



# 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](mailto:CBHSGCodingQuestions@azahcccs.gov).

**YELLOW HIGHLIGHT** - INDICATES THAT AN UPDATED LINK IS COMING SOON

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## The Guide to Covered Behavioral Health Services

This guide does not supersede any information contained in the AHCCCS Medical Policy Manual (AMPM) nor does it supersede information in the Fee-for-Service (FFS) Provider Manual. The Covered Behavioral Health Services Guide (CBHSG) is provided as a resource for general information regarding services and commonly used billing codes. Providers shall conform all billing practices to comply with all federal, state and local laws, rules, regulations, standards, executive orders, AHCCCS and/or contractor provider manuals, policy guidelines, and standards (including reference tables), ICD10, CPT, HCPCS, CDT, and Health Insurance Portability and Accountability Act Transactions and Code Sets (HIPAA TCS) compliance standards, notwithstanding anything contained in this document, whether expressed or implied.

The purpose of this document is to compile billing and compliance information and clarify rules for service delivery, billing, and encounters. Appendix A contains links to documents which contain important information about AHCCCS covered behavioral health services. The documents listed in Appendix A are referenced repeatedly throughout the document to help providers identify where guidance regarding specific services is located.

For the purposes of this document, the array of covered behavioral health services are organized into a continuum of service categories for the purpose of promoting clarity of understanding through the consistent use of common terms that reach across populations. The individual domains are:

- Services Not Covered by Medicaid
- Outpatient Treatment Services
- Medical Services
- Support Services
- Crisis Intervention Services
- Residential Services
- Behavioral Health Day Programs
- Inpatient Services

Within each category, specific services are defined and described including identification of specific provider qualifications/service standards and limitations. Clinical guidelines, service standards, and provider qualifications are located in the AMPM and links to the appropriate locations will be provided in this document. In addition, FFS billing guidelines are located in the AHCCCS Fee-for-Service Provider Manual and AHCCCS IHS/Tribal Provider Billing Manual and links to the appropriate locations will also be located in this document. When the phrase "Fee-for-Service" is used in this guide, it is referring to the AHCCCS Fee-for-Service (FFS) programs (such as the American Indian Health Program [AIHP]). The AHCCCS FFS program is inclusive of non managed care programs.

General information is also provided about the use of national UB04 revenue codes, national drug codes and CPT codes; however, detailed procedure code descriptions for these codes covered by AHCCCS should be referenced in the following manuals.

- UB04 Manual

- National Drug Coding (NDC) Standards
- Physicians' Current Procedural Terminology (CPT) Standards
- Health care Procedure Coding System (HCPCS) Standards

## Provision of Services

A provider is a person or entity which is registered with AHCCCS to provide covered services directly to members. Registration with AHCCCS is required for a provider to be able to provide behavioral health services. AMPM Chapter 600 - Provider Qualifications and Provider Requirements Section 610-AHCCCS Provider Qualifications provides the current procedures for registering with AHCCCS [AHCCCS MEDICAL POLICY MANUAL CHAPTER 600 – PROVIDER QUALIFICATIONS AND PROVIDER REQUIREMENTS 610](#).

A list of current provider types and the regulatory agencies overseeing them are listed in the Provider Enrollment Screening glossary, available at <https://www.azahcccs.gov/PlansProviders/Downloads/apep/PEP-903.xlsx>.

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, may provide behavioral health services rendered as specified in the [IHS/Tribal Billing Manual](#).

### Behavioral Health Professionals (BHPs)

Independently licensed BHPs who are eligible for AHCCCS enrollment are independent billers. A BHP who is an independent biller is only allowed to use their own NPI as servicing/rendering provider to bill for behavioral health services that they themselves provided. In accordance with the Provider Participation Agreement, AHCCCS does not permit a BHP to bill for behavioral health services under their own NPI for services provided by another person.

In compliance with Arizona Department of Health Services (ADHS) Licensure, a BHP providing services for a licensed health care institution shall meet the requirements specified in Arizona Administrative Code (A.A.C) Title 9 Health Services, Chapter 10 and be designated to direct and oversee treatment services at behavioral health facilities. As specified in A.A.C Title 9 Health Services, Chapter 10, a BHP is responsible for directing and overseeing the clinical care and treatment for members they are directly serving as well as members being served by BHTs and BHPPs for whom the BHP is providing clinical oversight or supervision. BHP's who are not independently licensed, but authorized to provide services in accordance with A.A.C. Title 9, Chapter 10 shall bill for services as specified under the Core Limitations section of this guide (see #19).

BHP's providing services for IHS/638 providers and tribal health programs operated under P.L. 93-638 shall bill for services as specified in the [IHS/Tribal Billing Manual](#).

## **Behavioral Health Technicians (BHTs)**

A Behavioral Health Technician (BHT) is an individual who is not a Behavioral Health Professional (BHP) who provides behavioral health services at or for a licensed health care institution in accordance with the members treatment or service plan, best practice standards, AHCCCS Policy, ADHS licensure requirements, and the health care institution's policies and procedures, to address the member's behavioral health needs. BHT's providing services 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, may provide behavioral health services rendered as specified in the [IHS/Tribal Billing Manual](#).

Services rendered by a BHT shall only be billed for under an ADHS Licensed Facility's National Provider Identifier (NPI), utilizing service-specific HCPCS Codes. Claims for services rendered by a BHT shall be submitted utilizing the licensed behavioral health facility NPI as the rendering provider, and the name of the individual providing the service shall be reported in Box 19 of the CMS 1500 or UB04 claim form or on the 837 Professional (Electronic Claim): 2300 NTE, utilizing the format described for reporting Participating/Performing Provider in the FFS Provider Billing Manual Chapter 10 Addendum - FQHC/RHC.

## **Behavioral Health Paraprofessionals (BHPPs)**

Behavioral Health Paraprofessionals are individuals who are not behavioral health professionals or behavioral health technicians who provide services to support and enhance members' behavioral health and/or substance use treatment goals, at or for a health care institution according to the members treatment or service plan in accordance with current best practice standard.

BHPPs are limited to providing services under an ADHS licensed Health Care Institution/agency and the supervision of a BHP as specified in ADHS licensure requirements. BHPPs providing services that would otherwise require a license if provided outside of a licensed health care facility, must be under direct observation of a BHP during service delivery. Services that would not require a license, such as supportive services, do not require direct observation but are still subject to supervision requirements as specified within applicable ADHS licensure requirements, AMPM 965 and the [IHS/Tribal Billing Manual](#).

## **BHP, BHT and BHPP Qualifications, Certifications, Clinical Oversight and Supervision**

BHP, BHT and BHPP education, license, certification, and or required experience, clinical oversight and supervision requirements are specified in A.A.C. Title 9, Chapter 10 or for IHS/638 providers and tribal health programs operated under P.L. 93-638, may provide behavioral health services rendered as specified in the [IHS/Tribal Billing Manual](#).

BHT's and BHPP providing supportive services for a Community Services Agency (CSA) refer to [AMPM 965](#) for qualifications and service provision requirements.

## **Peer and Recovery Support Specialist (PRSS)**

A peer is an individual with lived experience of mental health conditions, substance use, and/or other traumas resulting in emotional distress and significant life disruption, for which they have sought help or care, and has an experience of recovery to share.

A Peer and Recovery Support Specialist (PRSS) is a peer who has completed training and passed a competency test through an AHCCCS-recognized Peer Support Employment Training Program, and meets the credentialing requirement to function, at a minimum, as a BHPP. A PRSS can be a BHPP, BHT, BHPP Supervisor, or BHP, as

long as the individual meets education, training, and licensure requirements as specified in A.A.C. Title 9, Chapter 10 or for IHS/638 providers and tribal health programs operated under P.L. 93-638, may provide behavioral health services rendered as specified in the [IHS/Tribal Billing Manual](#). Experience and education should be documented in personnel files and available upon request. Required minimum recommended qualifications for a PRSS are noted in AMPM Policy 963.

As outlined in AMPM Policy 963, peer support services include the provision of assistance to utilize the service delivery system more effectively (e.g., assistance in developing plans of care, identifying needs, accessing supports, partnering with other practitioners, overcoming service barriers); or understanding and coping with the stressors of the individual's disability (e.g., support groups, coaching, role modeling, and mentoring).

### **Credentialed Family Support Partner (CFSP)**

A Credentialed Family Support Partner is a person, with a family peer perspective, who meet specific criteria in AMPM Policy 964, and has completed an AHCCCS, OIFA approved Credentialed Family Support Training program qualifying the individual to deliver Family Support Services, and meeting credentialing requirements, to function, at a minimum, as a BHPP. A CFSP can be a BHPP, BHT, or BHP, as long as the individual meets education, training, and licensure requirements as specified in A.A.C. Title 9, Chapter 10 or for IHS/638 providers and tribal health programs operated under P.L. 93-638, may provide behavioral health services rendered as specified in the [IHS/Tribal Billing Manual](#). Experience and education should be documented in personnel files and available upon request. Required minimum recommended qualifications for a CFSP are noted in AMPM Policy 964.

Family support services are defined in AMPM Policy 964 as homecare training (family support) with family members directed toward restoration, enhancement, or maintenance of the family functions to increase the family's ability to effectively interact and care for the individual in the home and community. Family support services include, but are not limited to:

1. Assisting the family to adjust to the member needs,
2. Developing skills to effectively interact, and/or guide the member,
3. Understanding of the causes and treatment of behavioral health challenges,
4. Understanding the effective utilization of the system, and
5. Planning for ongoing and future support for the member and family.

## Billing for Services

Providers are required to utilize national coding standards including the use of applicable modifier(s). Refer to the [AHCCCS Medical Coding Resources web page](#) for up to date information about valid modifiers, place of service codes, category of service and appropriate provider types.

Providers who are contracted with an AHCCCS Managed Care Organization (MCO) must also follow all additional MCO billing requirements established by the MCO.

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. The values listed throughout the Guide for Covered Behavioral Health Services Guide are only provided as information and should not be used to determine if a value can be used on an encounter or claim.

All applicable Current Procedural Terminology (CPT) and Health care Common Procedure Coding System (HCPCS) for Non-Title XIX/XXI Services are listed in the AHCCCS Behavioral Health Services Matrix found on the AHCCCS website.

### Services Covered by AHCCCS

To bill AHCCCS allowable codes the provider must be an AHCCCS registered provider. AHCCCS allowable codes can be further subdivided into the following categories:

#### Current Procedural Terminology (CPT) Codes

American Medical Association's (AMA) Current Procedural Terminology (CPT) Guide contains nationally recognized service codes. For more information regarding these codes, see the [AMA's CPT Guide \(Current Procedural Terminology\)](#), which contains a systematic listing and coding of procedures and services, such as surgical, diagnostic or therapeutic procedures.

#### Health care Common Procedure Coding System (HCPCS) Codes

Health care Common Procedure Coding System (HCPCS) contains nationally recognized service codes. For more information regarding these codes see the *Health care Common Procedure Coding System (HCPCS) Manual*, which is a systematic listing and coding for reporting the provision of supplies, materials, injections and certain non-physician services and procedures. For AHCCCS published information on HCPCS Procedures Daily Limit please see <https://www.google.com/url?q=https://azahcccs.gov/PlansProviders/Downloads/MedicalCodingResources/HCPCSCPTProcedureswithDailyLimits.xlsx&sa=D&source=docs&ust=1719245940974554&usg=AOvVaw0pWDBsrHSEbBzvk-p5D9OD>

#### National Drug Codes (NDC)

These nationally recognized drug codes are used to bill for prescription [drugs](#).

#### UB04 Revenue Codes



These nationally recognized revenue codes are used to bill for all inpatient and certain residential treatment or outpatient services. Information regarding these codes can be found in the *UB04 Manual* <https://www.nubc.org/available-july-1-2021-official-ub-04-data-specifications-manual-2022-ed-0>.

## Modifiers

In some instances, in order to delineate the service being provided, a “modifier” must be submitted along with the service code. In these circumstances codes are assigned modifiers. For example, there is a single code for counseling, but reimbursement for counseling provided in the office, the home or in a group can vary, so the accurate use of modifiers is essential. Assigned codes and when applicable, modifiers, must be used on submitted claims and encounters to specify service(s) rendered. Additional modifiers may be used as indicated by CPT or HCPCS to further define a procedure code.

For a listing of which modifiers are applicable to which behavioral health codes, visit the AHCCCS Behavioral Health Services Matrix.

## 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](#). A complete listing of the services that can be billed utilizing telehealth services can be found in the [AHCCCS Behavioral Health Services Matrix](#). 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.

## Place of Service (POS) Codes

Accurate Place of Service (POS) codes must be submitted on claims and encounters to specify where service was rendered. The following is a link to the Centers for Medicare and Medicaid Services (CMS) POS table that lists POS codes and descriptions:

<https://www.cms.gov/medicare/coding-billing/place-of-service-codes/code-sets>

For a listing of which place of service codes are applicable to which behavioral health codes, visit AHCCCS Behavioral Health Services Matrix.

## 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 – 10<sup>th</sup> 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.

The diagnosis code shall meet specificity for medical necessity, within the scope of practice of the rendering provider. There are many options available in the ICD-10 CM coding books and all codes submitted must meet medical necessity as well as be supported in the medical record. This also includes Z codes, if that is the code that is the most specific code identified as a primary or principal diagnosis for services provided. SDOH codes are Z55-Z65 and can be found here:

<https://azahcccs.gov/Resources/Downloads/BHDiagnosisListApproved.pdf>).

Inpatient UB04 encounters/claims for revenue codes submitted by inpatient provider types (02, 71, 78, B1, B2, B3, B5, and B6) must be submitted indicating a principal ICD-10 mental health or substance abuse diagnosis. Although a patient may have other diagnosis codes (e.g., a “Z” code or other ICD-10 diagnostic code, the encounter/claim for inpatient psychiatric service must indicate a principle mental health or substance abuse diagnosis to adjudicate successfully. The exception is the use of ICD-10 Chapter 15 codes that have sequencing priority over codes from other chapters, e.g. diagnostic codes 099.32\* (report correct trimester) and 099.34\* (report correct trimester) as principal diagnosis for complications of pregnancy while an individual is receiving inpatient psychiatric services.

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.

## **Group Payment ID**

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. Group payment providers submit claims or encounters according to established procedures.

Each AHCCCS registered provider using the group payment arrangement must sign a group payment authorization form and ensure their provider ID number appears on each claim even though a group payment ID number will be used for payment. A service provider may be affiliated with multiple groups. If the provider has multiple service addresses, each address must be listed on the service provider’s profile.

## **Training Resources**

New requirements for Fee-for-Service claims are added to the monthly electronic newsletter titled “Claims Clues.” These helpful documents can be found on the [AHCCCS Claims Clues](#) web page on the AHCCCS website. AHCCCS encourages all providers to sign up to receive e-news from DFSM and can sign up via an [online form](#).

Resources for providers billing MCOs can be found on the individual MCOs provider websites. Additional information may also be found on the [AHCCCS Medical Coding Resources](#) web page.

