REVISION DATE: 2/11/2023; 10/1/2021: ; 7/14/2020; 7/8/2020; 12/7/2018; 7/31/2018; 2/16/2018; 1/17/2018; 12/29/2017; 10/01/2016; 10/01/2015

Behavioral Health Services

The covered services, limitations, and exclusions described are global in nature and are listed in this chapter to offer general guidance to providers. Specific information regarding covered services, limitations, and exclusions can be found in the AHCCCS Medical Policy Manual (AMPM), AHCCCS Administrative Code A.A.C. R9-28-201 et seq., and R9-22-201 et seq. The AHCCCS Medical Policy Manual (AMPM) is available on the AHCCCS website at: http://www.azahcccs.gov/

This policy applies to Indian Health Services (IHS) or Tribal owned and/or operated facilities (638), for the purpose of benefit coordination and determining financial responsibility for AHCCCS covered behavioral health services provided to Fee-For-Service members.

AHCCCS covered behavioral health services include, but are not limited to:

- Inpatient hospital services
- Behavioral Health Inpatient Facilities (BHIF)
- Behavioral Health Residential Facilities (BHRF)
- Partial care (supervised day program, therapeutic day program, medical day program)
- Individual therapy and counseling
- Group and/or family therapy and counseling
- Emergency/crisis behavioral health services
- Behavior management (behavioral health personal assistance, family support, peer support)
- Evaluation and diagnosis
- Psychotropic medication, including adjustment and monitoring of medication
- Psychosocial Rehabilitation (living skills training; health promotion; pre-job training, education and development; job coaching; and employment support)
- Laboratory and Radiology Services for medication regulation and diagnosis
- Screening

- Case Management Services
- Emergency Transportation
- Non-Emergency Transportation
- Respite Care (with limitations)
- Therapeutic foster care services

Members Enrolled in an Integrated Health Plan for Physical and Behavioral Health Services

On October 1, 2018, AHCCCS integrated acute physical and behavioral health services for most members. This is referred to as AHCCCS Complete Care (ACC).

Title XIX and Title XXI (KidsCare) members are eligible to receive behavioral health services through their integrated health plan. American Indian/Alaskan Native (AI/AN) members may choose either the American Indian Health Program (AIHP); AIHP and a Tribal Regional Behavioral Health Authority (TRBHA), if a TRBHA is available in their area; or an AHCCCS Complete Care (ACC) Health Plan.

AIHP is an integrated Fee-For-Service (FFS) program administered by AHCCCS for eligible American Indians, which reimburses for both physical and behavioral health services, including Children's Rehabilitative Services (CRS), provided by and through the Indian Health Services (IHS), tribal health programs operated under 638, or any other AHCCCS registered provider.

AI/AN members who enroll with AIHP for their physical health services also receive their behavioral health services through AIHP, or may choose to receive their behavioral health services through a TRBHA, if a TRBHA is available in their area.

The ACC plan, AIHP or AIHP/TRBHA is responsible for the payment of *both* physical and behavioral health services, including CRS services. (For exceptions, see Benefit Coordination for Members Enrolled with Different Entities for Physical and Behavioral Health Services, below.)

Claims for *both* physical and behavioral health services, including CRS services, should be sent to the member's integrated health plan*. Integrated health plans include:

- ACC health plans,
- AIHP, and
- AIHP/TRBHA.

Claims for AIHP and TRBHA members should be sent to AHCCCS DFSM.

***** Claims for services provided for Title XIX members through IHS or Tribal 638 facilities should be sent to AHCCCS DFSM.

Claims for services provided for Title XXI (Kidscare) members through IHS/638 facilities should be sent to the enrolled ACC plan, or to AHCCCS DFSM for AIHP enrolled members.

ALTCS/Tribal ALTCS EPD

MCO ALTCS and Tribal ALTCS Elderly and Physically Disabled (EPD) plans are integrated long term care services plans that reimburse for both physical and behavioral health services, including CRS services.

Tribal ALTCS Programs provide case management services to American Indians who reside on reservation. Members enrolled with Tribal ALTCS Programs may receive behavioral health services on a Fee-For-Service basis from any AHCCCS registered Fee-For-Service provider, with prior authorization from the tribal case manager.

Claims for Tribal ALTCS members should be sent to AHCCCS DFSM.

