AHCCCS COVERED BEHAVIORAL HEALTH SERVICES GUIDE

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TABLE OF CONTENTS

I. INTRODUCTION 4

A. PURPOSE 4
B. ORGANIZING PRINCIPLES 6
C. GENERAL GUIDELINES 7
D. PROVISION OF SERVICES 7
E. PROVIDER QUALIFICATIONS AND REGISTRATION 10
F. BILLING FOR SERVICES 14

II. SERVICE DESCRIPTIONS 24

II. A. TREATMENT SERVICES 24
II. A. 1. Behavioral Health Counseling and Therapy 24
II. A. 2. Assessment, Evaluation and Screening Services 28
II. A. 3. Other Professional 35
II. B. REHABILITATION SERVICES 38
II. B. 1. Skills Training and Development and Psychosocial Rehabilitation Living Skills Training 39
II. B. 2. Cognitive Rehabilitation 41
II. B. 3. Behavioral Health Prevention/Promotion Education and Medication Training and Support Services (Health Promotion) 42
II. B. 4. Psychoeducational Services and Ongoing Support to Maintain Employment 44
II. C. MEDICAL SERVICES 47
II. C. 1. Medication Services 48
II. C. 2. Laboratory, Radiology and Medical Imaging 51
II. C. 3. Medical Management 59
II. C. 4. Electroconvulsive Therapy 70
II. D. SUPPORT SERVICES 71
II. D. 1. Case Management 72
II. D. 2. Personal Care Services 77
II. D. 3. Home Care Training Family (Family Support) 79
II. D. 4. Self-Help/Peer Services (Peer Support) 81
II. D. 5. Home Care Training to Home Care Client 83
II. D. 6. Unskilled Respite Care 86
II. D. 7. Supported Housing 89
II. D. 8. Sign Language or Oral Interpretive Services 90
II. D. 9. Non-Medically Necessary Covered Services 92
II. D. 10. Transportation 94
II. E. CRISIS INTERVENTION SERVICES 99
II. E. 1. Crisis Intervention Services (Mobile, Community Based) 101
II. E. 2. Crisis Intervention Services (Stabilization, facility based) 103
II. E. 3. Crisis Intervention (Telephone) 105
II. F. INPATIENT SERVICES 106

II. F. 1. Hospital 113
II. F. 2. Subacute Facility 118
II. F. 3. Residential Treatment Center 120
II. G. BEHAVIORAL HEALTH RESIDENTIAL SERVICES 123
II. G. 1. Behavioral Health Residential Facility, Without Room and Board 124
II. G. 2. Mental Health Services NOS (Room and Board) 125
II. H. BEHAVIORAL HEALTH DAY PROGRAMS 126
II. H. 1. Supervised Behavioral Health Treatment and Day Programs 127
II. H. 2. Therapeutic Behavioral Health Services and Day Programs 129
II. H. 3. Community Psychiatric Supportive Treatment and Medical Day Programs 131
II. I. PREVENTION SERVICES 133

III. APPENDICES ..... **ERROR! BOOKMARK NOT DEFINED.**

BILLING FOR BEHAVIORAL HEALTH SERVICES: IHS AND 638 TRIBAL FACTSHEETS **ERROR! BOOKMARK N**
A.1 Memorandum ..... **Error! Bookmark not defined.**
A.2 638 Billing Matrix ..... **Error! Bookmark not defined.**
A.3 PowerPoint ..... **Error! Bookmark not defined.**
A.4 Case Management Billing Guidelines ..... **Error! Bookmark not defined.**
B. REFERENCE TABLES ..... **ERROR! BOOKMARK NOT DEFINED.**
B-1. Reserved ..... **Error! Bookmark not defined.**
B-2. AHCCCS BEHAVIORAL HEALTH SERVICES Allowable Procedure Code Matrix ..... **Error! Bookmark not defined.**
B-3. Encounter/Claims Principle Behavioral Health ICD-9 Diagnostic Codes ..... **Error! Bookmark not defined.**
B-4. Reserved ..... **Error! Bookmark not defined.**
B-5. Billing Limitations Matrix 142

I. Introduction

A. Purpose

The AHCCCS Behavioral Health Services has developed a comprehensive array of covered behavioral health services to assist, support and encourage each eligible person to achieve and maintain the highest possible level of health and self-sufficiency. The goals that influenced how covered services were developed include:

- Align services to support a person/family centered service delivery model.
- Focus on services to meet recovery goals.
- Increase provider flexibility to better meet individual person/family needs.
- Eliminate barriers to service.
- Recognize and include support services provided by non-licensed individuals and agencies.
- Streamline service codes.
- Maximize Title XIX/XXI funds.

Title XIX is Federal Medicaid and Title XXI is State Children's Health Insurance Program. The impact of maximizing Title XIX/XXI funds is far-reaching. Not only will it bring more federal dollars into the state to pay for services, but it also will free up non-Title XIX/XXI dollars to provide services to non-Title XIX/XXI eligible persons and to provide non-Title XIX/XXI services to all eligible persons. To maximize Title XIX/XXI funds, it is critical Tribal and Regional Behavioral Health Authorities (T/RBHAs) and their subcontractors also maximize their efforts to ensure all Title XIX/XXI eligible individuals are enrolled in the Arizona Health Care Cost Containment System (AHCCCS).

In addition, maximization of Title XIX/XXI funds is dependent on claims being submitted correctly. There are three critical components that must be in place to successfully bill for Title XIX/XXI reimbursement:

- The person receiving the service must be Title XIX/XXI eligible.
- The individual or agency submitting the bill must be an AHCCCS registered provider.
- The service must be a recognized Title XIX/XXI covered behavioral health service and be billed using the appropriate billing code.

These individual components are addressed in depth in this service guide.

In order to maintain the integrity of the AHCCCS Behaviorial Health Covered Services Guide, a consistent process for requesting and considering changes has been developed. Requested changes, including changes to the services, the service codes, the provider types, and the listed rates, will be implemented on a quarterly basis unless the Deputy

Director authorizes a change to take effect immediately. Changes that must take effect immediately will be communicated to T/RBHAs through Edit Alerts.

A request for change to the AHCCCS BEHAVIORAL HEALTH Covered Services Guide may be made by representatives of AHCCCS BEHAVIORAL HEALTH SERVICES, the T/RBHAs or their contractors, persons and/or their families, advocates or other state agencies/stakeholders. Written requests should be forwarded to the AHCCCS BEHAVIORAL HEALTH SERVICES Policy Office for consideration. The final disposition of any written requests for changes to the AHCCCS BEHAVIORAL HEALTH SERVICES Covered Services Guide will be communicated back to the requestor.

B. Organizing Principles

AHCCCS BEHAVIORAL HEALTH SERVICES has organized its array of covered behavioral health services into a continuum of service domains for the purpose of promoting clarity of understanding through the consistent use of common terms that reach across populations. The individual domains are:

- Treatment Services
- Rehabilitation Services
- Medical Services
- Support Services
- Crisis Intervention Services
- Inpatient Services
- Residential Services
- Behavioral Health Day Programs
- Prevention Services

This continuum not only applies to delivering services but also serves as the framework for program management and reporting.

Within each domain, specific services are defined and described including identification of specific provider qualifications/service standards and limitations. Additionally, code specific information (both service descriptions and billing parameters) is provided.

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 BEHAVIORAL HEALTH SERVICES should be referenced in the following manuals:

- *UB04 Manual*
- *First Data Bank (i.e., pharmacy information)*
- *Physicians' Current Procedural Terminology (CPT) Manual*
- *Healthcare Procedure Coding System (HCPCS) Manual*

C. General Guidelines

In order to appropriately utilize the array of covered services to improve a person's functioning and to be able to effectively bill for those services provided, there are a number of general principles/guidelines that are important to understand. While Section II discusses the delivery of specific services, there are overarching themes that apply to the delivery of all services, which must be understood. This discussion is divided into three subsections:

- Provision of Services
- Provider Qualifications and Registration
- Billing for Services

These guidelines provide an overview of key covered services components. More detailed descriptions and requirements can be found in AHCCCS BEHAVIORAL HEALTH SERVICES policies.

D. Provision of Services

1. Eligibility and Funding Source

Factors that may impact the provision and availability of behavioral health services are the eligibility status of the person being served as well as the funding source and fund availability. AHCCCS BEHAVIORAL HEALTH SERVICES is responsible for providing services to persons with behavioral health needs including:

- Title XIX eligible persons enrolled with Arizona Health Care Cost Containment System (AHCCCS) acute care health plans or American Indian Health Program (AIHP).
- Title XIX eligible persons enrolled with Arizona Long Term Care System (ALTCS) – Arizona Department of Economic Security/Division of Developmental Disability (ADES/DDD).
- Title XXI (Kids Care) eligible children and parents enrolled with AHCCCS acute care health plans.
- Non-Title XIX/XXI eligible persons determined to have Serious Mental Illness (SMI).
- Non-SMI, Non-Title XIX/XXI eligible persons, based on the availability and prioritization of funding.

Depending on a person's eligibility status, funding can impact benefit coverage. Services for non-Title XIX/XXI persons must be paid for with non-Title XIX/XXI monies. In addition, non-Title XIX/XXI funds are used to pay for services (e.g., flex fund services and room and board), not covered by Title XIX/XXI, to both Title XIX/XXI and non-Title XIX/XXI eligible persons. The ability to provide these services may be limited by the amount of state funds that are appropriated

annually or by the availability of other non-Title XIX/XXI funds. Since non-Title XIX/XXI funds are limited, AHCCCS BEHAVIORAL HEALTH SERVICES requires they be prioritized according to procedures set forth in AHCCCS BEHAVIORAL HEALTH SERVICES policy.

Lastly, some coverage restrictions may apply depending on the funding source. For example, federal block grants designate both the type of services to be funded as well as the priority populations to be served.

Non-Title XIX/XXI persons determined to have a Serious Mental Illness (SMI) are eligible for services listed in Policy 201 Covered Services AHCCCS BEHAVIORAL HEALTH SERVICES Policy and Procedures Manual Policy 201, Covered Health Services.

CPT and HCPCS codes that can be used to bill for services provided to Non-Title XIX/XXI persons determined to have SMI are limited. The following codes can be used to bill for the service categories listed below (see http://www.azdhs.gov/bhs/non-title19.htm for further information regarding services available to Non-Title XIX/XXI persons determined to have SMI):

Psychiatric Assessment (for newly enrolled Non-Title XIX/XXI SMI members or when a new or different medical professional assumes responsibility for treatment of the member): 90791, H0031, 99201, 99202, 99203, 99204 and 99205.

Psychiatric Follow-up Visits (for medication management): 99212, 99213, 99214, 99215, 99354, 99355, 99358, 99359 and 90853.

Non-emergency Transportation: A0090, A0100, A0110, A0120, A0120 TN, A0130, A0130 TN, A0160, T2003, S0209, S0215, S0215 TN, T2005, T2005 TN, T2049 and T2049 TN.

2. Enrollment

AHCCCS eligible persons are enrolled with AHCCCS for acute care and behavioral health services. AHCCCS assigns individuals to a Tribal or Regional Behavioral Health Authority (T/RBHA) based on the zip code in which individuals reside. Although American Indian members are also automatically assigned based on zip code, American Indians have the option to receive behavioral health services from a RBHA, TRBHA, IHS, or a 638 tribal facility. Services provided to American Indian members who receive behavioral health services at IHS or 638 tribal facilities are billed directly to AHCCCS (see Appendix A for further information). However, emergency and other behavioral health services provided off reservation to these members at a non-IHS or non-638 tribal facility continue to be billed through a T/RBHA to AHCCCS BEHAVIORAL HEALTH SERVICES.

Non-Title XIX/XXI eligible persons are enrolled with a T/RBHA to receive behavioral health services in Arizona's public behavioral health system. Enrollment by a T/RBHA is based on the zip code or tribal community in which the behavioral health recipient resides.

When encounters are submitted for "unidentified" individuals (such as in crisis situations when a person's eligibility or enrollment status is unknown), the service provider should use the applicable pseudo-ID numbers (e.g., NR010XXMO) that are assigned to each RBHA. Pseudo ID numbers are not assigned to TRBHAs. Encounters are not submitted for prevention services.

3. Family Members

For purposes of service coverage and this guide, family is defined as:

"The primary care giving unit and is inclusive of the wide diversity of primary care giving units in our culture. Family is a biological, adoptive or self-created unit of people residing together consisting of adult(s) and/or child(ren) with adult(s) performing duties of parenthood for the child(ren). Persons within this unit share bonds, culture, practices and a significant relationship. Biological parents, siblings and others with significant attachment to the individual living outside the home are included in the definition of family."

In many instances it is important to provide behavioral health services to the family member as well as the person seeking services. For example, family members may need help with parenting skills, education regarding the nature and management of the mental health disorder, or relief from care giving. Many of the services listed in the service array can be provided to family members, regardless of their enrollment or entitlement status as long as the enrolled person's treatment record reflects that the provision of these services is aimed at accomplishing the service plan goals (i.e., they show a direct, positive effect on the individual). This also means that the enrolled person does not have to be present when the services are being provided to family members.

For situations in which a family member is determined to have extensive behavioral health needs, (e.g., substance abusing parent) the family member her/himself should be enrolled in the system, if eligible.

E. Provider Qualifications and Registration

Any person or agency may participate as an AHCCCS BEHAVIORAL HEALTH SERVICES provider if the person or agency is qualified to render a covered service and meets the AHCCCS BEHAVIORAL HEALTH SERVICES requirements for provider participation. These requirements include:

- Obtaining any necessary license or certification (including Centers for Medicare and Medicaid Services - CMS certification for tribal providers).
- Meeting provider standards as set forth in this service guide for the covered service, which the provider wishes to deliver.
- Registering with AHCCCS as an AHCCCS provider.
- Obtaining an AHCCCS BEHAVIORAL HEALTH SERVICES provider ID as directed by AHCCCS BEHAVIORAL HEALTH SERVICES.
- Contracting with the appropriate Regional Behavioral Health Authority (RBHA) or Tribal Regional Behavioral Health Authority (TRBHA).

For some services, individual providers are required to register, render and bill for the service. In other instances, individual providers are required to be affiliated with an agency that in turn is responsible for billing for the service. Individual provider qualification and provider billing requirements are discussed for each service in Section II of this guide.

1. AHCCCS Registered Providers

For most covered behavioral health services, a provider must be registered with the AHCCCS Administration as a Title XIX/XXI provider regardless of whether the service is provided to a Title XIX/XXI or a non-Title XIX/XXI eligible individual. (See discussion below regarding billing provider type).

A provider's AHCCCS ID number will be terminated for inactivity if the provider has not submit a claim or encounter to the AHCCCS Administration within the past 24 months, effective January 2014.

A new registration packet will be required to reactivate providers who reapply following termination for inactivity. Providers should refer to Chapter 3 of the AHCCCS Fee-for-Service Provider Manual for information on provider participation.

Category of Service

For all provider types there are mandatory and occasionally optional AHCCCS Categories of Services (COS). In addition to the provider type, the COS will

determine the specific services for which the provider can bill. For purposes of behavioral health, the following COSs are relevant:

01 – Medicine
06 – Physical Therapy
09 – Pharmacy
10 – Inpatient Hospital
12 – Pathology & Laboratory
13 – Radiology
14 – Emergency Transportation
16 – Outpatient Facility Fees
26 – Respite Care Services
31 – Non-Emergency Transportation
39 – Habilitation
47 – Mental Health Services

In order to qualify for some of these COSs the providers may have to meet additional licensing/certification requirements. It is important for providers when registering to make sure they qualify and register for the necessary COS that will allow them to bill the desired service codes. Providers should reference Appendix B-2, AHCCCS BEHAVIORAL HEALTH SERVICES Allowable Procedure Code Matrix to identify the applicable COS associated with each procedure code.

Additional information as well as registration materials may be obtained by calling the AHCCCS Provider Registration Unit at:
Phoenix area: (602) 417-7670 (Option 5)
In-State: 1-800-794-6862 (Option 5)
Out of state: 1-800-523-0231 (Ext. 77670)

AHCCCS Provider Registration materials are also available on the AHCCCS Web site at www.ahcccs.state.az.us.