## Core Billing Limitations

For some of the services there are core billing limitations, which must be followed when billing. Services may have additional billing limitations, which are applicable to that specific service. Specific billing limitations for each type of behavioral health service are set forth in the following sections of this guide. General core billing limitations include the following:

1. AHCCCS shall cover procedures, products, and services related to this policy when they are medically necessary, and:
  - a. The procedure, product, or service is 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. The behavioral health needs of the member must be documented in the behavioral health service plan;
  - b. The procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
  - c. The procedure, product, or service is furnished in a manner not primarily intended for the convenience of the member, the member's caretaker, or the provider.
2. A provider can only bill for their time spent in providing the actual service. All CPT and HCPCS codes must meet all coding, documentation and scope of practice as well as all policy guidelines. Unless the CPT/HCPCS codes specify they are allowed non face to face time, the provider may not bill for any time associated with note taking and/or medical record keeping as this is included in the rate established for these codes.
3. AHCCCS may request and review clinical documents prior to paying for services.
4. The provider signature in medical record documentation must be in electronic or in legible written form in blue or black ink. Provider signature must be followed by their approved credential (eg. LPC, BHT, BHPP, etc.) and indicate the exact date and time of the signature.
5. For services billed with a HCPC code (except case management, T1016), the provider may not bill any time associated with leaving voice messages, sending emails and/or collateral contact with the enrolled person, family and/or other involved parties as this time is included in the rate calculation.
6. Excluding inpatient evaluation and management codes, providers should bill all time spent in directly providing the actual service, regardless of the assumptions made in the rate model.
7. Providers must indicate begin and end times on all progress notes and all documentation of services rendered by the provider. The beginning and end time must be accurate to the time each member participated in the service. Templated and/or pre printed times based on a schedule are not permitted. Providers engaging in care coordination, case staffing, or other coordination efforts that directly support the member's treatment may bill this time utilizing the appropriate HCPCS Code.
8. A professional who provides clinical oversight or supervision to a Behavioral Health Professional, a Behavioral Health Technician and/or a Behavioral Health Paraprofessional providing services may not bill separately for the oversight or supervision activities.
9. If the person and/or family member(s) misses their appointment, the provider shall not bill for the service.
10. When only one service is provided in a day, providers should not bill for services performed for less than 8 minutes. 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. If the duration of a single modality or procedure in a day is greater than or equal to 23 minutes through and including 37 minutes, then 2 units should be billed.

- a. 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
  - b. The pattern remains the same for treatment times in excess of 2 hours. If a service represented by a 15 minute timed code is performed in a single day for at least 15 minutes, that service shall be billed for at least one unit.
  - c. If the service is performed for at least 30 minutes, that service shall be billed for at least two units, etc.
  - d. 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.
  - e. When more than one service represented by 15 minute timed codes is performed in a single day, the total number of minutes of service determines the number of timed units billed.
  - f. 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.
  - g. 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.
  - h. There are codes that are specific to time and providers must follow the guidelines as outlined in the American Medical Association CPT coding book.
11. If otherwise allowed, behavioral health service codes which may be billed on the same day as admission to and discharge from inpatient services include mobile crisis intervention service (HCPCS H2011 Crisis intervention service, per 15 minutes) on the same day of admission to Inpatient Hospital (Bill type 0114).
  12. A single provider cannot bill for any other covered service while providing transportation to client(s).
  13. Some CPT and HCPCS codes are restricted to independent practitioners with specialized behavioral health training and licensure. Please refer to the behavioral health services matrix to identify providers who can bill using CPT codes if they meet all the coding, scope of practice and documentation.
  14. AHCCCS registered providers who are Behavioral Health Professionals (independent billers) shall utilize only CPT codes when billing for services. The only allowable exception is for alcohol

and/or drug services and multisystemic therapy (MST) for juveniles provided by behavioral health professionals billed using the appropriate HCPC codes.

15. Additional supporting clinical documentation for review may be required when billing certain codes. Providers are prohibited from voiding and replacing claims with new codes or billing in smaller units to avoid submission of clinical documentation.
16. Information regarding provider travel billing limitations is located in AMPM Chapter 300, Section 310 - Covered Services [AMPM 310-B](#).
17. The group payment ID (PT 01) may only be used as billing. A PT 01 cannot be used as a servicing provider.
18. 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.
19. Hospital provider types may bill BHT charges incident to an appropriate licensed provider on a UB04 claim form.
20. To bill AHCCCS for behavioral health services, a Behavioral Health facility shall be licensed through the Arizona Department of Health Services 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 and oversee all behavioral health treatment services.
21. Independent billers are required to be registered with AHCCCS before they can deliver services.
22. In order to bill services to an MCO, the provider must be credentialed and contracted with the MCO.
23. Only one per diem behavioral health service may be billed on a single day for a single member.
24. A provider shall not split services among more than one claim to avoid bundling edits
25. Any service provided in a group is limited to no more than 12 members unless otherwise specified by AHCCCS.

### **Services Not Covered by Medicaid**

Non-Title NTXIX/XXI are non Medicaid dollars. Non-Medicaid dollars may come from grants, State appropriations or through other sources. Codes that are not allowable under Medicaid can only be paid for with NTXIX/XXI funds. Codes billed to the Mental Health Block Grant (MHBG) must be submitted with the UB modifier. Codes billed to the Substance Use Prevention Treatment and Recovery Block Grant (SUBG) must be submitted with the U7 modifier. A provider must be contracted with and receive payment through a Tribal Behavioral Health Authority (TRBHA), an AHCCCS Complete Care Contractor with Regional Behavioral Health Agreement (ACC-RBHA) or another entity with a Non-Titled XIX/XXI contractual relationship with AHCCCS in order to be able to access and use these funds. A list of Tribal Regional Behavioral Health Authorities (TRBHAs) may be found here: [Tribal Regional Behavioral Health Authorities](#). Information about AHCCCS Complete Care Contractors with Regional Behavioral Health Agreements (ACC-RBHAs) can be found here: [Behavioral Health Contracts](#). Services which may be covered by NTXIX/XXI funds through TRBHAs or ACC-RBHAs include, but are not limited to:

- Acupuncture
- Traditional healing
- Child care (Child Sitting)
- Room and board

For Non-Title XIX/XXI eligible populations, most behavioral health services that are covered through Title XIX/XXI funding are also covered through Non-Title XIX/XXI based on eligibility, medical necessity, priority population and other restrictions based on the funding source. Services provided through Non-Title XIX/XXI funding are limited by the availability of funds and are not an entitlement benefit. Non-Title XIX/XXI eligible populations are enrolled with an ACC-RBHA or TRBHA and other entities that have a direct Non-Title XIX/XXI funded contractual relationship with AHCCCS. Enrollment with an ACC-RBHA or TRBHA is based on the zip code or tribal community in which the member resides.

See [AMPM 320T1](#) and [AMPM 320T2](#) for additional guidance on NTXIX services and funding requirements.

### **CPT Codes**

- 97810 - Acupuncture, one or more needles, without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient. Provider Types: 71, 73, 77, 02, B1, B2, B3, B5, B6 and IC. Modifiers UB and H9.
- 97811 - Acupuncture, one or more needles, without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient with re-insertion of needle(s). (listed separately in addition to the code for primary procedure). Provider Types: 71, 73, 77, 02, B1, B2, B3, B5, B6 and IC. Modifiers UB and H9.
- 97813 - Acupuncture, one or more needles, without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient. Provider Types: 71, 73, 77, 02, B1, B2, B3, B5, B6 and IC. Modifiers UB and H9.
- 97814 - Acupuncture, one or more needles, without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient with re-insertion of needle(s). (listed separately in addition to the code for primary procedure). Provider Types: 71, 73, 77, 02, B1, B2, B3, B5, B6 and IC. Modifiers UB and H9.

### **HCPCS Codes**

- T1009 - Child Sitting services for children for the individual receiving alcohol or substance abuse services. Provider Types: B8, 77, C2 and 29. Modifiers U7, and H9.
- H0046 - Mental Health Services NOS (Room and Board) (Traditional Healing). Provider Types: 72, 77, A3, A5, A6, B8 and IC. Modifiers UB, H9 and SE.

### **Billing Limitations**

For services not covered by Medicaid the following billing limitations apply:

1. See general core billing limitations.
2. Where applicable, modifiers shall be used to identify the NTXIX funding applied to the service.
3. For T1009 Modifier U7 must be paired with the code to ensure only SUBG funding is applied to these claims/encounters.
4. For T1009: B8 providers must have approved grant funded residential programs for parenting women that allow the child(ren) to reside with the parent during treatment. Child sitting hours are only allowable during active treatment (e.g. Groups, MAT/MOUD, counseling, therapy). Contractor approved programs who provide child sitting services must have, at minimum, policies and procedures that cover:
  - a. Informed consent

- b. Facility safety measures
- c. Staffing ratios
- d. Supervision of staff
- e. Monitoring of child sitting programs
- f. Documentation of child drop off time, pick up time and services provided.
- g. Service descriptions, including educational support service accessibility to the children
- h. Ages of children accepted into the program

## Outpatient Treatment Services

Outpatient treatment services are provided by or under the direction and clinical oversight of behavioral health professionals to reduce symptoms and improve or maintain functioning. These services have been further grouped into the following subcategories:

- Assessment, Evaluation and Screening Services
- Behavioral Health Counseling and Therapy
- Behavior Analysis Services
- Partial Hospitalization Programs
- Intensive Outpatient Programs
- Behavioral Health Day Programs
- Rehabilitation Services
- Other Services

### Assessment, Evaluation and Screening Services

Assessment, evaluation, and screening services involve gathering and assessing historical and current information about a person who will be receiving behavioral health services. Assessment involves face-to-face contact with the person and/or the person's family or other informants, or group of individuals resulting in a written summary report and recommendations. For specific services that meet the face-to-face requirement and are allowable under telehealth please see [AHCCCS Policy 320-I, Use of Telemedicine](#).

AHCCCS Medical Policy Manual Section 320-O addresses clinical requirements related to behavioral health assessments, service, and treatment planning.

### CPT Codes

The following CPT Codes may only be used by behavioral health professionals. Please refer to the American Medical Association CPT Code Book for specific guidance on which professionals can bill which codes. All codes must meet scope of practice, policy and documentation guidelines. It is the providers responsibility to make sure that all the services reported meet the national guidelines for coding and documentation. It is also the providers/facilities responsibility to have the current coding books. These codes are updated quarterly by CMS and American Medical Association.

- 90791 - Psychiatric diagnostic evaluation
- 90792 - Psychiatric diagnostic evaluation with medical services
- 96130 - Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour
- 96131 - Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure)
- 96136 - Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes



- 96137 - Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure)
- 96138 - Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes
- 96139 - Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure)
- 96146 - Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only
- 96110 - Developmental screening (e.g., developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument
- 96112 - Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified Health care professional, with interpretation and report; first hour
- 96113 - Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified Health care professional, with interpretation and report; each additional 30 minutes (List separately in addition to code for primary procedure)
- 96116 - Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified Health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour
- 96132 - Neuropsychological testing evaluation services by physician or other qualified Health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour
- 96133 - Neuropsychological testing evaluation services by physician or other qualified Health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure)
- 99242 - Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
- 99243 - Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
- 99244 - Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.

- 99245 - Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded.
- 99304 - Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.
- 99305 - Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.
- 99306 - Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 50 minutes must be met or exceeded.
- 99307 - Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.
- 99308 - Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
- 99309 - Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
- 99310 - Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
- 99315 - Nursing facility discharge management; 30 minutes or less total time on the date of the encounter
- 99316 - Nursing facility discharge management; more than 30 minutes total time on the date of the encounter
- 99408 - Alcohol and drug abuse brief screening and intervention between 15-30 minutes.
- 99409 - Alcohol and drug abuse brief screening and intervention greater than 30 minutes

### **HCPCS Codes**

Except for assessment, evaluation and screening provided by those independently registered individual behavioral health professionals billing CPT codes, all other assessment, evaluation and screening services should be billed using the following HCPCS codes. The following HCPCS Codes may be used by a Behavioral Health Professional (BHP) who does not meet the professional requirements of a BHP or is a behavioral health technician (BHT) as specified in A.A.C. Title 9, Chapter 10 or for IHS/638 providers and tribal health programs operated under P.L. 93-638, as specified in the [IHS/Tribal Billing Manual](#). They may not be billed by a behavioral health paraprofessional (BHPP).

- H0001 - Alcohol and/or drug assessment
- H0002 - Behavioral Health Screening to Determine Eligibility for Admission to a treatment program.
  - Additional Guidance - Information gathered using a standardized screening tool or criteria including those behavioral health screening activities associated with DUI screening. 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.
- H0031 - Mental Health Assessment By Non-Physician
  - Additional Guidance - 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.

### **Billing Limitations**

For assessment, evaluation and screening services the following billing limitations apply:

1. See general core billing limitations.
2. Where applicable, travel time by the provider is included in the rates.
5. Transportation (emergency and non-emergency) provided to persons and/or family members is not included in the rate and should be billed separately using the appropriate transportation procedure codes.
6. Rehabilitative employment support assessments may only be provided when the assessment service is not available through the federally funded Rehabilitation Act program administered by Arizona Department of Economic Security/Rehabilitation Service Administration (ADES/RSA) or the Tribal Rehabilitation Services Administration.
7. Preparation of a report of a member's psychiatric status for primary use with the court is not Title XIX/XXI reimbursable. Title XIX/XXI funds may be used for a report to be used by a treatment team or physician. The fact that the report may also be used in court does not disqualify the service for Title XIX/XXI reimbursement.
8. A behavioral health assessment is necessary for initiation of outpatient behavioral health treatment services. The behavioral health assessment shall align with AMPM Policy 320-O and AMPM Policy 940.
  - a. A behavioral health assessment is completed by an independent biller using an appropriate CPT code or an associate licensed BHP or BHT using HCPCS. The assessment shall be completed at least once annually for an adult and once every six months for a child. The assessment documents clinical justification for medical necessity and evidence that the member is receiving services in the least restrictive environment. The assessment is completed to document progress and the need for continued service.
  - b. The initial comprehensive assessment and annual assessment updates, including updates to service plans, must be signed by a qualifying BHP within 72 hours of the service being completed.
9. Use of H0031 shall only be used for completion of a full comprehensive assessment. Non-clinical/non-clinically significant changes to a member's assessment and/or updating of a member's treatment plan do not qualify for use of H0031.

10. The member receiving an alcohol and/or drug assessment which is billed using H0001 or H0002 must be at least 11 years of age and the tool used for the assessment must be normed for the age of the member.
  - a. The assessment instrument must be available for review upon request and normed for the age, literacy, and language of the member.
11. Assessments for behavioral health services are conducted by behavioral health professionals or behavioral health technicians. When behavioral health screening, assessment and evaluation services are performed by a BHT, that BHT must be employed by and use the NPI of a behavioral health agency licensed by ADHS and meet the requirements for the provision of behavioral health assessment, evaluation and screening services as set forth in A.A.C. Title 9, Chapter 10 and AHCCCS Policy.
12. Modifier U9 for an ASAM CONTINUUM® assessments can be paired with H0001, H0031, 90791, and 90792
13. Outpatient services for substance use disorders (SUD) are for beneficiaries assessed as meeting, at minimum, the American Society of Addiction Medicine (ASAM) level of 0.5 (Early Intervention) or 1.0 (Outpatient Services)<sup>1</sup> or as determined medically necessary by a behavioral health professional.
14. Screening services are limited to no more than one service 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.

