ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

COVERED BEHAVIORAL HEALTH SERVICES GUIDE (CBHSG)

EFFECTIVE DATE: October 1, 2025

The footnotes in the CBHSG indicate areas of revision in this most recent version of the Guide.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

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Introduction

The AHCCCS Covered Behavioral Health Services Guide (CBHSG) is provided as a resource for general information regarding behavioral health services and commonly used billing codes. This Guide does not supersede any information contained in the AHCCCS Medical Policy Manual (AMPM) AHCCCS Contractors Operations Manual (ACOM), the Fee-for-Service (FFS) Provider Manual, or the AHCCCS IHS/Tribal Provider Billing Manual. AHCCCS-contracted Managed Care Organizations (MCOs) and providers shall conform all billing practices to comply with all federal, state and local laws, rules, regulations, standards, executive orders, AHCCCS and/or MCO provider manuals, policy requirements, and standards (including reference tables), ICD10, CPT, HCPCS, CDT, and Health Insurance Portability and Accountability Act Transactions and Code Sets (HIPAA TCS) compliance standards, notwithstanding anything contained in this document, whether expressed or implied.

The CBHSG does not contain an exhaustive list of all available or open codes; for a complete list of open behavioral health related codes see the AHCCCS Medical Coding Resources and Fee For Service Fee Schedules webpages. Provider compliance with billing practices shall comply with all federal, state, and local laws, rules, regulations, standards, executive orders, AHCCCS and/or MCO provider manuals, policy, and the AHCCCS Provider Participation Agreement (PPA).

Billing practices and compliance with all applicable standards are subject to verification during standard monitoring and auditing activities conducted by AHCCCS, TRBHAs, and MCOs. Exceptions to limitations on service frequency or duration may be approved based on medical necessity. Providers shall submit requests for exceptions to the applicable MCO, TRBHA, or AHCCCS and follow the applicable process for submitting documentation to support a request to exceed a limitation.

Appendix A of this Guide contains links to documents which contain important information about AHCCCS' covered behavioral health services. The documents listed in Appendix A are also referenced throughout the document to provide additional guidance regarding specific services.

Covered behavioral health services are organized throughout this document into a continuum of service categories for the purpose of promoting clarity and understanding to promote the consistent use of common terms that reach across populations receiving behavioral health services. The individual domains are:

- Outpatient Treatment Services
- Intensive Outpatient Treatment Programs
- Behavioral Health Day Programs
- Rehabilitation Services
- Other Services
- Medical Services
- Support Services
- Crisis Intervention Services
- Outpatient Residential Services
- Inpatient Services

Within each domain, specific services are defined and described including identification of specific provider qualifications/service standards and billing limitations. Clinical guidelines, service standards, and provider qualifications are also located in the AMPM and links to the appropriate AMPM Policies are provided.

In addition, FFS billing guidelines are located in the AHCCCS Fee-for-Service Provider Manual and AHCCCS IHS/Tribal Provider Billing Manual. When the phrase “Fee-for-Service'' is used in this Guide, it is referring to the AHCCCS Fee-for-Service (FFS) programs (such as the American Indian Health Program [AIHP]). The AHCCCS FFS program is inclusive of non-managed care programs.

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

- UB04 Manual
- National Drug Coding (NDC) Standards
- Physicians’ Current Procedural Terminology (CPT) Standards
- Health care Procedure Coding System (HCPCS) Standards

Provision of Services

A provider is a person or entity which is registered with AHCCCS to provide covered services directly to members. Registration with AHCCCS is required for a provider to be able to render services and submit claims for services provided to AHCCCS eligible members. AMPM Chapter 600 - Provider Qualifications and Provider Requirements, AMPM Policy 610, AHCCCS Provider Qualifications, provides the current procedures for registering with AHCCCS.

A list of current Provider Types (PTs) and applicable enrollment requirements, including the regulatory agencies overseeing them are listed in the Provider Enrollment Screening Glossary, Provider Type Code Order available at https://www.azahcccs.gov/PlansProviders/Downloads/apep/PEP-903.xlsx.

IHS/638 providers and tribal health programs operated under PL 93-638, in accordance with the scope of services within their PL 93-638 contract or compact, may provide behavioral health services rendered as specified in the AHCCCS IHS/Tribal Billing Manual.

As specified in the PPA, only providers who render services to members may bill for, and be reimbursed for, the services provided. If an AHCCCS-registered provider brings in a third-party entity, who is not an AHCCCS-registered provider, to deliver services to members, that AHCCCS-registered provider may not bill for and be reimbursed for those services being rendered by that third-party entity. The AHCCCS-registered provider may bill for other services rendered to members during the course of the activity to support the member's active engagement and participation.

Behavioral Health Professionals (BHPs)

Independently licensed BHPs who are eligible for AHCCCS enrollment are independent billers and are required to register with AHCCCS per AMPM Policy 610. A BHP, who is an independent biller, is only allowed to use their own NPI as servicing/rendering provider to bill for behavioral health services that they personally and directly provide. In accordance with the Provider Participation Agreement, AHCCCS does not permit a BHP to bill for behavioral health services under their own NPI for services provided by another person with the exception of PT BC in accordance with AMPM Policy 320-S Behavior Analysis Services and Arizona Revised Statutes (ARS) 32-2091.

BHPs who are not independently licensed (i.e., associate level BHP) but who are authorized to provide services in accordance with AAC Title 9, Chapter 10 shall bill for services as specified under the Core Billing Limitations section of this Guide (see #18).

Associate level BHPs (i.e., non-independent billers) shall only practice in compliance with clinical supervision requirements as prescribed by the Arizona Board of Behavioral Health Examiners (AzBBHE).

BHPs providing services for IHS/638 providers and tribal health programs operated under PL 93-638 shall bill for services as specified in the AHCCCS IHS/Tribal Billing Manual.

In compliance with Arizona Department of Health Services (ADHS) Licensure, a BHP providing services for a licensed health care institution shall meet the requirements specified in Arizona Administrative Code (AAC) Title 9 Health Services, Chapter 10 and be designated to direct and oversee treatment services at behavioral health facilities. As specified in AAC Title 9 Health Services, Chapter 10, BHPs are responsible for directing and overseeing the clinical care and treatment for members they are directly serving as well as members being

served by BHTs and BHPPs for whom the BHP is providing supervision or clinical oversight . A BHP who is not independently licensed (e.g. associate level BHP) may provide supervision of BHPPs and clinical oversight to BHTs only if the associate level BHP is practicing in compliance with clinical supervision of an independently licensed BHP as prescribed by the AzBBHE.

Behavioral Health Technicians (BHTs)

A Behavioral Health Technician (BHT) is an individual who is not a BHP who provides behavioral health services at or for a licensed health care institution in accordance with the member's treatment or service plan, best practice standards, AHCCCS Policy, ADHS licensure requirements, and the health care institution's policies and procedures, to address the member's behavioral health needs. BHTs providing services for IHS/638 providers and tribal health programs operated under PL 93-638, in accordance with the scope of services within their PL 93-638 contract or compact, may provide behavioral health services rendered as specified in the AHCCCS IHS/Tribal Billing Manual.

Services that, if provided in a setting other than a licensed health care institution, would be required to be provided by a licensed individual as specified in ARS Title 32, Chapter 33, when rendered by a BHT or associate level licensee shall only be billed for under an ADHS Licensed Facility's National Provider Identifier (NPI), utilizing service-specific HCPCS Codes. Claims for services rendered by a BHT or associate level licensee shall be submitted utilizing the licensed behavioral health facility NPI as the servicing/rendering provider, and the name of the individual providing the service shall be reported in Box 19 of the CMS 1500 or UB04 claim form or on the 837 Professional (Electronic Claim): 2300 NTE, utilizing the format described for reporting Participating/Performing Provider in the FFS Provider Billing Manual Chapter 10 Addendum - FQHC/RHC.

Behavioral Health Paraprofessionals (BHPPs)

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

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

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

BHP, BHT, and BHPP education, license, certification, and or required experience, clinical oversight and supervision requirements are specified in AAC Title 9, Chapter 10 or for IHS/638 providers and tribal health programs operated under PL 93-638, may provide behavioral health services rendered as specified in the AHCCCS IHS/Tribal Billing Manual.

BHTs and BHPPs providing supportive services for a Community Services Agency (CSA) see the AMPM Policy 965 for qualifications and service provision requirements.

Peer and Recovery Support Specialist (PRSS)

A Peer and Recovery Support Specialist (PRSS) is an individual who has completed training and passed a competency test through an AHCCCS-recognized Peer Support Employment Training Program, and meets the credentialing requirement to function, at a minimum, as a BHPP. A PRSS can be a BHPP, BHT, BHPP Supervisor, or BHP, as long as the individual meets education, training, and licensure requirements as specified in AAC Title 9, Chapter 10 or for IHS/638 providers and tribal health programs operated under PL 93-638, may provide behavioral health services rendered as specified in the AHCCCS IHS/Tribal Billing Manual. Experience and education should be documented in personnel files and available upon request. Required minimum recommended qualifications for a PRSS are noted in AMPM Policy 963.

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

Credentialed Family Support Partner (CFSP)

A Credentialed Family Support Partner is a person, with a family peer perspective, who meet specific criteria in AMPM Policy 964, and has completed an AHCCCS, OIFA approved Credentialed Family Support Training program qualifying the individual to deliver Family Support Services, and meeting credentialing requirements, to function, at a minimum, as a BHPP. A CFSP can be a BHPP, BHT, or BHP, as long as the individual meets education, training, and licensure requirements as specified in AAC Title 9, Chapter 10 or for IHS/638 providers and tribal health programs operated under PL 93-638, may provide behavioral health services rendered as specified in the AHCCCS IHS/Tribal Billing Manual. Experience and education should be documented in personnel files and available upon request. When billing for services delivered by a Credentialed Family Support Provider (CFSP), the CG modifier must be used. For a listing of codes that are available to be paired with the CG modifier see the AHCCCS Behavioral Health Services Matrix. Required minimum recommended qualifications for a CFSP are noted in AMPM Policy 964.

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

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

Billing for Services

Providers are required to utilize national coding standards including the use of applicable modifier(s). See the AHCCCS Medical Coding Resources web page for up to date information about valid modifiers, Place of Service (POS) codes, Category of Service (COS), and appropriate Provider Types (PT).

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

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

The AHCCCS Provider and Reference files should be used by all providers to determine the correct values on submitted claims/encounters. The values listed throughout the Guide for Covered Behavioral Health Services Guide are only provided as information and should not be used to determine if a value can be used on an encounter or claim.