2. Tribal Provider Certification and Registration

In addition to registering with AHCCCS and in lieu of Division of Licensing Services (DLS), tribal providers must be certified by the Center for Medicare and Medicaid Services (CMS) to provide services. Tribal providers must submit completed certification forms indicating that the provider meets the same standards as other comparable providers. AHCCCS will review the provider application and submit the CMS certification to CMS for approval.

Additional information regarding tribal provider certification and registration can be found in the AHCCCS IHS/Tribal Provider Billing Manual.

3. Individuals Employed by or Under Contract with Licensed DLS Agencies

For licensed DLS residential and outpatient clinics, there are three (3) types of individual providers who are not allowed to bill independently for services. These include:

- Behavioral Health Professionals: Only a subset of behavioral health professionals as defined in 9 A.A.C. 10 must be affiliated with an Outpatient Clinic. This primarily includes social workers, counselors, marriage and family therapists, and substance abuse counselors who are licensed by the Arizona Board of Behavioral Health Examiners pursuant to ARS Title 32, Chapter 33 or other recognized licensing boards and who either are not allowed to practice independently or do not meet the AHCCCS registration criteria as an independent biller (Provider Types 08, 11, 12, 18, 19, 31, 85, 86, 87 and A4).

- Behavioral Health Technicians as defined in 9 A.A.C. 10.

- Behavioral Health Paraprofessionals as defined in 9 A.A.C. 10.

4. Community Service Agencies

Non-DLS licensed agencies can become a Community Service Agency (CSA) and provide rehabilitation and support services. To provide these services, individual providers have to meet certain qualifications and have to be associated with a CSA.

In addition to meeting specific provider requirements set forth in this guide for the services they will be providing, these providers will need to submit certain documentation as part of their registration packet. A description of documentation requirements is described in AHCCCS BEHAVIORAL HEALTH SERVICES Policy and Procedures Manual, Policy 406, Community Service Agencies-Title XIX Certification available on line at http://www.azdhs.gov/bhs/policy/index.php.

5. Habilitation Providers

A Habilitation Provider is a Home and Community Based Service (HCBS) provider certified through the Arizona Department of Economic Security/Division of Developmental Disabilities (ADES/DDD) and registered with the AHCCCS Administration. T/RBHAs must ensure adequate liability insurance before contracting with a Habilitation Provider, regardless if the provider is an ADES certified individual or agency.

Prior to the delivery of behavioral health services, the Habilitation Provider must receive an orientation to the unique characteristics and specific needs of the eligible person under their care. Habilitation Providers must be informed regarding whom to contact in an emergency, significant events or other incidents involving the eligible person. The behavioral health provider is responsible for the timely review and resolution of any known issues or complaints involving the eligible person and a Habilitation Provider.

A Habilitation Provider (Provider Type 39) who is ADES/HCBS certified to provide habilitation services must contact ADES HCBS Certification to add Category of Service 47 (Mental Health) to their profile. Only the following COS 47 and COS 26 codes are available to Provider Type 39:

- H2014 – Skills training and development
- H2014 HQ – Skills training and development, group
- S5150 and S5151 – Unskilled respite (COS 26)
- T1019 and T1020 – Personal care services
- H2017 – Psychosocial rehabilitation service
- S5110 – Home care training, family

The child and family team or the eligible person's treatment team as part of the service planning process must periodically review services provided by Habilitation Providers. Further, services provided by Habilitation Providers must be documented per AHCCCS BEHAVIORAL HEALTH SERVICES policy.

F. Billing for Services

In addition to the general principles related to the provision of services, there are also general guidelines, which must be followed in billing for covered behavioral health services to ensure that services will be reimbursed, and/or the encounters accepted.

The Covered Behavioral Health Services Guide is provided for general information purposes only. Providers shall conform all billing practices to comply with all federal, state and local laws, rules, regulations, standards, and executive orders, all AHCCCS and/or contractor provider manuals, policy guidelines, and standards (including reference tables), ICD9 or ICD10, whichever is in effect on the date of service, CPT, HCPCS, CDT, and Health Insurance Portability and Accountability Act Transactions and Code Sets (HIPAA TCS) compliance standards, **notwithstanding** anything contained in this Covered Services Guide, whether expressed or implied.

Reference tables are provided by AHCCCS to AHCCCS BEHAVIORAL HEALTH SERVICES and the T/RBHAs twice a month and should be used by all T/RBHAs and Providers to determine the correct values on submitted claims/encounters. The values listed throughout the Covered Behavioral Health Services Guide and on the B2 Appendix are only provided as information and should not be used to determine if a value can be used on an encounter or claim.

1. Service Codes

There are two types of codes that can be billed for services provided:

- AHCCCS Allowable Codes that may be paid for with Title XIX/XXI funds and/or non-Title XIX/XXI funds depending on the person's eligibility status; and
- Codes that are not allowable under AHCCCS and can **only** be paid for with non-Title XIX/XXI funds.

a. AHCCCS Allowable Codes

AHCCCS allowable codes are to be used to bill for services provided to any person eligible to receive services through AHCCCS BEHAVIORAL HEALTH SERVICES, regardless of their eligibility status (e.g., Title XIX/XXI, non-Title XIX/XXI). To bill AHCCCS allowable codes the provider must be an AHCCCS registered provider.

AHCCCS allowable codes can be further subdivided into the following categories:

(1.) CPT

- Physicians' Current Procedural Terminology (CPT) contains nationally recognized service codes. For more information regarding these codes see the *Physicians' Current Procedural Terminology (CPT) Manual,* which contains a systematic listing and coding of procedures and services, such as surgical, diagnostic or therapeutic procedures.

(2.) HCPCS

Healthcare Procedure Coding System (HCPCS) contains nationally recognized service codes. For more information regarding these codes see the *Healthcare 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. A subset of the HCPCS codes are not Title XIX/XXI reimbursable; these are identified in the Appendix B-2, AHCCCS BEHAVIORAL HEALTH SERVICES Allowable Procedure Code Matrix, where COS is S.

(3.) National Drug Codes (NDC)

These nationally recognized drug codes are used to bill for prescription drugs. Information regarding these pharmacy-related codes can be found in the *First Data Bank.*

(4.) 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.*

b. Codes that are not Allowable under AHCCCS

Some codes are not reimbursable under Title XIX/XXI. Appendix B-2, AHCCCS BEHAVIORAL HEALTH SERVICES Allowable Procedure Code Matrix (where COS is S) identifies the service codes that are not reimbursable through AHCCCS funding. If there is not an applicable AHCCCS allowable code, then these codes may be used to bill for the service. These codes may be billed regardless of the person's Title XIX/XXI eligibility status.

2. Billing Provider Types

Appendix B-2, Allowable Procedure Code Matrix provides a listing of the service codes that can be billed by each provider type.

a. AHCCCS Provider Billing Types

All AHCCCS reimbursable service codes must be billed by an AHCCCS registered provider. AHCCCS provider billing types relevant to behavioral health providers include the following:

02 – Level I Hospital
03 – Pharmacy
04 – Laboratory
06 – Emergency Transportation
08 – Physician (Allopathic)*
11 – Psychologist*
12 – Certified Registered Nurse Anesthetist*
18 – Physician Assistant*
19 – Nurse Practitioner*
28 – Non-emergency Transportation
29 – Rural Health Clinics (RHCs)
31 – Physician (Osteopathic)*
39 – Habilitation Provider
71 – Level I Psychiatric Hospital (IMD)
72 –Tribal Regional Behavioral Health Authority/Regional Behavioral Health Authority (T/RBHA)
73 – Out-of-state, One Time Fee For Service Provider
77 – Behavioral Health Outpatient Clinic
78 – Level I Residential Treatment Center – Secure (non-IMD)
85 – Licensed Clinical Social Worker*
86 – Licensed Marriage/Family Therapist*
87 – Licensed Professional Counselor*
97 – Air Transport Providers
A3 – Community Service Agency
A4 – Licensed Independent Substance Abuse Counselor*
A5 – Behavioral Health Therapeutic Home
A6 – Rural Substance Abuse Transitional Agency
B1 – Level I Residential Treatment Center – Secure (IMD)
B2 – Level I Residential Treatment Center – Non-Secure (non-IMD)
B3 – Level I Residential Treatment Center – Non-Secure (IMD)
B5 – Level I Subacute Facility (non-IMD)
B6 – Level I Subacute Facility (IMD)
B7 – Crisis Services Provider
B8 – Behavioral Health Residential Facility
C2 – Federally Qualified Health Centers (FQHCs)
IC – Integrated Clinics

* These individuals are referred to as "Independent Billers."

In addition to having the correct provider type, providers also have to be registered to provide the COS in which the service code is classified.

3. Modifiers

In some instances, in order to clearly delineate the service being provided, a "modifier" must be submitted along with the service code. In these circumstances codes are assigned modifiers as described in the text of this guide and in Appendix B-2, AHCCCS BEHAVIORAL HEALTH SERVICES Allowable Procedure Code Matrix. For example, there is a single code for counseling, but reimbursement for counseling provided in the office, the home or in 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 to further define a procedure code. The following is a list of modifiers used in this guide:

GT- Via interactive audio and video telecommunication systems- The physical location of the provider, when providing services via telecommunication, is the location used as the billable place of service.
HA- Child/Adolescent Program
HB- Adult Program, Non Geriatric
HC- Adult Program, Geriatric
HG- Opioid addiction treatment program
HK- Specialized mental health programs for high risk populations
HN- Bachelor's degree program (for staff not designated as behavioral health professionals)
HO- Master's degree level (for behavioral health professionals)
HQ- Group setting
HR- Family/couple with client present
HS- Family/couple without client present
HT- Multi-disciplinary team
HW- Funded by State Mental Health Agency (Service Delivery Fully Aligns with SAMHSA's Permanent Supportive Housing or Supported Employment Evidence-Based Practice. Please only use with members of the SMI population.)
SE- State and/or federally funded programs/services (May also be used to identify Support and Rehabilitation Services – Generalist Type Program)*
TF- Intermediate level of care
TG- Complex/high level of care
TN- Rural

* Modifier SE is to be used to identify when services are being provided for a child (birth through 17 years) as part of a Support and Rehabilitation Services – Generalist Type Program and should only be used by employees of a recognized Support and Rehabilitation Services – Generalist Type provider. The modifier should not be used with other support and rehabilitation services that are provided as part of a regular outpatient program. This modifier can only be used with the following service codes: H0004, H0004HR, H0004HS, H0001, H0002, H0031, H2014, H2014HQ, H2017, H0025, H0034, H2025, H2026, H2027, T1016HO, T1016HN, T1019, T1020, S5110, H0038, H0038HQ, H2016, S5150, S5151, H0043, H2011, S9484 and S9485.

4. Place of Service (POS) Codes

Accurate 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 their descriptions: http://www.cms.gov/physicianfeesched/downloads/Website_POS_database.pdf. To determine which POS codes are available for use with specific service codes, please reference the B2 matrix (see Appendix B-2, AHCCCS BEHAVIORAL HEALTH SERVICES Allowable Procedure Code Matrix)

5. Group Payment ID

An organization may act as the financial representative for any AHCCCS registered provider or group of providers who have authorized this 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 and encounters to the RBHA according to established procedures. The RBHA then submits the encounters to AHCCCS BEHAVIORAL HEALTH SERVICES. TRBHA group payment providers submit claims directly to AHCCCS 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. If a provider has multiple locations, the provider may be affiliated with multiple group payment associations.

6. Diagnosis Codes

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

The ICD-9-CM diagnosis codes must be used when submitting claims and encounters (see the *International Classification of Diseases – 9th Revision – Clinical Modification Manual)*. While each claim or encounter must include at least one valid ICD-9 diagnosis code describing the person's condition, there are a number of very general ICD-9 codes that can be used for those cases in which no specific diagnosis has been established at the time of the service.

If a code of 799.9 is assigned under the DSM-IV criteria and is not changed to a more specific diagnostic or descriptive "V" code before a claim is submitted to AHCCCS BEHAVIORAL HEALTH SERVICES, the AHCCCS PMMIS data system reads it as if it were an ICD-9-CM code, that is, the clinician does not know what the specific problem is. This diagnosis code will be denied for any inpatient or laboratory service. Further, it is difficult to gather meaningful data regarding populations, trends and program effectiveness when the primary diagnostic code is 799.9.

Providers are strongly encouraged to limit the use of 799.9 and to use instead codes which more clearly describe the person's situation. An individual who presents to the mental health system for services but who does not have a diagnosis on Axis I or II will very likely have a situation that is described by a "V" code (e.g., V61.20, counseling for parent-child problem, unspecified; V61.21, counseling for victim of child abuse, etc.).

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 principle ICD-9 mental health or substance abuse diagnosis (see Appendix B-3: Encounter/Claims Principle Behavioral Health ICD-9 Diagnostic Codes). Although a patient may have other diagnosis codes (e.g., a "V" code or other ICD-9 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-9 diagnostic codes 648.33 and 648.43 as principle diagnoses for complications of pregnancy while an individual is receiving inpatient psychiatric services.

Although ICD-9 and DSM-IV diagnosis codes are substantially alike, DSM-IV codes must not be used. Areas of differences include:

- Two ICD-9 codes (i.e., 312.8 and V61.) require a 5th digit. See ICD-9-CM manual to determine appropriate 5th digit.

ICD-9 codes should be used at their highest level of specificity (i.e., highest number of digits possible). This means:

- Use a three-digit code only if there is no four-digit code within the coding category.
- Use a four-digit code only if there is no fifth digit subclassification for that category.
- Use a five-digit code for those categories where the fifth digit subclassification exists.

ICD-9 codes are the industry standard and are required for Medicaid/Medicare billing purposes.

7. 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. The specific billing limitations are set forth in Section II of this guide.

a. General Core Billing Limitations

General core billing limitations include the following:

1. A provider can only bill for their time spent in providing the actual service. For all services, the provider may not bill any time associated with note taking and/or medical record upkeep as this time has been included in the rate.

2. For all services except case management and assessment services, the provider may not bill any time associated with phone calls, 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.

3. The provider may only bill the time spent in face-to-face direct contact; however, when providing assessment or case management services, the provider may also bill indirect contact. Indirect contact includes phone calls, leaving voice messages and sending emails (with limitations), picking up and delivering medications, and/or collateral contact with the enrolled person, family and/or other involved parties.

4. A provider should bill all time spent in directly providing the actual service, regardless of the assumptions made in the rate model. Providers must indicate begin and end times on all progress notes.

5. A professional who supervises the Behavioral Health Professional, Behavioral Health Technician and/or Behavioral Health Paraprofessional providing the service may not bill this supervision function as a HCPCS/CPT code. Employee supervision has been built into the service code rates. Supervision means direction or oversight of behavioral health services provided by a qualified individual in order to enhance therapeutic competence and clinical insight and to ensure client welfare by guiding, evaluating, and advising how services are provided.

6. If the person and/or family member(s) misses their appointment, the provider may not bill for the service.

7. Parents (including natural parent, adoptive parent and stepparent) **may** only provide personal care services if the adult child receiving services is 21 years or older and the parent is not the adult child's legal guardian. Under **no** circumstances may the spouse be the personal care services provider. The T/RBHA is responsible for monitoring that personal care services are provided by appropriate personnel.

8. Parents (including natural parent, adoptive parent and stepparent) who are certified Habilitation providers may only encounter/bill for applicable covered behavioral health services delivered to their adult children who are 21 years or older.

9. When necessary, covered services, in addition to those offered through a DLS Level I Behavioral Health facility, may be delivered to the enrolled person. See the billing limitation section associated with each specific service for additional information.

10. For services with billing units of 15 minutes, the first unit of service can be encountered/billed when 1 or more minutes are spent providing the service. To encounter/bill subsequent units of the service, the provider must spend at least one half of the billing unit for the subsequent units to be encountered/billed. If less than one half of the subsequent billing unit is spent providing the service, then only the initial unit of service can be encountered/billed.

11. More than one provider agency may bill for certain services provided to a behavioral health recipient at the same time if indicated by the person's clinical needs. Please refer to the billing limitations for each service for applicability.

12. If otherwise allowed, service codes may be billed on the same day as admission to and discharge from inpatient services (e.g., billing Crisis Intervention Service (H2011) on the same day of admission to Inpatient Hospital (0114)).