## **Behavioral Health Counseling, Therapy and Psychotherapy**

Counseling is an interactive therapy designed to elicit or clarify presenting and historical information, identify behavioral problems or conflicts, and provide support, education or understanding for the person, group or family to resolve or manage the current problem or conflict and prevent, resolve or manage similar future problems or conflicts. Services may be provided to an individual, a group of people, a family or multiple families. Services provided shall be based on best practice for the presenting concern and shall be provided within the scope of practice of the rendering provider.

### **CPT Codes**

- 90832 - Psychotherapy, 30 minutes with patient
- 90833 - Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure) Code also (99202-99255, 99304-99316, 99341-99350)
- 90834 - Psychotherapy, 45 minutes with patient
- 90836 - Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure) Code also (99202-99255, 99304-99316, 99341-99350)
- 90837 - Psychotherapy, 60 minutes with patient
- 90838 - Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure) Code also (99202-99255, 99304-99316, 99341-99350)
- 90845 - Psychoanalysis
- 90846 - Family psychotherapy (without the patient present), 50 minutes
- 90847 - Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes

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<sup>1</sup> Note Indian Health Services and 638 providers are not required to administer the ASAM CONTINUUM.

- 90849 - Multiple-family group psychotherapy
- 90853 - Group psychotherapy (other than of a multifamily group)

Except for psychotherapy services provided by those individual behavioral health professionals allowed to bill CPT codes, all other behavioral health counseling and therapy services should be billed using the following HCPCS codes.

#### **HCPCS Codes**

- H0004 - Behavioral health counseling and therapy, per 15 minutes, up to 8 units per day.

#### **Provider Qualifications**

When behavioral health counseling and therapy services are provided by a BHT, the BHT shall work for a ADHS licensed behavioral health facility, with the clinical oversight of a BHP in alignment with requirements as specified in A.A.C. Title 9, Chapter 10 or for IHS/638 providers and tribal health programs operated under P.L. 93-638, as specified in the [IHS/Tribal Billing Manual](#). They may not be conducted nor billed by a behavioral health paraprofessional (BHPP).

#### **Billing Limitations**

For behavioral health counseling and therapy services the following billing limitations apply:

1. See general core billing limitations.
2. Transportation provided to persons and/or family members is not included in the rate and should be billed separately using the appropriate transportation procedure codes.
3. When counseling from more than one provider organization is medically necessary, a description of the specialty service which is outside of the primary provider's scope of practice must be listed in the treatment plan including frequency and duration of specialty services.
4. The 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.
5. 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.
6. Documentation of counseling services 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.
7. Counseling services using H0004:
  - a. Must not be billed on the same day that any per diem code is billed.
  - b. H0004 may not be billed on the same day as services rendered from an inpatient facility.
  - c. Provider travel time for the initial 25 miles each way is included in the rates for H0004—Individual Behavioral Health Counseling and Therapy, Family Behavioral Health Counseling and Therapy, and Group Behavioral Health Counseling and Therapy. See AMPM 310-B for provider travel billing limitations.
  - d. Counseling services using H0004 must be performed by an independently licensed BHP in the practice of behavioral health as defined in ARS 32-325, an associate licensed BHP in the practice of behavioral health who is engaged in direct supervision as outlined in R4-6-211,s,

or a BHT who is clinically overseen by a behavioral health professional as specified in A.A.C. Title 9, Chapter 10 or for IHS/638 providers and tribal health programs operated under P.L. 93-638, as specified in the [IHS/Tribal Billing Manual](#).

- e. Except for behavioral health counseling and therapy services provided by independently licensed behavioral health professionals allowed to bill CPT codes, all other behavioral health counseling and therapy services must be billed using HCPCS codes and the NPI of the licensed behavioral health facility. Incident of billing using the NPI of a behavioral health professional who did not actually perform the counseling service in an outpatient setting is prohibited.
8. In reporting psychotherapy services, choose the code closest to the actual time. See CPT 2024 for the complete coding guidelines for these codes.
    - a. 90832 - Psychotherapy, 30 minutes with patient
    - b. 90834 - Psychotherapy, 45 minutes with patient and Psychotherapy, 60 minutes with patient.
    - c. 90833 - Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
    - d. 90836 - Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
    - e. 90838 - Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)

## Behavior Analysis Services

Behavior analysis is the design, implementation, and evaluation of instructional and environmental modifications to produce socially significant improvements in human behavior. It includes the empirical identification of functional relations between behavior and environmental factors, known as functional assessment and analysis. Behavior analysis interventions are based on scientific research and the direct observation and measurement of behavior and the environment. Behavior analysts utilize contextual factors, motivating operations, antecedent stimuli, positive reinforcement, and other consequences to help people develop new behaviors, increase, or decrease existing behaviors, and emit behaviors under specific environmental conditions. AMPM's [320-S, Behavior Analysis Services](#) specifically addresses all aspects of provision of behavior analysis services.

### CPT Codes

- 97151 - Behavior identification assessment, administered by a physician or other qualified health care professional, each 15 minutes of the physician's or other qualified health care professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan
- 97152 - Behavior identification supporting assessment, administered by one technician under the direction of a physician or other qualified Health care professional, face-to-face with the patient, each 15 minutes
- 97153 - Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified Health care professional, face-to-face with one patient, each 15 minutes
- 97154 - Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified Health care professional, face-to-face with two or more patients, each 15 minutes
- 97155 - Adaptive behavior treatment with protocol modification administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes

- 97156 - Family adaptive behavior treatment guidance, administered by physician or other qualified Health care professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes
- 97157 - Multiple-family group adaptive behavior treatment guidance, administered by a physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, every 15 minutes
- 97158 - Group adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional face-to-face with multiple patients, each 15 minutes

### **Partial Hospitalization Programs (PHPs)**

Partial Hospitalization Programs (PHPs) are structured **non-residential** treatment programs intended to be an alternative to inpatient psychiatric care. PHP services include intensive therapeutic treatment and must be targeted to meet the goals of alleviating impairments and maintaining or improving functioning to prevent relapse or hospitalization. PHPs are a comprehensive outpatient treatment program which provides a minimum of 20 hours of services per week. PHPs must include a combination of psychiatric services, individual, group, and family therapy, peer support services, and educational groups. An individualized, written plan for furnishing PHP services that identifies the diagnosis, type, amount, frequency, duration of services, and the goals for treatment must be established by and reviewed periodically by a physician. Services must be provided to the individual while under a physician's care and the individual must be determined not less frequently than monthly by a physician to need such services for a minimum of 20 hours per week.

PHP services 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. The staff who deliver the specific services within the partial hospitalization program shall also meet the individual provider qualifications associated with those services.

#### **HCPCS Code**

- H0035 - Mental health partial hospitalization, treatment, less than 24 hours

#### **Billing Limitations**

For PHPs the following billing limitations apply:

1. See general core billing limitations.
2. Partial Hospitalization services may only be provided by the following provider types: B2, B3, B5, B6, 02, and 71.
3. A physician recommending partial hospitalization services must determine at least once monthly that the member still needs a minimum of 20 hours of services a week.
4. Payment for partial hospitalization services may be made only when the individual would require inpatient psychiatric care in the absence of such services.
5. Approved places of service for H0035 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
6. H0035 is an all-inclusive behavioral health code.

7. Behavioral health HCPCS codes are included in the H0035 per diem rate and cannot be billed separately during the same time as H0035.
8. H0035 can be paired with the U9 modifier at intake and discharge when the ASAM is used to determine appropriate level of care.
9. RN/LPN services are included in the per diem rate.
10. Case management and rehabilitation services are included in the per diem rate.
11. Psychiatric, BHP, and other behavioral health professional CPT services are included in the per diem rate and cannot be billed separately.
12. GT modifier may not be billed with H0035. All H0035 services must be delivered in person.

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

### Psychiatric Collaborative Care Model (CoCM)

The Psychiatric Collaborative Care Model (CoCM) is a behavioral health integration model that enhances primary care by adding care management support for patients receiving behavioral health treatment and regular psychiatric inter-specialty consultation to the primary care team. Members' care is directed by the primary care team and includes structured care management with regular assessments of clinical status using validated screening tools and modification of treatment plans as appropriate. The psychiatric consultant provides regular consultations to the primary care team to ensure each member's treatment plan aligns with the member's goals and improves clinical outcomes.

#### CPT Codes

- 99492 - Initial psychiatric collaborative care management, **first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified Health care professional, with the following required elements:** outreach to and engagement in treatment of a patient directed by the treating physician or other qualified Health care professional, initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan, review by the psychiatric consultant with modifications of the plan if recommended, entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant, and provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies. with the following required elements:
  - Outreach to and engagement in treatment of a patient directed by the treating physician or other qualified Health care professional,
  - Initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan,
  - Review by the psychiatric consultant with modifications of the plan if recommended;
  - Entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant, and
  - Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.
- 99493 - Subsequent psychiatric collaborative care management, **first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified Health care professional, with the following required elements:** tracking patient follow-up and progress using the registry, with



appropriate documentation, participation in weekly caseload consultation with the psychiatric consultant, ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers, additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant, provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies, monitoring of patient outcomes using validated rating scales, and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment with the following required elements:

- Tracking patient follow-up and progress using the registry, with appropriate documentation;
  - Participation in weekly caseload consultation with the psychiatric consultant;
  - Ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers;
  - Additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant;
  - Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies;
  - Monitoring of patient outcomes using validated rating scales; and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.
- 99494 - Initial or subsequent psychiatric collaborative care management, **each additional 30 minutes in a calendar month of behavioral health care manager activities**, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified Health care professional (List separately in addition to code for primary procedure). (Use 99494 in conjunction with 99492, 99493.)
  - 99484 - Care management services for behavioral health conditions, **at least 20 minutes of clinical staff time**, directed by a physician or other qualified Health care professional, per calendar month, with the following required elements: initial assessment or follow-up monitoring, including the use of applicable validated rating scales, behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes, facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation, and continuity of care with a designated member of the care team with the following required elements:
    - Initial assessment or follow-up monitoring, including the use of applicable validated rating scales,
    - Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes,
    - Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation, and
    - Continuity of care with a designated member of the care team.

## Intensive Outpatient Programs (IOP)

Intensive outpatient programs (IOP) are structured **non-residential** treatment programs which address mental health and substance use disorders (SUDs) that do not require detoxification through a combination of psychiatric services, individual, group, and family counseling, therapy and educational groups.

All services provided by Intensive Outpatient Programs shall adhere to all ADHS and AHCCCS requirements specific to each service being delivered as a component of the program.

IOPs shall be provided by an appropriately licensed Outpatient Treatment Center (OTC) and as specified with applicable service requirements set forth in A.A.C. Title 9, Chapter 10, Article 10. The staff who deliver the specific services within the IOP shall also meet the individual provider qualifications associated with those services as specified in A.A.C. Title 9, Chapter 10 or for IHS/638 providers and tribal health programs operated under P.L. 93-638, may provide behavioral health services rendered as specified in the [IHS/Tribal Billing Manual](#).

Intensive Outpatient Programs treating substance use disorder and co-occurring disorders shall align with The American Society of Addiction Medicine (ASAM) treatment level 2.1 standards and requirements.

### Intensive Outpatient Psychiatric Services

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. Intensive outpatient psychiatric services are provided to the member a minimum of 9 hours per week, no less than 3 hours per day for two or more days per week. These services may be used as a step down from a higher level of care (inpatient, residential, or PHP program) or a step up from less intensive outpatient services.

Psychiatric IOP requirements are based on level of service intensity as described in the following two tiers:

Tier I Psychiatric IOP consists of the following minimum standards:

- A. One session with the members treating psychiatric Provider (Behavioral Health Medical Practitioner-BHMP) per week,
- B. One to three individual counseling sessions, with a BHP, no less than 50 minutes in duration, per week,
- C. Two group counseling sessions, no less than 50 minutes in duration, per week,
- D. A BHMP shall be available either on-site or via interactive audio-visual means at least 80% of the time during IOP Program operation,
- E. BHP IOP caseload shall not exceed 16 active members,
- F. Group sessions will include no more than 8 members and will be facilitated by a BHP, and
- G. Non IHS/638 Programs focused on the treatment of substance use and co-occurring disorders shall utilize the American Society of Addiction Medicine (ASAM) Criteria (3rd edition).

Tier II Psychiatric IOP consists of the following minimum standards:

- A. One session with the members treating BHMP per month,
- B. One or two individual counseling sessions with a BHP per week, totaling at least 50 minutes in duration per week,
- C. BHP IOP caseload not to exceed 24 active members,

- D. Group sessions will include no more than 12 members and will be facilitated by a BHP, and
- E. Non IHS/638 Programs focused on the treatment of substance use and co-occurring disorders shall utilize the American Society of Addiction Medicine (ASAM) Criteria (3rd edition).

#### **HCPCS Code**

- S9480 - Tier I Intensive outpatient psychiatric services, per diem,
- TBD<sup>2</sup> - Tier II Intensive outpatient psychiatric services, per diem

#### **Billing Limitations**

For intensive outpatient programs the following billing limitations apply:

1. See general core billing limitations.
2. S9480 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 S9480 (i.e., H0031, H0004, H0038, H2014, H2016, etc.)
3. Psychiatric and other behavioral health professional CPT services are included in the S9480 per diem rate and cannot be billed separately on the same day as S9480.
4. GT modifier may not be billed with S9480. All S9480 services must be delivered in person with the exception of the psychiatric (BHMP) visit.
5. 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.
6. Duration of treatment is determined by medical necessity and documented in assessment and service plan.

### **Intensive Outpatient Alcohol and/or Drug Services**

Intensive outpatient alcohol and/or drug services provide substance use disorder and co-occurring treatment in alignment with ASAM Criteria, 3rd Edition, level 2.1. Programming includes a minimum of 9 hours per week for adults and 6 hours per week for adolescents of skilled treatment services. Such 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. Individuals appropriate for an intensive outpatient program (IOP) typically require close monitoring and frequent contact to reduce risk of continued use, relapse, and worsening mental health problems. Individuals receiving this service should be medically stable and at minimal risk for severe withdrawal. In addition to the SUD, they may have mild psychiatric problems that need monitoring or lack a supportive recovery environment.

Treatment shall consist of a minimum of 9 hours of services a week, conducted for at least 3 hours a day and at least 3 days a week.

#### **HCPCS Code**

- H0015 - Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling; crisis intervention, and activity therapies or education.

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<sup>2</sup> AHCCCS will continue to develop a rate and code or set and revise once complete.

## **Billing Limitations**

For intensive outpatient alcohol and/or drug services the following billing limitations apply:

1. See general core billing limitations.
2. 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.).
3. Duration of treatment is determined by medical necessity and documented in assessment and service plan.
4. 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.

## Behavioral Health Day Programs

Behavioral health day programs are categorized as Supervised, Therapeutic, or Community Psychiatric Supportive Treatment.

Behavioral health day programs provide services scheduled on a regular basis either hourly, half day or full day and 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. Title 9, Chapter 10, Article 10 and as specified below.

### Supervised Behavioral Health Day Programs

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 the following rehabilitative and support services: skills training and development, behavioral health prevention/promotion, medication training and support, pre-vocational services and ongoing support to maintain employment, peer and recovery support, and home care training family (family support).

Supervised behavioral health day programs may be provided by either licensed behavioral health agencies or Title XIX certified Community Service Agencies (CSA). The individual staff that delivers specific services within the supervised behavioral health day program shall meet the individual provider qualifications associated with those services and supervision of behavioral health day programs associated with those services as specified in AMPM Policy 965.