Additional information on behavioral health services for Tribal ALTCS members can be found in AMPM 1620-G, Behavioral Health Standards.

Benefit Coordination for Members Enrolled with Different Entities for Physical and Behavioral Health Services

This section assists Fee-for-Service providers in benefit coordination and in determining financial responsibility for AHCCCS covered physical and behavioral health services for members enrolled with **different entities** for their physical and behavioral health services. These members include:

- ALTCS members enrolled with DES/DDD;
- Foster care children enrolled with the Comprehensive Medical Dental Program (CMDP); and
- Adults with a Serious Mental Illness (SMI) designation.

Behavioral Health services for the above members are provided through the RBHAs or TRBHAs.

For the above members enrolled with different entities for their physical and behavioral health services, payment is determined by the principal diagnosis appearing on the claim, except in limited circumstances as described in ACOM Policy 432, Attachment A - Matrix of

Financial Responsibility.

Definitions

For definitions regarding behavioral health services and practitioners, please see AMPM 310-B, Behavioral Health Service Benefit.

Behavioral health diagnoses can be located in the AHCCCS Outpatient Behavioral Health Diagnosis List available on the AHCCCS website.

Behavioral Health Entity
For members enrolled with different entities for their physical and behavioral health services, the Behavioral Health Entity is the entity which provides behavioral health services.

Behavioral Health Entities can be one of the following:

- Regional Behavioral Health Authority (RBHA);
- Tribal Regional Behavioral Health Authority (TRBHA)

Enrolled Health Plan
For members enrolled with different entities for their physical and behavioral health services, the Enrolled Health Plan is the entity which provides physical health services.

- For members who elect AIHP, the enrolled health plan is AIHP. This includes AIHP members with or without a CRS designation.
- For members who elect an ACC plan, the enrolled health plan is the ACC plan.
- For members enrolled in DDD, the enrolled health plan is DDD. This includes DDD members with or without a CRS designation.
- For members enrolled in CMDP, the enrolled health plan is CMDP. This includes CMDP members with or without a CRS designation.
- For members with an SMI designation who elect a TRBHA or non-integrated RBHA for behavioral health services, the enrolled health plan is the elected ACC plan or AIHP.
- For members receiving all services from Tribal ALTCS, including acute services and behavioral health services, the enrolled health plan is Tribal ALTCS.

Medication Assisted Treatment (MAT)
The use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders. A combination of medication and behavioral therapies is effective in the treatment of substance use disorders, and can help some people to sustain recovery.

Principal Diagnosis

The condition established after study to be chiefly responsible for occasioning the admission or care for the member, as indicated by the principal diagnosis on a UB-04 claim form from a facility or the first-listed diagnosis on a CMS 1500 claim form.

The principal diagnosis should not be confused with the admitting diagnosis or any other diagnosis on the claim. Neither the admitting diagnosis nor any other diagnoses on the claim should be used in the assignment of payment responsibility.

Payment Responsibility for Members Enrolled with Different Entities for their Physical and Behavioral Health Services

Payment for AHCCCS covered services for members enrolled with different entities for their physical and behavioral health services is determined by the principal diagnosis appearing on the claim, except in limited circumstances. Benefit coordination and financial responsibilities for AHCCCS covered behavioral health services can be found in the AHCCCS Contractor Operations Manual (ACOM) Policy 432, Attachment A, Matrix of Financial Responsibility. ACOM is available online at:

https://www.azahcccs.gov/shared/ACOM/

For further information on requirements for providers in determining payment responsibility and a member's eligibility, please refer to AMPM Chapter 650, Behavioral Health Provider Requirements for Assisting Individuals with Eligibility Verification and Screening/Application for Public Health Benefits.

Inpatient Facility Payment Responsibility

Facility Claims

1. The claim requires an admitting and principal diagnosis. Claims come to the AHCCCS Administration and are reimbursed at the AIR.

Professional Claims

The Inpatient AIR does not include professional fees.

1. Payment responsibility for professional services associated with an inpatient stay is determined by the principal diagnosis on the professional claim.

   For members enrolled with a TRBHA or RBHA, the AHCCCS Fee-For-Service Administration or RBHA is responsible for payment of behavioral health professional services, such as psychiatric consults.

   Case management is billable as a behavioral health service professional claim, and must be billed on a 1500 claim form.