13. A single provider cannot bill for any other covered service while providing transportation to client(s).

14. Payment for services related to Provider-Preventable Conditions is prohibited, in accordance with 42 CFR Section 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.

15. CPT codes are restricted to independent practitioners with specialized behavioral health training and licensure. Please refer to Appendix B-2, Allowable Procedure Code Matrix to identify providers who can bill using CPT codes.

b. Core Provider Travel Billing Limitations

The mileage cost of the first 25 miles of provider travel is included in the rate calculated for each service; therefore, provider travel mileage may not be billed separately except when it exceeds 25 miles. In these circumstances, providers bill the additional miles traveled in excess of 25 miles using the HCPCS code A0160.

When a provider is traveling to one destination and returns to the office, the 25 miles is assumed to be included in the round trip. If a provider is traveling to multiple out-of-office settings, each segment of the trip is assumed to include 25 miles of travel. The following examples demonstrate when to bill for additional miles:

1. If Provider A travels a total of 15 miles (to the out-of-office setting in which the service is delivered and back to the provider's office), travel time and mileage is included in the rate and may not be billed separately.

2. If Provider B travels a total of 40 miles (to the out-of-office setting in which the service is delivered and back to the provider's office), the first 25 miles of provider travel are included in the rate but the provider may bill 15 miles using the provider code A0160 (40 miles minus 25 miles).

3. If Provider C travels to multiple out-of-office settings (in succession), he/she must calculate provider travel mileage by segment. For example:
   First segment = 15 miles; 0 travel miles are billed
   Second segment = 35 miles; 10 travel miles are billed
   Third segment = 30 miles; 5 travel miles are billed
   Total travel miles billed = 15 miles are billed using provider code A0160. The provider may bill for travel miles in excess of 25 miles for the return trip to the provider office.

4. Providers may not bill for travel for missed appointments.

8. Telehealth Services

While telehealth services is not a treatment service ("modality") AHCCCS BEHAVIORAL HEALTH SERVICES does recognize real time telehealth services as an effective mechanism for the delivery of certain covered behavioral health services (see AHCCCS BEHAVIORAL HEALTH SERVICES Policy 410, Use of Telemedicine). The following types of covered behavioral health services may be delivered to persons enrolled with a T/RBHA utilizing telehealth services technology:

- Diagnostic consultation and assessment
- Psychotropic medication adjustment and monitoring
- Individual and family counseling
- Case management

A complete listing of the services that can be billed utilizing telehealth services can be found in Appendix B-2, Allowable Procedure Code Matrix. Services provided through telehealth should be billed/encountered as any other specialty consultation with the exception that the 'GT' modifier must be used to designate the service being billed as telehealth services.

9. Claim Information

For more detailed information about submitting claims and encounters refer to the AHCCCS BEHAVIORAL HEALTH SERVICES Policy and Procedures Manual, /Section 2, Finance/Billing.

10. Reimbursement

Appendix B-2, Allowable Procedure Code Matrix provides a listing of fee-for-service rates established by AHCCCS BEHAVIORAL HEALTH SERVICES for allowable procedure codes. These rates function as "default" payment rates for service providers in absence of a contract (i.e., fee-for-service) and for providers subcontracted with a Tribal RBHA. Use of these rates in contracts is not required except for Tribal RBHA subcontracted providers; the Non-Tribal RBHAs are encouraged to use them only as benchmarks when contracting for services. Providers should contact their RBHA for specific contracted rates. TRBHA providers may view rates on the AHCCCS website at: www.azahcccs.gov/commercial/ProviderBilling/rates/rates.aspx.

II. Service Descriptions

II. A. Treatment Services

Treatment services are provided by or under the supervision of behavioral health professionals to reduce symptoms and improve or maintain functioning. These services have been further grouped into the following three subcategories:

- Behavioral Health Counseling and Therapy
- Assessment, Evaluation and Screening Services
- Other Professional

II. A. 1. Behavioral Health Counseling and Therapy

General Information

General Definition

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.

Service Standards/Provider Qualifications

Behavioral Health Counseling and Therapy services must be provided by individuals who are qualified *behavioral health professionals* or *behavioral health technicians* as defined in 9 A.A.C. 10.
For behavioral health counseling and therapy services that are billed by a behavioral health agency, the agency must be licensed by DLS and meet the requirements for the provision of behavioral health counseling and therapy services as set forth in 9 A.A.C. 10.

Code Specific Information

CPT Codes

CODE	DESCRIPTION-Individual Counseling and Therapy
90832	Psychotherapy, 30 minutes with patient and/or family member.
90833	Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service (list separately in addition to the code for primary procedure).

90834	Psychotherapy, 45 minutes with patient and/or family member.
90836	Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service (list separately in addition to the code for primary procedure).
90837	Psychotherapy, 60 minutes with patient and/or family member.
90838	Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service (list separately in addition to the code for primary procedure)
90845	Medical psychoanalysis - No units specified
90880	Hypnotherapy

CODE	**DESCRIPTION-Family Counseling and Therapy**
90846	Family psychotherapy (without the patient present)
90847	Family psychotherapy (conjoint psychotherapy, with patient present)
90849	Multiple-family group psychotherapy

CODE	**DESCRIPTION-Group Counseling and Therapy**
90853	Group psychotherapy (other than of a multiple-family group)

HCPCS Codes

Except for behavioral health counseling and therapy 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.

- **H0004 - Individual Behavioral Health Counseling and Therapy -- Office:** Counseling services (see general definition above for behavioral health counseling and therapy) provided face-to-face at the provider's work site to an individual person.

  Billing Unit: 15 minutes

- **H0004 - Individual Behavioral Health Counseling and Therapy – Home:** Counseling services (see general definition above for counseling and therapy) provided face-to-face to an individual person at the person's residence or other out-of-office setting.

Billing Unit: 15 minutes

- **H0004 HR - Family Behavioral Health Counseling and Therapy – Office, With Client Present:** Counseling services (see general definition above for counseling and therapy) provided face-to-face to the member and member's family at the provider's work site. ****HR modifier required and must specify place of service****

  Billing Unit: 15 minutes per family

- **H0004 HS - Family Behavioral Health Counseling and Therapy – Office, Without Client Present:** Counseling services (see general definition above for counseling and therapy) provided face-to-face to members of a person's family at the provider's work site. ****HS modifier required and must specify place of service****

  Billing Unit: 15 minutes per family

- **H0004 HR – Family Behavioral Health Counseling and Therapy – Out-of-Office, With Client Present:** Counseling services (see general definition above for counseling and therapy) provided face-to-face to members of a person's family at the family's residence or other out-of-office setting. ****HR modifier required and must specify place of service****

  Billing Unit: 15 minutes per family

- **H0004 HS – Family Behavioral Health Counseling and Therapy - Out-of-Office, Without Client Present:** Counseling services (see general definitions above for counseling) provided face-to-face to members of a person's family at the family's residence or other out-of-office setting. ****HS modifier required and must specify place of service****

  Billing Unit: 15 minutes per family

- **H0004 HQ - Group Behavioral Health Counseling and Therapy:** Counseling services (see general definition above for counseling and therapy) provided to a group (of any size) of persons, which occurs at a provider's worksite. For example, if eight persons participated in group counseling for 60 minutes, the provider would bill four units for each person for a total of 32 units. ****HQ modifier required and must specify place of service****

  Billing Unit: 15 minutes per each person in the group

Billing Limitations

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

1. See general core billing limitations in Section I.

2. Provider travel time 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 core provider travel billing limitations in Section I.

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 counseling and therapy services provided to a behavioral health recipient at the same time if indicated by the person's clinical needs.

5. Generally, H0004 HQ (Group Behavioral Health Counseling and Therapy) may not be billed on the same day as Level I Residential Treatment Center (0114, 0124, 0134, 0154, 0116, 0126, 0136 or 0156) or Behavioral Health Short-Term Residential (H0018) Services. However, based on behavioral health recipient needs, certain specialized group behavioral health counseling and therapy services may be billed on the same day as Level I Residential Treatment Center or Behavioral Health Short-Term Residential Services and be provided in the residential setting or other places of service listed for H0004 HQ. The clinical rationale for providing specialized group behavioral health counseling and therapy services must be specifically documented in the Service Plan and Progress Note. AHCCCS BEHAVIORAL HEALTH SERVICES has created a quarterly report to monitor the appropriate use of H0004 HQ when billed on the same day as Level I Residential Treatment Center or Behavioral Health Short-Term Residential services.

II. A. 2. Assessment, Evaluation and Screening Services

General Information

General Definition

Gathering and assessment of historical and current information which includes 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.

Service Standards/Provider Qualifications:

Behavioral health professionals or *behavioral health technicians* (as defined in 9 A.A.C. 10) must meet the AHCCCS BEHAVIORAL HEALTH SERVICES credentialing requirements in order to provide assessment and evaluation services.

For behavioral health screening, assessment and evaluation services that are billed by a behavioral health agency, the agency must be licensed by DLS and meet the requirements for the provision of behavioral health assessment, evaluation and screening services as set forth in 9 A.A.C. 10.

Code Specific Information

CPT Codes

CODE	DESCRIPTION- Assessment, Evaluation and Screening Services
90791	Psychiatric diagnostic evaluation
90792	Psychiatric diagnostic evaluation with medical services
96101	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology (e.g., MMPI, Rorshach WAIS), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report
96102	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology (e.g., MMPI, Rorshach and WAIS), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face
96103	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology (e.g., MMPI,

	Rorshach, WAIS), administered by a computer, with qualified health care professional interpretation and report.
96110	Developmental screening, with interpretation and report, per standardized instrument form.
96111	Developmental testing, (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments) with interpretation and report.
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), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report
96118	Neuropsychological testing (e.g., Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting test results and preparing the report
96119	Neuropsychological testing (e.g., Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face
96120	Neuropsychological testing (e.g., Wisconsin Card Sorting Test), administered by a computer, with qualified health care professional interpretation and report
99241	Office consultation for a new or established patient, which requires these 3 key components: A problem focused history; a problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family.
99242	Office consultation for a new or established patient, which requires these 3 key components: an expanded problem focused history; an expanded problem focused examination; and, straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or

family's needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

99243	Office consultation for a new or established patient, which requires these 3 key components: a detailed history; a detailed examination; and, medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.
99244	Office consultation for a new or established patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and, medical decision-making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.
99245	Office consultation for a new or established patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 80 minutes face-to-face with the patient and/or family.
99304	Initial nursing facility care, per day, for the evaluation and management of a patient which requires these 3 key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the problem(s) requiring admission are of low severity. Physicians typically spend 25 minutes at the bedside and on the patient's facility floor or unit.
99305	Initial nursing facility care, per day, for the evaluation and management of a patient which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the

patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 35 minutes at the bedside and on the patient's facility floor or unit.

99306 Initial nursing facility care, per day, for the evaluation and management of a patient which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 45 minutes at the bedside and on the patient's facility floor or unit.

99307 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a problem focused interval history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Physicians typically spend 10 minutes at the bedside and on the patient's facility floor or unit.

99308 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: an expanded problem focused interval history; an expanded problem focused examination; medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 15 minutes at the bedside and on the patient's facility floor or unit.

99309 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a detailed interval history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient has developed a significant complication or a significant new problem. Physicians typically spend 25 minutes at the bedside and on the patient's facility floor or unit.

99310 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a comprehensive interval history; a comprehensive examination; medical

decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 35 minutes at the bedside and on the patient's facility floor or unit.

99315 Nursing facility discharge day management. (30 minutes or less)

99316 Nursing facility discharge day management. (More than 30 minutes)

99318 Evaluation and management of a patient involving an annual nursing facility assessment, which requires these 3 key components: a detailed interval history; a comprehensive examination; and medical decision making that is of low to moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Physicians typically spend 30 minutes with the patient and/or family or caregiver. (Do not report 99318 on the same day of service as nursing facility services codes 99304-99316).

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.

- **H0001 – Alcohol and/or drug assessment**

  Provider Qualifications:
  AHCCCS BEHAVIORAL HEALTH SERVICES credentialed behavioral health professionals and behavioral health technicians

- **H0002 - Behavioral Health Screening to Determine Eligibility for Admission:** 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.

  Provider Qualifications:
  Behavioral health technician or behavioral health professional as defined in 9 A.A.C. 10.

- **H0031- Mental Health Assessment –By Non-Physician-:** Gathering and assessment of 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. May also include the review and modifications to the person's service plan, comprehensive assessments, a rehabilitative employment support assessment and DES-DDD Positive Support Plans.

  Provider Qualifications:
  AHCCCS BEHAVIORAL HEALTH SERVICES credentialed behavioral health professionals and behavioral health technicians

- **H0031 -Mental Health Assessment-By Board Certified Behavior Analysts:** See definition of mental health assessment above.

  Provider Qualifications:
  Board Certified Behavior Analysts

  Billing Provider Type:
  Behavioral Health Outpatient Clinic (77)

Billing Limitations

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

1. See general core billing limitations in Section I.

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

3. 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.

4. 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. The T/RBHA must monitor the proper provision of this service.

5. 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.

II. A. 3. Other Professional

General Information

In addition to behavioral health counseling therapy and assessment, evaluation and screening, there are a number of 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.

Code Specific Information

CPT Codes

CODE	DESCRIPTION-Other Professional
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); approximately 20-30 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); approximately 45-50 minutes
90899	Unlisted psychiatric services or procedure (Psychiatric services without patient face to face contact)
90901	Biofeedback training by any modality
99199	Unlisted special service, procedure or report

HCPCS Codes

Except for alcohol and/or drug services and multisystemic therapy (MST) for juveniles provided by behavioral health professionals allowed to bill CPT codes, all other alcohol and/or drug and multisystemic behavioral health services should be billed using the following HCPCS codes.

- **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.**

  Billing Unit: Per Diem

Billing Limitations

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

1. See general core billing limitations in Section I.

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

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. Alcohol and/or drug services (H0015) and multisystemic therapy for juveniles (H2033) may not be billed on the same day as each other or on the same day as an inpatient service.

- **H2033 – Multisystemic therapy for juveniles:** Multisystemic therapy uses the strengths found in key environmental settings of juveniles (under age 21) 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.

  Billing Unit: 15 minutes

Billing Limitations

For multisystemic therapy for juveniles the following billing limitations apply:

1. 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.

2. 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.

3. See general core billing limitations in Section I.

4. Travel time and expenses are not billable activities and cannot be included in units billed during claims submission.

5. 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.

6. Alcohol and/or drug services (H0015) and multisystemic therapy for juveniles (H2033) may not be billed on the same day as each other or on the same day as an inpatient service.

State Funded HCPCS Codes (not reimbursable by Medicaid Title XIX or KidsCare Title XXI)

- **H0046 –Mental Health Services (NOS) (formerly Traditional Healing Services):** Treatment services for mental health or substance abuse problems provided by qualified traditional healers. These services include the use of routine or advanced techniques aimed to relieve the emotional distress evident by disruption of the person's functional ability.

  Billing Unit: 15 minutes

  Auricular Acupuncture general definition:
  The application by a certified acupuncturist practitioner pursuant to: A.R.S. 32-3922 of auricular acupuncture needles to the pinna, lobe or auditory meatus to treat alcoholism, substance abuse or chemical dependency.

  - **97810 –Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient.**
    - **+97811 –Acupuncture, 1 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). (List separately in addition to code for primary procedure)***

  - **97813-Acupuncture, 1 or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient.**
    - **+97814-Acupunture, 1or more needles; with electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s). (List separately in addition to code for primary procedure)**

II. B. Rehabilitation Services

Rehabilitation services include the provision of educating, coaching, training and demonstrating. Other services include securing and maintaining employment to remediate residual or prevent anticipated functional deficits. Except for cognitive rehabilitation, which is billed using a CPT code, rehabilitation services are billed using HCPCS codes. Rehabilitation services include:

- Skills Training and Development and Psychosocial Rehabilitation Living Skills Training
- Cognitive Rehabilitation
- Behavioral Health Prevention/Promotion Education and Medication Training and Support (Health Promotion)
- Psychoeducational Service (Pre-Job Training and Job Development) and Ongoing Support to Maintain Employment (Job Coaching and Employment Support)

II. B. 1. Skills Training and Development and Psychosocial Rehabilitation Living Skills Training

General Information

General Definition

Teaching independent living, social, and communication skills to persons and/or their families in order to maximize the person's ability to live and participate in the community and to function independently. Examples of areas that may be addressed include self-care, household management, social decorum, same- and opposite-sex friendships, 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 or their families with the person(s) present.