#### HCPCS Codes

- H2012 - Behavioral Health Day Treatment, per hour: See general definition above. Per hour, up to 5 hours in duration.
- H2015 - Comprehensive Community Support Services per 15 minutes: (Supervised Day Program): See general definition above. Greater than 5 hours, up to 10 hours in duration.

#### Billing Limitations

For supervised behavioral health day programs, the following billing limitations apply:

1. See general core billing limitations.
2. School attendance and education hours are not included as part of this service and may not be provided simultaneously with this service.
3. Meals provided as part of the supervised day treatment are included in the rate and should not be billed separately.
4. Emergency and non-emergency transportation provided to a person is not included in the rate and should be billed separately using the appropriate transportation procedure codes.
5. H2012 and H2015 are all inclusive codes and separate services must not be billed at the same time that supervised behavioral health day program services are provided.

### Therapeutic Behavioral Health Services and Day Programs General<sup>3</sup>

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<sup>3</sup> The definition of therapeutic behavioral health services and day programs may be found in [AMPM Chapter 300, Section 310- Covered Services](#). This section also addresses service standards and provider qualifications.

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, skills training and development, behavioral health prevention/promotion, medication training and support, pre-vocational services and ongoing support to maintain employment, home care training family (family support), medication monitoring, case management, peer and recovery support, and/or medical monitoring,

Therapeutic behavioral health day programs shall be provided by an appropriately licensed Outpatient Treatment Center and as specified with applicable service requirements set forth in A.A.C. Title 9, Chapter 10, Article 10. The staff who deliver the specific services within the therapeutic behavioral health day program shall meet the individual provider qualifications associated with those services.

### **HCPCS Codes**

- H2019 - Therapeutic Behavioral Service, per 15 minutes: See general definition above. Up to 5 hours in duration.
- H2020 - Therapeutic Behavioral Services, per diem: See general definition above. One unit procedure daily maximum for services exceeding 5 hours.

### **Billing Limitations**

1. See general core billing limitations.
2. School attendance and education hours are not included as part of this service and may not be provided simultaneously with this service.
3. A registered nurse who supervises therapeutic behavioral health services and day programs may not bill this function separately. Employee supervision has been built into the procedure code rates.
4. Meals provided as part of therapeutic behavioral health services and day programs are included in the rate and should not be billed separately.
5. H2019 and H2020 are all inclusive codes and separate services such as H2014, H0025, etc. should not be separately billed during the same time period.
6. Emergency and non-emergency transportation provided to a person is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

### **Community Psychiatric Supportive Treatment and Medical Day Programs<sup>4</sup>**

Community Psychiatric Supportive Treatment Program 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, skills training and development, behavioral health prevention/promotion, medication training and support, ongoing support to maintain employment, pre-vocational services, home care training family (family support), peer and recovery support, and/or other nursing services such as medication monitoring, methadone administration, and medical/nursing assessments.

Community Psychiatric Supportive Treatment Programs shall be provided by an appropriately licensed behavioral health agency and as specified with applicable service requirements set forth in A.A.C. Title 9, Chapter 10, Article 10. These programs shall be under the direction of a licensed physician, nurse practitioner, or physician assistant. The staff who deliver the specific services within the medical behavioral health day program shall meet the individual provider qualifications associated with those services.

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<sup>4</sup> The definition of community psychiatric treatment and medical day programs may be found in [AMPM Chapter 300, Section 310- Covered Services](#). This section also addresses service standards and provider qualifications.

## HCPCS Codes

- H0036 - Community Psychiatric Supportive Treatment, face-to-face, per 15 minutes:
  - The TF modifier is used to indicate an intermediate level of services (e.g., clients needing more intensive supervision, a sitter and/or 1:1 staffing).
- H0037 - Community Psychiatric Supportive Treatment Program, per diem: See general definition above.
  - The TF modifier is used to indicate an intermediate level of services (e.g., clients needing more intensive supervision, a sitter and/or 1:1 staffing).
- H2041 - Coordinated specialty care, team-based, for first episode psychosis, per encounter
  - Only approved providers will be allowed to bill this code after verification and approval by AHCCCS.

## Billing Limitations

1. See general core billing limitations.
2. School attendance and education hours are not included as part of this service and may not be provided simultaneously with this service.
3. Meals provided as part of community psychiatric supportive treatment and medical day programs are included in the rate and should not be billed separately.
4. Emergency and non-emergency transportation provided to a person is not included in the rate and should be billed separately using the appropriate transportation procedure codes.
5. Only one per diem code per day may be billed for a member.

## Rehabilitation Services

Rehabilitation services teach independent living, social, and communication skills to persons (or their families) to promote the maximum reduction of behavioral health symptoms and/or restoration of an individual to his/her best age appropriate functional level for the purpose of maximizing the person's ability to live independently and function in the community.

## Skills Training and Development

Teaching independent living, social, and communication skills to persons and/or their families in order to maximize the person's ability to live independently, participate in the community, and manage their behavioral health needs. Examples of areas that may be addressed include self-care, household management, appropriate social engagement, friendships and relationships, avoidance of exploitation, budgeting, recreation, development of social support networks and use of community resources. Services may be provided to a person, a group of individuals and/or their families with the person(s) present.

## Psychosocial Rehabilitation

Psychosocial Rehabilitation Services help individuals to compensate for or to eliminate functional deficits and environmental and interpersonal barriers associated with mental illness. The goal of the service is to help individuals achieve the fullest possible integration as an active and productive member of their family and community with the least possible ongoing professional intervention. This is a face-to-face intervention and the services may be provided in a group or an individual setting.

Skills training and development and psychosocial rehabilitation living skills training services must be provided by individuals who are qualified *behavioral health professionals, behavioral health technicians or behavioral health paraprofessionals* as defined in 9 A.A.C. 10 and AMPM Policy 310-B.

### HCPCS Codes

- H2014 - Skills training and development, per 15 minutes (up to 8 hours per day)<sup>5</sup>
- H2017 - Psychosocial rehabilitation services, per 15 minutes (up to 8 hours per day)

### Billing Limitations

1. See general core billing limitations.
2. Where applicable, travel time by the provider is included in the rates.
3. Transportation provided to persons and/or family members is not included in the rate and should be billed separately using the appropriate transportation procedure codes.
4. Service codes H2038, Skills Training and Development and Service code H2018, Psychosocial Rehabilitation cannot be billed on the same day.
5. More than one provider agency may bill for skills training and development services provided to a behavioral health recipient at the same time if indicated by the person's clinical needs as documented in the comprehensive assessment and specifically documented in the treatment plan.

### Cognitive Rehabilitation

Facilitation of recovery from cognitive impairments to achieve independence or the highest level of functioning possible.

1. Goals of cognitive rehabilitation include relearning of targeted mental abilities, strengthening of intact functions, relearning of social interaction skills, substitution of new skills to replace lost functioning and controlling the emotional aspects of one's functioning.
2. Treatment may include techniques such as auditory and visual attention directed tasks, memory training, and training in the use of assistive technology, and/or anger management.
3. Training can be done through exercises or stimulation, cognitive neuropsychology, cognitive psychology and behavioral psychology, or a holistic approach to include social and emotional aspects. Training is generally provided one-on-one and is highly customized to each individual's strengths, skills, and needs.
4. Cognitive rehabilitation services shall be provided only by qualified BHPs.

### CPT Codes

- 97129 - Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes
- 97130 - Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (List separately in addition to code for primary procedure)

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<sup>5</sup> AHCCCS is working through the process to open applicable per diem codes to pair with H2014 and H2017 to support 8 hour days and will move 15 min code max to 5 hours when per diem codes are available.



## Health Promotion

Education and training about health-related topics that can be provided in single or multiple sessions provided to an individual or a group of people and/or their families. Health promotion sessions are usually presented using a standardized curriculum with the purpose of increasing an individual's behavioral knowledge of a health-related topic such as the nature of an illness, relapse and symptom management, medication management, stress management, safe sex practices, Human Immunodeficiency Virus (HIV) education, parenting skills education, and healthy lifestyles (e.g., diet, exercise). Driving Under the Influence (DUI) health promotion education and training shall be approved by Arizona Department of Health Services (ADHS).

1. More than one provider agency may bill for health promotion provided to a member at the same time if indicated by the member's clinical needs as identified in their service plan.

## HCPCS Codes

- H0025 - Behavioral Health Prevention Education Service: (delivery of services with target population to affect knowledge, attitude and/or behavior). Billing unit: 30 min.
- H0034 - Medication training and support, per 15 minutes

## Billing Limitations

For behavioral health prevention/promotion education and medication training and support services the following billing limitations apply:

1. See general core billing limitations.
2. Where applicable, travel time by the provider is included in the rates.
3. Transportation provided to persons and/or family members is not included in the rate and should be billed separately using the appropriate transportation procedure codes.
4. More than one provider agency may bill for behavioral health prevention/promotion education and medication training and support services provided to a behavioral health recipient during the same date span when indicated by the member's clinical needs and documented in their comprehensive assessment and service plan.

## Psychoeducational Services and Ongoing Support to Maintain Employment

Psychoeducational Services (pre-vocational services) and Ongoing Support to Maintain Employment (job coaching and employment support) are designed to assist a person or group to choose, acquire, and maintain a job or other meaningful community activity (e.g., volunteer work). These services are only appropriate for members who are preparing to work and/or volunteer or currently employed. These services shall be provided using tools, strategies, and materials that meet the members needs and are tailored to support members in a variety of settings.

Pre-vocational Services prepare members to engage in meaningful work-related activities, such as full- or part-time, competitive employment. Such activities may include, but are not limited to, the following: career/educational counseling, job training, assistance in the use of educational resources necessary to obtain employment, attendance to Rehabilitation Services Administration/Vocational Rehabilitation (RSA/VR) orientations, attendance to job fairs, assistance in finding employment, and other training, like resume preparation, job interview skills, study skills, budgeting skills (when it pertains to employment), professional decorum, and time management.

Ongoing support to maintain employment services are post-vocational services, often called job coaching, which enable members to maintain their current employment. Services may include, but are not limited to,

the following: monitoring and supervision, assistance in performing job tasks, and supportive counseling. Ongoing support to maintain employment can also be used when assisting employed members with services traditionally used as pre-vocational to gain skills for promotional employment or alternative employment. Ongoing support to maintain employment may be provided individually or in a group setting, as well as telephonically. Services may include, but are not limited to:

1. Monitoring and supervision, assistance in performing job tasks, and supportive counseling.
2. Assisting employed members with services traditionally used as pre-vocational to gain skills for promotional employment or alternative employment.
3. Ongoing support to maintain employment may be provided individually or in a group setting, as well as telephonically.

Prevocational services and ongoing support to maintain employment services are provided only if the services are not available through the federally funded Rehabilitation Act program administered by Arizona Department of Economic Security Rehabilitation Service Administration (DES/RSA), which is required to be the primary payer for Title XIX/XXI eligible individuals.

- a. The following services are not TXIX/TXXI covered treatment services: Rehabilitative employment support assessments when available through the federally funded Rehabilitation Act program administered by the Tribal Rehabilitation Services Administration, and preparation of a report of a member's psychiatric status for primary use with a court. Refer to [ACOM 447](#).

Vocational services prepare members to engage in meaningful work-related activities, such as full- or part-time, competitive employment. Such activities may include, but are not limited to, the following:

- a. Career/educational counseling, job training, assistance in the use of educational resources necessary to obtain employment, attendance to Rehabilitation Services Administration/Vocational Rehabilitation (RSA/VR) orientations, attendance to job fairs, assistance in finding employment, and other training, like resume preparation, job interview skills, study skills, budgeting skills (when it pertains to employment), professional decorum, and time management.
- b. More than one provider agency may bill for psychoeducational services and ongoing support to maintain employment services provided to a member at the same time, if indicated by the member's clinical needs as identified in their service plan.

For Community Service Agencies (CSAs), refer to [AMPM Policy 965](#) for further detail on service standards and provider qualifications for this service.

### **HCPCS Codes**

- H2027 - Psychoeducational service, per 15 minutes (Pre-Job Training and Development): Services which prepare a person to engage in meaningful work-related activities may include but are not limited to the following: career/educational counseling, job shadowing, job training, including Work Adjustment Training (WAT); assistance in the use of educational resources necessary to obtain employment; attendance to RSA/VR Information Sessions; attendance to Job Fairs; training in resume preparation, job interview skills, study skills, budgeting skills (when it pertains to employment), work activities, professional decorum, time management, and assistance in finding employment. Billing unit: 15 min
- H2025 - Ongoing support to maintain employment, per 15 minutes: Includes support services that enable a person to maintain employment. Services may include monitoring and supervision, assistance in performing job tasks, and supportive counseling. Billing unit: 15 min

- H2026 - Ongoing support to maintain employment, per diem

### **Billing Limitations**

1. See general core billing limitations.
2. Where applicable, travel time by the provider is included in the rates.
3. Transportation provided to persons is not included in the rate and should be billed separately using the appropriate transportation procedure codes.
4. Pre-vocational services (psychoeducational services) and ongoing support to maintain employment services are provided only if the services are not available through the federally funded Rehabilitation Act program administered by ADES-RSA, which is required to be the primary payer for Title XIX eligible persons. The availability of services administered by ADES-RSA must be documented in the comprehensive assessment and service plan.
5. Service code H2025, Ongoing support to maintain employment, per 15 minutes, may be billed up to 5 hours.
6. Service code H2026, Ongoing support to maintain employment, per diem, can only be billed for services over 5 hours and should be billed for the length of the service and cannot be billed on the same day as H2025. If providers are serving more than one member during the same time period H2026 must be paired with the HQ modifier<sup>6</sup>.
7. Service code H2027 - Psychoeducational service, per 15 minutes, may be billed for up to 5 hours.
8. More than one provider agency may bill for psychoeducational services and ongoing support to maintain employment services provided to a behavioral health recipient during the same date span when the member's clinical needs for this are documented in the service plan and comprehensive assessment.
9. Costs associated with training an agency's own employees are non-reimbursable.
10. Observing a member while they are working is not reimbursable. Time spent in assessment for level of functionality, assessment of interpersonal effectiveness skills, and any interventions utilized by the provider per the member's treatment plan goals and objectives must be documented in order for the service to be eligible for reimbursement.

### **Other Services**

In addition to behavioral health counseling therapy and assessment, evaluation and screening, there are other treatment services that may be provided by qualified individuals in order to reduce symptoms and improve or maintain functioning. These services are described below.

#### **CPT Codes**

- 90875 - Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); 30 minutes
- 90876 - Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); 45 minutes
- 90901 - Biofeedback training by any modality

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<sup>6</sup> H2026 HQ modifier rate is currently under development. Provider notice of final rate will be sent out once approved.

## HCPC Code

- H2033 - Multisystemic therapy for juveniles, per 15 minutes: Multisystemic therapy uses the strengths found in key environmental settings of juveniles to promote and maintain positive behavioral changes. These services focus on individual, family and extrafamilial (such as peer, school and neighborhood) influences and can include a range of family and community-based services that vary from outpatient to home-based. Documentation of services must include weekly progress notes. Multisystemic Therapy is a family and community-based intervention for youth between the ages of 12 and 17 years old who have engaged in serious antisocial or delinquent behaviors that would warrant arrest. Youth appropriate to receive this intervention are at risk for out-of-home placement or are transitioning back from an out-of-home setting. The primary goal is to develop independent skills among parents and youth with behavioral problems to cope with family, peers, school, and neighborhood problems through a period of brief but intense treatment typically lasting from three to five months.

