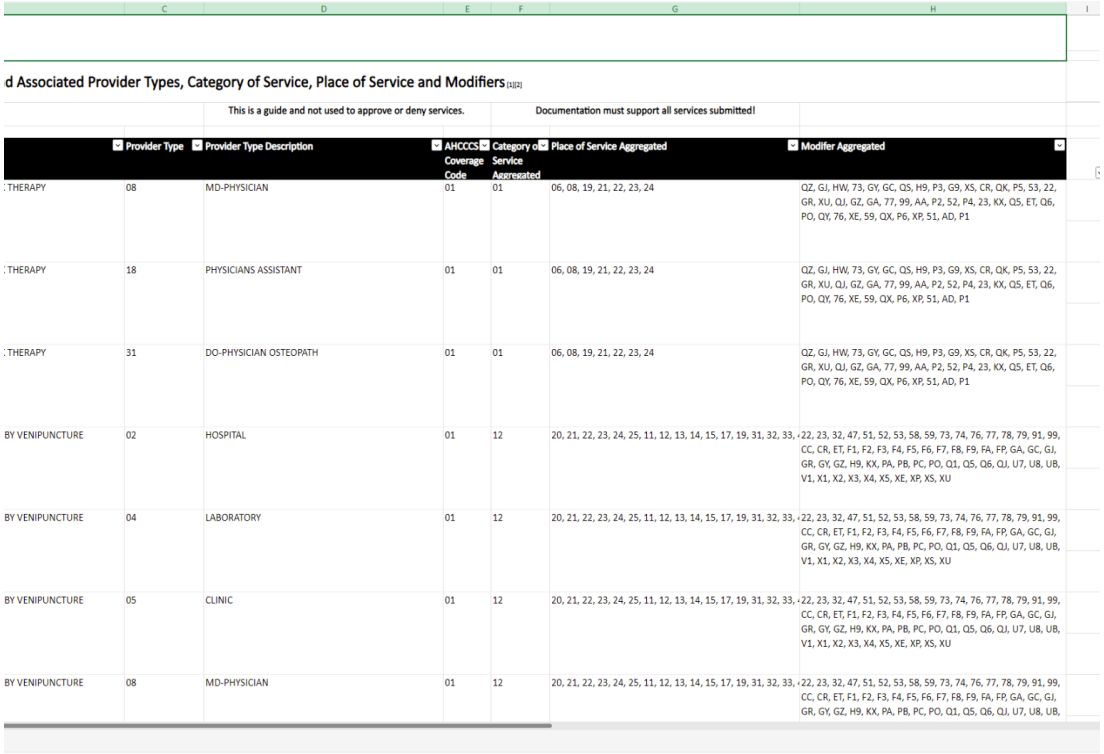
YELLOW HIGHLIGHT - INDICATES THAT AN UPDATED LINK IS COMING SOON

Covered Services Guide Questions

CBHSGCodingQuestions@azahcccs.gov

This email should be used for questions directly related to the Covered Behavioral Service Guide.

B2 Matrix



d Associated Provider Types, Category of Service, Place of Service and Modifiers [1][2]

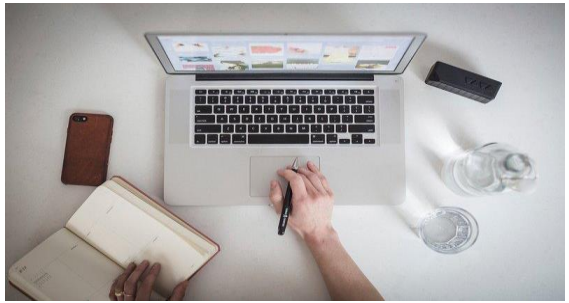
This is a guide and not used to approve or deny services. Documentation must support all services submitted!