Service Standards/Provider Qualifications

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 para-professionals* as defined in 9 A.A.C. 10. This may also include Licensed Practical Nurses (LPNs) who have training in providing these services as required by the person's service plan.

Code Specific Information

HCPCS Codes

Skills training and development and psychosocial rehabilitation living skills training services should be billed using the following codes:

- **H2014 –Skills Training and Development – Individual:** See general definition above.

  Billing Unit: 15 minutes

- **H2014 –Skills Training and Development-By Board Certified Behavior Analysts:** See general definition above.

  Billing Provider Type:
  Behavioral Health Outpatient Clinic (77)

  Billing Unit: 15 minutes

- **H2014 HQ –Skills Training and Development – Group:** See general definition above. If eight persons participated in group skills training and development session for 60 minutes, the provider would bill four units for each person for a total of 32 units.

  Billing Unit: 15 minutes per person

- **H2017–Psychosocial Rehabilitation Services (Living Skills Training):** See general definition above.

  Billing Unit: 15 minutes per person

Billing Limitations

For skills training and development services the following billing limitations apply:

1. See general core billing limitations in Section I.

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 code H2014, Skills Training and Development, may be billed up to 8 hours. Service code H2017, Psychosocial Rehabilitation, cannot be billed if under 8 hours are needed and should be billed for the length of the service. Service codes H2014, Skills Training and Development and Service code H2017, Psychosocial Rehabilitation cannot be billed on the same day, with certain exceptions. For exceptions see section Home Care Training to Home Care Client under Billing Limitations.

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.

II. B. 2. Cognitive Rehabilitation

General Information

General Definition

The facilitation of recovery from cognitive impairments in order to achieve independence or the highest level of functioning possible. 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. Treatment may include techniques such as auditory and visual attention directed tasks, memory training, training in the use of assistive technology, and anger management. 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.

Service Standards/Provider Qualifications
Cognitive rehabilitation services must be provided by individuals who are qualified *behavioral health professionals* as defined in 9 A.A.C. 10 and who can bill independently using the appropriate CPT codes.

Code Specific Information

CPT Codes

CODE	DESCRIPTION-Cognitive Rehabilitation
97532	Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one on one) patient contact by the provider, each 15 minutes.

II. B. 3. Behavioral Health Prevention/Promotion Education and Medication Training and Support Services (Health Promotion)

General Information

General Definition

Education and training are single or multiple sessions provided to an individual or a group of people and/or their families related to the enrolled person's treatment plan. Education and training 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, HIV education, parenting skills education and healthy lifestyles (e.g., diet, exercise). DUI health promotion education and training must be approved by DLS.

Service Standards/Provider Qualifications

Behavioral health prevention/promotion education services may be provided by individuals who are qualified *behavioral health professionals* or *behavioral health technicians* as defined in 9 A.A.C. 10 or who are educators or subject matter experts. This may also include other medical personnel, such as Licensed Practical Nurses (LPNs) or Registered Nurses (RNs) who are not allowed to bill independently using CPT codes. All individual providers must be appropriately licensed/certified/trained in the area in which they are providing training.

Code Specific Information

HCPCS Codes

Behavioral health prevention/promotion education and medication training and support services should be billed using the following codes:

- **H0025 - Behavioral Health Prevention Education Service: (delivery of** services with target population to affect knowledge, attitude and/or behavior). See general definition above.

  Billing Unit: 30 minutes

- **H0034 – Medication Training and Support: (**Health promotion) Education and training provided to a person and/or their family related to the enrolled person's medication regime.

  Billing Unit: 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 in Section I.

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

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 at the same time if indicated by the person's clinical needs.

II. B. 4. Psychoeducational Services and Ongoing Support to Maintain Employment

General Information

General Definition

Psychoeducational services and ongoing support to maintain employment services are designed to assist a person or group to choose, acquire, and maintain a job or other meaningful community activity (e.g., volunteer work)

Service Standards/Provider Qualifications

Psychoeducational services and ongoing support to maintain employment services may be provided individually. These services must be provided using tools, techniques and materials which meet the individual's needs and are appropriate for the person's age and mental and physical status. While the goal may be for persons to achieve full time employment in a competitive, integrated work environment, there may be persons for whom this goal is not applicable. Therefore, these services need to be tailored to support persons in a variety of settings (e.g., part time job, unpaid work experience or in meaningful volunteer work). Some individuals may not be ready to identify an educational or employment goal, and will need assistance in exploring their strengths. Some individuals may desire to focus on socialization goals, which should also be addressed in rehabilitation services, and are often the first step to moving towards competitive employment and further independent involvement in the community.

Code Specific Information

HCPCS Codes

- **H2027 – Psychoeducational Services (Pre-Job Training and Development):** Services which prepare a person to engage in meaningful work-related activities may include: career/educational counseling, job shadowing, assistance in the use of educational resources, training in resume preparation, job interview skills, study skills, work activities, professional decorum and dress, time management, and assistance in finding employment.

  Provider Qualifications:

  Behavioral health professionals, behavioral health technicians and behavioral health paraprofessionals with one year of experience in providing rehabilitation services to persons with disabilities.

  For Community Service Agencies, please see AHCCCS BEHAVIORAL HEALTH SERVICES Policy and Procedures Manual, Policy 406, Community Service

Agencies-Title XIX Certification AHCCCS BEHAVIORAL HEALTH SERVICES Policy and Procedures Manual, Policy 406, Community Service Agencies-Title XIX Certification for further detail on service standards and provider qualifications for this service.

Billing Unit: 15 minutes

- **H2025 – Ongoing Support to Maintain Employment:** Includes support services that enable a person to complete job training or maintain employment. Services may include monitoring and supervision, assistance in performing job tasks, work-adjustment training, and supportive counseling.

  Provider Qualifications:

  Behavioral health professionals, behavioral health technicians and behavioral health paraprofessionals with one year of experience in providing rehabilitation services to persons with disabilities.

  For Community Service Agencies, please see AHCCCS BEHAVIORAL HEALTH SERVICES Policy and Procedures Manual, Policy 406, Community Service Agencies-Title XIX Certification for further detail on service standards and provider qualifications for this service.

  Billing Unit: 15 minutes

- **H2026 – Ongoing Support to Maintain Employment:** See definition above.

  Provider Qualifications:

  Behavioral health professionals, behavioral health technicians and behavioral health paraprofessionals with one year of experience in providing rehabilitation services to persons with disabilities.

  For Community Service Agencies, please see AHCCCS BEHAVIORAL HEALTH SERVICES Policy and Procedures Manual, Policy 406. Community Service Agencies-Title XIX Certification for further detail on service standards and provider qualifications for this service.

  Billing Unit: Per Diem

Billing Limitations

For psychoeducational services and ongoing support to maintain employment services the following billing limitations apply:

1. See general core billing limitations in Section I.

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

3. Transportation provided to persons is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

4. 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 DES-RSA, which is required to be the primary payer for Title XIX eligible persons. The T/RBHA must monitor the proper provision of this service.

5. Service code H2025, Ongoing Support to Maintain Employment, may be billed up to 8 hours. Service code H2026, Ongoing Support to Maintain Employment (per diem), cannot be billed if under 8 hours are needed and should be billed for the length of the service. Service codes H2025, Ongoing Support to Maintain Employment and Service code H2026, Ongoing Support to Maintain Employment (per diem) cannot be billed on the same day.

6. More than one provider agency may bill for psychoeducational services and ongoing support to maintain employment services provided to a behavioral health recipient at the same time if indicated by the person's clinical needs.

7. Peer employment training is not a billable service for costs associated with training an agency's own employees.

II. C. Medical Services

Medical services are provided or ordered by a licensed physician, nurse practitioner, physician assistant, or nurse to reduce a person's symptoms and improve or maintain functioning. These services have been further grouped into the following four subcategories:

- Medication
- Laboratory, Radiology and Medical Imaging
- Medical Management (including medication management)
- Electroconvulsive Therapy (ECT)

II. C. 1. Medication Services

General Information

General Definition

Drugs prescribed by a licensed physician, nurse practitioner or physician assistant to prevent, stabilize or ameliorate symptoms arising from a behavioral health condition or its treatment.

Service Standards/Provider Qualifications

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, or physician assistant.

AHCCCS BEHAVIORAL HEALTH SERVICES maintains a minimum list of medications to ensure the availability of necessary, safe and cost effective medications for persons with behavioral health disorders. These medications must be made available to persons in accordance with the AHCCCS BEHAVIORAL HEALTH SERVICES Policy 1301AHCCCS BEHAVIORAL HEALTH SERVICES Drug List.

Code Specific Information

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 Codes

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

HCPCS Codes

CODE	DESCRIPTION-Medication Services
J0515	Injection, Benztropine 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
J2680	Injection, Fluphenazine Decanoate, up to 25 mg
J2794	Injection, Risperidone (Risperidal Consta), long-acting, 0.5 mg
J3410	Injection, Hydroxyine HCL, up to 25 mg

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 CFR Part 8), state regulations (9 A.A.C. 10) and AHCCCS BEHAVIORAL HEALTH SERVICES guidelines related to opioid agonist administration.

- **H2010 HG –Comprehensive Medication Services**: 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).

  Billing Unit: 15 minutes

- **H0020 HG – Alcohol and/or Drug Services; Methadone Administration and/or Services (provision of the drug by a licensed program)**: Administration of prescribed opioid agonist drugs for a person *to take at home* in order to reduce physical dependence on heroin and other opiate narcotics. Providers must be AHCCCS registered as a Category of Service (COS) type 01 (Medicine).

  Billing Unit: 1 dose per day (includes cost associated with drug and administration). While the billing unit is a single dose of medication per day, the take home medicine can be provided for more than one day.

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 the AHCCCS BEHAVIORAL HEALTH SERVICES Policy and Procedures Manual, Policy 902 Coordination of Care with AHCCCS Health Plans, PCP and Medicare Providers, in certain circumstances the person's primary care physician (PCP) may prescribe psychotropic medications (For the treatment of mild depression, anxiety and Attention-Deficit Hyperactivity Disorder). Care should be coordinated with other prescribers including AHCCCS Health Plan PCPs.

3. Other than opioid agonist drugs (see limitation #4 below), the T/RBHA and/or 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 BEHAVIORAL HEALTH SERVICES does not cover items relating to medical marijuana. This includes application fees or the drug itself.

6. Transportation provided to the AHCCCS BEHAVIORAL HEALTH SERVICES person is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

II. C. 2. Laboratory, Radiology and Medical Imaging

General Information

General Definition

Medical tests ordered for diagnosis, screening or monitoring of a behavioral health condition. 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, 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 9 A.A.C.14-101 and the federal code of regulations 42 CFR 493, Subpart A).

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

Code Specific Information

CPT Codes

CODE	DESCRIPTION-Laboratory, Radiology and Medical Imaging
36415	Collection of venous blood by venipuncture
80048	Basic metabolic panel, this panel must include the following: calcium total, carbon dioxide, chloride, creatinine, glucose, potassium, sodium, urea nitrogen (BUN)
80050	General health panel, this panel must include the following: comprehensive metabolic panel, blood count complete (CBC) automated and automated differential WBC count or blood count, complete (CBC) automated and appropriate manual differential WBC count, thyroid stimulating hormone (TSH).
80051	Electrolyte panel, this panel must include the following: carbon dioxide, chloride, potassium, sodium.

80053	Comprehensive metabolic panel, this panel must include the following: albumin, bilirubin total, calcium total, carbon dioxide (bicarbonate), chloride, creatinine, glucose, phosphatase alkaline, potassium, protein total, sodium, transferase alanine amino (ALT) (SGPT), transferase aspartate amino (AST) (SGOT), urea nitrogen (BUN).
80061	Lipid panel, this panel must include the following: cholesterol serum total, lipoprotein direct measurement, high density cholesterol (HDL cholesterol), triglycerides.
80076	Hepatic function panel, this panel must include the following: albumin, bilirubin total, bilirubin direct, phosphatase alkaline, protein total, transferase alanine amino (ALT) (SGPT), transferase aspartate amino (ALT) (SGOT).
80156	Carbamazepine; total
80164	Dipropylacetic acid (valproic acid)
80171	Drug Screen Quantitative Gabapentin
80178	Lithium
80299	Quantitation of drug, Not Elsewhere Specified (NOS)
80420	Dexamethasone suppression panel, 48 hour, this panel must include the following: free cortisol urine, cortisol, volume measurement for timed collection.
81000	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, Ph, protein, specific gravity, urobilinogen, and 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, and 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, and 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	Catechloamines, 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 (GGT)
83036	Hemoglobin; Glycosylated (A1C)

83037	Hemoglobin; Glycosylated (A1C) by device cleared by FDA
83788	Mass Spect & Tandem Mass Spect Anal Qual Ea Spec
83789	Mass Spect & Tandem Mass Spect Anal Quan Ea Spec
83986	PH body fluid Not Elsewhere Specified
83992	Assay of 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, blood (BUN); 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 enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; HIV-1
87391	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; 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, one to three leads, with interpretation and report
93041	Rhythm ECG, one to three leads, tracing only, without interpretation and report
93042	Rhythm ECG, one to three leads, interpretation and report only
95819	Electroencephalogram (EEG) including recording awake and asleep

<u>HCPCS Codes</u>

G0431	Drug screen, qualitative; multiple drug classes by high complexity test method (e.g., immunoassay, enzyme assay), per patient encounter
G0434	Drug screen, other than chromatographic; any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter
G6030	Assay of Amitriptyline
G6031	Assay of Benzodiazepines
G6032	Assay of Desipramine
G6034	Assay of Doxepin
G6035	Assay of Gold
G6036	Assay of Imipramine
G6037	Assay of Nortriptyline
G6038	Assay of Salicylate

G6039	Assay of Acetaminophen
G6040	Assay of Alcohol; Any Specimen except Breath
G6041	Alkaloids Urine Quantitative
G6042	Assay of Amphetamine or Methamphetamine
G6043	Assay of Barbiturates Not Elsewhere Specified
G6044	Assay of Cocaine or Metabolite
G6045	Assay of Dihydrocodeinone
G6046	Assay of Dihydromorphinone
G6047	Assay of Dihydrotestosterone
G6048	Assay of Dimethadione
G6049	Assay of Epiandrosterone
G6050	Assay of Ethchlorvynol
G6051	Assay of Flurazepam
G6052	Assay of Meprobamate
G6053	Assay of Methadone
G6054	Assay of Methsuximide
G6055	Assay of Nicotine
G6056	Opiate Drug and Metabolites Each Procedure
G6057	Assay of Phenothiazine
G6058	Drug Confirmation Each Procedure

Billing Limitations

For laboratory, radiology and medical imaging the following billing limitation applies:

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

II. C. 3. Medical Management

General Information

General Definition

Assessment and management services that are provided by a licensed medical professional (i.e., physician, nurse practitioner, 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.

Service Standards/Provider Qualifications

Appropriately licensed physicians, nurse practitioners, physician assistants, and nurses must provide medical management services. Psychiatric consultation services are provided for AHCCCS primary care providers who wish to prescribe psychotropic medications in accordance with AHCCCS BEHAVIORAL HEALTH SERVICES Policy and Procedures Manual, Policy 902 Coordination of Care with AHCCCS Health Plans, PCP and Medicare Providers DLS licensed agencies must operate within the scope of services authorized through the agency's license.

Code Specific Information

CPT Codes

CODE	DESCRIPTION-Medical Management
99201	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a problem-focused history; a problem-focused examination; straightforward medical decision-making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: an expanded problem-focused history; an expanded problem-focused examination; straightforward medical decision-making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to

moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.