2. Payment responsibility for the inpatient facility claim and payment responsibility for the associated professional services is not necessarily the same entity.

3. Payment of the professional claim shall not be denied by the responsible entity due to lack of authorization/notification of the inpatient stay regardless of the entity that authorized the inpatient stay.

Emergency Department Payment Responsibility

Facility Claims

1. Payment for an emergency department facility claim is reimbursed at the AIR. These claims would come to the AHCCCS Administration.

Professional Fees

The Inpatient AIR does not include professional fees.

1. Payment responsibility for professional services associated with the emergency department visit is determined by the principal diagnosis on the professional claim.

   For members enrolled with a TRBHA or RBHA, the AHCCCS Fee-For-Service Administration or RBHA is responsible for payment of behavioral health professional services, such as psychiatric consults.

2. Payment responsibility for the emergency department visit and professional services may not necessarily be the same entity.

3. Payment of the professional claim shall not be denied by the responsible entity due to lack of authorization/notification of the emergency department visit.

IHS/Tribally Owned or Operated 638 Facilities

1. AHCCCS Fee-For-Service (FFS) is responsible for payment of claims for physical and behavioral health services provided by an IHS or tribally owned and/or operated 638 facility to Title XIX members, whether enrolled in an AHCCCS Complete Care (ACC) health plan or FFS.
2. If the member is a RBHA enrolled member, with a behavioral health diagnosis, the RBHA will be responsible for payment of claims for (physical and behavioral) health services that are provided by an IHS or tribally owned and/or operated 638 facility to Title XIX members.
3. KidsCare members enrolled with an ACC health plan should have claims sent to the ACC health plan.

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

Primary Care Provider Payment Responsibility

1. The enrolled health plan is responsible for reimbursement of services associated with a primary care provider visit, when behavioral health services are provided by a PCP within their scope of practice, including professional fees, related prescriptions, laboratory and other diagnostic tests.

   The primary care providers who treat members with these behavioral health conditions may provide medication management services including prescriptions, laboratory, and other diagnostic tools necessary for diagnosis and treatment. Clinical tool kits for the treatment of anxiety, depression, postpartum depression, and ADHD are available in Appendix F, Adult Behavioral Health Tool Kits of the AMPM.

   The enrolled health plan is responsible for payment of medication management services provided by the primary care provider, while the member may simultaneously be receiving counseling and other medically necessary rehabilitative services from the assigned behavioral health entity.

   Note: For Tribal ALTCS members with an AHCCCS ID card, the member ID card may state the Tribal ALTCS Program the member is enrolled in, however, claims should still be submitted to AHCCCS DFSM.

MCO ALTCS and Tribal ALTCS Members

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

MCO ALTCS EPD Enrolled Members
Payment for an emergency department facility claim and inpatient services for ALTCS EPD members enrolled in managed care is the responsibility of the enrolled entity.

- The ALTCS contractor should be notified within 24 hours of admission.

Tribal ALTCS EPD Enrolled Members
Payment for an emergency department facility claim and/or inpatient services for Tribal ALTCS EPD members is the responsibility of the AHCCCS administration.

- A tribal case manager should be notified within 24 hours of admission.

Additional Information

For information further regarding payment responsibility for transportation, outpatient and physician services, and therapies associated with behavioral health, or for additional

information on inpatient and ER payment responsibilities, please see ACOM Policy 432 Attachment A, the Matrix of Financial Responsibility by Responsible Party Matrix.

https://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/400/432A.pdf

All AHCCCS services musts be medically necessary, cost effective, and federally and state reimbursable. For specific information on inpatient reimbursement rates refer to A.A.C. R9-22-712 et seq.

General Billing Information

Place of Service

To determine which place of service codes are available with specific service codes, please reference the Behavioral Health Services Matrix at: https://www.azahcccs.gov/PlansProviders/Downloads/MedicalCodingResources/BehavioralHealthServicesMatrix.xlsx

Common Modifiers for the Billing of Behavioral Health Services

For additional information on modifiers please reference the Behavioral Health ServicesMatrix at https://www.azahcccs.gov/PlansProviders/Downloads/MedicalCodingResources/BehavioralHealthServicesMatrix.xlsx

Emergency Services

Emergency behavioral health services may include inpatient services, evaluation, crisis management counseling, psychotropic medication stabilization, and/or other therapeutic activities to reduce or eliminate the emergent/crisis situation.