	Provider Type	Provider Type Description	AHCCCS Coverage Code	Category of Service Aggregated	Place of Service Aggregated	Modifer Aggregated
THERAPY	08	MD-PHYSICIAN	01	01	06, 08, 19, 21, 22, 23, 24	QZ, GJ, HW, 73, GY, GC, QS, H9, P3, G9, XS, CR, QK, P5, 53, 22, GR, XU, QJ, GZ, GA, 77, 99, AA, P2, 52, P4, 23, KX, Q5, ET, Q6, PO, QY, 76, XE, 59, QX, P6, XP, 51, AD, P1
THERAPY	18	PHYSICIANS ASSISTANT	01	01	06, 08, 19, 21, 22, 23, 24	QZ, GJ, HW, 73, GY, GC, QS, H9, P3, G9, XS, CR, QK, P5, 53, 22, GR, XU, QJ, GZ, GA, 77, 99, AA, P2, 52, P4, 23, KX, Q5, ET, Q6, PO, QY, 76, XE, 59, QX, P6, XP, 51, AD, P1
THERAPY	31	DO-PHYSICIAN OSTEOPATH	01	01	06, 08, 19, 21, 22, 23, 24	QZ, GJ, HW, 73, GY, GC, QS, H9, P3, G9, XS, CR, QK, P5, 53, 22, GR, XU, QJ, GZ, GA, 77, 99, AA, P2, 52, P4, 23, KX, Q5, ET, Q6, PO, QY, 76, XE, 59, QX, P6, XP, 51, AD, P1
BY VENIPUNCTURE	02	HOSPITAL	01	12	20, 21, 22, 23, 24, 25, 11, 12, 13, 14, 15, 17, 19, 31, 32, 33,	22, 23, 32, 47, 51, 52, 53, 58, 59, 73, 74, 76, 77, 78, 79, 91, 99, CC, CR, ET, F1, F2, F3, F4, F5, F6, F7, F8, F9, FA, FP, GA, GC, GJ, GR, GY, GZ, H9, KX, PA, PB, PC, PO, Q1, Q5, Q6, QJ, U7, U8, UB, V1, X1, X2, X3, X4, X5, XE, XP, XS, XU
BY VENIPUNCTURE	04	LABORATORY	01	12	20, 21, 22, 23, 24, 25, 11, 12, 13, 14, 15, 17, 19, 31, 32, 33,	22, 23, 32, 47, 51, 52, 53, 58, 59, 73, 74, 76, 77, 78, 79, 91, 99, CC, CR, ET, F1, F2, F3, F4, F5, F6, F7, F8, F9, FA, FP, GA, GC, GJ, GR, GY, GZ, H9, KX, PA, PB, PC, PO, Q1, Q5, Q6, QJ, U7, U8, UB, V1, X1, X2, X3, X4, X5, XE, XP, XS, XU
BY VENIPUNCTURE	05	CLINIC	01	12	20, 21, 22, 23, 24, 25, 11, 12, 13, 14, 15, 17, 19, 31, 32, 33,	22, 23, 32, 47, 51, 52, 53, 58, 59, 73, 74, 76, 77, 78, 79, 91, 99, CC, CR, ET, F1, F2, F3, F4, F5, F6, F7, F8, F9, FA, FP, GA, GC, GJ, GR, GY, GZ, H9, KX, PA, PB, PC, PO, Q1, Q5, Q6, QJ, U7, U8, UB, V1, X1, X2, X3, X4, X5, XE, XP, XS, XU
BY VENIPUNCTURE	08	MD-PHYSICIAN	01	12	20, 21, 22, 23, 24, 25, 11, 12, 13, 14, 15, 17, 19, 31, 32, 33,	22, 23, 32, 47, 51, 52, 53, 58, 59, 73, 74, 76, 77, 78, 79, 91, 99, CC, CR, ET, F1, F2, F3, F4, F5, F6, F7, F8, F9, FA, FP, GA, GC, GJ, GR, GY, GZ, H9, KX, PA, PB, PC, PO, Q1, Q5, Q6, QJ, U7, U8, UB,

- Excel file showing the appropriate combinations of provider types, service codes, place of service, and modifiers
- https://azahcccs.gov/PlansProviders/Downloads/MedicalCodingResources/B2Matrix2024.xlsx

Reminders

- There will be frequent updates. Always refer to the most recent version online.
- These are pending directives until the finalized manual is released 10/1/24.
- This training will not address pre payment review or denial codes. Please direct questions pertaining to these issues to DFSMclaimsassistance@azahcccs.gov.
- This training is specific to Division of Fee for Service programs such as AIHP. The MCOs will release their own trainings.



Provision of Services

Provision of Services

This section focuses on the different behavioral health provider practitioners to include but not limited to:

- Behavioral Health Professional,
- Behavioral Health Technician, and
- Behavioral Health ParaProfessional,
- Qualification, Certifications, Clinical oversight and supervision,
- Peer and Recovery Support Specialist, and
- Credentialed Family Support Partner.

Provider

Provider Enrollment Screening Glossary

This guide is used to review each available AHCCCS provider type and its applicable enrollment requirements.