99203	Office or other outpatient visit for the evaluation and management of new patient, which requires these 3 key components: a detailed history; a detailed examination; and, medical decision-making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.
99204	Office or other outpatient visit for the evaluation and management of new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and, medical decision-making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.
99205	Office or other outpatient visit for the evaluation and management of new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and, medical decision-making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a problem-focused history; a problem-focused examination; straightforward medical decision-making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self

	limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: an expanded problem-focused history; an expanded problem-focused examination; medical decision-making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a detailed history; a detailed examination; medical decision-making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a comprehensive history; a comprehensive examination; and medical decision-making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.
99304	Initial nursing facility care, per day, for the evaluation and management of a patient which requires these three key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the problem(s) requiring admission are of low severity. Physicians typically spend 25 minutes at the bedside and on the patient's facility floor or unit.

99305	Initial nursing facility care, per day, for the evaluation and management of a patient which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 35 minutes at the bedside and on the patient's facility floor or unit.
99306	Initial nursing facility care, per day, for the evaluation and management of a patient which requires these 3 key components: a comprehensive history; a comprehensive examination, and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 45 minutes at the bedside and on the patient's facility floor or unit.
99307	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a problem focused interval history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the patient is stable, recovering, or improving. Physicians typically spend 10 minutes at the bedside and on the patient's facility floor or unit.
99308	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: an expanded problem focused interval history; an expanded problem focused examination; medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 15 minutes at the bedside and on the patient's facility floor or unit.
99309	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a detailed interval history; a detailed examination; medical decision making of moderate complexity. Counseling and/or

coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient has developed a significant complication or a significant new problem. Physicians typically spend 25 minutes at the bedside and on the patient's facility floor or unit.

99310	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a comprehensive interval history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 35 minutes at the bedside and on the patient's facility floor or unit.
99315	Nursing facility discharge day management. (30 minutes or less)
99316	Nursing facility discharge day management. (more than 30 minutes)
99318	Evaluation and management of a patient involving an annual nursing facility assessment, which requires these 3 key components: a detailed interval history; a comprehensive examination; and medical decision making that is of low to moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Physicians typically spend 30 minutes with the patient and/or family or caregiver. (Do not report 99318 on the same day of service as nursing facility services codes 99304-99316.)
99324	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: a problem focused history; a problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 20 minutes with the patient and/or family or caregiver.
99325	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: an expanded

	problem focused history; an expanded problem focused examination; and medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes with the patient and/or family or caregiver.
99326	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: a detailed history; a detailed examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes with the patient and/or family or caregiver.
99327	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity. Physicians typically spend 60 minutes with the patient and/or family or caregiver.
99328	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention. Physicians typically spend 75 minutes with the patient and/or family or caregiver.
99334	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a problem focused interval history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's

and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Physicians typically spend 15 minutes with the patient and/or family or caregiver.

99335	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: an expanded problem focused interval history; an expanded problem focused examination; medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 25 minutes with the patient and/or family or caregiver.
99336	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a detailed interval history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes with the patient and/or family or caregiver.
99337	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a comprehensive interval history; a comprehensive examination; and medical decision making of moderate to high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 60 minutes with the patient and/or family or caregiver.
99341	Home visit for the evaluation and management of a new patient which requires these 3 key components: a problem-focused history; a problem-focused examination; straightforward medical decision-making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.

99342	Home visit for the evaluation and management of a new patient which requires these 3 key components: an expanded problem-focused history; an expanded problem-focused examination; and medical decision-making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.
99343	Home visit for the evaluation and management of a new patient which requires these 3 key components: a detailed history; a detailed examination; and decision-making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.
99344	Home visit for the evaluation and management of a new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision-making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.
99345	Home visit for the evaluation and management of a new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision-making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention. Physicians typically spend 75 minutes face-to-face with the patient and/or family.
99347	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a problem focused interval history; a problem-focused examination; straightforward medical decision-making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or

family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

99348	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: an expanded problem focused interval history; an expanded problem focused examination; medical decision-making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.
99349	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a detailed interval history; a detailed examination; medical decision-making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.
99350	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a comprehensive interval history; a comprehensive examination; medical decision-making of moderate to high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 60 minutes face-to-face with the patient and/or family.
99354	Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service; first hour. (List separately in addition to code for office or other outpatient evaluation and management service)
99355	Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service; each additional 30 minutes (list separately in addition to code for prolonged physician service 99354)

99358	Prolonged evaluation and management service before and/or after direct (face-to-face) patient care (e.g., review of extensive records and tests, communication with other professionals and/or the patient/family); first hour (list separately in addition to code(s) for other physician service(s) and/or inpatient or outpatient evaluation and management service).
99359	Prolonged evaluation and management service before and/or after direct (face-to-face) patient care (e.g., review of extensive records and tests, communication with other professionals and/or the patient/family); each additional 30 minutes (list separately in addition to code for prolonged physician service 99358)
99499	Unlisted evaluation and management service.

HCPCS Codes

- **T1002 - RN Services:** Medical management services (including medication monitoring) related to the treatment of a behavioral health disorder. As allowed by the individual provider's scope of practice may include such activities as the measurement of vital signs, assessment and monitoring of physical/medical status, review of the effects and side effects of medications and administration of medications.

  Provider Qualifications:
  Licensed registered nurse (within the scope of their license)

  Billing Unit: 15 minutes

- **T1003 – LPN Services:** Medical management services (including medication monitoring) related to the treatment of a behavioral health disorder. As allowed by the individual provider's scope of practice may include such activities as the measurement of vital signs, assessment and monitoring of physical/medical status, review of the effects and side effects of medications and administration of medications.

  Provider Qualifications:
  Licensed practical nurse (within the scope of their license)

  Billing Unit: 15 minutes

- **T1015 –** Clinic visit/encounter, all-inclusive A face-to-face encounter with a licensed AHCCCS-registered practitioner during which an AHCCCS-covered ambulatory service is provided when that service is not incident to another service. A service which is provided incident to another service, whether or not on the same day or at the same location, is considered to be part of the visit and is not reimbursed separately.

  Provider Qualifications:
  Federally Qualified Health Center (FQHC)
  Community/Rural Health Center (RHC)

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 inclusive of the higher level of service. See also general core billing limitations applicable to T1002 and T1003 in Section I." The same day billing limitation was communicated through AHCCCS BEHAVIORAL HEALTH SERVICES Office of Program Support (OPS@azahcccs.gov) on November 18, 2013, and is effective for services provided on or after October 1, 2013.

2. Where applicable, travel time by the provider is included in the rate for RN and LPN Services (T1002 and T003). See core provider travel billing limitations in Section I.

3. Nursing services provided in a DLS licensed inpatient, residential or medical day program setting are included in the rate and cannot be billed separately.

4. Transportation provided to the AHCCCS BEHAVIORAL HEALTH SERVICES enrolled member is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

II. C. 4. Electroconvulsive Therapy

General Information

General Definition

The application of alternating current at or slightly above the seizure threshold through the use of electrodes attached to the scalp of a person who has received short-acting general anesthetic and muscle depolarizing medication.

Service Standards/Provider Qualifications

Electroconvulsive therapy services must be provided by a licensed physician with anesthesia support in a hospital.

Code Specific Information

CPT Codes

CODE	DESCRIPTION-Electroconvulsive Therapy
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. The rate for revenue code 0901 is set by report.

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

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.

II. D. 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)
- Home Care Training to Home Care Client (HCTC)
- Unskilled Respite Care
- Supported Housing
- Sign Language or Oral Interpretive Services
- Non-Medically Necessary Covered Services (Flex Fund Services)
- Transportation

II. D. 1. Case Management

General Information

General Definition

Case management is a supportive service provided to enhance treatment goals and effectiveness. Activities may include:

- Assistance in maintaining, monitoring and modifying covered services;
- Brief telephone or face-to-face interactions with a person, family or other involved party for the purpose of maintaining or enhancing a person's functioning;
- Assistance in finding necessary resources other than covered services to meet basic needs;
- Communication and coordination of care with the person's family, behavioral and general medical and dental health care providers, community resources, and other involved supports including educational, social, judicial, community and other State agencies;
- Coordination of care activities related to continuity of care between levels of care (e.g., inpatient to outpatient care) and across multiple services (e.g., personal assistant, nursing services and family counseling);
- Outreach and follow-up of crisis contacts and missed appointments;
- Participation in staffings, case conferences or other meetings with or without the person or their family participating; and
- Other activities as needed.

Case management **does not** include:

- Administrative functions such as authorization of services and utilization review;
- Other covered services listed in the AHCCCS BEHAVIORAL HEALTH SERVICES Covered Behavioral Health Services Guide.

Service Standards/Provider Qualifications

Case management 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.

If case management services are not provided by behavioral health professionals, these services must be provided under their direction or supervision.

Code Specific Information

CPT Codes

CODE	DESCRIPTION
98966	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.
98967	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion.
98968	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion.
99367	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician.
99368	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by nonphysician qualified health care professional.
99441	Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.
99442	Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor

leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion.

99443	Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion.
90887	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient.
90889	Preparation of report of patient's psychiatric status, history, treatment, or progress (other than legal or consultative purposes) for other physicians, agencies, or insurance carriers.

HCPCS Codes:

- **T1016 HO– Case Management by Behavioral Health Professional - Office:** Case management services (see general definition above for case management services) provided at the provider's work site.

  Provider Qualifications:
  Behavioral health professional

  Billing Unit: 15 minutes

- **T1016 HO – Case Management by Behavioral Health Professional - Out-of-Office:** Case management services (see general definition above for case management services) provided at a person's place of residence or other out-of-office setting.

  Provider Qualifications:
  Behavioral health professional

  Billing Unit: 15 minutes

- **T1016 HN – Case Management - Office:** Case management services (see general definition above for case management services) provided at the provider's work site.

  Provider Qualifications:
  Behavioral health technician or Behavioral health paraprofessional

Billing Unit: 15 minutes

- **T1016 HN – Case Management - Out-of-Office:** Case management services (see general definition above for case management services) provided at a person's place of residence or other out-of-office setting.

  Provider Qualifications:
  Behavioral health technician or behavioral health paraprofessional

  Billing Unit: 15 minutes

Billing Limitations

For case management services the following billing limitations apply:

1. Case management services provided by a DLS licensed inpatient, residential 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.

2. A single provider may not bill case management for any time associated with a therapeutic interaction, nor simultaneously with any other services.

3. Multiple provider agencies may bill for this service during the same time period when more than one provider is simultaneously providing a case management service (e.g., a staffing). In addition, more than one individual within the same agency may bill for this service (e.g., individuals involved in transitioning a person from a residential level of care to a higher (subacute) or lower (outpatient) level of care, staff from each setting may bill case management when attending a staffing.

4. 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).

5. Transportation provided to an AHCCCS BEHAVIORAL HEALTH SERVICES enrolled member is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

6. For Case Management codes:

    - See general core billing limitations in Section I.
    - Where applicable, travel time by the provider is included in the rates. See core provider travel billing limitations in Section I.
    - 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/service plan. Indirect contact includes telephone calls, picking up and delivering medications, and/or collateral contact with the person, family and/or other involved parties.
    - Written electronic communication (email) and leaving voice messages are allowable as case management functions. These functions are not to become the predominant means of providing case management services and require specific documentation as specified below.
    - Written electronic communication (email) must be about a specific individual and is allowable as case management, as long as documentation (a paper copy of the email) exists in the case record.
    - 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.
    - When leaving voice messages, a signed document in the client chart granting permission to leave specific information is required.

7. When a provider is picking up and dropping off medications for more than one behavioral health recipient, the provider must divide up the time spent and bill the appropriate case management code for each involved behavioral health recipient.

8. In accordance with other case management restrictions, RBHAs shall be permitted to encounter behavioral health case management for services provided within 60 days of planned discharge from the Arizona State Hospital for the purposes of coordinating care between inpatient and outpatient providers.

II. D. 2. Personal Care Services

General Information

General Definition

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.

Service Standards/Provider Qualifications

Personal care services may be provided by a licensed behavioral health agency or Community Service Agency (CSA)utilizing individuals who are qualified as *behavioral health professionals, behavioral health technicians, or behavioral health paraprofessionals* as defined in 9 A.A.C. 10.

Code Specific Information

HCPCS Codes

- **T1019 –Personal Care Services, not for an inpatient or resident of a hospital, nursing facility, Intermediate Care Facility for the Mentally Retarded (ICF/MR) or (Institution of Mental Disease (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).

Billing Unit: 15 minutes

- **T1020 – Personal Care Services, not for 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 Unit: Per Diem

Billing Limitations

For personal care services the following billing limitations apply:

1. See general core billing limitations in Section I.

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

3. Personal care services provided in a DLS 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 on Modifiers. This service is also included in the HCTC service rate and cannot be billed separately for persons receiving HCTC services. See also section on Home Care Training to Home Care Client under Billing Limitations.

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. More than one provider agency may bill for personal care services provided to a behavioral health recipient at the same time if indicated by the person's clinical needs.

7. A Community Service Agency cannot provide services that would otherwise require the agency to be licensed as a health care institution (see 9 A.A.C. 10)..

II. D. 3. Home Care Training Family (Family Support)

General Information

General Definition

Home care training family services (family support) involve face-to-face interaction 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.

Service Standards/Provider Qualifications

Home care training family services (family support) must be provided by *behavioral health professionals, behavioral health technicians, or behavioral health para-professionals* as defined in 9 A.A.C. 10.

Code Specific Information

HCPCS Codes

- **S5110 –Home Care Training, Family; (Family Support):** See general definition above.

Billing Unit: 15 minutes

Billing Limitations

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

1. See general core billing limitations in Section I.

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

3. Family support services provided in a DLS 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. This service is also included in the HCTC service rate and cannot be billed

separately by the behavioral health therapeutic home, with certain exceptions. For exceptions see section Home Care Training to Home Care Client 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.

II. D. 4. Self-Help/Peer Services (Peer Support)

General Information

General Definition

This may involve assistance with more effectively utilizing the service delivery system (e.g., assistance in developing plans of care, identifying needs, accessing supports, partnering with professionals, overcoming service barriers) or understanding and coping with the stressors of the person's disability (e.g., support groups), coaching, role modeling and mentoring.

Self-help/peer services are intended for enrolled persons and/or their families who require greater structure and intensity of services than those available through community-based recovery fellowship groups and who are not yet ready for independent access to community-based recovery groups (e.g., Alcoholics Anonymous (AA), (Narcotics Anonymous (NA), Dual Recovery). These services may be provided to a person, group or family and are aimed at assisting in the creation of skills to promote long-term, sustainable recovery.

Service Standards/Provider Qualifications

Individuals providing self-help/peer services must be employed by or contracted with a Community Service Agency or a licensed facility allowed to bill the procedure code. Community Service Agencies providing this service must be Title XIX certified by AHCCCS.

Self-help/peer services are provided by those who have been certified as Peer/Recovery Support Specialists through an AHCCCS BEHAVIORAL HEALTH SERVICES approved Peer Support Employment Training Program, self-identify as a "peer" and are qualified as *behavioral health professionals, behavioral health technicians, or behavioral health para-professionals* as defined in 9 A.A.C. 10. A "peer", as referenced in these provider qualifications, is defined as an individual who is, or has been a recipient of behavioral health services or substance abuse and has an experience of recovery to share.

Code Specific Information

HCPCS Codes

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

Billing Unit: 15 minutes

- **H0038 HQ – Self-Help/Peer Services - Group**: Self-help/peer services (see general definition above) provided to a group of individuals and/or their families.

Billing Unit: 15 minutes

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

Billing Unit: Per Diem

Billing Limitations

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

1. See general core billing limitations in Section I.

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

3. Self-help/peer services provided in a 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.

6. More than one provider agency may bill for self-help/peer services provided to a behavioral health recipient at the same time if indicated by the person's clinical needs.

II. D. 5. Home Care Training to Home Care Client

General Information

General Definition

Home Care Training to Home Care Client (HCTC) services are provided by a behavioral health therapeutic home to a person residing in their home in order to implement the in-home portion of the person's behavioral health service plan. HCTC services assist and support a person in achieving their service plan goals and objectives. It also helps the person remain in the community setting, thereby avoiding residential, inpatient or institutional care. These services include supervision and the provision of behavioral health support services such as personal care (especially prescribed behavioral interventions), psychosocial rehabilitation, skills training and development, transportation of the person to therapy or visitations and/or the participation in treatment and discharge planning. (See HCTC billing limitations below)

Service Standards/Provider Qualifications

Provider of Services to Children
Behavioral health therapeutic homes providing HCTC services to children must meet the following qualifications:

- Be a ADES licensed professional foster care home (A.A.C. R6-5-5850); or
- Be licensed by federally recognized Indian Tribes that attest to CMS (via AHCCCS) that they meet equivalent requirements.