Emergency behavioral health services are provided in situations where the absence of immediate medical attention could result in:

- Placing the member's health in serious jeopardy,
- Serious impairment of bodily functions,
- Serious dysfunction of any bodily organ or part, or
- Serious physical harm to self or another person.

A behavioral health evaluation provided by a psychiatrist or a psychologist is covered as an emergency service, if required to evaluate or stabilize an acute episode of mental disorder or substance abuse.

Providers of emergency behavioral health services must verify a member's eligibility and enrollment status to determine the need for notification for care coordination (e.g., ALTCS program, ACC plan, RBHA, TRBHA, AIHP), and to determine who is responsible for payment for services rendered (e.g., ACC plan, RBHA, AHCCCS DFSM for AIHP, TRBHA, Tribal ALTCS).

Claims for emergency services do not require prior authorization, but when requested, the provider must submit documentation with the claim which justifies the emergent nature of the service.

In the event of an emergency behavioral health admission for FFS members, the provider is required to coordinate care with the member's enrolled health plan and/or behavioral health entity. Contact information for RBHA/TRBHAs, ACC health plans, AIHP, and Tribal ALTCS Programs is available on the AHCCCS website.

In the case of an emergency admission for a Tribal ALTCS member, the provider should notify a tribal case manager within 24 hours of the emergency admission, and for MCO ALTCS, the provider should notify the ALTCS contractor within 24 hours of the emergency admission.

The provider must notify the AHCCCS Prior Authorization Unit within 72 hours of the emergency behavioral health admission of a Tribal ALTCS, AIHP or TRBHA-Assigned Fee-For-Service (FFS) member. AHCCCS may perform concurrent review to determine whether the hospitalization of a member for emergency behavioral health services is medically necessary.

Claims for emergency services rendered at an IHS facility will go to the AHCCCS Administration for payment. Claims for emergency services rendered at an IHS facility for a KidsCare member enrolled with an AHCCCS Complete Care health plan will go the ACC health plan.

Crisis Services

There has been no change for crisis services for American Indian/Alaskan Native (AI/AN) members located on tribal lands. RBHAs will continue to serve the same geographic service areas that they served prior to 10/1/2018.

A crisis is any situation in which a person's behaviors put them at risk of hurting themselves and/or others, and/or when they are not able to resolve the situation with the skills and resources available to them. Persons in a crisis present with sudden, unanticipated, or potentially dangerous behavioral health conditions, episodes or behaviors.

Crisis services include mobile team services, telephone crisis response, and facility based

crisis intervention services, including those provided at a hospital, sub-acute and/or residential treatment center. Crisis stabilization services will continue to include related transportations and facility charges.

For crisis services for American Indian/Alaskan Native (AI/AN) members, who are in an area where a Tribal Regional Behavioral Health Authority (TRBHA) is present, the provider should work with the TRBHA.

For crisis services for AI/AN members, who are in an area where a TRBHA is not present, crisis services are the responsibility of the Regional Behavioral Health Authority (RBHA). Please note, the RBHA must have a Right of Entry for tribal lands in order to provide services for the tribe's AI/AN members.

Crisis services for non-Title XIX members are not billable. Crisis services for Title XIX members are billable to AHCCCS DFSM.

Crisis services for Title XXI (KidsCare) members are billable to the health plan of enrollment.

For questions on crisis services providers should outreach the member's tribe, TRBHA or the RBHA affiliated health plan.

Billing for Title XIX

First 24 Hours of Crisis Services

The first 24 hours of crisis services are the responsibility of the RBHA and should be billed to the RBHA located in the GSA where the crisis occurred.

- For Federal Emergency Services Program (FESP) members, the first 24 hours of crisis services are the responsibility of the RBHA and should be billed to the RBHA located in the GSA where the crisis occurred.

Services up to and including the fifth hour should be billed using the hourly code S9484. Services over the fifth hour, up to and including the 24th hour, should be billed per diem using S9485.

After the First 24 Hours of Crisis Services

After the first 24 hours (i.e. the 25th hour forward) crisis services should be billed to the member's enrolled health plan.

The health plan of enrollment is responsible for payment of[1] medically necessary covered services (which may include follow up stabilization services) post-24 hours; the RBHA will remain responsible for any costs associated with follow up phone calls related to the crisis

episode post-24 hours.