Provider Type Code	Provider Type Name	Enrollment Type	National Provider Identifier (NPI) Required? (Yes/No)	Enrollment Fee Required? (Yes/No)	Site Visit Required? (Yes/No)	Risk Category	Regulatory Agency and Certifications	Fingerprint-based Criminal Background Check Required?
A5	Behavioral Health Therapeutic Home	INDIVIDUAL	Yes	No	No	Limited	Child Services: Arizona Department of Child Safety (DCS) https://dcs.az.gov Adult Services: Arizona Department of Health Services (ADHS) www.azdhs.gov Behavioral Health Provider Certification and Transmittal (BH C&T)	No
A6	Rural Substance Abuse Transitional Agency	FAO	Yes	Yes	No	Limited	Adult Services: Arizona Department of Health Services (ADHS) www.azdhs.gov Behavioral Health Provider Certification and Transmittal (BH C&T)	No
A8	Individual Home Respite (IHR)	FAO	Yes	Yes	No	Limited	Adult Services: Arizona Department of Health Services (ADHS) www.azdhs.gov Behavioral Health Provider Certification and Transmittal (BH C&T)	No
B1	Residential Treatment Center - Secure (17+ Beds) (IMD)	FAO	Yes	Yes	No	Limited	Adult Services: Arizona Department of Health Services (ADHS) www.azdhs.gov Behavioral Health Provider Certification and Transmittal (BH C&T)	No
B2	Residential Treatment Center Non-Secure (1-16 Beds)	FAO	Yes	Yes	No	Limited	Adult Services: Arizona Department of Health Services (ADHS) www.azdhs.gov Behavioral Health Provider Certification and Transmittal (BH C&T)	No
B3	Residential Treatment Center Non-Secure (17+ Beds) (IMD)	FAO	Yes	Yes	No	Limited	Adult Services: Arizona Department of Health Services (ADHS) www.azdhs.gov Behavioral Health Provider Certification and Transmittal (BH C&T)	No
B5	Subacute Facility (1-16 Beds)	FAO	Yes	Yes	No	Limited	Adult Services: Arizona Department of Health Services (ADHS) www.azdhs.gov Behavioral Health Provider Certification and Transmittal (BH C&T)	No
B6	Subacute Facility (17+Beds)(IMD)	FAO	Yes	Yes	No	Limited	Adult Services: Arizona Department of Health Services (ADHS) www.azdhs.gov Behavioral Health Provider Certification and Transmittal (BH C&T)	No
B7	Crisis Services Provider	FAO	Yes	Yes	No	Limited	Adult Services: Arizona Department of Health Services (ADHS) www.azdhs.gov Behavioral Health Provider Certification and Transmittal (BH C&T)	No
B8	Behavioral Health Residential Facility	FAO	Yes	Yes	Yes	High	Adult Services: Arizona Department of Health Services (ADHS) www.azdhs.gov Behavioral Health Provider Certification and Transmittal (BH C&T)	Yes
BC	Board Certified Behavior Analyst	INDIVIDUAL	Yes	No	No	Limited	Arizona Board of Psychologist Examiners https://psychboard.az.gov	No
C2	Federally Qualified Health Center (FQHC)	FAO	Yes	Yes	No	Limited	Arizona Department of Health Services (ADHS) www.azdhs.gov & Proof of FQHC designation	No
C4	Specialty Per Diem Hospitals	FAO	Yes	No	No	Limited	Arizona Department of Health Services (ADHS) www.azdhs.gov	No
C5	638 Federally Qualified Health Center (FQHC)	FAO	Yes	Yes	No	Limited	Refer to Arizona Health Care Cost Containment System – Provider Enrollment	No
CH	Community Health Worker Organizations	ATYPICAL-FAO	No	Yes	Yes	High	Arizona Department of Health Services (for Community Health workers employed by the organization)	Yes

- A person or entity registered with AHCCCS to provide covered services directly to members.
- Registration with AHCCCS is required.
- Provider Enrollment Screening glossary: https://www.azahcccs.gov/PlansProviders/Downloads/apep/PEP-903.xlsx
- A BH facility shall be licensed through ADHS or for IHS/638 providers and tribal health programs operated under P.L. 93-638, in accordance with the scope of services within their P.L. 93-638 contract or compact, and shall designate one or more BHPs to direct & oversee all behavioral health treatment services.

Billing For Services

Billing for Services

This section outlines general billing and coding guidance for Behavioral Health Services.

- Services Covered by AHCCCS
- Modifiers
- Telehealth Services
- Place of Service (POS) Codes
- Diagnosis Codes
- Group Payment ID
- Training Resources
- Core Billing Limitations
- Services Not Covered by Medicaid

Medical Coding Resources

Providers can contact the AHCCCS Medical Coding Unit for questions related to specific coding and/or AHCCCS policy.