Provider of Services to Adults
Behavioral health therapeutic homes providing HCTC services to adults must meet the following qualifications:

- Be a DLS licensed Behavioral Health Therapeutic Home (9 A.A.C. 10); or
- Be licensed by federally recognized Indian Tribes that attest to CMS (via AHCCCS) that they meet equivalent requirements.

For all providers of HCTC services, prior to providing a service for either an adult or child, the T/RBHAs must ensure that:

a. The behavioral health therapeutic home providers have successfully completed pre-service training in the type of care and services required for the individual being placed in the home.

b. The behavioral health therapeutic home providers have access to crisis intervention and emergency consultation services.

c. A Clinical Supervisor has been assigned to oversee the care provided by the behavioral health therapeutic home provider.

Code Specific Information

HCPCS Codes

- **S5109 HB–Home Care Training to Home Care Client (Adult) – Age 18-64 years**
- **S5109 HC-Home Care Training to Home Care Client (Adult geriatric) – Age 65 years and older**
- **S5109 HA-Home Care Training to Home Care Client (Child) – Age 0-17 years**

Billing Unit: Per Session

Billing Limitations

For HCTC services the following billing limitations apply:

1. Personal care services, skills training and development and home care training family services (family support) are provided by the behavioral health therapeutic home provider and are included in the HCTC rate. Counseling, evaluation, support and rehabilitation services provided to the AHCCCS BEHAVIORAL HEALTH SERVICES member may be billed using the appropriate procedure code.

2. The HCTC procedure code does not include any professional services; therefore, professional services provided should be billed by the appropriate provider using the applicable CPT codes.

3. The HCTC procedure code does not include day program services, this service should be billed by the appropriate provider using the applicable procedure code.

4. Room and board services are to be billed separately. The State-funded HCPCS code for room and board is to be used for all persons except for state-placed children (i.e., ADES or AOC) whose room and board should be paid by the placing agency.

5. A licensed professional who supervises and trains the behavioral health therapeutic home provider may not bill for these functions. Employee supervision and training has been built into the procedure code rate.

6. Pre-training activities associated with the HCTC setting is included in the rate. This service may not be billed outside the HCTC procedure code rate by either the licensed professional or behavioral health therapeutic home provider.

7. Prescription drugs are not included in the rate and should be billed by appropriate providers using the applicable NDC procedure codes.

8. Over-the-counter drugs and non-customized medical supplies are included in the rate and should not be billed separately.

9. Emergency transportation provided to an AHCCCS BEHAVIORAL HEALTH SERVICES member is not included in the rate and should be billed separately by the appropriate provider using the applicable transportation procedure codes.

10. Non-emergency transportation is included in the rate and cannot be billed separately.

11. Any medical services provided to persons, excluding those medical services included in the AHCCCS BEHAVIORAL HEALTH SERVICES covered service array as set forth in this guide should be billed to the member's health plan.

12. HCTC services cannot be encountered/billed on the same day as Unskilled Respite Care (S5151).

13. Based on behavioral health recipient needs, Personal Care Services (T1019), Skills Training and Development (H2014/H2014HQ), Home Care Training Family Services (S5110) and Psychosocial Rehabilitation Services (H2017) may be provided and billed on the same day that HCTC services are furnished. The clinical rationale for providing these additional services must be specifically documented in the Service Plan and Progress Note.

II. D. 6. Unskilled Respite Care

General Information

General Definition

"Respite" means short term behavioral health services or general supervision that provides rest or relief to a family member or other individual caring for the behavioral health recipient. Respite services are designed to provide an interval of rest and/or relief to the family and/or primary care givers and may include a range of activities to meet the social, emotional and physical needs of the behavioral health recipient during the respite period. These services may be provided on a short-term basis (i.e., 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, agency personnel will assess the situation with the caregiver and recommend the appropriate setting for respite.

Licensed programs providing respite must develop and implement policy and procedures demonstrating the following:

- A respite admission does not cause the agency to exceed the licensed capacity identified on the agency's license,
- A behavioral health recipient being admitted for respite meets the admission requirements in 9 A.A.C. 10,
- A behavioral health recipient being admitted for respite receives an assessment and treatment plan for the period of time the person is receiving respite from the agency, and
- A behavioral health recipient's treatment plan addresses how the person will be oriented to and integrated into the daily activities at the agency.

The setting in which respite services are received should be the most conducive to the behavioral health recipient's situation. A behavioral health recipient in need of assistance in the self administration of medication while receiving respite services must be able to get the assistance from a provider meeting the requirements in 9 A.A.C. 10. A behavioral health recipient's clinical team must consider the appropriateness of the setting in which the recipient receives respite services. Safety of the behavioral health recipient and the provider must be considered when the recipient has exhibited behavior requiring an emergency safety response (see 9 A.A.C. 10). When respite services are provided in a home setting, household routines and preferences should be respected and maintained when possible. It is essential that the respite provider receive orientation from the family/caregiver regarding the behavioral health recipient's needs as well as the individual service plan (ISP). At all times the respite provider shall respect and maintain the confidentiality of the family/caregiver.

Respite services, including the goals, setting, frequency, duration and intensity of the service, are defined in the behavioral health recipient's service plan. Respite services are not a substitute for other medically necessary covered services. The treatment team will also explore the availability and use of informal supports and other community resources to meet the caregiver's respite needs.

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.

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

Service Standard/Provider Qualifications

Respite services may be provided in a variety of settings (for licensed providers, this would include settings listed in 9 A.A.C. 10). Each provider type must meet licensing or certification requirements and other local authorities (i.e., county, city, etc.). The type of setting in which respite services are provided must ensure the behavioral health recipient's current service plan can be appropriately supported and services provided are within the respite provider's qualifications and experience.

Licensed providers must meet all applicable qualifications, as described in 9 A.A.C. 10.

Code Specific Information

Revenue Codes

Respite services provided in a DLS licensed Level I 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:** Unskilled respite services (see general definition above) provided to a person for a short period of time (up to 12 hours in duration).

  Billing Unit: 15 minutes

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

  Billing Unit: Per Diem

Billing Limitations

For respite services, the following billing limitations apply:

1. See general core billing limitations in Section I.

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 1st through September 30th) per person. T/RBHAs must ensure the accurate tracking of respite service limitations for their enrolled members.

3. For Behavioral Health Residential facilities providing respite services, room and board may be billed in addition to the per diem rate.

4. Where applicable, travel time by the provider is included in the rates. See core provider travel billing limitations in Section I.

5. 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.

6. Respite services cannot be billed for persons who are residing and receiving treatment in a DLS licensed Level I facility, ADES group home or nursing home.

7. A Community Service Agency cannot provide respite services.

II. D. 7. Supported Housing

General Information

General Definition

Supported housing services are provided to assist individuals or families to obtain and maintain housing in an independent community setting including the person's own home or apartments and homes owned or leased by a subcontracted provider. These services may include rent and utility subsidies, and relocation services to a person or family for the purpose of securing and maintaining housing.

Service Standards/Provider Qualifications

Supported housing services are provided by *behavioral health professionals*, *behavioral health technicians* or *behavioral health paraprofessionals*. Staff providing the services must have knowledge of state and local landlord/tenant laws.

Code Specific Information

State Funded HCPCS Codes:

- **H0043 – Supported Housing**

  Billing Unit: Per Diem

Billing Limitations

For supported housing services the following billing limitations apply:

1. Supported housing services do not include meals, furnishing(s), cost of telephones or telephone usage fees or other household equipment. (See Flex Fund Services). The T/RBHA must monitor to ensure the proper use of this service code.

2. Direct payment for supported housing services to the behavioral health recipient and/or their family are not permitted.

3. Supported housing services must not be used to cover residential treatment facility room and board charges.

II. D. 8. Sign Language or Oral Interpretive Services

General Definition

Sign Language and oral interpretation services are required to be made available to members free of charge; services for all non-English languages and the hearing impaired must be available to potential members, free of charge, when oral information is requested.

Sign language or oral interpretive services are required by Medicaid regulations and as defined in 9 A.A.C. 21 and must be paid for with Title XIX and Title XXI Administrative Capitation Funds or grant funding for services provided with grant funding. Sign language or oral interpretive services are provided to persons and/or their families with limited English proficiency or other communication barriers (e.g., sight or sound) during instructions on how to access services, counseling, and treatment activities that will ensure appropriate delivery of mental health services for individuals.

Service Standards/Provider Qualifications

Oral interpretive services must be provided by: qualified interpreter staff, qualified bilingual staff, contracted qualified interpreters, telephone interpretation services or from a qualified individual provider office, agency, or facility. Sign language services are to be provided by license interpreters for the deaf and the hard of hearing pursuant to A.R.S. § 36-1946.

Code Specific Information

Encounters are to be submitted to AHCCCS BEHAVIORAL HEALTH SERVICES for sign language or oral interpretive services, utilizing the T1013 code requirements as described below.

State Funded HCPCS Codes

- **T1013 –Sign Language or Oral Interpretive Services:** (see general definition above)

  Billing Unit: 15 minutes

Billing Limitations

For interpreter services the following billing limitation applies:

1. The sign language or oral interpretive service code must be billed in combination with a code for a behavioral health service that cannot be delivered effectively without the availability of sign language or interpreter services.

2. For DLS licensed inpatient and residential facilities, sign language or oral interpretive services are included in the per diem rate, however, these services must be documented and encountered separately by the facility with a zero dollar bill value (0.00).

II. D. 9. Non-Medically Necessary Covered Services

General Information

General Definition

Non-medically necessary covered services or "flex funds" refers to funding designated for the uses described in this section. T/RBHAs may access flex funds to purchase any of a variety of one-time or occasional goods and/or services needed for enrolled persons (children or adults) and their families, when the goods and/or services cannot be purchased by any other funding source, and the service or good is directly related to the enrolled person's service plan. Additionally, "flex funds" include the Arizona State Hospital (ASH) Transition Fund, which provides living support and assistance to T/RBHA enrolled adults determined to have a Serious Mental Illness and TXIX/XXI eligible children with serious emotional disturbance who are discharged from the Arizona State Hospital (Civil and Adolescent Units). The funds are intended to promote wellness, comfort and safety for vulnerable children and adults returning to the community in a respectful, individualized manner.

Non-medically necessary covered services and/or supports (flex funds) must be described in the person's service plan, and must be related to one or more of the following outcomes: a.) success in school, work or other occupation; b.) living at the person's own home or with family; c.) development and maintenance of personally satisfying relationships; d.) prevention of or reduction in adverse outcomes; and/or e.) becoming or remaining a stable and productive member of the community.

Program Standards/Provider Qualifications

In consideration with other available resources, the service provider may approve flex fund expenditures as permitted by the T/RBHA.

Code Specific Information

State Funded HCPCS Code:

- **S9986 –Non-Medically Necessary Services (Flex Fund Services)**

Billing Unit: Not applicable

Billing Limitations for "flex funds"

For Non-Medically Necessary Covered Services or "flex funds" the following billing limitations apply:

1. Non-Medically Necessary Covered Services are subject to availability of funds.

2. T/RBHAs shall establish procedures for approval of flex fund expenditures, and may allow approval directly by the treatment team. T/RBHAs shall also establish procedures for maintenance of documentation of flex fund expenditures.

3. AHCCCS BEHAVIORAL HEALTH SERVICES must give its prior approval of requests for flex funds exceeding $1,525 per individual per fiscal year.

4. Non-Medically Necessary Covered Services may not be used to provide inpatient or any other covered medical or behavioral health services. T/RBHAs and their treatment teams must attempt to identify alternative funding/resources prior to approving the expenditure of flex funds. (Examples of alternative funding/resources might include: state, federal or tribal funds; family resources; donations; and community funds).

5. Direct cash payments to the person and/or their family are not permitted.

6. Non-Medically Necessary Covered Services may not be used to: a.) purchase or improve land; b.) purchase, construct or permanently improve any building or other facility; or c.) purchase major medical equipment. Non-Medically Necessary Covered Services may be used to pay for minor remodeling consistent with these guidelines.

7. Flex funds are not intended to be used toward payment of items relating to medical marijuana. This includes application fees or the drug itself.

II. D. 10. Transportation

General Information

General Definition

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. Odometer readings or other T/RBHA approved documentation methods that clearly and accurately support mileage may be used when billing transportation services.

Service Standards/Provider Qualifications

Transportation services may be provided by:

- Non-emergency transportation providers (e.g., vans, buses, taxis) who are registered with AHCCCS as a non-emergency transportation provider and have proof of insurance, drivers with valid driver's licenses and any other insurance as required by state law.
- Emergency transportation providers (e.g., air or ground ambulance) who are registered with AHCCCS as emergency transportation providers and have been granted a certificate of necessity by the AHCCCS Behavioral Health Services/Bureau of Emergency Medical Services (A.R.S. 36-2233).

In most instances, transportation services should be provided by non-emergency transportation providers. Transportation services furnished by a ground or air ambulance provider should be provided in situations in which the person's condition is such that the use of any other method of transportation is contraindicated and medically necessary behavioral health services are not available in the hospital from which the person is being transported.

Emergency transportation service shall not require prior authorization.

Non-emergency transportation must be provided for persons and/or families who are unable to arrange or pay for their transportation or who do not have access to free transportation in order to access medically necessary covered behavioral health services.

Record Keeping for Non-Emergency Transportation Providers

AHCCCS BEHAVIORAL HEALTH SERVICES has added the following guidance based on AHCCCS' established guidelines for documentation of non-emergency transportation services.

1. Complete Service Provider's Name and Address
2. Name and signature of the driver who provided the service
3. Vehicle Identification (car, van, wheelchair van, etc.)
4. Recipient (being transported) name
5. Recipient's AHCCCS ID
6. Complete date of service, including month, day and year
7. Complete address of the pick-up site
8. Complete address of drop off destination
9. Type of trip - round trip or one way
10. Escort (if any) must be identified by name and relationship to the member being transported
11. Signature of recipient, verifying services were rendered

It is the provider's responsibility to maintain documentation that supports each transport provided. Transportation providers put themselves at risk of recoupment of payment IF the required documentation is not maintained or covered services cannot be verified.

Code Specific Information

<u>HCPCS Codes-Emergency Transportation Providers Only</u>

- **A0382 – Basic Life Support (BLS) routine disposable supplies**
- **A0398 – Advanced Life Support (ALS) routine disposable supplies**
- **A0420 – Ambulance waiting time (ALS or BLS), one-half (½) hour increments**
- **A0422 – Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining situation**
- **A0888 – Non-covered ambulance mileage, per mile (e.g., for miles traveled beyond closest appropriate facility)**
- **A0426 – Ambulance service, ALS; non-emergency transport, level 1 (ALS 1)**
- **A0427 – Ambulance service, ALS; emergency transport, level 1 (ALS 1-emergency**

- **A0428 – Ambulance service, BLS base rate, non-emergency transport (BLS)**
- **A0429 – Ambulance service, BLS base rate, emergency transport (BLS-emergency)**
- **A0434 – Specialty Care Transport (SCT) (this code may be used only by TRBHAs)**
- **A0430 – Ambulance service, conventional air services, transport, one-way (fixed wing)**
- **A0431 – Ambulance service, conventional air services, transport, one way (rotary wing)**
- **A0435 – Fixed wing air mileage, per statute mile**
- **A0436 – Rotary wing air mileage, per statute mile**

HCPCS Codes-Non-Emergency Transportation Providers Only

- **A0090* – Non-emergency transportation, per mile - vehicle provided by individual (family member, self, neighbor) with vested interest**

*This code must be used by friends/relatives/neighbors when transporting a client.