- For FESP members, claims for crisis services after the first 24 hours (i.e. the 25th hour forward) should be billed to AHCCCS Division of Fee-for-Service Management (DFSM). Please note that only emergency services that meet FESP guidelines outlined in AMPM 1100 shall be eligible for reimbursement.

Depending on the place of service where crisis services occur, either the AIR, APM or crisis service codes at the capped FFS rate can be billed.

For Title XIX members who receive crisis services from an IHS/638 provider, regardless of the health plan of enrollment, the crisis services would be billed to AHCCCS DFSM with the appropriate revenue code or CPT/HCPCS code (depending on where the service was provided to the member).

If the service was provided at a hospital-affiliated IHS/638 clinic or within the 4 walls of a non-hospital affiliated IHS/638 clinic then the revenue code would be billed for reimbursement at the AIR.

If the service was provided by a 638 FQHC then the service would be billed for reimbursement at the APM.

If the service was provided outside of the 4 walls of a non-hospital affiliated IHS/638 clinic, then the CPT/HCPCS code would be billed for reimbursement at the capped FFS rate, except for 638 FQHCs.

If crisis services are provided outside of the 4 walls of a 638 FQHC, the 638 FQHC could bill for reimbursement at the APM, so long as all other qualifying criteria for a clinic visit are met. (Please refer to Chapter 20, 638 FQHC, of the IHS/Tribal Provider Billing Manual for additional information.)

For additional information on crisis service code(s) please refer to Chapter 19, Behavioral Health Services, of the Fee-For-Service Provider Billing Manual.

For additional information on crisis services please refer to the Crisis Services FAQs on the AHCCCS website at:

https://www.azahcccs.gov/AHCCCS/Downloads/ACC/View_Crisis_System_FAQs.pdf

Crisis Service Billing (Telephonic Services)

Effective 7/1/2020, HCPCS code H0030 (Behavioral Health Hotline Service) shall replace T1016 as the dedicated crisis telephone billing code. The applicable rates and modifiers for crisis telephone billing that were valid for T1016 will now be valid for H0030. This includes

modifiers HO (Master's Degree level), HN (Bachelor's Degree level) and ET (Emergency Services).

> Note: Providers rendering telephonic crisis services to Tribal ALTCS members shall also bill for these services with H0030.

When billing more than (1) unit of H0030 per day, all units should be included on the same line. Reporting units on more than one line may cause the claim to deny as a duplicate.

For additional information refer to the Behavioral Health Services Matrix on the Medical Coding Resources web page at: https://www.azahcccs.gov/PlansProviders/MedicalCodingResources.html

Pre-Petition Screening, Court Ordered Evaluations, and Court Ordered Treatment

At times it may be necessary to initiate civil commitment proceedings to ensure the safety of a person, or the safety of other persons, due to a person's mental disorder when that person is unable or unwilling to participate in treatment. For specific information pertaining to the pre-petition screening that examines the person's mental status please refer to AMPM 320-U.

Financial responsibility for the cost of legal proceedings, the pre-petition screening, and the court-ordered evaluation is the responsibility of the county, unless the county has an agreement with AHCCCS to provide those services. For specific information pertaining to such agreements and financial responsibility please see ACOM 437. For specific policy information pertaining to court ordered evaluations and treatments please refer to AMPM 320-U.

Arizona tribes are sovereign nations, and tribal courts have jurisdiction over their members residing on reservation. Tribal court jurisdiction, however, does not extend to tribal members residing off the reservation or to state court ordered evaluation or treatment ordered because of a behavioral health crisis occurring off reservation.

Services are no longer the county/tribe's responsibility after the earliest of the following events:

- The member decides to seek treatment on a voluntary basis,
- A petition for court ordered treatment is filed with the court, or
- The member is released following the evaluation.

Court ordered treatment or voluntary treatment, following one of the above events, should be billed to the entity responsible for reimbursement of the member's behavioral health services.

During the pre-petition screening and court-ordered evaluation process, the member's enrolled entity is responsible for those medically necessary, covered behavioral health services that are not associated with the pre-petition screening and court-ordered evaluations. Services that are Medicaid covered for an enrolled member, separate from the pre-petition screening and court-ordered evaluation services, such as case management, may also be paid with Title XIX or Title XXI funding. Physical health services provided during the court-ordered evaluation process remain with the member's enrolled entity, and are not the responsibility of the county.