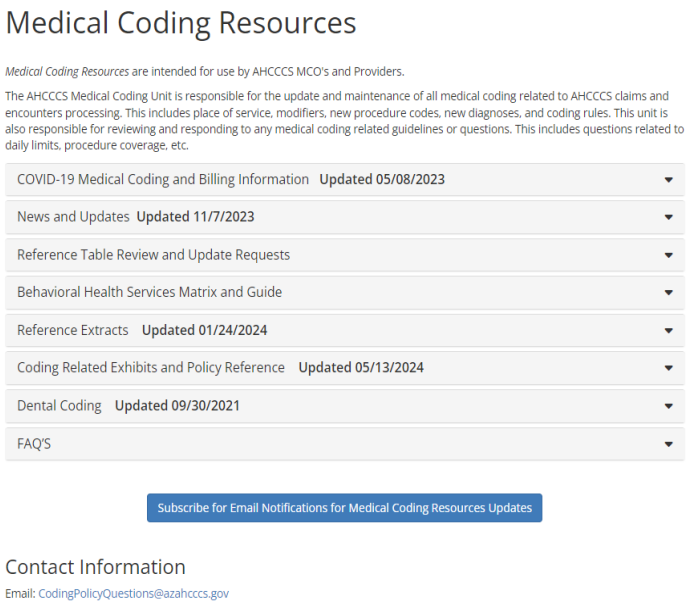
- Email: CodingPolicyQuestions@AZAHCCCS.gov
  - ***REMINDER* AHCCCS Medical Coding Unit does NOT advise providers/entities on how to code, nor do we review documentation or investigate denials.**
- Request for coding updates can be submitted via an RTRU form and there are instructions on how to fill this out. It must be sent to the coding unit in WORD format, or it will be returned.
- Refer to the AHCCCS Medical Coding Resources page for instructions on how to complete the RTRU form.

Billing for Services

- In addition to the general principles related to the provision of services, there are also general guidelines, which must be followed in billing for covered behavioral health services to ensure that services will be reimbursed, and/or the encounters accepted.
- AHCCCS Provider, Profile and Reference tables should be used by all providers to determine the correct values on submitted claims/encounters.

Modifiers

- Use national coding standards including the use of applicable modifier(s).
- Refer to the AHCCCS Medical Coding Resources webpage for up to date information about valid modifiers, place of service codes, category of service and appropriate provider types.
- Use modifiers when documentation supports their usage.
- Some services require use of modifiers to align with correct coding guidelines & policy.
- For a listing of which modifiers apply to which behavioral health codes, visit the AHCCCS Behavioral Health Services Matrix.



Medical Coding Resources

Medical Coding Resources are intended for use by AHCCCS MCO's and Providers.

The AHCCCS Medical Coding Unit is responsible for the update and maintenance of all medical coding related to AHCCCS claims and encounters processing. This includes place of service, modifiers, new procedure codes, new diagnoses, and coding rules. This unit is also responsible for reviewing and responding to any medical coding related guidelines or questions. This includes questions related to daily limits, procedure coverage, etc.

COVID-19 Medical Coding and Billing Information **Updated 05/08/2023**

News and Updates **Updated 11/7/2023**

Reference Table Review and Update Requests

Behavioral Health Services Matrix and Guide

Reference Extracts **Updated 01/24/2024**

Coding Related Exhibits and Policy Reference **Updated 05/13/2024**

Dental Coding **Updated 09/30/2021**

FAQ'S

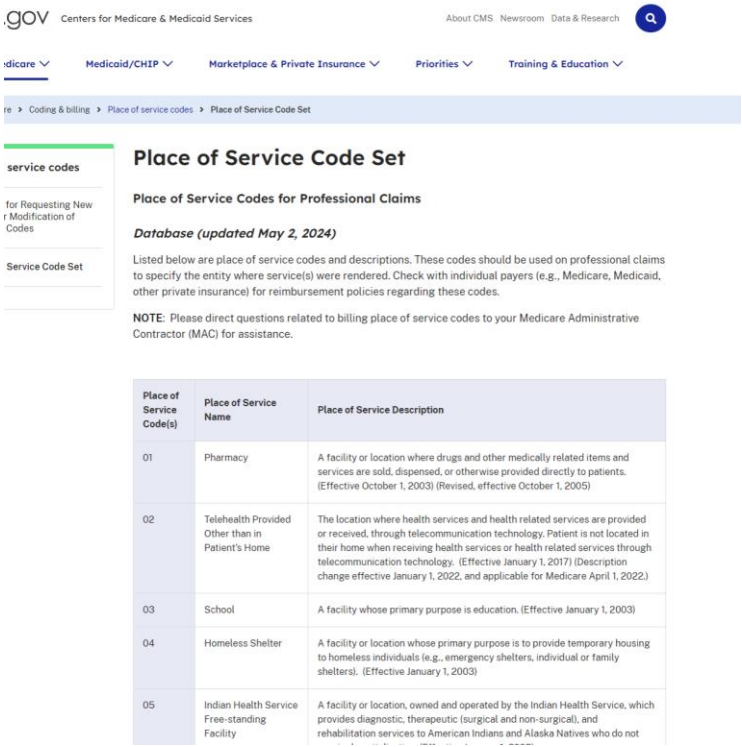
Subscribe for Email Notifications for Medical Coding Resources Updates

Contact Information

Email: CodingPolicyQuestions@azahcccs.gov

Place of Service

- Accurate Place of Service (POS) codes must be submitted on claims and encounters to specify where service was rendered.
- The Centers for Medicare and Medicaid Services (CMS) place of service table: https://www.cms.gov/medicare/coding-billing/place-of-service-codes/code-sets



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re › Coding & billing › Place of service codes › Place of Service Code Set

service codes

for Requesting New r Modification of Codes

Service Code Set

Place of Service Code Set

Place of Service Codes for Professional Claims

Database (updated May 2, 2024)

Listed below are place of service codes and descriptions. These codes should be used on professional claims to specify the entity where service(s) were rendered. Check with individual payers (e.g., Medicare, Medicaid, other private insurance) for reimbursement policies regarding these codes.