- **A0100 – Non-emergency transportation; taxi**
- **A0110 – Non-emergency transportation and bus, intra- interstate carrier (may be used to encounter and/or bill for bus passes)**
- **A0170 –Transportation ancillary; parking fees, tolls, other**
- **A0180 – Non-emergency transport; ancillary: lodging-recipient**
- **A0190 – Non-emergency transport; ancillary: meals-recipient**
- **A0200 – Non-emergency transport; ancillary lodging-escort**
- **A0210 – Non-emergency transport; ancillary meals-escort**
- **A0120* – Non-emergency transportation; mini-bus, mountain area transports or other transportation systems**

*This code may be used for vans or cars.

- **A0120 TN* - Non-emergency transportation; mini-bus, mountain area transports - Rural**

* This code may be used for vans or cars.

- **A0130 – Non-emergency transport; wheel-chair van**
- **A0130 TN – Non-emergency transport; wheel-chair van - Rural**
- **A0140 – Non-emergency transport; and air travel (private or commercial), intra- or interstate**
- **A0160 – Non-emergency transportation per mile-case worker or social worker**
- **T2003 – Non-emergency transportation; encounter/trip**

HCPCS Codes-Emergency and Non-emergency Transportation Providers

- **S0209 – Wheelchair van mileage, per mile**
- **S0209 TN – Wheelchair van mileage, per mile- Rural**
- **S0215 – Non-emergency transportation mileage, per mile**
- **S0215 TN – Non-emergency transportation mileage, per mile - Rural**
- **T2005 – Non-emergency transportation; stretcher van**
- **T2005 TN - Non-emergency transportation; stretcher van – Rural**
- **T2007 – Transportation waiting time, air ambulance and non-emergency vehicle, ½ hour increments**
- **A0425 – Ground mileage, per statute mile**
- **T2049 – Non-emergency transportation; stretcher van, mileage; per mile**
- **T2049 TN - Non-emergency transportation; stretcher van, mileage; per mile – Rural**
- **A0999 – Unlisted ambulance service. Determine if an alternative national HCPCS Level II code or a CPT code better describes the service. This code should be used only if a more specific code is unavailable.**

Billing Limitations

For transportation services the following billing limitations apply:

1. See core transportation billing limitations in Section I.

2. Emergency transportation required to manage an emergency medical condition and includes the transportation of a person to the same or higher level of care for immediate medically necessary treatment at the nearest appropriate facility is covered for AHCCCS members and is the responsibility of the AHCCCS contracted Health Plan.

3. Depending on the setting and the service being provided, certain transportation costs may be included as part of a provider's rate and cannot be billed separately.

4. Like all other non-emergency transportation, A0090 may only be billed if a person and/or family is unable to arrange or pay for their transportation or does not have access to free transportation in order to obtain medically necessary covered behavioral health services.

5. When providing transportation to multiple clients, the provider bills a base rate for each client and the loaded mileage for each person transported. Loaded mileage is the actual number of miles each enrolled person is transported in the vehicle beginning when the enrolled person is picked up and ending when the enrolled person is dropped off.

6. For most transports, the provider should bill the applicable base rate code and the number of loaded miles using the appropriate mileage code. Loaded mileage is the distance traveled while a person and/or family is being transported.

7. The following provider types may bill A0120, S0215, S0215 TN or A0120 TN, when providing crisis intervention – (H2011 HT) or crisis intervention service via two-person team or crisis intervention service (H2011):
   -Level I Hospital (02)
   -Out-of-state, One Time Fee For Service Provider (73)
   -Behavioral Health Outpatient Clinic (77)

8. More than one provider agency may bill for transportation services provided to a behavioral health recipient at the same time if indicated by the person's clinical needs.

9. A provider may bill for transportation services provided to a behavioral health recipient in order to receive a Medicare covered service.

II. E. Crisis Intervention Services

Beginning July 1, 2010, "crisis" is defined as: "A Crisis is when a person presents with a sudden, unanticipated, or potentially dangerous behavioral health condition, episode or behavior." Crisis intervention services are provided to a person for the purpose of stabilizing or preventing a sudden, unanticipated, or potentially dangerous behavioral health condition, episode or behavior. Crisis intervention services are provided in a variety of settings (see places of service below) or over the telephone. These intensive and time limited services may include screening, (e.g., triage and arranging for the provision of additional crisis services) counseling to stabilize the situation, medication stabilization and monitoring, observation and/or follow-up to ensure stabilization, and/or other therapeutic and supportive services to prevent, reduce or eliminate a crisis situation.

T/RBHAs are responsible for providing 72 hours of inpatient emergency behavioral health services to Title XIX/XXI members with psychiatric or substance abuse diagnoses. AHCCCS health plans continue to be responsible for all emergency medical services including triage, physician assessment and diagnostic tests. T/RBHAs will continue to be responsible for medically necessary psychiatric consultations provided to Title XIX/XXI members in emergency room settings.

Many types of services throughout this Covered Behavioral Health Services Guide may be billed when providing crisis intervention services (e.g. screening, counseling and therapy, case management). All services billed/encountered as crisis must be identified by entering the emergency indicators. This section describes codes for additional crisis intervention services.

CPT Codes:

CODE	DESCRIPTION-Crisis Services
99281	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: a problem-focused history; a problem-focused examination; and straightforward medical decision-making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor.
99282	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: an expanded problem-focused history; an expanded problem-focused examination; and medical decision-making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or

	family's needs. Usually, the presenting problem(s) are of low to moderate severity.
99283	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: an expanded problem-focused history; an expanded problem-focused examination; and medical decision-making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) are of moderate severity.
99284	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: a detailed history; a detailed examination; and medical decision-making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.
99285	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status; a comprehensive history; a comprehensive examination; and medical decision- making of high complexity. Usually the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.

II. E. 1. Crisis Intervention Services (Mobile, Community Based)

General Information

General Definition

Crisis intervention services are provided by a mobile team or individual who travels to the place where the person is having the crisis (e.g., person's place of residence, emergency room, jail, community setting). Crisis intervention services include services aimed at the assessment and immediate stabilization of acute symptoms of mental illness, alcohol and other drug abuse, and emotional distress. The purpose of this service is to:

- Stabilize acute psychiatric or behavioral symptoms;
- Evaluate treatment needs; and
- Develop plans to meet the needs of the persons served.

Depending on the situation, the person may be transported to a more appropriate facility for further care (e.g., a crisis services center).

Service Standards/Provider Qualifications

Crisis intervention services must be provided by DLS licensed agencies.

If a two-person team responds, one person may be a Behavioral Health Paraprofessional, including a peer or family member, provided he/she has supervision and training as currently required for all mobile team members.

In some situations (e.g., the safety of staff and control of the environment are not primary concerns, such as in hospitals, schools, residential settings) it may only be necessary to send a single individual out to intervene, however that individual must be a behavioral health professional or a behavioral health technician. Depending on the acuity of the person, the crisis intervention services may be provided by either a qualified behavioral health professional or behavioral health technician.

All individuals providing this service must at a minimum have been trained in first aid, Cardiopulmonary Resuscitation (CPR) and non-violent crisis resolution. Additionally, individuals must have valid Arizona driver licenses and vehicles used must be insured as required by Arizona law.

The T/RBHA or applicable provider agency must ensure that:

- Individuals providing this service have a means of communication, such as a cellular phone, pager, or radio for dispatch, that is available at all times.
- On-call behavioral health professionals are available 24 hours a day for direct consultation.

- If transporting persons, the requirements specified in 9 A.A.C. 10 (outings and transportation) are met.

Code Specific Information

HCPCS Codes

- **H2011 HT – Crisis Intervention Service – multi-disciplinary team:** See general definition above.

  Billing Unit: 15 minutes

- **H2011 – Crisis Intervention Service, per 15 minutes –** See general definition above.

  Billing Unit: 15 minutes

Billing Limitations

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

1. See general core billing limitations in Section I.

2. Billing for this service should not include mobile crisis response services provided by fire, police, EMS, and other providers of public health and safety services.

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.

II. E. 2. Crisis Intervention Services (Stabilization, facility based)

General Information

General Definition

Crisis intervention services (stabilization) is an immediate and unscheduled behavioral health service provided: (a) In response to an individual's behavioral health issue to prevent imminent harm, to stabilize or resolve an acute behavioral health issue; and (b) At an inpatient facility or outpatient treatment center (Provider Type IC) in accordance with 9 A.A.C. 10. Persons may walk-in or be referred/transported to these settings.

Provider Standards/Service Standards

Crisis intervention services (stabilization) must be provided by facilities that are DLS licensed facilities (excluding behavioral health residential facilities). Individuals providing these services must be *behavioral health professionals, behavioral health technicians or behavioral health para-professionals* as defined in 9 A.A.C. 10.

Laboratory, radiology and psychotropic medications may be provided by an AHCCCS registered provider if prescribed by a qualified practitioner.

Code Specific Information

HCPCS Codes

- **S9484 – Crisis Intervention Mental Health Services – (Stabilization)** See definition above. Up to 5 hours in duration.

  Billing Unit: One hour

- **S9485 – Crisis Intervention Mental Health Services – (Stabilization)** See definition above. More than 5 hours and up to 24 hours in duration.

  Billing Unit: Per Diem

Billing Limitations

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

1. See general core billing limitations in Section I.

2. Crisis intervention services are limited to up to 24 hours per episode. After 24 hours the person, depending on their discharge plan, must be transferred and/or admitted to a more appropriate setting for further treatment (e.g., inpatient hospital, subacute facility, respite, etc.) or sent home with arrangements made for follow-up services, if needed (e.g., prescription for follow-up medications, in-home stabilization services).

3. 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.

4. 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.

5. Meals are included in the rate and should not be billed separately.

6. Transportation services are not included in the rate and should be billed separately using the appropriate transportation procedure codes.

7. Laboratory and radiology services are not included in the rate and should be billed separately.

8. Medications are not included in the rate and should be billed separately.

II. E. 3. Crisis Intervention (Telephone)

General Information

General Definition

Crisis intervention (telephone) services provide triage, referral and telephone-based support to persons in crisis; often providing the first place of access to the behavioral health system. The service may also include a follow-up call to ensure the person is stabilized.

Service Standards/Provider Qualifications

The personnel for the crisis phone must include, at a minimum, behavioral health technicians supervised by a behavioral health professional. These individuals must be able to quickly assess the needs of the caller. While some situations may be resolved on the telephone, other situations may require face-to-face intervention in which case the telephone personnel must be able to ensure the provision of the most appropriate intervention (e.g., call 911, dispatch mobile team, referral to crisis intervention services).

Billing Information

When a behavioral health provider provides crisis telephone services to an enrolled person, the provider should bill the appropriate case management service code.

II. F. Inpatient Services

Inpatient services (including room and board) are provided by a DLS licensed Level I behavioral health agency and include the following subcategories:

- Hospitals
- Subacute Facilities
- Residential Treatment Centers (RTC)

These facilities provide a structured treatment setting with 24 hour supervision and an intensive treatment program, including medical support services.

Service Standards/Provider Qualifications

Inpatient services may only be provided by DLS licensed behavioral health agencies that meet the general Level I licensure requirements set forth in 9 A.A.C. 10. In addition, depending on the type of services being provided, the facility may need to meet supplemental requirements as set forth in the licensing rules.

Institution for Mental Diseases (IMD)

Except for general hospitals with distinct units (Provider Type 02), all other Level I facilities with more than 16 beds (Provider Types 71, B1, B3 and B6) are considered under Title XIX/XXI to be Institutions for Mental Diseases (IMDs). An IMD is defined under 42 CFR 435.1010 as an institution with more than 16 beds that are primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and other related services.

Code Specific Information

CPT Codes

Services provided in hospitals are inclusive of all services, supplies, accommodations, staffing, and equipment. T/RBHAs are responsible for the payment of behavioral health professional services, such as psychiatric consultations, provided in an inpatient setting (regardless of the bed or floor where the patient is located).

CODE	DESCRIPTION-Inpatient Services (Professional)
99217	Observation care discharge day management (this code is to be utilized by the physician to report all services provided to a patient on discharge from “observation status” if the discharge is on other than the initial date of “observation status”). To report services to a patient designated as “observation status” or “inpatient status” and discharge on the same date, use the code for Observation or Inpatient care

services (including Admission and Discharge services, 99234-99236 as appropriate).

99218	Initial observation care, per day, for the evaluation and management of a patient which requires these 3 key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to "observation status" are of low severity. Physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit.
99219	Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to "observation status" are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit.
99220	Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to "observation status" are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit.
99221	Initial hospital care, per day, for the evaluation and management of a patient which requires these 3 key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision-making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit.
99222	Initial hospital care, per day, for the evaluation and management of a

patient which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision-making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit.

99223 Initial hospital care, per day, for the evaluation and management of a patient which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision-making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit.

99231 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a problem-focused interval history; a problem-focused examination; medical decision-making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Physicians typically spend 15 minutes at the bedside and on the patient's hospital floor or unit.

99232 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: an expanded problem-focused interval history; an expanded problem-focused examination; medical decision-making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's hospital floor or unit.

99233 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a detailed interval history; a detailed examination; medical decision-making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the

	nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit.
99234	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these 3 key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision-making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of low severity.
99235	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical-decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of moderate severity.
99236	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these 3 key components: a comprehensive history; comprehensive examination; and medical-decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of high severity.
99238	Hospital discharge day management; 30 minutes or less.
99239	Hospital discharge day management; more than 30 minutes.
99251	Inpatient consultation for a new or established patient, which requires these 3 key components: a problem-focused history; a problem-focused examination; and straightforward medical decision-making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 20 minutes at the bedside and on the patient's hospital floor or unit.

99252	Inpatient consultation for a new or established patient, which requires these 3 key components: an expanded problem-focused history; an expanded problem-focused examination; and straightforward medical decision-making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 40 minutes at the bedside and on the patient's hospital floor or unit.
99253	Inpatient consultation for a new or established patient, which requires these 3 key components: a detailed history; a detailed examination; and medical decision-making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 55 minutes at the bedside and on the patient's hospital floor or unit.
99254	Inpatient consultation for a new or established patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision-making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 80 minutes at the bedside and on the patient's hospital floor or unit.
99255	Inpatient consultation for a new or established patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision-making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 110 minutes at the bedside and on the patient's hospital floor or unit.
99307	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a problem focused interval history; a problem focused examination; straightforward medical decision-making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Physicians typically spend 10 minutes at the bedside and

on the patient's facility floor or unit.

99308	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: an expanded problem focused interval history; an expanded problem focused examination; medical decision-making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 15 minutes at the bedside and on the patient's facility floor or unit.
99309	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a detailed interval history; a detailed examination; medical decision-making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient has developed a significant complication or a significant new problem. Physicians typically spend 25 minutes at the bedside and on the patient's facility floor or unit.
99310	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a comprehensive interval history; a comprehensive examination; medical decision-making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 35 minutes at the bedside and on the patient's facility floor or unit.
99356	Prolonged physician service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; first hour (list separately in addition to code for inpatient evaluation and management service)
99357	Prolonged physician service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; each additional 30 minutes (list separately in addition to code for prolonged physician service-99356)

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.

II. F. 1. Hospital

General Information

General Definition

Provides 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. Also includes 24 hour nursing supervision and physicians on site and on call.

The Contractor's responsibility for payment of behavioral health services includes per diem claims for inpatient hospital services, when the principal diagnosis on the hospital claim is a behavioral health diagnosis. The hospital claim, which may include both behavioral health and physical health services, 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. For more detailed information about Contractor payment responsibility for physical health services that may be provided to members who are also receiving behavioral health services refer to ACOM Policy 432.

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 DLS if providing treatment to clients under the age of 21; and
- Meets the requirements of 42 CFR 440.10 and Part 482 and is licensed pursuant to A.R.S. 36, Chapter 4, Articles 1 and 2 and 9 A.A.C. 10; 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 Office of Medical Facility Licensing and DLS to meet such requirements.

If seclusion and restraint is provided, then the facilities must meet the requirements set forth in 9 A.A.C. 10.