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

Services Covered by AHCCCS

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

Current Procedural Terminology (CPT) Codes

American Medical Association's (AMA) Current Procedural Terminology (CPT) Guide contains nationally recognized service codes. For more information regarding these codes, see the AMA CPT Guide (Current Procedural Terminology), which contains a systematic listing and coding of procedures and services, such as surgical, diagnostic or therapeutic procedures. Some CPT codes may have time-based coding/time ranges for the minutes in order to meet one code or another, providers should review current CPT coding guidelines regularly to ensure compliance with appropriate code utilization.

Healthcare Common Procedure Coding System (HCPCS) Codes

Healthcare Common Procedure Coding System (HCPCS) contains nationally recognized service codes. For more information regarding these codes, see the Healthcare Common Procedure Coding System (HCPCS) Manual, which is a systematic listing and coding for reporting the provision of supplies, materials, injections and certain non-physician services and procedures. For AHCCCS published information on HCPCS Procedures Daily Limit see HCPCS/CPT Procedure Daily Guidelines.

National Drug Codes (NDC)
These nationally recognized drug codes are used to bill for prescription drugs.

UB04 Revenue Codes
These nationally recognized revenue codes are used to bill for all inpatient and certain residential treatment or outpatient services. Information regarding these codes can be found in the UB04 Manual.

Modifiers

In some instances, in order to delineate the service being provided, a "modifier" must be submitted along with the service code. In these circumstances codes are assigned modifiers. For example, there is a single code for counseling, but reimbursement for counseling provided in the office, the home or in a group can vary, so the accurate use of modifiers is essential. Assigned codes and when applicable, modifiers, must be used on submitted claims and encounters to specify service(s) rendered. Additional modifiers may be used as indicated by CPT or HCPCS to further define a procedure code. Modifiers shall only be added to claims if there is sufficient clinical documentation supporting the use of a modifier. Some modifiers have been included throughout this document to help provide examples or to clarify requirements. A full listing of available modifiers that can be paired with available services codes can be found in the AHCCCS Behavioral Health Services Matrix. See AMPM Policy 310 B for provider usage of applicable modifier(s).

Telehealth Services

AHCCCS recognizes telehealth services as an effective mechanism for the delivery of certain covered behavioral health services; see AMPM Policy 320-I Telehealth. Telehealth must be clearly identified using the applicable telehealth modifier or telehealth code and place of service. A listing of the services, modifiers, and POS codes that can be billed utilizing telehealth services can be found in the AHCCCS Telehealth Code Set.

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

Place of Service (POS) Codes

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

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

Diagnosis Codes

A diagnostic code is needed for service code billing. International Classification of Disease (ICD)-10 codes are the industry standard and are required for all Medicaid/Medicare billing purposes. The ICD-10-CM diagnosis codes must be used when submitting claims and encounters (see the International Classification of Diseases – 10th Revision – Clinical Modification Manual).

While each claim or encounter must include at least one valid ICD-10 diagnosis code describing the member's condition, all ICD-10 codes are to be submitted based on documentation and must be reported to its highest specificity.

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

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

Although ICD-10 and Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis codes are substantially alike, DSM codes must not be used for billing a claim. DSM diagnostic criteria and symptom severity measures may be used by a qualifying provider to justify a diagnosis.

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

Group Payment ID

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

Each AHCCCS registered provider using the group payment arrangement must sign a group payment authorization form and ensure their provider ID number appears on each claim even though a group payment ID number will be used for payment. A service provider may be affiliated with multiple groups. If the provider has multiple service addresses, each address must be listed on the service provider's profile and must be registered separately with AHCCCS as specified in AMPM Policy 610.

Training Resources

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

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

Core Billing Limitations

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

1. AHCCCS shall cover procedures, products, and services related to this Guide when they are medically necessary, and:
    a. The procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the member's needs. The behavioral health needs of the members must be documented in the behavioral health service plan,
    b. The procedure, product, or service can be safely furnished, and not equally effective and more conservative or less costly treatment is available statewide, and
    c. The procedure, product, or service is furnished in a manner not primarily intended for the convenience of the member, the member's caretaker, or the provider.
2. A provider can only bill for their time spent providing the actual service. All CPT and HCPCS codes must meet all coding, documentation, and scope of practice as well as all policy guidelines. Unless the CPT code specify, they are allowed non-face-to-face time, the provider may not bill for any time associated with note taking and/or medical record keeping as this is included in the rate established for these codes.
3. AHCCCS may request and review clinical documents prior to paying for services.
4. The provider's signature in medical record documentation must be in electronic or in legible written form in blue or black ink. Provider signature must be followed by their approved credential (e.g., LPC, BHT, BHPP) and indicate the exact date and time of the signature. AHCCCS expects documentation to be generated at the time of service or shortly thereafter. Delayed entries within a reasonable timeframe (24-48 hours) are acceptable for purposes of clarification, error correction, the addition of information not initially available, and if certain unusual circumstances prevented the generation of the note at the time of service.
5. For services billed with a HCPCS code the provider may not bill any time associated with leaving voice messages, sending emails, and/or contact with the enrolled member, family and/or other involved parties as this time is included in the rate calculation. T1016 - Case Management and H0023 - Targeted Behavioral Health Outreach are exceptions to this rule, see specific descriptions and billing limitations in the Case Management and Targeted Behavioral Health Outreach sections of this Guide.

6. Excluding inpatient evaluation and management codes, providers should bill all time spent directly providing the actual service, regardless of the assumptions made in the rate model.
7. Providers must indicate begin and end times on all progress notes and all documentation of services rendered by the provider. The beginning and end time must be accurate to the time each member participated in the service. Templated and/or pre-printed times based on a schedule are not permitted. Providers engaging in care coordination, case staffing, or other coordination efforts that directly support the member's treatment may bill this time utilizing the appropriate HCPCS Code.
8. A professional who provides clinical oversight or supervision to a Behavioral Health Professional, a Behavioral Health Technician, and/or a Behavioral Health Paraprofessional providing services may not bill separately for the oversight or supervision activities.
9. If the member and/or family member(s) miss their appointment, the provider shall not bill for the service.
10. When only one service is provided in a day, providers should not bill for services performed for less than 8 minutes. For any single timed CPT or HCPCS code in the same day measured in 15-minute units, providers bill a single 15-minute unit for treatment greater than or equal to 8 minutes through and including 22 minutes. If the duration of a single modality or procedure in a day is greater than or equal to 23 minutes through and including 37 minutes, then 2 units should be billed.
    a. Time intervals for 1 through 8 units are as follows: Units Number of Minutes

       1 unit = 8 minutes through 22 minutes
       2 units = 23 minutes through 37 minutes
       3 units = 38 minutes through 52 minutes
       4 units = 53 minutes through 67 minutes
       5 units = 68 minutes through 82 minutes
       6 units = 83 minutes through 97 minutes
       7 units = 98 minutes through 112 minutes
       8 units = 113 minutes through 127 minutes
       See CMS Manual System for additional CMS billing guidance for timed codes.
    b. The pattern remains the same for treatment times in excess of 2 hours. If a service represented by a 15-minute timed code is performed in a single day for at least 15 minutes, that service shall be billed for at least one unit.
    c. If the service is performed for at least 30 minutes, that service shall be billed for at least two units, etc.
    d. It is not appropriate to count all minutes of treatment in a day toward the units for one code if other services were performed for more than 15 minutes.
    e. When more than one service represented by 15-minute timed codes is performed in a single day, the total number of minutes of service determines the number of timed units billed.
    f. The expectation (based on the work values for these codes) is that a provider's direct patient contact time for each unit will average 15 minutes in length. If a provider has consistent practice of billing less than 15 minutes for a unit, these situations should be highlighted for review. If more than one 15-minute timed CPT code is billed during a

single calendar day, then the total number of timed units that can be billed is constrained by the total treatment minutes for that day.

g. There are codes that are specific to time and providers must follow the guidelines as outlined in the American Medical Association CPT coding book.

11. If otherwise allowed, behavioral health service codes which may be billed on the same day as admission to and discharge from inpatient services include, mobile crisis intervention service (HCPCS H2011 Crisis intervention service, per 15 minutes), case management, and care coordination to support the intake/discharge on the same day of admission to or discharge from an Inpatient Hospital (Bill type 0114).
12. A single provider cannot bill for any other covered service while simultaneously providing transportation to members(s).
13. Some CPT and HCPCS codes are restricted to independently licensed practitioners with specialized behavioral health training and licensure. See the AHCCCS Behavioral Health Services Matrix to identify providers who can bill using CPT codes if they meet all the coding, scope of practice and documentation requirements.
14. AHCCCS registered providers who are independently licensed BHPs shall utilize all available CPT codes when billing for services. IHS/638 providers and tribal health programs operated under PL 93-638, may provide behavioral health services rendered as specified in the AHCCCS IHS/Tribal Billing Manual. The following are examples of when a BHP would not bill a CPT code for services and would use a HCPCS code:
    a. Alcohol and/or drug services and multisystemic therapy (MST) for juveniles provided by BHPs billed using the appropriate HCPCS codes.
    b. Any service that does not have an applicable CPT code available for the service (e.g., CFT/ART facilitation/participation, case management, mobile crisis intervention).
    c. Services provided by Licensed Independent Addiction Counselor (LIAC) who are disallowed from utilizing CPT codes.
    d. Case Management services that do not have an available CPT code.
15. Additional supporting clinical documentation for review may be required when billing certain codes. Providers are prohibited from voiding and replacing claims with new codes or billing in smaller units to avoid submission of clinical documentation.
16. Information regarding provider travel billing limitations is located in AMPM Policy 310-B.
17. The group payment ID (PT 01) may only be used for billing. A PT 01 cannot be used as a servicing provider.
18. Claims for services rendered by a non-independent billers using HCPCS codes (e.g., associate level BHP, a BHT, or BHPP) shall be submitted utilizing the licensed behavioral health facility NPI as the servicing/rendering provider and the name of the individual providing the service shall be reported per correct billing guidelines as published by the health plan or Fee-For-Service billing manual.
19. To bill AHCCCS for behavioral health services, a Behavioral Health facility shall be licensed through the Arizona Department of Health Services or for IHS/638 providers and tribal health programs operated under PL 93-638, in accordance with the scope of services within their PL 93-638 contract or compact and shall designate one or more BHPs to direct and oversee all behavioral health treatment services.
20. Independent billers are required to be registered with AHCCCS before they can deliver services.