NOTE: Please direct questions related to billing place of service codes to your Medicare Administrative Contractor (MAC) for assistance.

Place of Service Code(s)	Place of Service Name	Place of Service Description
01	Pharmacy	A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients. (Effective October 1, 2003) (Revised, effective October 1, 2005)
02	Telehealth Provided Other than in Patient's Home	The location where health services and health related services are provided or received, through telecommunication technology. Patient is not located in their home when receiving health services or health related services through telecommunication technology. (Effective January 1, 2017) (Description change effective January 1, 2022, and applicable for Medicare April 1, 2022.)
03	School	A facility whose primary purpose is education. (Effective January 1, 2003)
04	Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters). (Effective January 1, 2003)
05	Indian Health Service Free-standing Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not

Group Payment ID (Provider Type 01)

An organization may act as the financial representative for any AHCCCS registered provider or group of AHCCCS registered providers who have authorized the arrangement. Such an organization must register with AHCCCS as a group payment provider. Under their group payment ID number, the organization may not provide services or bill as the service provider.

A PT 01 cannot be used as a servicing provider.

Telehealth Services

AHCCCS recognizes telehealth services as an effective mechanism for the delivery of certain covered behavioral health services. See AHCCCS Policy 320-I, Use of Telemedicine.

Telehealth services should be clearly identified using the appropriate Place of Service (POS), 10 for services provided in a members home and 02 for telehealth providers in a place other than a members home as well as any applicable telehealth modifier.

Telehealth services provided by Assertive Community Treatment (ACT) Teams shall be provided in accordance with best practice as outlined in the Substance Abuse and Mental Health Services Administration (SAMHSA) Evidence-Based Practices (EBP) Toolkit, this includes the expectation of in-person support services. Services rendered by the medication prescriber for members on an ACT team may be provided via simultaneous real-time audio and video telecommunications if in-person services are not available.

Diagnosis Codes

While a diagnosis is not needed to receive treatment, a diagnostic code is needed for service code billing. ICD-10 codes are the industry standard and are required for all Medicaid/Medicare billing purposes.

The ICD-10-CM diagnosis codes must be used when submitting claims and encounters (see the *International Classification of Diseases – 10th Revision – Clinical Modification Manual)*. While each claim or encounter must include at least one valid ICD-10 diagnosis code describing the person's condition, all ICD-10 codes are to be submitted based on documentation and must be reported to its highest specificity.

Diagnosis Codes

Although ICD-10 and DSM diagnosis codes are substantially alike, DSM codes must not be used for billing a claim. DSM diagnostic criteria and symptom severity measures may be used by a qualifying provider in order to justify a diagnosis.

Documentation in the comprehensive assessment must include justification for establishing the diagnosis including but not limited to patient report of presenting problem(s), parent/guardian direct observations of presenting problem(s), and diagnostic impression from the clinician including measures of current severity on the claim. Subsequent determination that the medical record is lacking a justification will result in a retroactive denial of the claim.

Core Billing Limitations

Core Billing Requirements: Medical Necessity

- BH services must be medically necessary.
- Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the member's needs;
- Documented in the service plan;
- Safely furnished,
- No equally effective and more conservative or less costly treatment is available statewide; and
- Furnished in a manner not primarily intended for the convenience of the member, the member's caretaker, or the provider.

Core Billing Limitations: Coding

CPT and HCPCS codes must meet all coding, documentation and scope of practice as well as all policy guidelines.

8 Minute Rule

For any single timed CPT or HCPCS code in the same day measured in 15 minute units, providers bill a single 15-minute unit for treatment greater than or equal to 8 minutes through and including 22 minutes.

Time intervals for 1 through 8 units are as follows: Units Number of Minutes

- 1 unit: = 8 minutes through 22 minutes
- 2 units: = 23 minutes through 37 minutes
- 3 units: = 38 minutes through 52 minutes
- 4 units: = 53 minutes through 67 minutes
- 5 units: = 68 minutes through 82 minutes
- 6 units: = 83 minutes through 97 minutes
- 7 units: = 98 minutes through 112 minutes
- 8 units: = 113 minutes through 127 minutes

The pattern remains the same for treatment times in excess of 2 hours.