## Billing Limitations

1. See general core billing limitations.
2. Where applicable, travel time by the provider is included in the rates. See core provider travel billing limitations.
3. Transportation provided to persons and/or family members is not included in the rate and should be billed separately using the appropriate transportation procedure codes.
4. For multisystemic therapy for juveniles the following billing limitations apply:
  - a. Transportation provided to persons and/or family members is not included in the rate and should be billed separately using the appropriate transportation procedure codes.
  - b. Providers of this service must be trained and licensed in MST services in strict adherence to the Blueprints Project MST model and as approved by the MST Services.
  - c. Multisystemic therapy for juveniles (H2033) may not be billed on the same day as other per diem services or inpatient services.
  - d. MST is an all-inclusive service paid at a bundled rate. All case related direct- service activity is billable. Billing is submitted on a weekly basis. This includes all face-to-face time with clients as well as collateral contact related to the client treatment plan.
  - e. Weekly consultation and supervision of MST personnel with the national MST staff if considered part of the cost of rendering the service and has been factored in the rate. This is not considered a billable activity.
  - f. Travel time and expenses are not billable activities and cannot be included in units billed during claims submission.

## Medical Services

The definition of medical services may be found in AMPM Chapter 300, Section 310- Covered Services [AMPM Policy 310-B](#). This section also addresses service standards and provider qualifications.

### Medication Services

Medications prescribed and/or administered within scope of practice by a licensed physician, nurse practitioner, clinical nurse specialist or physician assistant with prescriptive authority in the state of Arizona to prevent, stabilize or ameliorate symptoms arising from a behavioral health condition or its treatment.

Most prescribed medications must be provided by a licensed pharmacy or dispensed under the direction of a licensed pharmacist. Some medications are administered by (e.g., injections, opioid agonist drugs) or under the direction of a licensed physician, nurse practitioner, clinical nurse specialist or physician assistant.

AHCCCS maintains a minimum list of medications to ensure the availability of necessary, safe and cost-effective medications for members with behavioral health disorders as further described in AMPM Policy 310-V.

The AHCCCS Drug List can be found on the [AHCCCS Pharmacy web page](#).

### Informed Consent

Informed consent shall be obtained from the member, or as applicable, the member's Health Care Decision Maker for each psychotropic medication prescribed, as required in [AMPM 310V](#).

### National Drug Codes

The National Drug Codes (NDC) must be used for billing all prescribed medications dispensed by a pharmacy (provider type 03). These pharmacy claims are reimbursed based on a fee schedule amount plus a dispensing fee.

### CPT Code

- 96372 - Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular

### HCPCS Codes

- J2060 Injection, Lorazepam, intramuscular, 2 mg
- J0400 Injection, Aripiprazole, intramuscular, 0.25 mg
- J0401 Injection, Aripiprazole, extended release, 1 mg
- J0515 Injection, Benzotropine Mesylate, per 1mg
- J1200 Injection, Diphenhydramine HCL, up to 50 mg
- J1630 Injection, Haloperidol, up to 5 mg
- J1631 Injection, Haloperidol Decanoate, per 50 mg
- J2358 Injection, Olanzapine, long acting, 1 mg
- J2426 Injection, Paliperidone Palmitate, extended release, 1 mg,
- J2680 Injection, Fluphenazine Decanoate, up to 25 mg
- J2794 Injection, Risperidone (Risperdal Consta), long-acting, 0.5 mg
- J3410 Injection, Hydroxyzine HCL, up to 25 mg

## Opioid Agonist Drugs

While prescribed opioid agonist drugs that are dispensed by a pharmacy should be billed using the NDC code for the drug itself, the administration of opioid agonist by licensed medical practitioners in an office setting (non-inpatient) should be billed using the codes listed below. The administration of opioid agonist drugs must be done in compliance with federal regulations, (see 42 C.F.R. Part 8), state regulations (A.A.C. Title 9, Chapter 10) and AHCCCS policy AMPM 660, Opioid Treatment Program, related to opioid agonist administration.

- H2010 - 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 opiate narcotics. Providers must be AHCCCS registered as a Category of Service (COS) type 01 (Medicine).
- H0020 - 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 opiate narcotics. Providers must be AHCCCS registered as a Category of Service (COS) type 01 (Medicine). Billing Unit: 1 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.

## Billing Limitations

For medication services the following billing limitations apply:

1. Medications provided in an inpatient general acute care or psychiatric hospital setting are included in the per diem rate and cannot be billed separately.
2. As described in AMPM Policy 510, Primary Care Providers, behavioral health services provided by a PCP within their scope of practice is covered. In certain circumstances the person's primary care physician (PCP) may prescribe psychotropic medications . Care should be coordinated with other prescribers including PCPs.
3. Other than opioid agonist drugs (see limitation #4 below), the provider should determine the maximum number of days and/or unit doses for prescriptions.
4. The Comprehensive Medication Services (Office) and Methadone Administration and/or Services (Take-Home) procedure codes are to be billed one dose per day (includes cost associated with drug and administration). While the billing unit for Methadone Administration and/or Services (Take-Home) is a single dose of medication per day, the take-home medicine can be provided for more than one day.
5. AHCCCS does not cover items relating to medical marijuana. This includes application fees or the drug itself.
6. Transportation provided to the AHCCCS member is not included in the rate and should be billed separately using the appropriate transportation procedure codes.
7. Providers who administer Medication Assisted Treatment (MAT) or Medications for Opioid Use Disorder (MOUD) must adhere to AHCCCS guidelines for opioid treatment receiving AHCCCS reimbursement shall adhere to all AHCCCS standards and reporting requirements.

## Laboratory, Radiology and Medical Imaging General Information

Medical tests ordered for diagnosis, screening or monitoring of a behavioral health condition, including adjustment and monitoring of psychotropic medication. This may include but is not limited to blood and urine tests, CT scans, MRI, EKG, and EEG.

## Service Standards/Provider Qualifications

Laboratory, radiology, and medical imaging services may be prescribed by a licensed physician, nurse practitioner, clinical nurse specialist, or physician assistant within the scope of their practice.

With the exception of specimen collections in a medical practitioner's office, laboratory services are provided in Clinical Laboratory Improvement Act (CLIA) approved hospitals, medical laboratories and other health care facilities that meet state licensure requirements as specified in [A.R.S. Title 36, Chapter 4](#). (Also see requirements related to federal Clinical Laboratory Improvement Amendments in [A.A.C. R9-14-101](#) and the federal code of regulations [42 C.F.R. Part 493 Subpart A](#)).

Presumptive drug testing is used when medically necessary to determine the presence or absence of drugs or drug classes in a urine sample. Presumptive drug testing must be reasonable and medically necessary. The appropriate indications for testing and expected frequency of testing must be specifically described in the member's service/treatment plan. AHCCCS has adopted the [Centers for Medicare and Medicaid Services for Local Coverage Determination \(LCD L36707\) for Urine Drug Testing \(UDT\)](#).

Radiology and medical imaging are provided in hospitals, medical practitioner's offices, and other health care facilities by qualified licensed health care professionals.

## CPT Codes

- 36415 - Collection of venous blood by venipuncture
- 80048 - Basic metabolic panel (Calcium, total)
- 80050 - General health panel
- 80051 - Electrolyte panel
- 80053 - Comprehensive metabolic panel
- 80061 - Lipid panel
- 80076 - Hepatic function panel
- 80156 - Carbamazepine; total
- 80159 - Clozapine; therapeutic drug assays
- 80164 - Valproic acid (dipropylacetic acid); total
- 80171 - Gabapentin, whole blood, serum, or plasma
- 80178 - Lithium
- 80299 - Quantitation of therapeutic drug, not elsewhere specified
- 80305 - Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; capable of being read by direct optical observation only (e.g., utilizing immunoassay [e.g., dipsticks, cups, cards, or cartridges]), includes sample validation when performed, per date of service
- 80306 - Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; read by instrument assisted direct optical observation (e.g., utilizing immunoassay [e.g., dipsticks, cups, cards, or cartridges]), includes sample validation when performed, per date of service
- 80307 - Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; by instrument chemistry analyzers (e.g., utilizing immunoassay [e.g., EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA]), chromatography (e.g., GC, HPLC), and mass spectrometry either with or without chromatography, (e.g., DART, DESI, GC-MS, GC-MS/MS, LC-MS, LC-MS/MS, LDTD, MALDI, TOF) includes sample validation when performed, per date of service

- 80358 - This test may be requested as a qualitative, quantitative, or combination analysis for methadone.
- 80420 - Dexamethasone suppression panel, 48 hour
- 81000 - Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy
- 81001 - Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy
- 81002 - Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, without microscopy
- 81003 - Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, without microscopy
- 81005 - Urinalysis; qualitative or semiquantitative, except immunoassays
- 81025 - Urine pregnancy test, by visual color comparison methods
- 81050 - Volume measurement for timed collection, each
- 82075 - Alcohol (ethanol); breath
- 82382 - Catecholamines, total urine
- 82465 - Cholesterol, serum or whole blood, total
- 82492 - Chromatography Quan Column Multiple Analytes
- 82530 - Cortisol, free
- 82533 - Cortisol, total
- 82542 - Column chromatography/mass spectrometry (EG, GC/MS, or HPLC/MS), analyte not elsewhere specified; quantitative, single stationary and mobile phase
- 82565 - Creatinine; blood
- 82570 - Creatinine (other source)
- 82575 - Creatinine, clearance
- 82607 - Cyanocobalamin (Vitamin B12)
- 82746 - Folic acid; serum
- 82947 - Glucose; quantitative, blood (except reagent strip)
- 82948 - Glucose, blood, reagent strip
- 82977 - Glutamyltransferase, gamma (GGT)
- 83036 - Hemoglobin; Glycosylated (A1C)
- 83037 - Hemoglobin; glycosylated (A1C) by device cleared by FDA for home use
- 83789 - Mass spectrometry and tandem mass spectrometry (e.g., MS, MS/MS, MALDI, MS-TOF, QTOF), non-drug analyte(s) not elsewhere specified, qualitative or quantitative, each specimen
- 83986 - PH body fluid Not Elsewhere Specified
- 83992 - Phencyclidine (PCP)
- 84132 - Potassium; serum, plasma or whole blood
- 84146 - Prolactin
- 84311 - Spectrophotometry Analyte Not Elsewhere Specified



- 84436 - Thyroxine; total
- 84439 - Thyroxine, free
- 84443 - Thyroid stimulating hormone (TSH)
- 84520 - Urea nitrogen; quantitative
- 84703 - Gonadotropin, chorionic (Hcg), qualitative
- 85007 - Blood count; blood smear, microscopic examination with manual differential WBC count
- 85008 - Blood count; blood smear, microscopic examination without manual differential WBC count
- 85009 - Blood count; manual differential WBC count, buffy coat
- 85013 - Blood count; spun microhematocrit
- 85014 - Blood count; hematocrit (Hct)
- 85018 - Blood count; hemoglobin (Hgb)
- 85025 - Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count
- 85027 - Blood count; complete (CBC), automated (Hgb), Hct, RBC, WBC, and platelet count)
- 85048 - Blood count, leukocyte (WBC), automated
- 85651 - Sedimentation rate, erythrocyte; non-automated
- 85652 - Sedimentation rate, erythrocyte; automated
- 86580 - Skin test, tuberculosis, intradermal
- 86592 - Syphilis test; qualitative (e.g., VDRL, RPR, ART)
- 86593 - Syphilis test; quantitative
- 86689 - Antibody; HTLV or HIV antibody, confirmatory test (e.g., Western Blot)
- 86701 - Antibody; HIV-1
- 86702 - Antibody; HIV-2
- 86703 - Antibody; HIV-1 and HIV-2, single result
- 87390 - Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; HIV-1
- 87391 - Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; HIV-2
- 70450 - Computed tomography, head or brain, without contrast material
- 70460 - Computed tomography, head or brain; with contrast material(s)
- 70470 - Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections
- 70551 - Magnetic resonance (e.g., proton) imaging, brain (including brain stem); without contrast material
- 70552 - Magnetic resonance (e.g., proton) imaging, brain (including brain stem); with contrast material(s)
- 70553 - Magnetic resonance (e.g., proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences
- 93000 - Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report
- 93005 - Electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpretation and report

- 93010 - Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only
- 93040 - Rhythm ECG, 1-3 leads; with interpretation and report
- 93041 - Rhythm ECG, 1-3 leads; tracing only without interpretation and report
- 93042 - Rhythm ECG, 1-3 leads; interpretation and report only
- 95819 - Electroencephalogram (EEG); including recording awake and asleep

### **Billing Limitations**

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

### **Medical Management**

Assessment and management services that are provided by a licensed medical professional (i.e., physician, nurse practitioner, clinical nurse specialist, physician assistant or nurse) to a person as part of their medical visit for ongoing treatment purposes. Includes medication management services involving the review of the effects and side effects of medications and the adjustment of the type and dosage of prescribed medications.

Appropriately licensed physicians, nurse practitioners, clinical nurse specialists, physician assistants, and nurses provide medical management services.

### **CPT Codes**

- 99202 - Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
- 99203 - Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
- 99204 - Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
- 99205 - Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
- 99211 - Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified Health care professional
- 99212 - Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.
- 99213 - Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision

making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.

- 99214 - Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
- 99215 - Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
- 99304 - Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.
- 99305 - Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.
- 99306 - Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 50 minutes must be met or exceeded.
- 99307 - Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.
- 99308 - Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
- 99309 - Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
- 99310 - Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
- 99315 - Nursing facility discharge management; 30 minutes or less total time on the date of the encounter
- 99316 - Nursing facility discharge management; more than 30 minutes total time on the date of the encounter
- 99341 - Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.

- 99342 - Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
- 99344 - Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
- 99345 - Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded.
- 99347 - Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
- 99348 - Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
- 99349 - Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
- 99350 - Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
- 99358 - Prolonged evaluation and management service before and/or after direct patient care; first hour
- 99359 - Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes (List separately in addition to code for prolonged service)

#### **HCPCS Codes**

- T1002 - RN services, up to 15 minutes.
- T1003 - LPN/LVN services, up to 15 minutes

#### **Billing Limitations**

For medical management services the following billing limitations apply:

1. RN and LPN Services (T1002 and T1003) provided on the same day as a higher level of service (e.g., services by a psychiatrist or other physician) are considered incident to the services of the provider and are not separately billable. See also general core billing limitations.
2. Where applicable, travel time by the provider is included in the rate for RN and LPN Services (T1002 and T003).
3. Nursing services provided in an ADHS licensed inpatient, residential or medical day program setting are included in the rate and cannot be billed separately.

4. Transportation provided to the AHCCCS enrolled member is not included in the rate and should be billed separately using the appropriate transportation procedure codes.
5. Medical management using CPT codes is not reimbursable when billed with a clinic ID as the servicing provider. The servicing provider NPI must belong to the individual person delivering the service.

## **Electroconvulsive Therapy**

Electroconvulsive therapy is a medical service. A description may be found in AMPM Chapter 300 - Section 310-Covered Services [AMPM Policy 310-B](#).