21. In order to bill services to an MCO, the provider must be credentialed and contracted with the MCO.
22. Only one per diem behavioral health service may be billed on a single day for a single member. For IHS/Tribal 638 providers billing the All Inclusive Rate (AIR), see the AHCCCS IHS/Tribal Billing Manual for guidance on AIR billing parameters.
23. A provider shall not split services among more than one claim to avoid bundling edits.
24. Any therapeutic service provided in a group is limited to no more than 15 members per group unless otherwise specified by AHCCCS and/or within specific sections of this Guide. CPT codes may have different descriptions for group therapy, and those guidelines must be followed as related specifically to CPT codes. For group sessions that include family members (e.g., family counseling/therapy) group size shall be calculated based on the number of members attending the group for which the provider is billing the service.
    a. Providers may request group limit exceptions from contractors, TRBHAs, and AHCCCS to support specialty programs and rural community needs.
25. When providing services to two or more members at the same time, providers are required to use the appropriate CPT or HCPCS with the group modifier (HQ), if available, to indicate that the service was provided to a group on all claim forms.[2]

Services Not Covered by Medicaid

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

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

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

[2] Added billing guideline for HQ modifier usage for groups of two or more.

AHCCCS. Enrollment with an ACC-RBHA or TRBHA is based on the zip code or tribal community in which the member resides.

See AMPM Policy 320-T1 and AMPM Policy 320-T2 for additional guidance on Non-Title XIX/XXI services and funding requirements.

CPT Codes

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

HCPCS Codes

- T1009 - Child Sitting services for children of the individual receiving alcohol and/or substance abuse services. Provider Types: B8, 77, C2, and 29. Modifiers U7, and H9.

- H0046 - Mental Health Services NOS (Room and Board) (Traditional Healing). Provider Types: 72, 77, A3, A5, A6, B8, and IC. Modifiers U7, UB, H9, and SE.

Billing Limitations

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

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

e. Monitoring of child sitting programs
f. Documentation of child drop off time, pick up time and services provided.
g. Service descriptions, including educational support service accessibility to the children
h. Ages of children accepted into the program

Outpatient Treatment Services

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

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

Assessment, Evaluation and Screening Services

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

A behavioral health assessment is necessary for initiation of outpatient behavioral health treatment services and shall align with AMPM Policy 320-O and AMPM Policy 940. A behavioral health assessment completed by an independent biller requires the use of an appropriate CPT code for reimbursement claims. A behavioral health assessment completed by an associate level BHP, or BHT under clinical oversight, requires the use of an appropriate HCPCS code for reimbursement claims.

The comprehensive assessment shall be completed at least once annually, to inform the development or an update of the members' service plan. The comprehensive assessment shall include documented clinical justification for medically necessary services and evidence that the member is receiving services in the least restrictive environment. Any assessment completed by a BHT, must be signed by a qualifying BHP as specified in AAC Article 9, Chapter 10 or, for IHS/638 providers and tribal health programs operated under PL 93-638, behavioral health services shall be rendered as specified in the AHCCCS IHS/Tribal Billing Manual.

AMPM Policy 320-O addresses clinical requirements related to behavioral health assessments, service, and treatment planning.

CPT Codes

CPT Codes may only be used by independently licensed qualified clinicians including Behavioral Health Medical Professionals (BHMPs) and BHPs. See the American Medical Association CPT Code Book for specific guidance on which professionals can bill which codes. All codes must meet scope of practice, policy, and documentation guidelines. It is the provider's responsibility to ensure that all the services reported meet the national guidelines for coding and documentation.

It is also the responsibility of the providers/facilities to have the current coding books. IHS/638 providers and tribal health programs operated under PL 93-638, may provide behavioral health services rendered as specified in the AHCCCS IHS/Tribal Billing Manual. These codes are updated quarterly by CMS and American Medical Association. Below are some of our most commonly used CPT codes. See the AHCCCS Behavioral Health Services Matrix and the provider specific exception table for a full listing of available behavioral health related CPT Codes.

- 90791 - Psychiatric diagnostic evaluation
- 90792 - Psychiatric diagnostic evaluation with medical services
- 96130 - Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour
- 96131 - Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure)
- 96136 - Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes
- 96137 - Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure)
- 96138 - Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes
- 96139 - Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure)
- 96146 - Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only
- 96110 - Developmental screening (e.g., developmental milestone survey, speech, and language delay screen), with scoring and documentation, per standardized instrument
- 96112 - Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified Health care professional, with interpretation and report; first hour

- 96113 - Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified Health care professional, with interpretation and report; each additional 30 minutes (List separately in addition to code for primary procedure)

- 96116 - Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified Health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour
- 96132 - Neuropsychological testing evaluation services by physician or other qualified Health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour
- 96133 - Neuropsychological testing evaluation services by physician or other qualified Health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure)
- 99242 - Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
- 99243 - Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
- 99244 - Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
- 99245 - Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded.
- 99304 - Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.
- 99305 - Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.

- 99306 - Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 50 minutes must be met or exceeded.

- 99307 - Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.
- 99308 - Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
- 99309 - Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
- 99310 - Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
- 99315 - Nursing facility discharge management; 30 minutes or less total time on the date of the encounter
- 99316 - Nursing facility discharge management; more than 30 minutes total time on the date of the encounter
- 99408 - Alcohol and/or substance (other than tobacco) abuse structured screening (e.g. AUDIT,DAST) and brief intervention(SBI) services 15 to 30 minutes
- 99409 - Alcohol and/or substance (other than tobacco) abuse structured screening (e.g. AUDIT, DAST) and brief intervention (SBI) services greater than 30 minutes

HCPCS Codes

Except for assessment, evaluation and screening provided by those independently registered individual behavioral health professionals billing CPT codes, all other assessment, evaluation, and screening services should be billed using the following HCPCS codes. The following HCPCS Codes may be used by a BHP who is an independent biller in the absence of a more descriptive or appropriate CPT, a BHP who does not meet the professional requirements of a BHP who is an independent biller (e.g., associate level BHP), or a behavioral health technician (BHT) under the clinical oversight of a BHP as specified in AAC Title 9, Chapter 10 or for IHS/638 providers and tribal health programs operated under PL 93-638, as specified in the AHCCCS IHS/Tribal Billing Manual. They may not be billed by a behavioral health paraprofessional (BHPP).

- H0001 - Alcohol and/or drug assessment
- H0002 - Behavioral Health Screening to Determine Eligibility for Admission to a treatment program
    - Additional Guidance - Information gathered using a standardized screening tool or criteria including those behavioral health screening. 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 member's service plan. May also include the preliminary collection of information necessary to complete a supported employment assessment.

- H0031 - Mental Health Assessment by Non-Physician
    - Additional Guidance - Mental health assessment provided by someone other than a physician, who is a trained staff member. The assessment identifies factors of mental illness, functional capacity, and gathers additional information used for the treatment of mental illness including gathering information necessary for assessment of a member, resulting in a written summary report. Recommendations, which may be in response to specific questions posed in an assessment request, are made to the member, family, referral source, provider, or courts, as applicable.

Billing Limitations

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

1. See general core billing limitations.
2. Transportation (emergency and non-emergency) provided to members and/or family members is not included in the rate and should be billed separately using the appropriate transportation procedure codes.
3. 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.
4. 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.
5. H0031 shall only be used for completion of a full comprehensive intake assessment, the annual reassessment, utilization of the CALOCUS assessment tool and the ASAM CONTINUUM® assessment tool. Changes to a member's assessment that does not represent a diagnostic change or require treatment intervention changes to the member's service plan or treatment plan do not qualify for use of H0031.
6. The member receiving an alcohol and/or drug assessment which is billed using H0001 must be at least 11 years of age and, if an assessment tool is utilized, said tool must be normed for the age of the member.
    a. If used, the assessment tool must be available for review upon request and normed for the age, literacy, population, culture, and language of the member.
7. When behavioral health screening, assessment and evaluation services are performed by a BHT, that BHT must be, employed by and use the NPI of a behavioral health agency licensed by ADHS, under the clinical oversight of a BHP, and meet the requirements for the provision of behavioral health assessment, evaluation and screening services as set forth in AAC Title 9, Chapter 10 or for IHS/638 providers and tribal health programs operated under PL 93-638, as specified in the AHCCCS IHS/Tribal Billing Manual to submit claims for reimbursement for the services described.

8. Modifier U9 for an ASAM CONTINUUM® assessment can be paired with H0001, H0031, 90791, and 90792. For additional information on the use of the ASAM Continuum see https://www.azahcccs.gov/PlansProviders/CurrentProviders/ASAM.html on the AHCCCS website.
9. Outpatient services for substance use disorders (SUD) are for beneficiaries assessed as meeting, at minimum, the American Society of Addiction Medicine (ASAM) level of 0.5 (Early Intervention) or 1.0 (Outpatient Services) or as determined medically necessary by a BHP.
10. IHS/638 facilities are not required to utilize ASAM.

Psychotherapy

Psychotherapy is the treatment of mental illness and behavioral disturbances in which the physician or other qualified health care professional, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development.

CPT Codes

- 90832 - Psychotherapy, 30 minutes with patient
- 90833 - Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
- 90834 - Psychotherapy, 45 minutes with patient
- 90836 - Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
- 90837 - Psychotherapy, 60 minutes with patient
- 90838 - Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure
- 90845 - Psychoanalysis
- 90846 - Family psychotherapy (without the patient present), 50 minutes
- 90847 - Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes
- 90849 - Multiple-family group psychotherapy
- 90853 - Group psychotherapy (other than of a multifamily group)

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

When reporting psychotherapy services, choose the code closest to the actual time spent with the member. See the American Medical Association CPT current year codebook for complete coding guidelines for using these codes.

Behavioral Health Counseling and Therapy

Counseling is an interactive therapy designed to elicit or clarify presenting and historical information, identify behavioral problems or conflicts, and provide support, education or understanding for the member, group or family to resolve or manage the current problem or conflict and prevent, resolve or manage similar future problems or conflicts. Services may be provided to an individual, a group of people, a family, or multiple

families. Services provided shall be based on best practice for the presenting concern and shall be provided within the scope of practice of the rendering provider.

HCPCS Codes

- H0004 - Behavioral health counseling and therapy, per 15 minutes.