Preparation of a report on the member's psychiatric status for primary use within the court is not a Title XIX or Title XXI reimbursable service. However, Title XIX or Title XXI funds may be used for a report on the member's psychiatric status if it is to be used by a treatment team or physician. The fact that the report may also be used in court, as long as it is not the primary reason for the report's creation, doesn't disqualify the service for Title XIX or Title XXI reimbursement.

Based on the results of the court-ordered evaluation and hearing, the member may be assigned to court-ordered treatment. Treatment may include a combination of inpatient and outpatient treatment. Fiscal responsibility for the court-ordered treatment will be with the member's enrolled entity.

For specific information regarding payment structures for American Indians behavioral health care, please see Tribal Court Procedures for Involuntary Commitment, available on the AHCCCS website at:

https://www.azahcccs.gov/AmericanIndians/TribalCourtProceduresForInvoluntaryCommitment/

Since many tribes do not have treatment facilities on reservation to provide court-ordered treatment, tribes may need to secure treatment off reservation for tribal members. To secure court ordered treatment off reservation, the tribal court order must be "recognized" or transferred to the jurisdiction of the state. This is done via A.R.S. 12-136, and once complete the tribal court order is enforceable off reservation. Treatment facilities, including the Arizona State Hospital, must then provide treatment, as identified by the tribe and recognized by the state.

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

Inpatient Services

Inpatient services include services provided in an acute care hospital or a distinct unit of an acute care hospital, inpatient psychiatric hospital, Level I residential treatment centers, and Level I sub-acute facilities.

Billing for Inpatient and Outpatient Services

For a list of allowable procedure codes by provider type, refer to the Provider Types and Allowable Procedure Codes Matrix at:

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

Inpatient services are billed on the UB-04 claim form and are reimbursed at the All Inclusive Rate (AIR). Inpatient services include all services provided during the inpatient stay, except those provided by behavioral health independent providers. Please refer to the Billing for Professional Services section below.

Outpatient hospital/clinic services are billed on a UB-04 and reimbursed at the AIR, subject to the daily visit limit.

Billing for Professional Services

Provider types that can bill for category of service 47 (mental health) include:

08 MD-physician with psychiatry and/or neurology specialty code 192 or 195

11 Psychologist

18 Physician Assistant

19 Registered Nurse Practitioner

31 DO-Physician Osteopath with psychiatry and/or neurology specialty code 192 or 195

77 Behavioral Health Outpatient Clinic

85 Licensed Independent Social Worker (LISW)

86 Licensed Marriage and Family Therapist (LMFT)

87 Licensed Professional Counselor (LPC)

A4 Licensed Independent Substance Abuse Counselor

BC Board Certified Behavioral Analyst

CN Clinical Nurse Specialist

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

https://www.azahcccs.gov/resources/Downloads/PerformanceMeasures/AccesstoBHProviderServiceCodes_CYE%2014.pdf

Claims from the above-listed providers must be submitted under the individual provider ID number.

Provider type 77 must use their facility **NPI** as the **billing** and **attending** provider, unless the attending provider is a registered AHCCCS provider, in which case they must use the attending provider NPI.

All other behavioral health professionals, like a behavioral health technician (BHT), must be affiliated with a licensed behavioral health agency/facility, clinic, alternative residential facility or outpatient hospital, and those services must be billed through the affiliated setting.

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

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

For BCBA and BHT criteria refer to:

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

Professional services not included as a part of the AIR must be billed on a CMS 1500 claim form with appropriate ICD diagnosis codes and CPT procedure codes. AHCCCS does not accept DSM-IV codes. Claims submitted with DSM-IV codes will be denied.

For Title XXI (KidsCare) members:

- When physician services are provided, except when BCBA, BHPP, or BHT professional services are provided, the physician's NPI number must be listed on the claim as the billing provider.

- When BCBA, BHPP, or BHT professional services are provided, the clinic NPI must be listed on the claim as the billing provider.