### **CPT Codes**

- 00104 - Anesthesia for electroconvulsive therapy.
- 90870 - Electroconvulsive therapy (includes necessary monitoring).

### **Revenue Codes**

In addition to the CPT codes billed for the professional services, hospitals (02), free standing psychiatric facilities (71) or subacute facilities (B5, B6) may bill Revenue Code 0901 – electro shock treatment for the facility based costs associated with providing electroconvulsive therapy to a person in the facility.

When electroconvulsive therapy is provided as part of an inpatient hospital admission, the following revenue codes are billed in addition.

- 0114 - Room & Board Private (One Bed)-Psychiatric
- 0124 - Room & Board Semi Private (Two Beds)-Psychiatric
- 0134 - Room & Board Three and Four Beds-Psychiatrics
- 0154 - Room & Board Ward-Psychiatric

## **Transcranial Magnetic Stimulation (TMS)**

Transcranial Magnetic Stimulation therapy is a medical service. A description may be found in

### **CPT Codes**

- 90867 - Therapeutic Repetitive Transcranial Magnetic Stimulation (Tms) Treatment; Initial, Including Cortical Mapping, Motor Threshold Determination, Delivery And Management
- 90868 - Therapeutic Repetitive Transcranial Magnetic Stimulation (Tms) Treatment; Subsequent Delivery And Management, Per Session
- 90869 - Therapeutic Repetitive Transcranial Magnetic Stimulation (Tms) Treatment; Subsequent Motor Threshold Re-Determination With Delivery And Management

## Support Services

Support services are provided to facilitate the delivery of or enhance the benefit received from other behavioral health services. These services have been grouped into the following categories:

- Case Management
- Personal Care Services
- Home Care Training Family Services (Family Support)
- Self-Help/Peer Services (Peer Support)
- Unskilled Respite Care
- Transportation

### Case Management

Case management is a supportive service provided to improve treatment outcomes and meet member's service or treatment plan goals. AHCCCS Medical Policy Manual Chapter 500, section 570- Provider Case Management provides detailed clinical guidelines for case management. This document may be found in the following location: [AHCCCS MEDICAL POLICY MANUAL CHAPTER 500 – CARE COORDINATION REQUIREMENTS 570 – PROVIDER CASE MANAGEMENT](#).

In addition, a definition of indirect contact may be found in AMPM Chapter 300, Section 310 - Covered Services [AMPM Policy 310-B](#).

#### .HCPCS Codes

- T1016 - Case management, each 15 minutes (see general definition above for case management services) Case management services using HCPCS codes are provided by individuals who are qualified behavioral health technicians or behavioral health paraprofessionals.

### Billing Limitations

1. See general core billing limitations.
2. Case management services provided by an ADHS licensed inpatient, behavioral health residential facility or in a therapeutic/medical day program setting are included in the rate for those settings and cannot be billed separately. However, providers other than the inpatient, residential facility or day program can bill case management services provided to the person residing in and/or transitioning out of the inpatient or residential settings or who is receiving services in a day program.
3. A single provider may not bill case management for any time associated with a therapeutic interaction, nor simultaneously bill case management with any other services. Case management should be documented and billed as a separate service from any other therapeutic service.
4. When multiple providers bill for case management services during the same time period (e.g., a staffing) each provider must complete unique documentation of the specific case management service they provided.
5. Billing for case management is limited to individual providers who are directly involved with service provision to the person (e.g., when a clinical team comprised of multiple providers, physicians, nurses etc. meet to discuss current case plans).
  - a. Outreach and communication needing to be clinical in nature and directly related to member needs and access to services.
  - b. Email and voicemails counted and billed as case management shall contain substantive clinical notes and or communication and do not include administrative or quick check-ins.

- c. When billing multiple units/types of case management for the same member on the day providers shall ensure all services are rolled up together vs billed as separate service/units (see core billing limitations #11).
- 6. Transportation provided to the member is not included in the rate and should be billed separately using the appropriate transportation procedure codes.
- 7. For Case Management codes:
  - a. Where applicable, travel time by the provider is included in the rates.
  - b. The provider should bill all time he/she spent in direct or indirect contact with the person, family and/or other parties involved in implementing the treatment or service plan. Indirect contact includes telephone calls, and/or collateral contact with the person, family and/or other involved parties.
  - c. Written electronic communication (email) and leaving voice messages are allowable as case management functions. These functions are not to be the predominant means of providing case management services and require specific documentation as specified below.
    - i. Written electronic communication (email) must be about a specific individual, and be sufficient to justify a case management service to be allowable as case management, as long as documentation exists in the medical record.
    - ii. When voice messages are used, the case manager must have sufficient documentation justifying a case management service was actually provided. Leaving a name and number asking for a return call is not sufficient to bill case management.
    - iii. When leaving voice messages, a signed document in the client chart granting permission to leave specific information is required.
  - d. Refer to AMPM 570 for more case management guidance related to case load, responsibilities, and complex member needs.

## Personal Care Services

Personal care services involve the provision of support activities to assist a person in carrying out daily living tasks and other activities essential for living in a community. These services are provided to maintain or increase the self-sufficiency of the person. For DD/ALTCS enrolled persons, Personal Care Services includes general supervision; however, providers must document the need for general supervision.

- i. 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. Personal care services provided by a member's spouse are not covered, and

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

## HCPCS Codes

- T1019 - Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant): Personal care services (see general definition above) provided to a person for a period of time (up to 11¾ hours).

- T1020 - Personal care services, per diem, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant): Personal care services (see general definition above) provided to a person, for 12 or more hours.

### **Billing Limitations**

For personal care services the following billing limitations apply:

1. See general core billing limitations.
2. Where applicable, travel time by the provider is included in the rates.
3. Personal care services provided in an ADHS licensed inpatient, residential or day program setting are included in the rate for those settings and cannot be billed separately, with certain exceptions. For exceptions see the section on modifiers.
4. Transportation (emergency and non-emergency) provided to persons and/or family members is not included in the rate and should be billed separately using the appropriate transportation procedure codes.
5. Personal Care Services (T1019) and Personal Care Services (T1020) cannot be billed on the same day.
6. A BHRF would have to have a license from ADHS to provide personal care service (using TF modifier) and is included in the rate.
7. More than one provider agency may bill for personal care services provided to a behavioral health recipient during the same date span when the need is documented in their comprehensive assessment and specified in the service plan.
8. A Community Service Agency cannot provide personal care services.

### **Home Care Training to Home Care Family (Family Support)**

Home care training family services (family support) with family member(s) directed toward restoration, enhancement, or maintenance of the family functioning to increase the family's ability to effectively interact and care for the person in the home and community. May involve support activities such as assisting the family to adjust to the person's disability, developing skills to effectively interact and/or guide the person, understanding the causes and treatment of behavioral health issues, understanding and effectively utilizing the system, or planning long term care for the person and the family.

Home care training family services (family support) must be provided by *behavioral health professionals, behavioral health technicians, or behavioral health paraprofessionals*. Refer to AMPM Policy 964 for training and credentialing standards for Credentialed Family Support Partners (CFSP) providing parent/family support services.

- *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.*

### **HCPCS Code**

- S5110 - Home care training, family; per 15 minutes

### **Billing Limitations**

For home care training family services (family support) the following billing limitations apply:

1. See general core billing limitations.



2. Travel time by the provider is included in the rates.
3. Family support services provided in an ADHS licensed inpatient, residential or day program setting are included in the rate for those settings and cannot be billed separately, with certain exceptions. For exceptions see section Behavioral Health Counseling and Therapy under Billing Limitations. However, providers other than the inpatient, residential facility, day program or behavioral health therapeutic homes can bill home care training family services (family support) provided to the person residing in and/or transitioning out of the inpatient, residential settings, behavioral health therapeutic home or who is receiving services in a day program.
4. Transportation provided to persons and/or family members is not included in the rate and should be billed separately using the appropriate transportation procedure codes.
5. More than one provider agency may bill for home care training family services (family support) services provided to a behavioral health recipient at the same time if indicated by the person's clinical needs.

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

Peer support is a behavioral health service available to AHCCCS members. Peer support services are for members who may need more personalized support than natural supports or community based recovery groups (such as 12 Step groups) can provide. Practitioners of Peer Support Services are called Peer and Recovery Support Specialists (PRSS). PRSS have their own story of behavioral health recovery and utilize their lived experience to help the people they serve and promote recovery-oriented environments. A PRSS works with individuals during their recovery journey, sharing skills, coaching, and providing support.<sup>7</sup>

PRSS are credentialed through an AHCCCS-recognized Peer Support Employment Training Program (PSETP) covered under AMPM Policy 963, and are qualified as *behavioral health professionals*, *behavioral health technicians*, or *behavioral health para-professionals* as defined in A.A.C. Title 9, Chapter 10.

Please visit the [AHCCCS Office of Individual and Family Affairs Peer Support](#) website, along with the [Peer Support FAQ](#) page for additional information.

### HCPCS Codes

- H0038 - Self-help/peer services, per 15 minutes: Self-help/peer services (see general definition above) provided to an individual person for a short period of time (up to 2 ¾ hours).
- H2016 - Comprehensive Community Support Services, per diem: Self- help/peer services (see general definition above) provided to a person for a period of time, 3 or more hours in duration.

### Billing Limitations

For self-help/peer services the following billing limitations apply:

1. See general core billing limitations.
2. Where applicable, travel time by the provider is included in the rates. See core provider travel billing limitations.

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<sup>7</sup> For more information about peer support services please visit:  
<https://azahcccs.gov/AHCCCS/Downloads/OIFA/PeerSupportFAQ.pdf>  
<https://www.azahcccs.gov/AHCCCS/Health careAdvocacy/OIFA/peersupport.html>

3. 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, with certain exceptions. However, providers other than the inpatient, residential facility or day program can bill self-help/peer services provided to the person residing in and/or transitioning out of the inpatient or residential settings or who is receiving services in a day program.
4. Transportation provided to persons and/or family members is not included in the rate and should be billed separately using the appropriate transportation procedure codes.
5. Self Help/Peer Services (H0038) and Comprehensive Community Support Services (H2016) cannot both be billed on the same day by any provider.
6. More than one provider agency may bill for (H0038) self-help/peer services provided to a behavioral health recipient on the same day only when indicated by the person's clinical needs as documented in their comprehensive assessment and service plan.
7. Only individuals holding a PRSS credential may deliver peer support services. Providers of peer support services shall maintain documentation of PRSS credentials per AMPM Policy 963.
8. Providers must have evidence of credentialing on file for all individuals delivering Medicaid reimbursable peer support services.
9. Providers serving 2 or more members for 3 or more hours must use the H2016 per diem code paired with the HG modifier<sup>8</sup>.

### Unskilled Respite Care

Unskilled respite care (respite) is short term behavioral health services or general supervision that provides an interval of rest or relief to a family member or other individual caring for the member receiving behavioral health services as authorized under the Section 1115 Waiver Demonstration and delivered by providers who meet the requirements in A.A.C. R9-10-1025 and A.A.C. R9-10 Article 16. The availability and use of informal support and other community resources to meet the caregiver's respite needs shall be evaluated in addition to formal respite services.

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

Respite may include a range of activities to meet the social, emotional, and physical needs of the member during the respite period. These services may be provided on a short-term basis (i.e., for a few hours during the day) or for longer periods of time involving overnight stays. Respite services can be planned or unplanned. If unplanned respite is needed, behavioral health providers will assess the situation with the caregiver and recommend the appropriate setting for respite. CSAs cannot provide respite services.

Respite services may be provided in a variety of settings including but not limited to:

- Habilitation Provider (A.A.C. R6-6-1523),
- Outpatient Clinic (A.A.C. R9-10-1025),
- Adult Therapeutic Foster Care – with collaboration health care institution (A.A.C. R9-10-1803),
- Behavioral Health Respite Homes (A.A.C. R9-10 Article 16), and
- Behavioral Health Residential Facilities with an approved supplemental application to provide respite services.

A member's clinical team shall consider the appropriateness of the setting in which the recipient receives respite services,

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<sup>8</sup> H2016 HQ modifier rate is currently under development. Provider notice of final rate will be sent out once approved.

- When respite services are provided in a home setting, household routines and preferences shall be respected and maintained when possible. The respite provider shall receive orientation from the family/caregiver regarding the member's needs and the service plan, and
- Respite services, including the goals, setting, frequency, duration, and intensity of the service shall be defined in the member's service plan. Respite services are not a substitute for other covered services. Summer day camps, day care, or other ongoing, structured activity programs are not respite unless they meet the definition/criteria of respite services and the provider qualifications.

Members receiving behavioral health services may receive necessary respite services for their non-enrolled children as indicated in the member's service plan. Non-enrolled siblings of a child receiving respite services are not eligible for behavioral health respite benefits.

### **Revenue Codes**

Respite services provided in a ADHS licensed facility should be billed using the applicable revenue codes listed in Section II. F. Inpatient Services for the facility type.

### **HCPCS Codes**

- S5150 - Unskilled respite care, not hospice; per 15 minutes: Unskilled respite services (see general definition above) provided to a person for a short period of time (up to 12 hours in duration)
- S5151 - Unskilled respite care, not hospice; per diem: Unskilled respite services provided to a person for more than 12 hours in duration.

### **Billing Limitations**

1. See general core billing limitations.
2. Respite services billed using the two HCPCS codes S5150 and S5151 are limited to no more than 600 hours of respite services per year (October 1 through September 30) per member.
3. Where applicable, travel time by the provider is included in the rates.
4. Transportation provided to persons and/or family members is not included in the rate and should be billed separately using the appropriate transportation procedure codes.
5. Respite services cannot be billed for persons who are residing and receiving treatment in a DHS licensed Behavioral Health Inpatient Facility, Behavioral Health Residential Facility, group home or nursing home.
6. A Community Service Agency cannot provide respite services.
7. S5150 and S5151 cannot be billed on the same date for the same member.
8. S5151 must not be billed with any other per diem code.
9. When respite services are provided to more than one member at a time the following modifiers shall be paired with the S5150 or S5151 codes:
  - a. UN - For two members served,
  - b. UP - For three members served,
  - c. UQ for four members served,
  - d. UR - For five members served, and
  - e. US - For six or more members served.

### **Transportation**

Transportation services involve the transporting of a person from one place to another to facilitate the receipt of, or benefit from, medically necessary covered behavioral health services, allowing the person

to achieve their service plan goals. The service may also include the transportation of a person's family/caregiver with or without the presence of the person, if provided for the purposes of carrying out the person's service plan (e.g., counseling, family support, case planning meetings). Urban transports are defined as those originating within the Phoenix or Tucson metropolitan areas. All other transports are defined as rural.

Additional information regarding the transportation benefit can be found in [AMPM Chapter 300, Policy 310-BB, Transportation](#).

Details pertaining to the billing of transportation services may be found in the AHCCCS Fee-For-Service Provider Billing Manual Chapter 14 Transportation.

For specific details pertaining to the billing of transportation services for members enrolled with a Managed Care health plan, refer to the specific health plan's website.

### **Housing Support Services**

Housing Support Services are flexible housing-based supports targeted towards individuals most in need based upon their health conditions, housing status, and current or potential system costs. Housing support services are distinguished by their specific focus on attaining and retaining housing for members who are experiencing, or are at risk for, homelessness and who have complex health, disability, and/or behavioral health conditions. Service scope, frequency, delivery, and setting should be individualized to the member's needs, circumstances, and choice. All services shall be consistent with evidence-based standards (including SAMHSA), nationally recognized or identified best practices, and all services shall be voluntary for the member.