8 Minute Rule

- It is not appropriate to count all minutes of treatment in a day toward the units for one code if other services were performed for more than 15 minutes.
- If any 15 minute timed service that is performed for 7 minutes or less than 7 minutes on the same day as another 15 minute timed service that was also performed for 7 minutes or less and the total time of the two is 8 minutes or greater than 8 minutes, then bill one unit for the service performed for the most minutes. This is correct because the total time is greater than the minimum time for one unit. The same logic is applied when three or more different services are provided for 7 minutes or less than 7 minutes.

8 Minute Rule (cont)

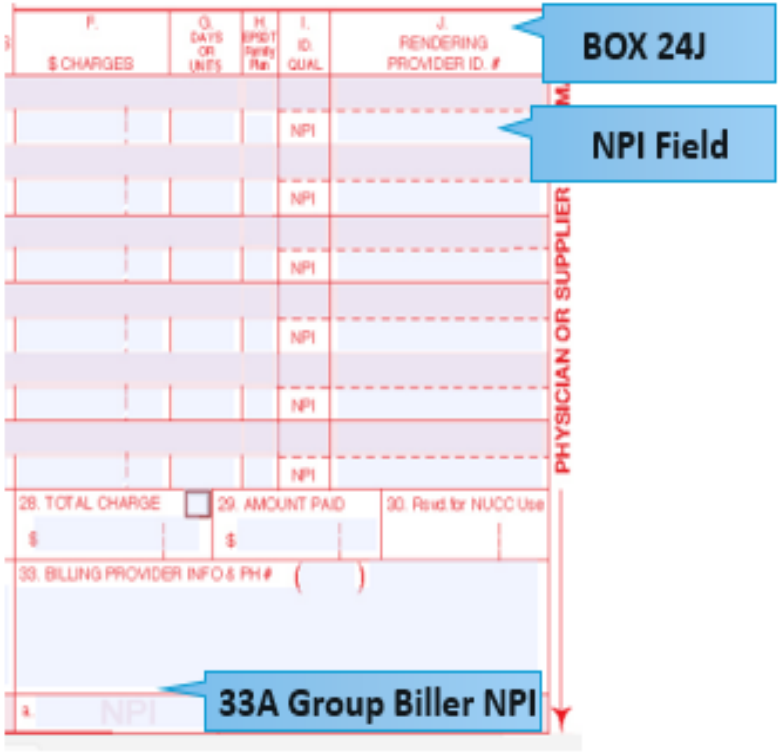
- The expectation (based on the work values for these codes) is that a provider's direct patient contact time for each unit will average 15 minutes in length. If a provider has a consistent practice of billing less than 15 minutes for a unit, these situations should be highlighted for review. If more than one 15 minute timed CPT code is billed during a single calendar day, then the total number of timed units that can be billed is constrained by the total treatment minutes for that day.
- **There are codes that are specific to time and providers must follow the guidelines as outlined in the American Medical Association CPT coding book.**

Servicing (rendering) vs. Billing vs. Participating Provider

Box 24J: NPI of the servicing/rendering provider.

- If the individual who delivered the service has a license, then use their NPI (service)
- If the individual who rendered the service is not licensed, then use the NPI of the licensed facility (PT 77, IC, or 05) and put the name of the individual in box 19 as the participating provider with the appropriate qualifier code.

Box 33A: NPI of the billing provider. This is where the payment will be sent.

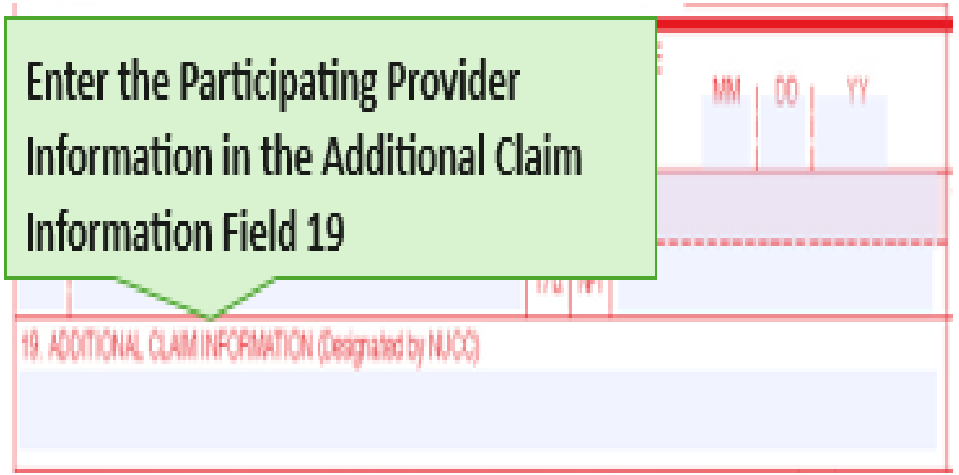


Servicing (rendering) vs. Billing vs. Participating Provider

Box 19: Participating provider is the name of the individual who delivered the service in the following formats:

AHCCCS registrable provider type: XXNPISmith, Tom

AHCCCS Non-registrable provider type: 9999999999Smith, Tom



Managed Care Organizations

- In order to bill services to a Managed Care Organization (MCO), the provider must be credentialed and contracted with the MCO.
- Providers contracted with an MCO must follow all additional billing requirements established by the MCO.
- The MCOs will provide their own training.