Provider Qualifications

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

Billing Limitations

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

1. See general core billing limitations.
2. Transportation provided to members and/or family members is not included in the rate and should be billed separately using the appropriate transportation procedure codes.
3. When counseling from more than one provider organization is medically necessary, a description of the specialty service which is outside of the primary provider's scope of practice must be listed in the treatment plan including frequency and duration of specialty services.
4. The clinical rationale for the number and length of counseling sessions must be indicated in the comprehensive assessment and treatment plan. Evidence-based interventions that require sessions over 60 minutes should be specified in the treatment plan.
5. Documentation of counseling services must include the member's presenting problem/reason for the session as it is listed in the service plan including the diagnosis being treated, the mental status/ appearance of the member and the evidenced-based interventions utilized in the session. The members' response to any interventions used as they apply to the service plan goals and objectives must also be included as well as any assessment or screener results as they apply to the service plan goals and objectives.
6. Counseling services using H0004:
    a. H0004 must not be billed on the same day that residential, Intensive Outpatient Program (IOP), Partial Hospitalizations Program (PHP) or inpatient per diem codes are billed, where counseling is included in the rate and documentation of medical necessity does not support the need for additional counseling services beyond the scope of the residential, Intensive Outpatient Program (IOP), Partial Hospitalizations Program (PHP) or inpatient program. Not all per diem codes would include counseling services, for example, a child receiving Therapeutic Foster Care services may require counseling services from a counseling or outpatient treatment plan provider. For additional detail review the AHCCCS Same Day Disallow Table.
    b. H0004 may not be billed on the same day as services rendered from a psychiatric inpatient hospital or a behavioral health inpatient facility.

c. H0004 must be paired with the HQ modifier when services are provided to two or more members at one time.

d. Provider travel time for the initial 25 miles each way is included in the rates for H0004—Individual Behavioral Health Counseling and Therapy, Family Behavioral Health Counseling and Therapy, and Group Behavioral Health Counseling and Therapy. See AMPM Policy 310-B for provider travel billing limitations.

e. Counseling services using H0004 must be performed by an associate licensed BHP in the practice of behavioral health who is engaged in direct supervision as outlined in AAC R4-6-211, or a BHT who is clinically overseen by a BHP as specified in AAC Title 9, Chapter 10 or for IHS/638 providers and tribal health programs operated under PL 93-638, as specified in the AHCCCS IHS/Tribal Billing Manual

f. Except for behavioral health counseling and therapy services provided by independently licensed BHPs allowed to independently bill using CPT codes, all other behavioral health counseling and therapy services must be billed using HCPCS codes and the NPI of the licensed behavioral health facility. Incident to billing using the NPI of a BHP who did not actually perform the counseling service in an outpatient setting is prohibited. IHS/638 providers and tribal health programs operated under PL 93-638, as specified in the AHCCCS IHS/Tribal Billing Manual.

g. H0004 can be paired with modifier HR for Family Behavioral Health Counseling and Therapy, Billing Unit: 15 minutes per family, performed in 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 the place of service.**

h. H0004 can be paired with modifier HS for Family Behavioral Health Counseling and Therapy, Billing Unit: 15 minutes per family, performed in an Office, Without Client Present: Counseling services (see general definition above for counseling and therapy) provided face-to-face to members of a member's family at the provider's work site. **HS modifier required and must specify place of service.**

7. In reporting psychotherapy services, choose the code closest to the actual time. See the American Medical Association current year CPT code set for the complete coding guidelines for these codes.

Applied Behavior Analysis (ABA) Services

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

CPT Codes

- 97151 - Behavior identification assessment, administered by a physician or other qualified health care professional, each 15 minutes of the physician's or other qualified health care professional's

time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan

- 97152 - Behavior identification supporting assessment, administered by one technician under the direction of a physician or other qualified Health care professional, face-to-face with the patient, each 15 minutes
- 97153 - Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified Health care professional, face-to-face with one patient, each 15 minutes
- 97154 - Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified Health care professional, face-to-face with two or more patients, each 15 minutes
- 97155 - Adaptive behavior treatment with protocol modification administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes
- 97156 - Family adaptive behavior treatment guidance, administered by physician or other qualified Health care professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes
- 97157 - Multiple-family group adaptive behavior treatment guidance, administered by a physician or other qualified health care professional (without the patient present), face-to-face with multiple sets partial of guardians/caregivers, every 15 minutes
- 97158 - Group adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional face-to-face with multiple patients, each 15 minutes

Partial Hospitalization Programs (PHPs)

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

PHP services shall be provided by an appropriately licensed provider and as specified with applicable service requirements set forth in AAC Title 9, Chapter 10, Article 10. The staff who deliver the specific services within the partial hospitalization program shall also meet the individual provider qualifications associated with those services.

HCPCS Code

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

Billing Limitations

For PHPs, the following billing limitations apply:

1. See general core billing limitations.
2. Partial Hospitalization services may only be provided by the following Provider Types: B5, B6, 02, and 71.
3. A physician recommending partial hospitalization services must determine at least once monthly that the member still needs a minimum of 20 hours of services a week.
4. Payment for partial hospitalization services may be made only when the individual would require inpatient psychiatric care in the absence of such services.
5. Approved places of service for H0035 are as follows:
    - 06 Indian Health Service - Provider Based Facility,
    - 08 Tribal 638 – Provider Based Facility,
    - 19 Off Campus-Outpatient Hospital,
    - 22 On Campus-Outpatient Hospital,
    - 52 Psychiatric Facility-Partial Hospitalization, and
    - 62 Comprehensive Outpatient Rehabilitation Facility
6. H0035 is an all-inclusive behavioral health code.
7. Behavioral health HCPCS codes are included in the H0035 per diem rate and cannot be billed separately during the same time as H0035.
8. H0035 can be paired with the U9 modifier at intake and discharge when the ASAM CONTINUUM® assessment tool is used to determine appropriate level of care.
9. RN/LPN services are included in the per diem rate.
10. Case management and rehabilitation services are included in the per diem rate.
11. Psychiatric, BHP, and other behavioral health professional CPT services are included in the per diem rate and cannot be billed separately.
12. GT modifier may not be billed with H0035. All H0035 services must be delivered in person.
13. PT 77 and ICs shall not bill for partial hospitalization services. Claims submitted by PT 77 and ICs will be denied.

Psychiatric Collaborative Care Model (CoCM)

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

CPT Codes

- 99492 - Initial psychiatric collaborative care management, **first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified Health care professional, with the following required elements**:

  - Outreach to and engagement in treatment of a patient directed by the treating physician or other qualified Health care professional,
  - Initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan,
  - Review by the psychiatric consultant with modifications of the plan if recommended,
  - Entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant, and
  - Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.
- 99493 - Subsequent psychiatric collaborative care management, **first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified Health care professional, with the following required elements:**
  - Tracking patient follow-up and progress using the registry, with appropriate documentation,
  - Participation in weekly caseload consultation with the psychiatric consultant,
  - Ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers,
  - Additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant,
  - Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies,
  - Monitoring of patient outcomes using validated rating scales, and
  - Relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.
- 99494 - Initial or subsequent psychiatric collaborative care management, **each additional 30 minutes in a calendar month of behavioral health care manager activities**, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified Health care professional (List separately in addition to code for primary procedure). (Use 99494 in conjunction with 99492, 99493).
- 99484 - Care management services for behavioral health conditions, **at least 20 minutes of clinical staff time**, directed by a physician or other qualified Health care professional, per calendar month, with the following required elements:
  - Initial assessment or follow-up monitoring, including the use of applicable validated rating scales,
  - Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes,
  - Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling, and/or psychiatric consultation, and
  - Continuity of care with a designated member of the care team.

- G2214[3] - Initial or subsequent psychiatric collaborative care management, **first 30 minutes in a month of behavioral health care manager activities**, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional.

[3] Code G2214 added to Psychiatric Collaborative Care Model section.

- The required elements include tracking patient follow-up and progress via registry; weekly caseload participation with a psychiatric consultant; working together and coordinating with the qualified clinician on a regular basis; additional ongoing review of the patient's progress and recommendations for treatment changes, including medications with the psychiatric consultant.
- Provision of brief interventions with the use of evidence-based techniques; monitoring patient outcomes using validated rating scales; and relapse prevention planning.
- This code reports the first 30 minutes of initial or subsequent psychiatric collaborative care management in a month.
    - **NOTE:** G2214 must not be reported in the same month by the same provider with CPT codes 99492–99494. See CPT coding book for full guidance.

Intensive Outpatient Programs (IOP)

Intensive outpatient programs (IOP) are structured **non-residential** treatment programs which address mental health and/or substance use disorders (SUDs) through a combination of psychiatric services, individual, group, and family counseling, therapy, and educational groups.

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

IOPs shall be provided by an appropriately licensed Outpatient Treatment Center (OTC) and as specified with applicable service requirements set forth in AAC Title 9, Chapter 10, Article 10. The staff who deliver the specific services within the IOP shall also meet the individual provider qualifications associated with those services as specified in AAC Title 9, Chapter 10 or for IHS/638 providers and tribal health programs operated under PL 93-638, may provide behavioral health services rendered as specified in the AHCCCS IHS/Tribal Billing Manual. Providers are required to ensure that the IOP treatment/programming provided meets the specific code requirements for each available IOP code described below.

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

Intensive Outpatient Psychiatric Services

Intensive outpatient psychiatric services are comprehensive outpatient treatment programs inclusive of psychiatric services, individual, group, family therapy, peer support services, and educational groups. These services may be used as a step down from a higher level of care (inpatient, residential, or PHP program) or a step up from less intensive outpatient services. Programming operates at least 3 hours per day for 2 or more days per week.

The intensive outpatient psychiatric service minimum requirements are as follows:

1. Administered and actively overseen by a BHP within their scope of practice.
2. A psychiatrist or psychiatric nurse practitioner shall be available during the program operation at a minimum by telephone; on-site availability is recommended.
3. A minimum of one individual session per month with the BHP, and/or more frequently as clinically indicated, must be incorporated. This session shall include a documented evaluation of member progress in the intensive outpatient psychiatric services and a determination that this level of care is still clinically indicated and medically necessary.
4. Group sessions include no more than 15 members and will be facilitated by a BHP, or a BHT with clinical oversight by a BHP as clinically appropriate.
5. Psychiatric medication management services are included in the IOP per diem rate and shall be conducted by the intensive outpatient psychiatric service provider with the following exception: if the member enters intensive outpatient psychiatric services with pre-established psychiatric medication management services from whom they have received service in the past 90 days, the psychiatric provider at the IOP may coordinate with that psychiatric provider in lieu of providing this direct service to the member.
6. Behavioral Health Counseling and Therapy (H0004) are also included in the IOP per diem rate and shall be conducted by the intensive outpatient psychiatric services BHP.