Providers shall ensure staff providing these services are knowledgeable in and can provide services consistent with evidence-based practice. Specific details on permanent supportive housing service delivery and housing practices can be found in AMPM Policy 320-H<sup>9</sup>.

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<sup>9</sup> Link to AMPM 320-H will be added once published.

## Crisis Intervention Services

Chapter 19, Behavioral Health Services of the AHCCCS Fee-For-Service Provider Billing Manual describes in detail the rules for billing crisis intervention service. This may be found on the AHCCCS website.

Requirements for crisis care coordination and crisis providers as applicable to AHCCCS Contracted health plans are found in [AMPM Chapter 500, Section 590](#).

### CPT Codes

- 90791 - Psychiatric diagnostic evaluation
- 90792 - Psychiatric diagnostic evaluation with medical services

### HCPCS Codes

- H2011 - Crisis Intervention Service, per 15 minutes – multi-disciplinary mobile team. H2011 is only to be used by mobile units providing crisis intervention services in the community.
- H2011 should be paired with the ET Modifier when ACC-RBHA or TRBHA contracted mobile teams are dispatched by the Statewide crisis call center or TRBHA dispatching system, to respond to an emergency crisis situation.
- S9484 - Crisis Intervention Mental Health Services, per hour – (Stabilization) Up to 5 hours in duration. Billing Unit: One hour
- S9485 - Crisis Intervention Mental Health services, per diem – (Stabilization) More than 5 hours and up to 24 hours in duration.
- H0030 - Behavioral Health Hotline Service
- H0030 should be paired with the ET Modifier when billing an ACC-RBHA or TRBHA for contracted emergency crisis call center services.

### Billing Limitations

For crisis intervention services (mobile) the following billing limitations apply:

1. See general core billing limitations
2. Emergency crisis intervention services are the responsibility of the ACC-RBHA or TRBHA and should be billed to the ACC-RBHA or TRBHA in the GSA where the crisis occurred. Emergency crisis coverage is limited to the first 24 hours for Title XIX/XXI members, 72 hours for Non-Title XIX/XXI or until the crisis has resolved, whichever occurs first. Refer to AMPM 590 for care coordination requirements.
3. Transportation provided to the person receiving the crisis intervention services is not included in the rate and should be billed separately using the appropriate transportation procedure codes.
4. Services provided in the jail setting are not Title XIX/XXI reimbursable.
5. If a client receives service code S9484 or S9485 at a Level I inpatient hospital or subacute facility, then the client is admitted to a Level I inpatient hospital or subacute bed in that same facility on the same day, the per diem Level I rate and code for the inpatient or subacute facility must be billed. Codes S9484 or S9485 for an inpatient hospital or inpatient subacute facility cannot be billed on the same date of service for the same client by the same provider.

6. Medical supplies provided to a person while in a crisis services setting and provided by the crisis service provider type are included in the rate and should not be billed separately.
7. Meals are included in the rate and should not be billed separately.
8. Laboratory and radiology services are not included in the rate and should be billed separately.
9. Medications are not included in the rate and should be billed separately.
10. When billing for emergency crisis intervention services in the first 24 hours to an ACC-RBHA, crisis service providers must identify those services by appending a modifier ET (Emergency Services) to those line items. The reporting of the ET modifier paired with an applicable crisis intervention HCPC allows AHCCCS and ACC-RBHAs to accurately monitor community need for emergency crisis intervention services. Only providers contracted with an ACC-RBHA for crisis intervention services may bill an ACC-RBHA for emergency crisis intervention services.

## Outpatient Residential Treatment

Outpatient residential treatment services are provided by or under the direction and clinical oversight of behavioral health professionals to reduce symptoms and improve or maintain functioning.

### Behavioral Health Residential Facility Services (BHRF)

A Behavioral Health Residential Facility is a Health care facility, licensed by ADHS, pursuant to A.A.C. Title 9, Chapter 10, Article 7. Comprehensive descriptions and minimum requirements for Behavioral Health Residential Facilities are outlined in [AMPM Policy 320-V](#).

Members eligible for a BHRF level of care are diagnosed with a behavioral health condition (inclusive of substance use conditions), which is causing significant functional and/or psychosocial impairment, leading to at least one area of significant risk of harm. This impairment and risk of harm warrants the need for 24- hour supervision while the member engages in treatment interventions to address behavioral health condition(s) that will allow the member to live safely in the community.

Care and services provided in a BHRF are provided under the direction and oversight of a qualified BHP, are billed as a daily rate, and must include all treatment services outlined in the members treatment plan.

In the case a specialized treatment need is identified while a member is in a BHRF level of care, the treatment team, inclusive of all team members involved outside the BHRF, must meet to establish, based on clinical best practice, the appropriateness of service provision, timeline for most appropriate implementation of service, and if established, the clinical need for the service to be initiated while the member is in BHRF care. For example, a member who has been engaged in Eye Movement Desensitization and Reprocessing (EMDR) Treatment and is responding well to treatment prior to entering a BHRF, may continue with treatment if the continuation of treatment is indicated by the treatment provider, member, and team indicating the service will continue to positively benefit the member while they are in BHRF care.

BHRF providers shall allow for and support member engagement with family, community, and/or other natural supports based on the individual's needs, circumstances, and in accordance with the members treatment plan, as this type of engagement facilitates positive transition from residential care. This engagement shall be individualized for each member and include appropriate supervision and safety planning based on member needs. For example, a member may attend Alcoholics Anonymous (AA) in the community, while being transported and supervised by their sponsor, who has attended team meetings and is aware of member needs, or a member may attend faith based activities with staff supervision, or a member may attend family outings with a family member who is able to provide appropriate supervision for the member and is aware of their needs.

### HCPCS Codes

- H0018 - Behavioral health; short-term residential (non-hospital residential treatment program), without room and board, per diem

### Billing Limitations

1. See general core billing limitations.
2. H0018 is a comprehensive service code inclusive of all screening, assessment, counseling, case management, rehabilitation, and supportive services that a member within the rate.

3. A member may receive specialty behavioral health services not provided by the BHRF only as specified in AMPM 320-V.
4. Sober living facilities are not behavioral health residential treatment facilities. Sober living facilities are not a covered service for AHCCCS.
5. In accordance with A.A.C. R9-22-1204, room and board is not a Medicaid covered service for persons residing in behavioral health residential facilities.
6. H0018 may only be provided by ADHS licensed behavioral health agency pursuant to licensure requirements set forth in A.A.C. Title 9, Chapter 10, Article 7.
7. In addition to being licensed by ADHS as a Behavioral Health Residential Facility, in order to provide personal care services, a BHRF shall be authorized by ADHS to provide personal care services as specified in A.A.C. Title 9, Chapter 10, Article 7.
8. H0018 may be paired with the U9 modifier at intake and during discharge planning (limit 2 per year) when using the ASAM to determine appropriate level of care.
9. Admission to a BHRF requires prior and continued authorization.<sup>10</sup>
10. H0018 may only be billed on days when the member is present overnight (present at 11:59 p.m. and 12:01 a.m. the following morning).
11. The Per diem rate cannot be billed for the day of discharge.

### **Adult Behavioral Health Therapeutic Homes (ABHTH)**

An ABHTH is a health care facility, licensed by ADHS, pursuant to A.A.C. R9-10-1801 et. seq and the Arizona State Plan for Medicaid. Care and services provided in a ABHTH are based on a per diem (daily) rate and services provided shall be included in the members treatment plan. Comprehensive descriptions and minimum requirements for AMPM 320-X-Adult Behavioral Health Therapeutic Homes [320-X-Adult Behavioral Health Therapeutic Homes](#).

#### **HCPCS Code**

- S5140 - Foster Care, Adult; Per Diem

#### **Billing Limitations**

1. A licensed Collaborating Health Care Institution (CHI) who supervises and trains the adult behavioral health therapeutic home provider may not bill for these administrative functions. Employee supervision and training has been built into the procedure code rate.
2. Pre-training activities associated with the ABHTH setting are included in the rate. This service may not be billed outside the procedure code rate by either the licensed professional or the ABHTH provider.
3. Room and Board is not included in the rate.
4. Prescription drugs are not included in the rate and should be billed by appropriate providers using the applicable NDC procedure codes.
5. Over-the-counter drugs and non-customized medical supplies are included in the rate and should not be billed separately.
6. Emergency transportation provided to a member is not included in the rate and should be billed separately by the appropriate provider using the applicable transportation procedure codes.
7. Non-emergency transportation is included in the rate and cannot be billed separately.
8. Any medical services provided to persons, excluding those medical services included in the covered service array as set forth in this guide should be billed to the member's health plan.

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<sup>10</sup> [AHCCCS DFSM Prior Authorization Training for BHRF](#)



9. Foster Care, Adult cannot be encountered/billed on the same day as Unskilled Respite Care (S5151).
10. S5140 may only be billed on days when the member is present overnight (present at 11:59 p.m. and 12:01 a.m. the following morning).
11. The Per diem rate cannot be billed for the day of discharge.

## **Therapeutic Foster Care (TFC)**

TFC is a covered behavioral health service that provides daily behavioral interventions within a licensed family setting. This service is designed to maximize the member's ability to live and participate in the community and to function independently, including assistance in the self administration of medication and any ancillary services (such as living skills and health promotion) indicated by the member's Service Plan as appropriate (Arizona State Plan for Medicaid). Guidelines for therapeutic foster care for children are provided in [AMPM Chapter 300 - Section 320- Services with Special Circumstances 320-W Therapeutic Foster Care for Children](#).

### **HCPC Code**

- S5145 - Foster Care, Therapeutic, Child; Per Diem

### **Billing Limitations**

1. A licensed professional who supervises and trains the behavioral health therapeutic home provider may not bill for these administrative functions. Employee supervision and training has been built into the procedure code rate.
2. Pre-training activities associated with the Therapeutic Foster Care setting is included in the rate. This service may not be billed outside the procedure code rate by either the licensed professional or behavioral health therapeutic home provider.
3. Room and Board is not included in the rate.
4. Prescription drugs are not included in the rate and should be billed by appropriate providers using the applicable NDC procedure codes.
5. Over-the-counter drugs and non-customized medical supplies are included in the rate and should not be billed separately.
6. Emergency transportation provided to a member is not included in the rate and should be billed separately by the appropriate provider using the applicable transportation procedure codes.
7. Non-emergency transportation is included in the rate and cannot be billed separately.
8. Any medical services provided to persons, excluding those medical services included in the covered service array as set forth in this guide should be billed to the member's health plan.
9. Therapeutic foster care cannot be encountered/billed on the same day as Unskilled Respite Care (S5151).
10. S5145 may only be billed on days when the member is present overnight (present at 11:59 p.m. and 12:01 a.m. the following morning).
11. The Per diem rate cannot be billed for the day of discharge.

## Inpatient Services

Inpatient services are provided by hospitals licensed in accordance with A.A.C. Title 9, Chapter 10, Article 2 or Article 3. IHS/638 facilities are subject to Centers for Medicaid and Medicare Services (CMS) certification requirements. These facilities provide a structured treatment setting with 24-hour supervision and an intensive treatment program, including medical support services. For information regarding Institutions for Mental Diseases, refer to ACOM Policy 109.

Inpatient services (including room and board) are further classified into the following subcategories:  
Hospital:

- Hospital services provide continuous treatment with 24-hour nursing supervision and physicians on site and on call which includes general psychiatric care, medical detoxification, and/or forensic services in a general hospital, a general hospital with a distinct psychiatric unit, or a freestanding psychiatric facility. Services provided in hospitals are inclusive of all services, supplies, accommodations, staffing, and equipment,
  - i. General and freestanding hospitals may provide services to members if the hospital:
    - 1) Meets the requirements of 42 C.F.R. § 440.10 and C.F.R. Title 42, Chapter IV, Subchapter G, Part 482, and
    - 2) Is licensed pursuant to A.R.S. Title 36, Chapter 4 and A.A.C. R9-10 Article 2.
  - ii. Prior authorization is required for Bed Hold/therapeutic leave,
  - iii. Bed Hold or home pass are days in which the facility reserves the member's bed, or member's space in which they have been residing, while the member is on an authorized/planned overnight leave from the facility for the purposes of therapeutic leave (i.e., home pass) to enhance psychosocial interaction or as a trial basis for discharge planning. As specified in the Arizona State Plan under Title XIX of the Social Security Act:
    - 1) For members ages 21 and older, therapeutic leave may not exceed nine days, and bed hold days may not exceed 12 days, per contract year, and
    - 2) For members under 21 years of age, total therapeutic leave and/or bed hold days may not exceed 21 days per contract year.
- Behavioral Health Inpatient Facilities (BHIF)

BHIFs provide continuous treatment to a person who is experiencing acute and significant behavioral health symptoms. BHIFs may provide observation/ stabilization services and child and adolescent residential treatment services, in addition to other behavioral health and/or physical health services, as identified under their licensure capacity,

  - i. Observation/Stabilization Services

In addition to 24-hour nursing supervision and physicians on site or on call, observation/stabilization services include emergency reception, screening, assessment, crisis intervention and stabilization, and counseling, and referral to appropriate level of services/care. Refer to the section on facility-based crisis intervention services for more information (A.A.C. R9-10-1012),

    - 1) Observation/stabilization services, within a BHIF, shall be provided according to the requirements in A.A.C. R9-10-1012 for outpatient treatment centers, and
    - 2) Facilities shall meet the requirements for reporting and monitoring the use of Seclusion and Restraint (S&R). The use of S&R shall only be used to the extent permitted by and in compliance with Arizona Administrative Code, and as authorized by ADHS. For additional information and requirements regarding reporting and monitoring of seclusion and restraint, refer to AMPM Policy 962.

## CPT Codes

- 99221 - Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
- 99222 - Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded.
- 99223 - Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded.
- 99231 - Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.
- 99232 - Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.
- 99233 - Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 50 minutes must be met or exceeded.
- 99234 - Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
- 99235 - Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 70 minutes must be met or exceeded.
- 99236 - Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 85 minutes must be met or exceeded.
- 99238 - Hospital inpatient or observation discharge day management; 30 minutes or less on the date of the encounter
- 99239 - Hospital inpatient or observation discharge day management; more than 30 minutes on the date of the encounter
- 99252 - Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.
- 99253 - Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When

using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

- 99254 - Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
- 99255 - Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 80 minutes must be met or exceeded.
- 99307 - Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.
- 99308 - Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
- 99309 - Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
- 99310 - Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

### **Revenue Codes**

Except for crisis intervention services, all Level I inpatient behavioral health facilities must bill on a UB04 claim form or electronically through an 837I for an inpatient residential stay. Unlike other services in which a specific rate has been established for a specific service code, the residential rates for these facilities have been established based on the provider type. For example, while a hospital and a Residential Treatment Center (RTC) may both bill revenue code 0114, the fee-for-service rate will be different depending on the provider type billing the service.

### **HCPCS Codes**

A licensed hospital, psychiatric hospital or subacute facility should use codes under category of service 47 (Mental Health) to bill for crisis intervention services provided in a crisis services setting in addition to the CPT codes for those services provided by certain health care professionals.