Core Billing Limitations

- AHCCCS may review clinical documents prior to payment (pre payment review)
- Only one per diem behavioral health service may be billed on a single day for a single member.
- A provider shall not split services among more than one claim to avoid bundling edits
- Providers are prohibited from voiding and replacing claims with new codes or billing in smaller units to avoid submission of clinical documentation.

Core Billing Limitations: Groups

- Groups are billed with an HQ modifier
- Some services cannot be delivered in group. Always check the B2 matrix.
- Any service provided in a group is limited to no more than 12 members unless otherwise specified by AHCCCS. *This applies to all codes even H0018.
- Some service codes are capped at fewer than 12 by definition. Please refer to AMA guidelines.

Outpatient Treatment Services

Outpatient Treatment Services

This section focuses on the individual types of behavioral health services and documentation.

- Assessment, Evaluation and Screening Services
- Behavioral Health Counseling, Therapy and Psychotherapy
- Behavior Analysis Services
- Partial Hospitalization Programs (PHPs)
- Psychiatric Collaborative Care Model (CoCM)

Assessment, Evaluation, and Screening

- H0001-AOD assessment - Limit 12/year (Ages 11 and older)
- H0002-BH screening to determine eligibility for admission to a treatment program. - Limit 24/year (Ages 11 and older)
  - Uses a standardized screening tool or criteria.
  - Includes the triage function of making preliminary recommendations for treatment interventions or determination that no behavioral health need exists and/or assisting in the development of the person's service plan.
  - May also include the preliminary collection of information necessary to complete a supported employment assessment.

*The assessment tool must be normed for the age, literacy, and language of the member. The instrument must be available for review upon request

H0031 Mental Health Assessment by Non Physician

Mental health assessment provided by someone other than a physician, who is a trained staff member. The assessment identifies factors of mental illness, functional capacity, and gathers additional information used for the treatment of mental illness including gathering information necessary for assessment of a person, resulting in a written summary report. Recommendations, which may be in response to specific questions posed in an assessment request, are made to the person, family, referral source, provider, or courts, as applicable.

- Limited to no more than 1 during each six-month period of continuous behavioral health enrollment when provided in a clinic as defined under 42 CFR 4409.90 and in accordance with the approved Arizona Medicaid State Plan.
- Every 6 months for DES children, once annually for others.

Behavioral Health Counseling, Therapy and Psychotherapy

- Codes in this section of the CBHSG have specific guidelines set by the AMA CPT codebook for psychotherapy on the same day as E/M services, time, crisis and add-on codes.
- The type and level of E/M service is selected based medical decision making as outlined in the AMA CPT Professional codebook.
- Review of the ***current*** AMA CPT Professional codebook is **HIGHLY** recommended.
- It is the responsibility of each provider to ensure they are meeting licensing, documentation, policy, medical necessity and all coding guidelines.

Behavioral Health Counseling, Therapy and Psychotherapy (continued)

- The psychotherapy service codes 90832-90838 include ongoing assessment and adjustment of psychotherapeutic interventions and may include involvement of informants in the treatment process.
- Codes 90832-90834,90836-90838 describe psychotherapy for the individual patient, although times are for face-to-face with patient and may include informant(s). The patient must be present for all or a majority of the service.
- **Please refer to the AMA CPT guidebook for specific coding requirements.**

Behavioral Health Counseling,Therapy and Psychotherapy HCPCS(H codes)

- HCPCS (H codes) in the CBHSG are defined as all other assessment, evaluation and screening services billed by behavioral health technicians or others who cannot bill CPT codes.
- Refer to the B2 matrix for additional details on provider types.
- H0004 - Behavioral health counseling and therapy, per 15 minutes.

Core Billing Limitations Counseling, Therapy and Psychotherapy

- Clinical rationale for the number and length of counseling sessions must be indicated in the comprehensive assessment and treatment plan.
- Evidence based interventions that require sessions over 60 minutes should be specified in the treatment plan.
- Clinical documentation supporting delivery of the service must be completed within 24 to 48 hours of the service being performed and available for review at any time as requested.

Core Billing Limitations
Counseling,Therapy and Psychotherapy

- Documentation must include the member's presenting problem/reason for the session as it is listed in the service plan including the diagnosis being treated, the mental status/ appearance of the client and the evidenced-based interventions utilized in the session.
- The member's response to any interventions used as they apply to the service plan goals and objectives must also be included as well as any assessment or screener results as they apply to the service plan goals and objectives.