- If the member enters intensive outpatient psychiatric services with a pre-established active therapeutic relationship with a BHP from whom they have received service in the past 90 days, for Behavioral Health Counseling and Therapy; H0004 may be billed separately outside of the time period IOP occurs.
- H0004 may also be billed if the BHP determines and documents within the assessment that the member requires specialized counseling/therapy that is beyond the scope of practice of the intensive outpatient psychiatric services provider. (See Billing Limitations below).

7. Non-IHS/638 Programs focused on the treatment of substance use and co-occurring disorders shall utilize the American Society of Addiction Medicine (ASAM) Criteria (3rd or 4th edition).

HCPCS Code

- S9480 - Intensive outpatient psychiatric services, per diem. Programming operates at least 3 hours per day for 2 or more days per week.

Billing Limitations

For intensive outpatient psychiatric services, the following limitations apply:

1. See general core billing limitations.
2. S9480 is an all-inclusive behavioral health code and all IOP related services and programming are included in the rate. Behavioral health HCPCS codes and professional CPT services cannot be billed separately during the same time period on the same day as S9480 to prevent overlapping. Example: If a patient is receiving IOP services from 1pm to 4pm, any additional services scheduled for that day must not be scheduled or provided within the 1pm through 4pm time period. Services that are provided on the same day in addition to IOP treatment must be medically necessary and clearly documented in the members comprehensive service plan. See the AHCCCS Same Day Disallow Table for guidance on services that would not be allowed on the same day as S9480.
3. Other residential, behavioral health day treatment programs, Intensive Outpatient Program (IOP), Partial Hospitalizations Program (PHP) or inpatient per diem codes may not be billed on the same day as S9480.
4. A BHP recommending intensive psychiatric services must evaluate and determine at least once monthly, or more as clinically warranted, that the member continues to meet medical necessity for IOP level of care.
5. Duration of treatment (e.g., 12 weeks, 18 weeks) is determined by medical necessity and documented in assessment and service plan.
6. IOP treatment providers shall require the member to agree to actively participate in programming at least 3 hours per day for at least 2 or 3 days per week. If a patient does not show for two or more days the provider shall outreach the member and ensure they are safe, document the purpose of the absence in the medical chart, and notify the BHP of the absence and the reason for the absence. The BHP shall assess the members' need for continued IOP programming based on the reason for the absence.
7. If the member is late for IOP or leaves early and does not meet the daily requirement of 3 hours the provider shall not bill S9480 and shall bill appropriate codes for each individual service provided during the time they were able to attend scheduled programming. Providers shall document the purpose of the absence in the medical chart and notify the BHP of the absence and the reason for

the absence. The BHP shall assess the members' need for continued IOP programming based on the reason for the absence.

8. Non-emergency transportation provided to a member for the purpose of coming to and/or returning home from IOP is not included in the rate and should be billed separately using the appropriate transportation procedure codes. Transportation provided as a part of the IOP programming, or scheduled activities is included in the rate and shall not be billed separately.

Intensive Outpatient Alcohol and/or Drug Services

Intensive outpatient alcohol and/or drug services provide substance use disorder and co-occurring treatment in alignment with ASAM Criteria, 3rd or 4th Edition, level 2.1. Treatment programming operates a minimum of 9 hours per week conducted for at least 3 hours a day and at least 3 days a week. Such services may include individual and group counseling, medication management, family therapy, educational groups, occupational and recreational therapy, and peer support. Services are provided in terms of amounts, frequencies, and intensities appropriate to the objectives of the treatment plan. Individuals appropriate for an intensive outpatient program (IOP) typically require close monitoring and frequent contact to reduce the risk of continued use, relapses, and worsening mental health problems. Individuals receiving this service should be medically stable and at minimal risk for severe withdrawal. In addition to the SUD, they may have mild psychiatric problems that need monitoring or lack a supportive recovery environment.

HCPCS Code

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

Billing Limitations

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

1. See general core billing limitations.
2. H0015 is an all-inclusive behavioral health code and all IOP related services and programming are included in the rate. Behavioral health HCPCS codes and professional CPT services cannot be billed separately during the same time period on the same day as H0015 to prevent overlapping. Example: If a patient is receiving IOP services from 1pm to 4pm, any additional services scheduled for that day must not be scheduled or provided within the 1pm through 4pm time period. Services that are provided on the same day in addition to IOP treatment must be medically necessary and clearly documented in the members comprehensive service plan. See the AHCCCS Same Day Disallow table for guidance on services that would not be allowed on the same day as H0015.
3. Other residential, Intensive Outpatient Program (IOP), Partial Hospitalizations Program (PHP) or inpatient per diem codes may not be billed on the same day as H0015.
4. IOP treatment providers shall require the member to agree to actively participate in programming at least 3 hours per day for at least 3 days per week. If a patient does not show for all three days the provider shall outreach the member and ensure they are safe, document the purpose of the absence in the medical chart, and notify the BHP of the absence and the reason for the absence. The BHP shall assess the members' need for continued IOP programming based on the reason for the absence.
5. If the member is late for IOP or leaves early and does not meet the daily requirement of 3 hours the provider shall not use H0015 and shall bill individual codes for the services that were provided during

the time they were able to attend scheduled programming. Providers shall document the purpose of the absence in the medical chart and notify the BHP of the absence and the reason for the absence. The BHP shall assess the members' need for continued IOP programming based on the reason for the absence. Duration of treatment (e.g., 12 weeks, 18 weeks) is determined by medical necessity and documented in assessment and service plan.

6. H0015 - Group sessions include no more than 15 members and will be facilitated by a BHP, or a BHT with clinical oversight by a BHP as clinically appropriate.
7. A BHP recommending intensive outpatient alcohol and/or drug services must reassess the member's need for a minimum of 9 hours of services per week at least once every 12 weeks during the assessment and treatment planning process.
8. Non-emergency transportation provided to a member for the purpose of coming to and/or returning home from IOP is not included in the rate and should be billed separately using the appropriate transportation procedure codes. Transportation provided as a part of the IOP programming, or scheduled activities is included in the rate and shall not be billed separately.

Behavioral Health Day Programs

Behavioral Health Day programs are categorized as Supervised, Therapeutic, or Community Psychiatric Supportive Treatment.

Behavioral Health Day programs provide services scheduled on a regular basis either hourly, half day or full day and may include services such as therapeutic nursery, in-home stabilization, after school programs, and specialized outpatient substance abuse programs. These programs can be provided to a member, group of individuals and/or families in a variety of settings, and shall be provided, based on licensure requirements as specified in AAC Title 9, Chapter 10, Article 10 and as specified below.

Supervised Behavioral Health Day Programs

Supervised behavioral health day programs consist of a regularly scheduled program of individual, group and/or family services related to the member's treatment plan designed to improve the ability of the member to function in the community and may include the following rehabilitative and support services: skills training and development, behavioral health prevention/promotion, medication training and support, pre-vocational services and ongoing support to maintain employment, peer and recovery support, and home care training family (family support).

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

HCPCS Codes

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

Billing Limitations

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

1. See general core billing limitations.
2. School attendance and education hours are not included as part of this service and may not be provided simultaneously with this service.
3. Meals provided as part of the supervised day treatment are included in the rate and should not be billed separately.
4. Emergency and non-emergency transportation provided to a member is not included in the rate and should be billed separately using the appropriate transportation procedure codes.
5. H2012 and H2015 are all inclusive codes, and separate services must not be billed at the same time that supervised behavioral health day program services are provided.
6. H2012 and H2015 are not subject to the group limit specified in Core Billing Limitation #24 if provided in person. Groups shall not exceed a 1:20 ratio.

Therapeutic Behavioral Health Services and Day Programs General

Therapeutic behavioral health day programs are regularly scheduled programs of active treatment modalities which may include services such as individual, group and/or family behavioral health counseling and therapy, skills training and development, behavioral health prevention/promotion, medication training and support, pre-vocational services and ongoing support to maintain employment, home care training family (family support), medication monitoring, case management, peer and recovery support, and/or medical monitoring,

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

HCPCS Codes

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

Billing Limitations

1. See general core billing limitations.
2. School attendance and education hours are not included as part of this service and may not be provided simultaneously with this service.
3. A registered nurse who supervises therapeutic behavioral health services and day programs may not bill this function separately. Employee supervision has been built into the procedure code rates.
4. Meals provided as part of therapeutic behavioral health services and day programs are included in the rate and should not be billed separately.
5. H2019 and H2020 are all inclusive codes. Included services codes such as H2014, H0025, etc. may not be simultaneously billed during the same time period to prevent overlapping. Example: If a patient is receiving day program services from 8am to 3pm, any additional services scheduled for that day must not be scheduled or billed by the day program provider within the 8am through 3pm time period.
6. Emergency and non-emergency transportation provided to a member is not included in the rate and should be billed separately using the appropriate transportation procedure codes.
7. H2019 and H2020 are not subject to the group limit specified in Core Billing Limitation #24 if group services are provided in person. Groups shall not exceed a 1:20 ratio.
8. The HQ modifier is not applicable to H2019 or H2020, these rates are developed with the understanding and methodology supporting group programming.

Community Psychiatric Supportive Treatment and Medical Day Programs

Community Psychiatric Supportive Treatment Program are a regularly scheduled programs of active treatment modalities, including medical interventions, in a group setting and may include individual, group and/or family behavioral health counseling and therapy, skills training and development, behavioral health prevention/promotion, medication training and support, ongoing support to maintain employment, pre-vocational services, home care training family (family support), peer and recovery support, and/or other nursing services such as medication monitoring, methadone administration, and medical/nursing assessments.

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

HCPCS Codes

- H0036 - Community Psychiatric Supportive Treatment, face-to-face, per 15 minutes. Billing unit: 15 min. Up to 5 hours in duration.
    - The TF modifier is used to indicate an intermediate level of services (e.g., members needing more intensive supervision, a sitter and/or 1:1 staffing).
- H0037 - Community Psychiatric Supportive Treatment Program, per diem: See general definition above.
    - The TF modifier is used to indicate an intermediate level of service (e.g., clients needing more intensive supervision, a sitter and/or 1:1 staffing).
- H2041 - Coordinated specialty care, team-based, for first episode psychosis, per encounter
    - Only approved providers will be allowed to bill this code after verification and approval by AHCCCS.

Billing Limitations

1. See general core billing limitations.
2. School attendance and education hours are not included as part of this service and may not be provided simultaneously with this service.
3. Meals provided as part of community psychiatric supportive treatment and medical day programs are included in the rate and should not be billed separately.
4. Emergency and non-emergency transportation provided to a member is not included in the rate and should be billed separately using the appropriate transportation procedure codes.
5. Only one per diem code per day may be billed for a member.
6. H0036 and H0037 are not subject to the group limit specified in core billing limitation #24 if group services are provided in person. Groups shall not exceed a 1:20 ratio.