Refer to the IHS/638 BH billing guide at:

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

Services are reimbursed at the Office of Management and Budget's **All Inclusive Rate (AIR).**

Claim Date Span Requirement

Effective with dates of service beginning February 17, 2023 and forward, Provider Types (77) Behavioral Health Outpatient Clinic and (IC) Integrated Clinics submitting claims to AHCCCS Division of Fee for Service Management must list a single claim line for each date of service equal to one (1) day of service, CPT/ HCPCS code and the total units for each line of service. This requirement applies to all forms of claims submission including, paper claim, 837P, and Provider Portal submissions.

AHCCCS DFSM shall deny any claim line submitted by a provider type 77 or IC when the billed claim line date span is greater than one (1) day of service.

Example of a Correct Claim Submission:

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	02	13	23	02	13	23	11		H0004	HQ		95 00	4		NPI	1234567890
2	02	14	23	02	14	23	11		H0004	HQ		95 00	4		NPI	1234567890
3	02	15	23	02	15	23	11		H0004	HQ		95 00	4		NPI	1234567890

SUPPLIER INFORMATION

Example of an Incorrect Claim Submission:

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	02	13	23	02	28	23	11		H0004	HQ		1500 00	480		NPI	1234567890
2															NPI	
3															NPI	

SUPPLIER INFORMATION

Medication Assisted Treatment (MAT)

Medication Assisted Treatment (MAT) is the use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders. A combination of medication and behavioral therapies is effective in the treatment of substance use disorders, and can help some people to sustain recovery.

To address the opioid use epidemic, the AHCCCS Administration and its Contractors shall provide coverage for medically necessary, cost-effective, and federally and state reimbursable behavioral health medications prescribed by a PCP within their scope of practice. This includes the monitoring and adjustments of behavioral health medications. For OUD the PCP must refer the member to a behavioral health provider for the psychological and/or behavioral therapy component of the MAT model and coordinate care with the behavioral health provider.

For further information regarding MAT please refer to AMPM 510, Primary Care Providers.

Billing for Methadone Administration

AHCCCS policy allows only five provider types to bill for methadone administration. Provider types 08 (MD-physician), 18 (Physician assistant), 19 (Registered nurse practitioner), 31 (DO-physician osteopath), and 77 (Clinic) may bill the AHCCCS Administration and its contracted health plans and program contractors for methadone administration. These codes are in category of service 01 – Medicine.

Methadone administration must be billed with the following codes:

- H2010 Comprehensive medication services, office, per 15 minutes; and/or
- H0020 Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program).

Both codes must be billed with the HG (Opioid addiction treatment program) modifier.

References

Please refer to the following chapters for additional information:

AMPM Exhibit 300-2A AHCCCS Covered Services Behavioral Health

AMPM Chapter 300, Policy 310-B Behavioral Health Services

AMPM 310-V Prescription Medications – Pharmacy Services (the section on behavioral health medication coverage)

AMPM Chapter 510 - Primary Care Providers

AMPM Chapter 320-U Pre-Petition Screening, Court Ordered Evaluation and Court Ordered Treatment

ACOM Chapter 437 Financial Responsibility for Services After the Completion of Court-Ordered Evaluation

ACOM Chapter 432, Attachment A – Matrix of Financial Responsibility by Responsible Party

AMPM Chapter 1200 contains additional information regarding behavioral health services for members eligible for the ALTCS program.

AMPM Chapter 650 – B, Behavioral Health Provider Requirements for Assisting Individuals with Eligibility Verification and Screening/Application for Public Health Benefits

Chapter 10, Pharmacy, of the IHS/Tribal Provider Billing Manual

Tribal Court Procedures for Involuntary Commitment:
https://www.azahcccs.gov/AmericanIndians/TribalCourtProceduresForInvoluntaryCommitment/

For the Case Manager Billing Guide refer to:
https://www.azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/AppendixA4.pdf

Presentation: Overview of BH Services for IHS and 638 Providers:
https://www.azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/AppendixA3.pdf

For additional crisis service billing examples please view the November 2018 edition of Claims Clues:

https://www.azahcccs.gov/PlansProviders/Downloads/ClaimsClues/2018/ClaimsCluesNov2018.pdf

In early 2019, information contained within the AHCCCS Covered Behavioral Health Services Guide (CBHSG) will be transitioned into the AHCCCS Medical Policy Manual and the FFS and IHS/Tribal Provider Billing Manuals. Please see 'Important Notice' on page 1.