H0035: Partial Hospitalization Programs

- Structured non-residential treatment programs.
- Alternative to inpatient psychiatric care.
- A minimum of 20 hours of services per week.
- Includes psychiatric services, individual, group, and family therapy, peer support services, and educational groups.
- Shall be provided by an appropriately licensed provider and as specified with applicable service requirements set forth in A.A.C. Title 9, Chapter 10, Article 10.
- RN/LPN services are included in the per diem rate.
- Must be delivered in person.

Intensive Outpatient Programs (IOP)

Intensive Outpatient Programs (IOP)

This section discusses the various IOP services related to Psychiatric and Alcohol and Drug use disorders. IOP programs generally require members to attend treatment at least 9 hours per week, which is often delivered in 3, 3-hour sessions.

- Intensive Outpatient Psychiatric Services - S9480
- Intensive Outpatient Alcohol and/or Drug Services - H0015

Intensive Outpatient (IOP)
Psychiatric and Alcohol and/or Drug Services

IOP is defined as:

- Direct services for people with substance use disorders or co-occurring mental and substance use disorders who do not require medical detoxification or 24-hour supervision.
- IOPs are alternatives to inpatient and residential treatment.

S9480 Intensive OP Psychiatric Services, Per Diem

Only reported **ONCE-a-day** based on documentation and medical necessity.

- Minimum 9 hours per week
- No less than 3 hours per day for two or more days per week.
- Includes but is not limited to the following;
  - 1 session with the members treating psychiatric provider (Behavioral Health Medical Practitioner-BHMP) per week, and
  - 1-3 individual counseling sessions with a BHP, no less than 50 minutes in duration, per week, and
  - 2 group counseling sessions, no less than 50 minutes in duration, per week.
  - Inclusive of psychiatric services, individual, group, and family therapy, peer support services, and educational groups.

S9480 Intensive OP Psychiatric Services, Per Diem (cont)

- A BHMP shall be available on-site at least 80% of the time during IOP Program operation, and
- BHP Caseloads shall not exceed 16 active members, and
- Group sessions shall include no more than 8 members and be facilitated by a BHP
- Intensive outpatient psychiatric services focused on the treatment of substance use and co-occurring disorders shall be consistent with the American Society of Addiction Medicine (ASAM) Criteria (3rd edition) level 2.1.

Billing Limitations: S9480

1. BH assessment, psychiatry, case management, peer support, and counseling are included in the rate and cannot be billed separately during the same time period as S9480.
2. GT modifier may not be billed with S9480. All S9480 services must be delivered in person with the exception of the psychiatric (BHMP) visit.
3. A physician recommending intensive psychiatric services must determine at least once monthly that the member still needs a minimum of 9 hours of services a week.
4. Duration is determined by medical necessity & documented in assessment and service plan.

H0015 - Alcohol and Other Drugs Intensive Outpatient Treatment

Operates **at least 3 hours/day and at least 3 days/week**

- Based on an individualized treatment plan, including assessment, counseling; crisis intervention, and activity therapies or education.
- Services may include individual and group counseling, medication management, family therapy, educational groups, occupational and recreational therapy, and peer support.
- Services are provided in amounts, frequencies, and intensities appropriate to the objectives of the treatment plan.
- Treatment shall consist of a minimum of 9 hours of services a week for adults
- Minimum 6 hours per week for adolescents
- SUD and co-occurring treatment in alignment w/ ASAM Criteria, 3rd Ed, level 2.1.

*This procedure code can only billed once per day based on documentation and medical necessity .

H0015 Billing Limitations

1. H0015 is an all-inclusive behavioral health code. Behavioral health HCPCS codes are included in the rate and cannot be billed separately during the same time period as H0015 (i.e. ,H0031, H0004, H0038, H2014, H2016, etc.).
2. Duration of treatment is determined by medical necessity and documented in assessment and service plan.
3. A physician recommending intensive outpatient alcohol and/or drug services must determine at least once monthly that the member still needs a minimum of 9 hours of services a week.

** The Centers for Medicare and Medicaid Services (CMS) defines a physician as a clinician who is legally authorized to practice medicine, osteopathy, dental surgery, dental medicine, podiatric medicine, or optometry by the state in which they perform their duties.

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Providers can view the **Medical Coding Resources** webpage which publishes news and updates related to AHCCCS claims and encounters processing, place of service, modifiers, new procedure codes, new diagnoses, and coding rules and more.

DFSM Training Contacts & Resources

For provider training requests email:

- ServiceDesk@azahcccs.gov

Provider Training Web Page:

- Division of Fee-For-Service-Management: Training Resources

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Thank You.