Code Specific Information

Revenue Codes:

Hospitals may bill 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
0110 – Room and board - private
0111 – Medical-Surgical-Gyn - private
0112 – OB - private
0113 – Pediatrics - private
0120 – Room and board - semi-private 2 beds
0121 – Medical-Surgical-Gyn - 2 beds
0122 – OB - 2 beds
0123 – Pediatrics - 2 beds
0130 – Room and board - Semi private 3 and 4 beds
0131 – Medical-Surgical-Gyn - 3 and 4 beds
0132 – OB - 3 and 4 beds
0133 – Pediatrics - 3 and 4 beds
0150 – Room and board - ward
0151 – Medical-Surgical-Gyn - ward
0152 – OB - ward
0153 – Pediatrics - ward
0160 – Room and board -general
0200 – Intensive Care
0201 – Intensive Care Unit - surgical
0202 – Intensive Care Unit - medical
0203 – Intensive Care Unit – pediatrics
0206 – Intensive Care Unit - intermediate
0209 – Intensive Care Unit - other
0210 – Coronary Care
0115 – Hospice private
0117 – Oncology private
0118 – Rehab private
0119 – Other private
0125 – Hospice 2 beds
0127 – Oncology 2 beds
0128 – Rehab 2 beds
0129 – Other 2 beds
0135 – Hospice 3 & 4 beds
0137 – Oncology 3 & 4 beds
0138 – Other 3 & 4 beds
0139 – Other 3 & 4 beds
0155 – Hospice ward
0157 – Oncology ward
0158 – Rehab ward
0159 – Other ward
0164 – R & B sterile

0167 – R & B self
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

Billing Provider Type:
Level I Hospital (02)
Level I Psychiatric Hospital (IMD) (71)

Billing Unit: Per Diem

A Level I Psychiatric Hospital (71) may bill for bed hold or home pass days. Level I Hospital (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:

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

0183 – Home pass

Billing Provider Type:
Level I Hospital (02)
Level I Psychiatric Hospital (IMD) (71)

Billing Unit: Per Diem

0189 – Bed hold

Billing Provider Type:
Level I Psychiatric Hospital (IMD) (71)

Billing Unit: Per Diem

Billing Limitations

1. Non-emergency travel for a person in a hospital/psychiatric hospital is included in the rate and should not be billed separately.

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. Medical 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. Medication 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 Level I hospital, (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 from the T/RBHA, the member is medically stable, and there is a principal mental health or

substance abuse diagnosis on the claim. The T/RBHA is only responsible for the inpatient stay while the member is primarily receiving psychiatric treatment.

II. F. 2. Subacute Facility

General Information

General Definition

Continuous treatment 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.

Service Standards/Provider Qualifications:

Subacute facilities must be accredited by The Joint Commission, COA, or CARF and licensed by DLS as a Level I facility meeting the specific requirements of 9 A.A.C. 10. Additionally, the facilities must meet the requirements set forth in 9 A.A.C. 10 for seclusion and restraint if the facility has been authorized by DLS to provide seclusion and restraint.

Code Specific Information

Revenue Codes:

Level I subacute facilities may bill 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

Billing Provider Type:
Level I Subacute Facility (non-IMD) (B5)
Level I Subacute Facility (IMD) (B6)

Billing Unit: Per Diem

Billing Limitations

1. See general core billing limitations in Section I.

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 T/RBHA.

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.

II. F. 3. Residential Treatment Center

General Information

General Definition:

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. There are two types of residential treatment centers:

Secure - a residential treatment center which generally employs security guards and uses monitoring equipment and alarms.

Non-secure – an unlocked residential treatment center setting.

Service Standards/Provider Qualifications:

Residential treatment facilities must be accredited by an accrediting body approved by CMS and licensed by DLS as a Level I facility meeting the specific requirements of 9 A.A.C. 10. Additionally, the facility must meet the requirements for seclusion and restraint set forth in 9 A.A.C. 10 and in accordance with 42 CFR 441 and 483 if the facility has been authorized by DLS to provide seclusion and restraint.

Code Specific Information

Revenue Codes:

For inpatient stays the residential treatment center may bill 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

Billing Provider Type:
Level I Residential Treatment Center – Secure (non-IMD) (78)
Level I Residential Treatment Center – Secure (IMD) (B1)
Level I Residential Treatment Center – Non-Secure (non-IMD) (B2)
Level I Residential Treatment Center – Non-Secure (IMD) (B3)

Billing Unit: Per Diem

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 1st through June 30th). The following revenue codes must be used to bill for bed hold or home pass days:

0183 – home pass
0189 – bed hold

Billing Provider Type:
Level I Residential Treatment Center – Secure (non-IMD) (78)
Level I Residential Treatment Center – Secure (IMD) (B1)
Level I Residential Treatment Center - Non-Secure (non-IMD) (B2)
Level I Residential Treatment Center – Non-Secure (IMD) (B3)

Billing Unit: Per Diem

Billing Limitations:

1. See general core billing limitations in Section I.

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.

II. G. Behavioral Health Residential Services

Residential services are provided on a 24 hour basis.

II. G. 1. Behavioral Health Residential Facility, Without Room and Board

General Information

General Definition

Residential services are provided by a licensed behavioral health agency. These agencies provide a structured treatment setting with 24 hour supervision and counseling or other therapeutic activities for persons who do not require on-site medical services, under the supervision of an on-site or on-call behavioral health professional.

RBHAs must clearly set forth in provider subcontracts the type of services which are to be provided as part of the residential program, type of persons to be served, expected program outcomes, services included in the rate and those that can be billed outside the rate and documentation requirements.

These services may only be provided by DLS licensed behavioral health agencies that meet the general licensure requirements set forth in 9 A.A.C. 10.

Room and board is not covered by Title XIX/XXI for persons residing in behavioral health residential facilities. (See service description on room and board.)

Code Specific Information

HCPCS Codes

- **H0018– Behavioral Health Short-Term Residential, without room and board:** Personal Care is included in the rate for this service. See general definition above.

Billing Unit: Per Diem

II. G. 2. Mental Health Services NOS (Room and Board)

General Information

General Definition

Room and board means provision of lodging and meals to a person residing in a residential facility or supported independent living setting which may include but is not limited to: services such as food and food preparation, personal laundry, and housekeeping. This code may also be encountered to report bed hold/home pass days in Behavioral Health Residential facilities.

Service Standards/Provider Qualifications

The provider must meet the following requirements:

- Provide safe and healthy living arrangements that meet the needs of the person and
- Provide or ensure the nutritional maintenance for the resident.

Code Specific Information

State Funded HCPCS Codes

- **H0046 SE – Mental Health Services NOS (Room and Board):** See general definition above.

  Billing Unit: Per Diem

Billing Limitations

For room and board services, the following billing limitations apply:

All other fund sources (e.g., ADES funds for foster care children, SSI) must be exhausted prior to billing this service. Outpatient Clinics may bill the Room and Board code only when providing services to persons in Supervised Independent Living settings.

II. H. Behavioral Health Day Programs

Behavioral health day program services are 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.

Based on the level/type of staffing, day programs are grouped into the following three subcategories:

- Supervised
- Therapeutic
- Psychiatric/Medical

RBHAs must clearly set forth in provider contracts the type of services which are to be provided as part of the behavioral health day program, type of persons to be served, expected program outcomes, documentation requirements and services included in the rate and services that are billed outside the rate.

II. H. 1. Supervised Behavioral Health Treatment and Day Programs

General Information

General Definition

A regularly scheduled program of individual, group and/or family activities/services related to the enrolled person'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, ongoing support to maintain employment, and self-help/peer services.

Service Standards/Provider Qualifications

Supervised behavioral health treatment and day programs may be provided by either DLS licensed behavioral health agencies or Title XIX certified Community Service Agencies. The individual staff that deliver specific services within the supervised behavioral health treatment and day programs must meet the individual provider qualifications associated with those services. Supervised behavioral health treatment and day programs provided by non-DLS licensed community service agencies must be supervised by a behavioral health technician or behavioral health para-professional.

Code Specific Information

HCPCS Codes

- **H2012 –-Behavioral Health Day Treatment (Supervised):** See general definition above. Per hour, up to 5 hours in duration.

  Billing Unit: Per hour

- **H2015 – Comprehensive Community Support Services (Supervised Day Program):** See general definition above. Greater than 5 hours, up to 10 hours in duration.

  Billing Unit: Per 15 minutes

Billing Limitations

For supervised day programs and treatment, the following billing limitations apply:

1. See general core billing limitations in Section I.

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.

II. H. 2. Therapeutic Behavioral Health Services and Day Programs

General Definition

A 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, ongoing support to maintain employment, home care training family (family support), medication monitoring, case management, self-help/peer services, and/or medical monitoring.

Service Standards/Provider Qualifications

Therapeutic behavioral health services and day programs must be provided by an appropriately licensed DLS behavioral health agency and in accordance with applicable service requirements set forth in 9 A.A.C. 10. These programs must be under the direction of a behavioral health professional. The staff who deliver the specific services within the therapeutic day program must meet the individual provider qualifications associated with those services.

Code Specific Information

HCPCS Codes

- **H2019 – Therapeutic Behavioral Services:** See general definition above. Up to 5 ¾ hours in duration.

  Billing Unit: 15 minutes

- **H2019 TF – Therapeutic Behavioral Services:** See general definition above. Up to 5 ¾ hours in duration. ****TF modifier required for intermediate level of care.**** The TF modifier is used to allow RBHAs to contract for an intermediate level of services (e.g., clients needing more intensive supervision, a sitter and/or 1:1 staffing).

  Billing Unit: 15 minutes

- **H2020 – Therapeutic Behavioral Services:** See general definition above.

  Billing Unit: Per Diem

Billing Limitations

For therapeutic behavioral health services and day programs, the following billing limitations apply:

1. See general core billing limitations in Section I.

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. 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.

II. H. 3. Community Psychiatric Supportive Treatment and Medical Day Programs

General Definition

A regularly scheduled program of active treatment modalities, including medical interventions, in a group setting. 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, home care training family (family support), and/or other nursing services such as medication monitoring, methadone administration, and medical/nursing assessments.

Service Standards/Provider Qualifications

Community psychiatric supportive treatment and medical day programs must be provided by an appropriately licensed DLS behavioral health agency and in accordance with applicable service requirements set forth in 9 A.A.C.10. These programs must be under the direction of a licensed physician, nurse practitioner, or physician assistant. The staff who deliver the specific services within the supervised day programs must meet the individual provider qualifications associated with those services.

Code Specific Information

HCPCS Codes

- **H0036– Community Psychiatric Supportive Treatment, face-to-face:** See general definition above.

  Billing Unit: 15 minutes

- **H0036 TF– Community Psychiatric Supportive Treatment, face-to-face:** See general definition above. ****TF modifier required for intermediate level of care.**** The TF modifier is used to allow RBHAs to contract for an intermediate level of services (e.g., clients needing more intensive supervision, a sitter and/or 1:1 staffing).

  Billing Unit: 15 minutes

- **H0036 TF –Community Psychiatric Supportive Treatment, face-to-face (Home):** See general definition above. ****TF modifier required for intermediate level of care.**** The TF modifier is used to allow RBHAs to contract for an intermediate level of services (e.g., clients needing more intensive supervision, a sitter and/or 1:1 staffing).

Billing Unit: 15 minutes

- **H0037– Community Psychiatric Supportive Treatment Program**: See general definition above.

  Billing Unit: Per Diem

Billing Limitations

For community psychiatric supportive treatment and medical day programs, the following billing limitations apply:

1. See general core billing limitations in Section I.

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.

II. I. Prevention Services

General Information

General Definition

Prevention services promote the health of persons, families, and communities through education, engagement, service provision and outreach. These services may involve:

-Implementation of strategic interventions to reduce the risk of development of emergence of behavioral health disorders, increase resilience and/or promote and improve the overall behavioral health status in targeted communities and among individuals and families;

-Education to the general public on improving their mental health and to general health care providers and other related professionals on recognizing and preventing behavioral health disorders and conditions;

-Identification and referral of persons and families who could benefit from behavioral health treatment services.

Prevention services should target conditions identified in research related to the on-set of behavioral health problems and be provided based on identified risk factors, the extent that the problem occurs in the community or target group, identified community needs and service gaps within each T/RBHA area. Prevention services should target communities, neighborhoods, and audiences who are at elevated risk for developing behavioral health disorders.

These services are generally provided in a group setting or public forum and are intended to target individuals and families who are not enrolled or involved in the AHCCCS BEHAVIORAL HEALTH SERVICES treatment system and who do not have a diagnosable behavioral health disorder or condition. Prevention services are not intended for individuals and family members requiring treatment interventions or for family members of an enrolled member.

Strategy Specific Information

The following strategies shall be used for services described in this section.

-Public Information on Substance Abuse and Mental Health: Public presentations of electronic, verbal and printed promotional material on preventable substance abuse and mental health disorders.

-Prevention Training to Professionals: Training provided to behavioral health or other prevention professionals on prevention concepts, strategies and activities with the purpose of enhancing the preventionist's skills, thereby improving the quality of prevention programs. May include training of trainers or professional seminars, and must include goals and objectives based on a training needs assessment.

-Community Education: Sequential educational sessions provided to a targeted group to promote change in unhealthful attitudes and behaviors.

-Parent/Family Education: Sequential educational sessions provided to parents and their family members to improve parenting skills and to promote healthy family functioning.

-Community Activities for At Risk Populations: Supervised alternative leisure/free time activities to enrich community opportunities for youth, families and adults at risk for the emergence or development of behavioral health disorders.

-Community Mobilization: Assistance to communities in the development of local solutions and community plans to address community conditions and behavioral health issues, in accordance with an approved community needs assessment. Also includes development of partnerships, assistance with planning, identification of needs, resources and strategies and ongoing training and technical assistance.

-Life Skills Development: Sequential educational sessions that assist individuals in developing or improving critical life skills, such as decision-making, coping with stress, values awareness, resistance skills, problem solving and conflict resolution.

-Peer Leadership Skills: Leadership skills development through the pairing of trained and supervised peers with others. Must have curriculum; may include a variety of activities designed to reinforce leadership capabilities.

-Mentorship: Use of role models to provide support and guidance to youth and adults at risk for the development or emergence of behavioral health disorders, through the establishment and maintenance of positive personal relationships.

Service Standards and Provider Qualifications

Prevention services may be provided by a variety of qualified prevention professionals, including but not limited to behavioral health technicians, behavioral health para-professionals, public health specialists, and educators. These individuals must have documented training in prevention theory and practice and demonstrate qualifications for the specific strategy and service delivered.

Billing Limitations

Reimbursement for these services is restricted to monies available to the state from the Federal Substance Abuse Prevention and Treatment Block Grant (SAPT) and other applicable state-funded appropriations and must be provided in accordance with limitations set forth by the applicable funding source. Prevention programs and services shall comply with AHCCCS BEHAVIORAL HEALTH SERVICES guidelines as described in the Prevention Framework for Behavioral Health.

Reimbursement

Prevention services are contracted through a Tribal or Regional Behavioral Health Authority. Contracts for prevention services shall specify the scope of work to be performed, duration and prevention strategy to be delivered, number of participants to be served, evaluation methods to be used, specific reporting requirements and method and amount of payment for satisfactory completion of services, among other provisions. Encounters are not submitted for prevention services.

B. Appendices

A. Billing for Behavioral Health Services: his and 638 Tribal Factsheets

A.1 Memorandum
https://www.azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/AppendixA1.pdf

A.2 638 Billing Matrix

https://www.azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/AppendixA2.pdf

A.3 PowerPoint

https://www.azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/AppendixA3.pdf

A.4 Case Management Billing Guidelines

https://www.azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/AppendixA4.pdf

B. Reference Tables

B-1. Reserved

https://www.azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/AppendixB1.pdf

B-2. AHCCCS BEHAVIORAL HEALTH SERVICES Allowable Procedure Code Matrix

https://www.azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/AppendixB2.xlsx

B-3. Encounter/Claims Principle Behavioral Health ICD-9 Diagnostic Codes

(COVER SERVICES PRIOR TO 09/30/2015)

https://www.azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/AppendixB3.pdf

B-4. eEncounters/Claims Principle Behavioral Health ICD-10 Diagnosis Codes. *(COVERED SERVICES EFFECTIVE 10/01/2015)*

https://www.azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/B-4-ICD-10-DIAGNOSIS-CODE-EFF-10-1-15.xlsx

B-5. Billing Limitations Matrix

https://www.azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/AppendixB5.pdf