Rehabilitation Services

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

Skills Training and Development

[4]Skills Training and Development provides structured, goal-oriented instruction to help members build or strengthen functional abilities necessary for independent living, community participation, and effective management of behavioral health needs. Services may be provided to an individual, a group, and/or to family/natural support when clinically indicated with or without the member present, if the service plan documents how the activity directly supports the member's goals.

Interventions focus on teaching and practicing practical skills using modeling, coaching, and reinforcement strategies.

Areas commonly addressed include:

- Independent Living Skills: personal hygiene, nutrition, meal preparation, medication organization, household management, and safety awareness.
- Behavioral Health Self-Management: recognition/understanding symptoms, identifying triggers, using coping strategies, and adhering to treatment recommendations.
- Social and Communication Skills: engaging appropriately in social settings, conflict resolution, relationship-building, and community integration.
- Resource and System Navigation: scheduling appointments, accessing community support/public benefits, transportation, and healthcare systems.
- Financial and Daily Life Skills: budgeting, shopping, managing personal funds, and planning daily routines.

The goal of Skills Training is to support members in gaining the functional skills necessary to succeed with the least reliance on formal services.

Examples of Appropriate Activities

Independent Living & Daily Functioning

- Practicing personal hygiene routines using step-by-step modeling (e.g., brushing teeth, shower sequencing).
- Training the member on meal planning, safe food handling, and basic meal preparation.
- Teaching members how to organize and maintain a clean-living space (laundry routines, safe storage, chore planning).
- Practicing medication organization (e.g., using a pillbox); teaching members how to request refills appropriately.

Behavioral Health Self-Management

[4] Added clarifying language and activities examples.

- Coaching a member on identifying early warning signs of symptom escalation and practicing coping strategies.
- Teaching members how to follow a daily schedule to improve structure and routine.
- Practicing techniques for emotional regulation, such as grounding exercises or problem-solving steps.

Social and Communication Skills Training

- Role playing how to express needs positively and in social or community settings.
- Practicing appropriate conversation skills, turn taking, and conflict resolution.
- Teaching how to safely build and maintain friendships and healthy relationships.

Financial and Practical Life Skills

- Teaching the members how to create a simple budget and track expenses.
- Practicing how to shop for groceries on a budget, comparing prices, and making healthy choices.

System and Resource Navigation

- Assisting the members in practicing how to call and schedule medical appointments.
- Teaching the member how to apply for community resources (transportation, public benefits), including practicing required steps.
- Practicing using public transportation routes or scheduling rides.

Family and Natural Support Training

- Coaching the family to reinforce learned skills being developed with the member (e.g., prompting use of coping strategies, supporting routines).
- Teaching the family how to support medication or appointment adherence without taking over member responsibilities.

Psychosocial Rehabilitation (PSR)

[5]Psychosocial Rehabilitation (PSR) services help individuals develop, restore, or maintain the social, emotional, and cognitive skills needed to achieve meaningful roles in their homes, families, and communities. These services target functional deficits and barriers associated with mental health conditions and are designed to promote long term recovery, community inclusion, and improved quality of life.

PSR is a face to face, skill building, and rehabilitative service delivered in individual or group settings. Interventions may include:

- Functional Skill Development: improving daily living skills, organization, time management, problem solving, and decision making.
- Interpersonal and Communication Skills: enhancing social interaction, relationship building, and the ability to engage with peers, family, employers, and community members.
- Recovery and Relapse Prevention: developing personalized strategies to manage symptoms, reduce risk of relapse, and increase resilience.

[5] Section has been expanded and clarified.

- Community Integration and Support: building natural support networks, participating in community activities, and reducing environmental barriers.
- Vocational and Educational Readiness: strengthening skills related to employment, volunteering, or academic goals when clinically appropriate.
- Caregiver/Family Support: educating and training families or natural support in ways that promote member independence and reinforce learned skills (with the member present).

The focus of PSR is to assist individuals in achieving their highest level of independent functioning with the least amount of ongoing professional intervention.

Examples of Appropriate Activities

Functional Skills & Cognitive Rehabilitation

- Practicing organizational strategies such as using a planner, reminders, or visual schedules.
- Teaching structured problem-solving skills for daily challenges (e.g., what to do if transportation is late).

Interpersonal, Communication, & Relationship Skills

- Coaching on how to initiate and maintain positive social interactions.
- Practicing communication approaches to reduce conflict in family or peer relationships.
- Training on how to interpret social cues and respond appropriately.

Recovery, Symptom Management & Relapse Prevention

- Developing individualized relapse prevention plans (identifying triggers, coping steps, crisis contacts).
- Teaching strategies for managing auditory hallucinations, anxiety, or mood fluctuations.
- Practicing healthy routines that support stability (sleep hygiene, scheduling, wellness habits).

Community Integration & Natural Support Building

- Skill building activities that help members practice participating in community events or activities.
- Teaching how to safely engage in volunteer opportunities or peer support groups.
- Coaching on how to build and maintain supportive relationships.

Vocational or Educational Readiness

- Teaching basic workplace behaviors (professional communication, punctuality, appropriate boundaries).
- Developing pre-employment skills such as filling out applications, preparing for interviews, or managing workplace expectations.

Family/Caregiver Involvement (with the member present)

- Training caregivers on strategies that reinforce member independence.
- Teaching families how to support problem solving and communication techniques learned in PSR sessions.

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

Documentation expectations (for both Skills Training and PSR) [6]
Progress notes should reflect:
(a) the specific skill(s) taught/practiced.
(b) method (modeling, coaching, rehearsal, feedback).
(c) members' active participation and response.
(d) functional progress toward measurable goals tied to the service plan; and
(e) required begin/end times for timed services.

HCPCS Codes

- H2014 - Skills training and development, per 15 minutes (up to 5 hours per day).
- H2038 – Skills training and development, per diem.
- H2017 - Psychosocial rehabilitation services, per 15 minutes (up to 5 hours per day).
- H2018 – Psychosocial rehabilitation services, per diem.

Billing Limitations

1. See general core billing limitations.
2. Transportation provided to members and/or family members is not included in the rate and should be billed separately using the appropriate transportation procedure codes.
3. H2014, H2038, H2017, H2018 are not subject to the group limit specified in Core Billing Limitation #24 if group services are provided in person at an AHCCCS registered provider site. Groups shall not exceed a 1:20 ratio.
4. H2018 and H2038 must be paired with the HQ modifier when providers are serving two or more members at the same time.[7]

Cognitive Rehabilitation

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

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

CPT Codes

- 97129 - Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory

[6] Documentation expectations added for PSR and Skills training.
[7] Added billing guideline to use HQ modifier when serving two or more members.

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

Health Promotion

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

See the ACOM Policy 423 for coverage of court ordered treatment coverage for DUI and domestic violence.

HCPCS Codes

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

Billing Limitations

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

1. See general core billing limitations.
2. Transportation provided to members and/or family members is not included in the rate and should be billed separately using the appropriate transportation procedure codes.
3. H0025 and H0034 are not subject to the group limit specified in Core Billing Limitation #24 if group services are provided in person at an AHCCCS registered provider site. Groups shall not exceed a 1:20 ratio.

Psychoeducational Services / Pre-vocational Services and Ongoing Support to Maintain Employment

Psychoeducational Services (when used for pre-vocational services and billing H2027) and Ongoing Support to Maintain Employment (job coaching/employment support) are designed to assist a member or group to choose, acquire, and maintain a job or other meaningful community activity (e.g., volunteer work) while managing their medical/mental health symptoms. These services may be used for members who are preparing to work and/or volunteer or are currently employed. These services shall be provided using tools, strategies, and materials that meet the members' needs and are tailored to support members in a variety of settings.

Psychoeducational Services/Pre-vocational services prepare members to engage in meaningful work-related activities, such as full- or part- time competitive employment. Psychoeducational Services/Pre-vocational services shall be provided in accordance with the member's individualized treatment plan to support specific goals aimed at gaining meaningful employment; activities may include, but are not limited to, the following:

1. Career/educational counseling - Assisting members in making decisions about their careers and education by identifying strengths, knowledge, skills, and abilities, then developing a plan to achieve their goals. This process also includes assisting members overcome any barriers they may have in achieving their goals.
2. Job training - Services that help members develop skills necessary to enter the workforce, including volunteer work, where members develop general strengths and skills that contribute to employability in paid competitive employment in integrated community settings that are not specific to a given job, such as:
    a. Personal skills (e.g., self-discipline, time management, task prioritization, accountability, and integrity).
    b. Interpersonal skills (e.g., accepting supervision, following directions, and effective communication).
    c. Work-related skills and knowledge (e.g., workplace conduct, ethics, and dress code, safety skills in the workplace, and staying on task).
    d. The service is intended to be received on a time-limited basis as preparation for securing paid employment by an employer other than the service provider.
3. Assistance in the use of educational resources necessary to obtain employment - Assisting current or potential students in accessing programs to support educational goals (e.g., mentoring, scholarships, financial assistance). This also includes assistance in accessing learning materials designed to support gaining employment (e.g., locating articles on writing resumes or materials with potential interview questions).
4. Attendance to Rehabilitation Services Administration/Vocational Rehabilitation (RSA/VR) Orientations - RSA/VR Orientations are recommended for members to attend prior to deciding whether or not to participate in the RSA/VR program. Per the Statewide Collaborative Protocols that are tied to the Interagency Service Agreement (ISA) between AHCCCS and the Arizona Department of Economic Security (ADES), a minimum of one provider staff must be present during group RSA/VR Orientations and is expected to be actively engaged during the sessions. This service includes accompanying a member or group of members to an RSA/VR Orientation. As Orientations are mostly conducted by RSA/VR staff, billable time may only be counted for the time behavioral health staff are providing actual services.
5. Assistance in finding employment - A range of services and support offered to members seeking employment that is aimed at helping navigate the job market effectively. This assistance can include, but is not limited to, job counseling, developing/updating resumes with members, interview preparation, job search strategies, and access to job listings or networking opportunities, such as attending job fairs with members.
6. Other training - This may include developing study skills, budgeting skills (when it pertains to employment), appropriateness on the job, and time management, among others.