### **Hospital**

Hospitals provide continuous treatment that includes general psychiatric care, medical detoxification, and/or forensic services in a general hospital or a general hospital with a distinct part or a freestanding psychiatric facility. A hospital also includes 24 hour nursing supervision and physicians on site and on call. The hospital claim will be paid by the Contractor at the per diem inpatient behavioral health rate prescribed by AHCCCS and described in A.A.C. R9-22-712.61.

A Psychiatric Hospital (provider type 71) may bill for bed hold or home pass days. Level I Hospital (provider type 02) can only bill for home pass days. These are days in which the hospital reserves the person's space in which they have been residing while the individual is on an authorized/planned overnight leave from the facility related to:

1. Therapeutic leave to enhance psychosocial interaction or as a trial basis for discharge planning (billed using revenue code 0183 – home pass), or
2. Admittance to a hospital for a short stay (billed using revenue code 0189 – bed hold).

After the leave, the person is returned to the same bed within the Level I Psychiatric Hospital. Any combination of bed hold leave is limited to up to 21 days per fiscal year (July 1st through June 30th). The following revenue codes must be used to bill for home pass and bed hold days:

- 0183 – Leave of Absence-Therapeutic Leave
- 0189 – Leave of Absence-Other LOA

Hospitals (provider type 02) may bill the following revenue codes:

- |   |   |
|---|---|
| <ul style="list-style-type: none"> <li>● 0114 – Psychiatric; room and board – (One Bed) private</li> <li>● 0124 – Psychiatric; room and board – semi private two beds</li> <li>● 0134 – Room &amp; Board Three and Four Beds -Psychiatric</li> <li>● 0154 – Room &amp; Board Ward-Psychiatric</li> <li>● 0116 –Room &amp; Board Private (One Bed) - Detoxification</li> <li>● 0126 – Detoxification; room and board – semi private two beds</li> <li>● 0136 – Room &amp; Board Three and Four Beds -Detoxification</li> <li>● 0156 – Detoxification; room and board – ward</li> <li>● 0110 – Room and board - private</li> <li>● 0111 – Medical-Surgical-Gyn - private</li> <li>● 0112 – OB - private</li> <li>● 0113 – Pediatrics - private</li> <li>● 0120 – Room and board - semi-private 2 beds</li> <li>● 0121 – Medical-Surgical-Gyn - 2 beds</li> <li>● 0122 – OB - 2 beds</li> <li>● 0123 – Pediatrics - 2 beds</li> <li>● 0130 – Room and board - Semi private 3 and 4 beds</li> <li>● 0131 – Medical-Surgical-Gyn - 3 and 4 beds</li> <li>● 0132 – OB - 3 and 4 beds</li> <li>● 0133 – Pediatrics - 3 and 4 beds</li> <li>● 0150 – Room and board - ward</li> <li>● 0151 – Medical-Surgical-Gyn - ward</li> </ul> | <ul style="list-style-type: none"> <li>● 0152 – OB - ward</li> <li>● 0153 – Pediatrics - ward</li> <li>● 0160 – Room and board -general</li> <li>● 0200 – Intensive Care</li> <li>● 0201 – Intensive Care Unit - surgical</li> <li>● 0202 – Intensive Care Unit - medical</li> <li>● 0203 – Intensive Care Unit – pediatrics</li> <li>● 0206 – Intensive Care Unit - intermediate</li> <li>● 0209 – Intensive Care Unit - other</li> <li>● 0210 – Coronary Care</li> <li>● 0115 – Hospice private</li> <li>● 0117 – Oncology private</li> <li>● 0118 – Rehab private</li> <li>● 0119 – Other private</li> <li>● 0125 – Hospice 2 beds</li> <li>● 0127 – Oncology 2 beds</li> <li>● 0128 – Rehab 2 beds</li> <li>● 0129 – Other 2 beds</li> <li>● 0135 – Hospice 3 &amp; 4 beds</li> <li>● 0137 – Oncology 3 &amp; 4 beds</li> <li>● 0138 – Other 3 &amp; 4 beds</li> <li>● 0139 – Other 3 &amp; 4 beds</li> <li>● 0155 – Hospice ward</li> <li>● 0157 – Oncology ward</li> <li>● 0158 – Rehab ward</li> <li>● 0159 – Other ward</li> <li>● 0164 – R &amp; B sterile</li> <li>● 0167 – R &amp; B self</li> </ul> |
|---|---|

- 0169 – R & B other
- 0190 – Subacute general
- 0191 – Subacute care level I
- 0192 – Subacute care level II
- 0193 – Subacute care level III
- 0194 – Subacute care level IV
- 0199 – Other Subacute Care
- 0204 – ICU/Psych stay
- 0207 – ICU/Burn care
- 0208– ICU/Trauma
- 0211 – CCU/MYO Infarc
- 0212 – CCU/Pulmonary
- 0213 – CCU/Transplant
- 0214 – CCU/Intermediate
- 0219 – CCU other

### **Service Standards/Provider Qualifications**

General and freestanding hospitals may provide services to persons if the hospital is:

- Accredited through an accrediting body approved by CMS or surveyed by ADHS if providing treatment to clients under the age of 21, and
- Meets the requirements of [42 C.F.R. § 440.10](#) and [Part 482](#) and is licensed pursuant to [A.R.S. Title 36, Chapter 4, Articles 1 and 2](#) and [A.A.C. Title 9 Chapter 10 Article 2](#) , or
- For adults age 21 or over, certified as a provider under Title XVIII of the Social Security Act, or
- For adults age 21 or over, currently determined by the ADHS Office of Medical Facility Licensing and ADHSto meet such requirements.

If seclusion and restraint is provided, then the facilities must meet the requirements set forth in [A.A.C. Title 9 Chapter 10](#).

### **Billing Limitations**

1. Non-emergency travel (NEMT) for a person in a hospital/psychiatric hospital is included in the rate and should not be billed separately. NEMT from the facility on the day of discharge remains covered because the per diem code is not paid for on the day of discharge.
2. Emergency transportation provided to a person residing in the facility is not included in the rate and should be billed separately using the appropriate transportation procedure codes.
3. Nursing services provided to a person while in a hospital/psychiatric hospital are included in the rate and should not be billed separately.
4. Medical supplies provided to a person while in a hospital/psychiatric hospital are included in the rate and should not be billed separately.
5. Miscellaneous costs such as insurance, housekeeping supplies, laundry, clothing, resident toiletries and expenses, and staff training materials, are included in the rate and should not be billed separately.
6. Meals are included in the rate and should not be billed separately.
7. The revenue codes for hospital/psychiatric hospital services are billed per day for each person receiving services.
8. Medications provided/dispensed by the hospital/psychiatric hospital are included in the rate and cannot be billed separately.
9. Laboratory, radiology and medical imaging provided by the hospital/psychiatric hospital are included in the rate and should not be billed separately.
10. A Provider Type 02, cannot bill for therapeutic leave/bed hold.

11. Accommodation revenue codes 0110-0113, 0120-0123, 0130-0133, 0150-0153, 0160, 0200-0203, 0206, 0209-0210 can be billed when prior authorization is obtained, the member is medically stable, and there is a principal mental health or substance abuse diagnosis on the claim.
12. Outpatient provider types 77 and IC are prohibited from billing on a UB form or using revenue codes.
13. Payment for services related to provider preventable conditions is prohibited, in accordance with [42 C.F.R. § 447.26](#). Provider-Preventable Condition means a condition that meets the definition of a Health Care-Acquired Condition (HCAC) or an Other Provider-Preventable Condition (OPPC). Additional information regarding the prohibition of payment for services related to Provider-Preventable Conditions is located in the [AHCCCS Medical Policy Manual \(AMPM\), Chapter 900, Policy 960](#).

## Subacute Facilities

Continuous treatment is provided in a subacute facility to a person who is experiencing acute and severe behavioral health and/or substance abuse symptoms. Services may include emergency reception and assessment; crisis intervention and stabilization; individual, group and family counseling; detoxification and referral. Also includes 24 hour nursing supervision and physicians on site or on call. May include crisis intervention services provided in a crisis services setting licensed as a subacute facility, but which does not require the person to be admitted to the facility.

Subacute facilities must be accredited by The Joint Commission, Certified Ophthalmic Assistant (COA), or Commission on Accreditation of Rehabilitation Facilities (CARF) and licensed by ADHS as meeting the specific requirements of [A.A.C. Title 9, Chapter 10](#). Additionally, the facilities must meet the requirements set forth in [A.A.C. Title 9, Chapter 10 10](#) for seclusion and restraint if the facility has been authorized by ADHS to provide seclusion and restraint.

## Revenue Codes

- 0114 – Psychiatric; room and board – private
- 0124 – Psychiatric; room and board – semi private two beds
- 0134 – Psychiatric; room and board – semi private three and four beds
- 0154 – Psychiatric; room and board – ward
- 0116 – Detoxification; room and board – private
- 0126 – Detoxification; room and board – semi private two beds
- 0136 – Detoxification; room and board – semi private three and four beds
- 0156 – Detoxification; room and board – ward

## HCPCS Codes

- H0006 - Alcohol and/or drug services; case management. Service unit: 15 minutes.
- H0014 - Alcohol and/or Drug Services, Ambulatory Detoxification

## Billing Provider Types

- Subacute Facility (1-16 Beds non-IMD) (B5)
- Subacute Facility (17+ Beds IMD) (B6)

## Billing Limitations

1. See general core billing limitations in the Core Billing Limitations Section.
2. The revenue codes for subacute facility services are billed per day for each person receiving services.
3. Non-emergency transportation for a person in a subacute facility is included in the rate and should not be billed separately.
4. Emergency transportation provided to a person residing in the facility is not included in the rate and should be billed separately using the appropriate transportation procedure codes.
5. Medical services provided to a person while in a subacute facility are included in the rate and should not be billed separately.
6. Laboratory, Radiology, Medical Imaging and Psychotropic Medication provided by the subacute facility are not included in the rate and should be billed separately. Laboratory, Radiology, Medical Imaging and Psychotropic Medication services related to a behavioral health condition are the responsibility of the enrolled health plan.
7. Miscellaneous costs such as insurance, housekeeping supplies, laundry, clothing, resident toiletries and expenses, and staff training materials are included in the rate and should not be billed separately.
8. Meals are included in the rate and should not be billed separately.
9. No outpatient HCPC codes may be billed on the same day as any of the per diem rev codes listed above.

## Residential Treatment Centers (RTC)

Inpatient psychiatric treatment, which includes an integrated residential program of therapies, activities, and experiences provided to persons who are under 21 years of age and have severe or acute behavioral health symptoms. Residential treatment services shall be accredited. Additionally, the facility shall meet the requirements for seclusion and restraint as authorized by ADHS as specified in Arizona Administrative Code and 42 C.F.R. Part 441 and 42 C.F.R. Part 483 if the facility has been authorized by ADHS to provide seclusion and restraint.

- Child and adolescent residential treatment services are behavioral health and physical health services provided by a BHIF to an individual who is under 18 years of age or under 21 years of age and as authorized by ADHS as specified in Arizona Administrative Code.

## Billing Provider Types

- Provider Type B1 Secure - a residential treatment center with 17 or more beds which generally employs security guards and uses monitoring equipment and alarms. (IMD)
- Provider Type B2 Non Secure - an unlocked residential treatment center setting with 1-16 beds
- Provider type B3 Non Secure - an unlocked residential treatment center setting with 17+ beds (IMD)

## Revenue Codes

For inpatient stays the residential treatment center may bill on a UB form and use the following revenue codes:

- 0114 – Psychiatric; room and board – private
- 0124 – Psychiatric; room and board – semi private two beds



- 0134 – Psychiatric; room and board – semi private three and four beds
- 0154 – Psychiatric; room and board – ward
- 0116 – Detoxification; room and board – private
- 0126 – Detoxification; room and board – semi private two beds
- 0136 – Detoxification; room and board – semi private three and four beds
- 0156 – Detoxification; room and board – ward

Residential treatment centers may bill for bed hold or home pass days. These are days in which the RTC reserves the person’s space in which they have been residing while the individual is on an authorized/planned overnight leave from the facility related to:

- Therapeutic leave to enhance psychosocial interaction or as a trial basis for discharge planning (billed using revenue code 0183 – home pass) or
- Admittance to a hospital for a short stay (billed using revenue code 0189 – bed hold).

After the leave, the person is returned to the same bed within the RTC. Any combination of bed hold leave is limited to up to 21 days per contract year (July 1 through June 30).

Service standards for residential treatment centers may be found in AMPM Chapter 300, Section 310-Covered Services <https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/310B.pdf>.

### **Billing Limitations**

1. See general core billing limitations.
2. The RTC revenue code is billed per day for each person receiving services.
3. The RTC revenue code is a “bundled” rate that includes all HCPCS procedure code services an individual receives.
4. Expenses related to the person’s education are not included in the RTC rate and should be billed separately.
5. Non-emergency transportation for a person in a RTC facility is included in the rate and should not be billed separately.
6. Emergency transportation provided to a person residing in the RTC facility is not included in the rate and should be billed separately using the appropriate transportation procedure codes.
7. Medical supplies provided to a person while in a RTC are included in the rate and should not be billed separately.
8. Miscellaneous costs such as insurance, housekeeping supplies, laundry, clothing, resident toiletries and expenses, and staff training materials, are included in the rate and should not be billed separately.
9. Meals are included in the rate and should not be billed separately.
10. Laboratory, Radiology, Medical Imaging and Psychotropic Medications are not included in the rate and should be billed separately by qualified providers.

## Appendix

The following is a list of links to documents which contain important information about AHCCCS behavioral health services.

- AMPM Exhibit 300-2A-AHCCCS Covered Services Behavioral Health <https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/Exhibit300-2A.pdf> is the chart which lists this types of services covered by AHCCCS based on member enrollment category.
- AMPM Chapter 300 - Section 310-B Title XIX/XXI Behavioral Health Service Benefit <https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/310B.pdf> provides a brief definition of most of the behavioral health services and includes general information about service requirements and provider qualifications. It also addresses issues like referrals, provider travel, room and board, clinical supervision, and services to families.
- AMPM Section 320 - Services with Special Circumstances 320-S- Behavior Analysis Services <https://azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/320S.pdf> specifically addresses all aspects of provision of behavior analysis services.
- AHCCCS Medical Policy Manual Chapter 300, section 320 -V addresses behavioral health residential service requirements <https://azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/320-V.pdf>.
- AHCCCS Medical Policy Manual Chapter 500, section 570- Provider Case Management provides detailed clinical guidelines for case management. This document may be found in the following location: <https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/500/570.pdf>
- AMPM Chapter 500, Policy 590, Behavioral Health Crisis Services and Care Coordination <https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/500/590.pdf>
- AMPM Chapter 300 - Section 320- Services with Special Circumstances 320-W Therapeutic Foster Care for Children <https://azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/320W.pdf>
- AMPM Section 320 - Services with Special Circumstances 320-X-Adult Behavioral Health Therapeutic Homes <https://azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/320X.pdf>.
- A definition of peer support services may be found on <https://www.azahcccs.gov/AHCCCS/HealthcareAdvocacy/OIFA/peersupport.html>. This web page also describes requirements for peer/recovery support specialist credentialing as well as a list of organizations that can provide this credential.
- AHCCCS Fee-For-Service Provider Billing Manual <https://azahcccs.gov/PlansProviders/RatesAndBilling/FFS/providermanual.html>.