Revision History

Date	Description of changes	Page(s)
2/11/2023	Added new section for Claim date span requirements	17
10/1/2021	Added Clinical Nurse Specialist to list of providers eligible to bill COS 47	16
7/14/2020	FESP Information added to chapter.	11-12
7/8/2020	Behavioral Health Service Matrix links (formerly B2 matrix) updated. Addition of crisis service telephonic service billing reference added: "For information on Crisis Service Billing for Telephonic Services, please refer to Chapter 19, Behavioral Health Services, of the Fee-for-Service Provider Billing Manual."	9 12

12/7/2018	The entire chapter was restructured and formatting updated. Important Notice regarding the Covered Behavioral Health Service (CBHSG) added. List of covered behavioral health services updated. New section added called 'Members Enrolled in an Integrated Health Plan for Physical and Behavioral Health Services.' ALTCS/Tribal ALTCS EPD section updated, including an addition regarding where claims should be sent for BH services. (To AHCCCS DFSM). New section added called 'Benefit Coordination for Members Enrolled with Different Entities for Physical and Behavioral Health Services.' The referenced populations are: • ALTCS members enrolled with DES/DDD; • Foster care children enrolled with the Comprehensive Medical Dental Program (CMDP); and • Adults with a Serious Mental Illness (SMI) designation. Definitions section updated for integration. The following definitions were removed (and a reference to where they can be found in AMPM has been added): Acute Care Services Acute Care Hospital American Indian Health Program (AIHP) Behavioral Health Diagnosis	1-20 1 1-2 2-3 3 4 4-5
	Court Ordered Evaluation Court Ordered Treatment CRS Fully Integrated CRS Only CRS Partially Integrated – Acute CRS Partially Integrated – Behavioral Health (BH) Primary Care Provider The following definitions were updated: Behavioral Health Entity Enrolled Health Plan Payer responsibility section updated to read as 'Payment Responsibility for Members Enrolled with Different Entities for their Physical and Behavioral Health Services.' The information regarding who the payer is for inpatient facility and professional claims, ER facility and professional claims, and primary care provider payments has been updated. A General Billing Information section was added.	5-9 9

	A Place of Service section was added. A Common Modifiers for the Billing of Behavioral Health Services section was added. The Emergency Services section was updated for integration billing information. A Crisis Services section was added with billing examples. The Pre-Petition, Court Ordered Evaluations, and Court Ordered Treatment section was updated. A minor update to the Medication Assisted Treatment section was done. It was changed from: "To address the opioid use epidemic, the AHCCCS Administration and its Contractors shall provide coverage for medically necessary, cost-effective, and federally and state reimbursable behavioral health medications prescribed by a PCP when used to treat anxiety, depression (including postpartum depression), ADHD, and/or Opioid Use Disorder (OUD)" to "To address the opioid use epidemic, the AHCCCS Administration and its Contractors shall provide coverage for medically necessary, cost-effective, and federally and state reimbursable behavioral health medications prescribed by a PCP within their scope of practice." The References section was updated.	9 9 9-10 10-12 12-14 16 17
7/31/2018	Link updated on page 8 to link to the AHCCCS Behavioral Health	9

	Allowable Procedure Code Matrix	
2/16/2018	Billing the AIR for BH services conducted by a non-AHCCCS registered behavioral health professional, like a BHT, clarification added.	10
1/17/18	IHS Tribally Owned or Operated 638 Facilities section corrected to read as "KidsCare members enrolled with a MCO should have claims sent to the TRBHA."	13
12/29/17	Definitions updated Emergency Services section updated Billing for Professional Services section updated Medication Assisted Treatment for Opioid Use Disorder added Billing for Methadone Administration section updated General Requirements Regarding Payment for Physical and Behavioral Health section updated. Inpatient Facility Payment Responsibility section updated Emergency Department Payment Responsibility section updated IHS Tribally Owned or Operated 638 Facilities section updated Specific Circumstances Regarding Payment for Behavioral Health section updated Court Ordered Evaluations & Financial Responsibility section added References updated Format changes	2-7 7-8 9-10 10 11 11-13 12 12-13 13 14-15 15-16 15-16 All
7/1/2016	Behavioral Health changes effective service date 07/01/2016 and later BH Billing Matrix	9 – 17 Exh 12-1
10/01/2015	New format ICD-9 replaced by ICD	All 7