Ongoing support to maintain employment services are post-vocational services, often called job coaching, which enable members to maintain their current employment. Services are provided in accordance with the member's individualized treatment plan to support specific goals aimed at maintaining employment or to

assist a member in obtaining the skills needed for promotional opportunities. Ongoing Support to Maintain employment may be provided individually or in a group setting, as well as via telehealth. Ongoing support to maintain employment activities may include, but are not limited to, the following:

1. Monitoring and supervision - Monitoring job performance and satisfaction for both the worker and employer to track progress over time.
2. Assistance in performing job tasks - Helping employed members learn new job duties, relearn skills, and solve problems on the job.
3. Supportive counseling - Support aimed at assisting members in maintaining employment by providing emotional support, guidance, and practical strategies to overcome challenges related to workplace integration, such as acclimating to workplace culture and etiquette. This may also include addressing specific barriers related to a disability and/or behavioral health condition.

For Community Service Agencies (CSAs), see the AMPM Policy 965 for further detail on service standards and provider qualifications for this service.

HCPCS Codes

- H2027 - Psychoeducational service, per 15 minutes (pre-vocational services). Billing unit: 15 min.
- H2025 - Ongoing support to maintain employment, per 15 minutes (job coaching/employment support). Billing unit: 15 min. Up to 5 hours in duration.
- H2026 -Ongoing support to maintain employment, per diem (job coaching/employment support), Over 5 hours per day.

Billing Limitations

1. See general core billing limitations.
2. Transportation provided to members is not included in the rate and should be billed separately using the appropriate transportation procedure codes.
3. Psychoeducational services/pre-vocational services and ongoing support to maintain employment services are provided only if the services are not available through the federally funded Rehabilitation Act program administered by Arizona Department of Economic Security Rehabilitation Service Administration (DES/RSA), which is required to be the primary payer for Title XIX/XXI eligible members. Members must be educated on the intended benefits of the ADES-RSA Vocational Rehabilitation program and decisions about participation must be documented accordingly, including in the service plan.
4. Service code H2026, Ongoing support to maintain employment, per diem, can only be billed for services over 5 hours and should be billed for the length of the service and cannot be billed on the same day as H2025. If providers are serving more than one member during the same time period, H2026 must be paired with the HQ modifier.
5. Service code H2027 - Psychoeducational service, per 15 minutes, may be billed for up to 8 hours when used to provide pre-vocational services. If providers are serving more than one member during the same time period, H2027 must be paired with the HQ modifier.
6. More than one provider agency may bill for psychoeducational services and ongoing support to maintain employment services provided to a member during the same date span when the member's clinical needs for this are clearly documented in the service plan or treatment plan.
7. Costs associated with training an agency's own employees are not reimbursable.

8. Billable time for psychoeducational services (including pre-vocational services) and ongoing support to maintain employment services may only be counted for the time a qualified behavioral health staff/professional is providing actual services. Observing a member while they are working is not reimbursable unless the observation is a part of an assessment of employment support interventions needed for the member.
9. H2025, H2026, and H2027 are not subject to the group limit specified in Core Billing Limitation #24 if group supported employment or pre-vocational services are provided in person at an AHCCCS registered provider service site or a member work site. Groups shall not exceed a 1:20 ratio.
10. Only AHCCCS registered providers who render services to members may bill for and be reimbursed for the services provided. If an AHCCCS registered provider brings in a third-party entity, who is not an AHCCCS-registered provider, to deliver services to members, such as job training, that AHCCCS-registered provider may not bill for and be reimbursed for services rendered by that third-party entity. The AHCCCS-registered provider may bill for other services rendered to members during the course of the activity to support their active engagement and participation.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Other Services

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

CPT Codes

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

HCPCS Code

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

Billing Limitations

1. See general core billing limitations.
2. Transportation provided to members and/or family members is not included in the rate and should be billed separately using the appropriate transportation procedure codes.
3. For MST for juveniles the following billing limitations apply:
    a. Transportation provided to members and/or family members is not included in the rate and should be billed separately using the appropriate transportation procedure codes.
    b. Providers of this service must be trained and licensed in MST services in strict adherence to the Blueprints Project MST model and as approved by MST Services.
    c. Multisystemic therapy for juveniles (H2033) may not be billed on the same day as other per diem services or inpatient services.
    d. MST is an all-inclusive service paid at a bundled rate. All case related direct- service activity is billable. Billing is submitted on a weekly basis. This includes all face-to-face time with members as well as collateral contact related to the member treatment plan.

e. Weekly consultation and supervision of MST personnel with the national MST staff if considered part of the cost of rendering the service and has been factored in the rate. This is not considered a billable activity.
f. Travel time and expenses are not billable activities and cannot be included in units billed during claims submission.

Medical Services

The definition of medical services may be found in AMPM Policy 310-B. This Medical Services section also addresses service standards and provider qualifications.

Medication Services

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

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

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

The AHCCCS Drug List can be found on the AHCCCS Pharmacy web page.

Informed Consent

Informed consent shall be obtained from the member, or as applicable, the member's Health Care Decision Maker for each psychotropic medication prescribed, as required in AMPM Policy 310-V. Informed consent for prescribed psychotropic medication shall be attempted for members on Court Ordered Treatment, however, is not required for administration of the Court Ordered prescribed medication.

National Drug Codes

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

CPT Code

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

HCPCS Codes

- J2060 - Injection, Lorazepam, intramuscular, 2 mg.
- J0401 - Injection, Aripiprazole, extended release, 1 mg.
- 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.
- J2358 - Injection, Olanzapine, long acting, 1 mg.
- J2426 - Injection, Paliperidone Palmitate, extended release, 1 mg.
- J2680 - Injection, Fluphenazine Decanoate, up to 25 mg.

- J2794 - Injection, Risperidone (Risperdal Consta), long-acting, 0.5 mg.
- J3410 - Injection, Hydroxyzine HCL, up to 25 mg.

Opioid Agonist Drugs

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

- H2010 - Comprehensive Medication Services, per 15 minutes
  - Lay Description: Administration of prescribed opioid agonist drugs to a person in the office setting in order to reduce physical dependence on heroin and other opiate narcotics.
  - Providers must be AHCCCS registered as a Category of Service (COS) type 01 (Medicine).
- H0020 - Methadone administration and/or service programs provide opioid replacement treatment (ORT) or opioid maintenance treatment (OMT), including the administration of methadone to an individual for detoxification from opioids and/or maintenance treatment.
  - Additional Guidance: Overall treatment must be delivered, which should include counseling/therapy, case review, and medication monitoring. ORT/OMT is delivered by providers functioning under a defined set of policies and procedures, including admission, discharge, and continued service criteria stipulated by state law and regulations, Substance Abuse and Mental Health Services Administration (SAMHSA) regulations, and Drug Enforcement Agency (DEA) regulations. The ORT must be licensed by the Drug Enforcement Agency. The ORT should also have accreditation from the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), Committee for Accreditation (COA), and/or the Commission on the Accreditation of Rehabilitation Facilities (CARF). The ORT/OMT must meet the requirements of the Substance Abuse and Mental Health Administration.
  - Providers must be AHCCCS registered as a Category of Service (COS) type 01 (Medicine).
  - Billing Unit: 1 per day (includes cost associated with drug and administration). While the billing unit is a single dose of medication per day, the take home medicine can be provided for more than one day.
- H0033 - Oral medication administration, direct observation.
  - Lay Description: Patients are assisted or observed by professional medical staff during the administration of oral medication. This is often used in the administration of drugs such as methadone when it must be established that the patient has received the medication.
  - Providers must be AHCCCS registered as a Category of Service (COS) type 01 (Medicine).
  - Billing Unit: 1 per day (includes cost associated with drug and administration).
- The HG modifier may be added to claims if the provider meets the definition of the HG Opioid Addiction Treatment program.

Billing Limitations

For medication services the following billing limitations apply:

1. Medications provided in an inpatient general acute care setting, provider type 02, or psychiatric hospital, PT 71, are included in the per diem rate and cannot be billed separately.

2. As described in AMPM Policy 510, behavioral health services provided by a PCP within their scope of practice is covered. In certain circumstances the member's primary care physician (PCP) may prescribe psychotropic medications. Care should be coordinated with other prescribers, including PCPs.
3. Other than opioid agonist drugs (see limitation #4 below), the provider should determine the maximum number of days and/or unit doses for prescriptions.
4. The Comprehensive Medication Services (Office) and Methadone Administration and/or Services (Take-Home) procedure codes are to be billed one dose per day (includes cost associated with drug and administration). While the billing unit for Methadone Administration and/or Services (Take-Home) is a single dose of medication per day, the take-home medicine can be provided for more than one day with an approved exemption request. Take-home methadone medication doses must align to the approved cadence in 42 CFR Part 8(h)3i-iii, based on the patient's time in treatment, and the clinical rationale of the prescribing practitioner, as documented within the patient's chart.
5. AHCCCS does not cover items relating to medical marijuana. This includes application fees or the drug itself.
6. Transportation provided to the AHCCCS members is not included in the rate and should be billed separately using the appropriate transportation procedure codes.
7. Providers who administer Medication Assisted Treatment (MAT) or Medications for Opioid Use Disorder (MOUD) must adhere to AHCCCS guidelines in compliance with federal regulations, (see 42 CFR Part 8), state regulations (AAC Title 9, Chapter 10) and AMPM Policy 660 for opioid treatment. Providers receiving AHCCCS reimbursement shall adhere to all AHCCCS standards and reporting requirements.
8. H2010 and H0033 cannot be billed on the same day.

Laboratory, Radiology and Medical Imaging General Information

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

Service Standards/Provider Qualifications

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

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

Urine drug testing (UDT) provides objective information to assist clinicians in identifying the presence or absence of drugs or drug classes in the body and making treatment decisions.

Presumptive/Qualitative UDT ("presumptive" UDT)

Presumptive UDT may be ordered by the clinician when it is medically necessary to rapidly obtain and/or integrate results into clinical assessment and treatment decisions. Presumptive UDT typically involves testing for multiple analytes based on the specific member's clinical history and risk assessment and must be documented in the medical record. A presumptive UDT consists of various platforms including cards, dipsticks, cassettes, and cups based on qualitative competitive immunoassay (IA) methodology with one or more analytes in the test. A presumptive IA test detects the presence of the amount of drug/substance present in urine above a predetermined "cut-off" value and may be read by direct optical observation or by instrument assisted direct optical observation. Thin layer chromatography is also a method of presumptive UDT. Chemistry analyzers with IA UDT technology can be used in an office or clinical laboratory setting. This test provides less immediate test results. At no time is IA technology by chemistry analyzer analysis considered confirmatory (definitive) testing. When presumptive UDT is insufficient for certain clinical needs, it may be medically necessary for clinicians to utilize definitive UDT. The clinical information supplied must support the medical necessity for definitive UDT, as described in the following section on definitive UDT.

Definitive/Quantitative/Confirmation ("definitive" UDT)
Definitive methods typically include GC-MS and LC-MS/MS testing methods. Gas Chromatography coupled with Mass Spectrometry (GC-MS) and Liquid Chromatography coupled with Mass Spectrometry (LC-MS/MS) are complex technologies that use the separation capabilities of gaseous or liquid chromatography with the analytical capabilities of mass spectrometry. These methodologies require the competency of on-site highly trained experts in this technology and interpretation of results. While these tests require different sample preparation and analytical runs, they identify specific drugs, metabolites, and most illicit substances and report the results as absent or present typically in concentrations of ng/mL.

Definitive UDT is considered medically necessary when the clinical information supplied supports the definitive testing as in:

1. Identify a specific substance or metabolite that is inadequately detected by a presumptive UDT Screen; Definitively identify specific drugs in a large family of drugs.
2. Identify a specific substance or metabolite that is not detected by presumptive UDT such as fentanyl, meperidine, synthetic cannabinoids, and other synthetic/analog drugs.
3. Identify drugs when a definitive concentration of a drug is needed to guide management (e.g., discontinuation of THC use according to a treatment plan).
4. Identify a negative, or confirm a positive, presumptive UDT result that is inconsistent with a patient's self-report, presentation, medical history, or current prescribed pain medication plan; Rule out an error as the cause of a presumptive UDT result.
5. Identify non-prescribed medication or illicit use for ongoing safe prescribing of controlled substances.
6. Use in a differential assessment of medication efficacy, side effects, or drug-drug interactions.

Definitive UDT orders should be individualized based on clinical history, risk assessment, substance use patterns, results of presumptive testing, and must be documented in the medical record. Definitive testing for more than 7 classes of drugs (including metabolites) may be subject to prepayment review.

It is not considered medically necessary to order definitive testing for all analytes in every drug test conducted on a patient and to do so repeatedly, without regard to the results from previous tests or the patient's overall response to addiction treatment interventions. To be considered medically necessary, drug testing requires that the scope of the analyte panel and the frequency of testing be justified by the patient's clinical status and the ordering clinician's need for information.

For both presumptive and definitive UDT to be considered medically necessary, drug testing shall be individualized to test only for substances specific to the individual member's clinical history and plan of treatment. Clinical documentation must specify how the test results will be used to guide clinical decision making. The medically necessary frequency of drug testing for any indication should be individualized and included in the treatment plan.

The following drug tests are not considered medically necessary:

1. Routine standing or blanket orders of drug tests (i.e., routine/same orders for all patients in a provider's practice that are not individualized to the member's history and clinical presentation).
2. Reflex definitive UDT not based on a specific clinician's order.
3. IA testing, regardless of whether it is qualitative or semi-quantitative (numerical), may not be used to "confirm" or definitively identify a presumptive test result obtained by cups, dipsticks, cards, cassettes, or other IA testing methods. Definitive UDT provides specific identification and/or quantification typically by GC-MS or LCMS/MS.
4. Simultaneous performance of presumptive and definitive tests for the same drugs or metabolites at the same time.
5. Presumptive Point of Care Testing (POCT) or IA testing and ordering presumptive IA UDT from a lab on the same day.
6. Reference laboratory performing and billing IA presumptive UDT prior to definitive testing without a specific physician's order for the presumptive testing. Drug testing of 2 different specimen types from the same patient on the same date of service for the same drugs/metabolites/analytes.
7. UDT for medico-legal and/or employment purposes or to protect a physician from drug diversion charges.
8. Specimen validity testing including, but not limited to, pH, specific gravity, oxidants, creatinine.

Diagnosis and treatment for substance abuse or dependence

The UDT result should guide clinical decision making, treatment planning and level of care decisions. Ordered tests and testing methods (presumptive and/or definitive) must match the stage of screening, treatment, or recovery; the documented history; and diagnosis.

For patients with known indicators of risk for SUD, the clinician may screen for a broad range of commonly abused drugs using presumptive UDT or using definitive UDT if medically necessary as described above.

For patients with a diagnosed SUD, the clinician should perform random UDT at random intervals to properly monitor the patient. Testing profiles must be determined by the clinician based on the following medical necessity guidance criteria:

1. Patient history, physical examination, and previous laboratory findings.

2. Stage of treatment or recovery.
3. Suspected abused substance.
4. Substances that may present high risk for additive or synergistic interactions with prescribed medication (e.g., benzodiazepines, alcohol).

The patient's medical record must include an appropriate number of UDTs billed over time based on the stage of screening, treatment, or recovery; and the rationale for the drugs/drug classes ordered; the results must be documented in the medical record and used to direct care.

Note on UDT for alcohol metabolites: these guidelines also apply to UDT for ethyl alcohol/ethanol metabolites, such as ethyl glucuronide (EtG). EtG tests can be conducted in reference laboratories, in clinical settings using a desktop analyzer, or by using a point of-care dip card.

Maximum Number of Allowed Presumptive UDTs for SUD The number of UDTs billed over time must meet medical necessity and be documented in the patient's medical record:

1. For patients with 0 to 30 consecutive days of abstinence, presumptive UDT is not to exceed 3 presumptive UDTs in 7 days. More than 3 presumptive UDTs in 7 days are not considered medically necessary and is not covered.
2. For patients with 31 to 90 consecutive days of abstinence, presumptive UDT is not to exceed 3 presumptive UDTs in 7 days. More than 3 presumptive UDTs in 7 days are not considered medically necessary and are not covered.
3. For patients with > 90 consecutive days of abstinence, presumptive UDT is not to exceed 3 presumptive UDTs in 30 days. More than 3 presumptive UDTs in 30 days is not considered medically necessary and are not covered.

Maximum Number of Allowed Definitive UDTs for SUD

Depending on the patient's specific substance use history, definitive UDT to accurately determine the specific drugs in the patient's system may be necessary. Definitive testing may be ordered when accurate and reliable results are necessary to integrate treatment decisions and clinical assessment. The number of UDTs billed over time and the rationale for definitive UDT must be documented in the patient's medical record.

1. For patients with 0 to 30 consecutive days of abstinence, definitive UDT is not to exceed 1 definitive UDT in 7 days. More than 1 definitive UDT in 7 days is not considered medically necessary and is not covered.
2. For patients with 31 to 90 consecutive days of abstinence, definitive UDT is not to exceed 3 definitive UDTs in 30 days. More than 3 definitive UDTs in 30 days is not considered medically necessary and are not covered.
3. For patients with > 90 days of consecutive abstinence, definitive UDT is not to exceed 3 definitive UDTs in 90 days. More than 3 definitive UDTs in 90 days is not considered medically necessary and are not covered.

Documentation Requirements

All documentation must be maintained in the patient's medical record and made available to the AHCCCS upon request.

The patient's medical record must include an appropriate number of UDTs billed over time based on the stage of screening, treatment, or recovery; and the rationale for the drugs/drug classes ordered; the results must be documented in the medical record and used to direct care.

Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service[s]). The documentation must include the legible signature of the clinician responsible for and providing care to the patient.

The medical record documentation must support the medical necessity of the services as stated in this Guide.

Medical record documentation (e.g., history and physical as well as, progress notes) maintained by the ordering/treating clinician must indicate the medical necessity for performing a presumptive/qualitative drug test. All tests must be ordered in writing by the treating clinician and all drugs/drug classes to be tested must be indicated in the order.

When a definitive/quantitative test is performed, the medical record documentation must show the ordering clinician's rationale for the definitive UDT and the tests including drugs ordered must be documented in the patient's medical record.

If the provider of the service is other than the ordering/referring clinician, that provider must maintain hard copy documentation of the lab results, along with copies of the ordering/referring clinician's order for the test. The clinician must include the clinical indication/medical necessity in the order for the test.

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

CPT Codes

- 36415 - Collection of venous blood by venipuncture
- 80048 - Basic metabolic panel (Calcium, total)
- 80050 - General health panel
- 80051 - Electrolyte panel
- 80053 - Comprehensive metabolic panel
- 80061 - Lipid panel
- 80076 - Hepatic function panel
- 80156 - Carbamazepine; total
- 80159 - Clozapine; therapeutic drug assays
- 80164 - Valproic acid (dipropylacetic acid); total
- 80171 - Gabapentin, whole blood, serum, or plasma
- 80178 - Lithium
- 80299 - Quantitation of therapeutic drug, not elsewhere specified

- 80305 - Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; capable of being read by direct optical observation only (e.g., utilizing immunoassay [e.g., dipsticks, cups, cards, or cartridges]), includes sample validation when performed, per date of service
- 80306 - Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; read by instrument assisted direct optical observation (e.g., utilizing immunoassay [e.g., dipsticks, cups, cards, or cartridges]), includes sample validation when performed, per date of service
- 80307 - Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; by instrument chemistry analyzers (e.g., utilizing immunoassay [e.g., EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA]), chromatography (e.g., GC, HPLC), and mass spectrometry either with or without chromatography, (e.g., DART, DESI, GC-MS, GC-MS/MS, LC-MS, LC-MS/MS, LDTD, MALDI, TOF) includes sample validation when performed, per date of service
- 80358 - This test may be requested as a qualitative, quantitative, or combination analysis for methadone.
- 80420 - Dexamethasone suppression panel, 48 hour
- 81000 - Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy
- 81001 - Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy
- 81002 - Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, without microscopy
- 81003 - Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, without microscopy
- 81005 - Urinalysis; qualitative or semiquantitative, except immunoassays
- 81025 - Urine pregnancy test, by visual color comparison methods
- 81050 - Volume measurement for timed collection, each
- 82075 - Alcohol (ethanol); breath
- 82382 - Catecholamines, total urine
- 82465 - Cholesterol, serum or whole blood, total
- 82492 - Chromatography Quan Column Multiple Analytes
- 82530 - Cortisol, free
- 82533 - Cortisol, total
- 82542 - Column chromatography/mass spectrometry (EG, GC/MS, or HPLC/MS), analyte not elsewhere specified; quantitative, single stationary and mobile phase
- 82565 - Creatinine; blood
- 82570 - Creatinine (other source)
- 82575 - Creatinine, clearance
- 82607 - Cyanocobalamin (Vitamin B12)

- 82746 - Folic acid; serum
- 82947 - Glucose; quantitative, blood (except reagent strip)
- 82948 - Glucose, blood, reagent strip
- 82977 - Glutamyltransferase, gamma (GGT)
- 83036 - Hemoglobin; Glycosylated (A1C)
- 83037 - Hemoglobin; glycosylated (A1C) by device cleared by FDA for home use
- 83789 - Mass spectrometry and tandem mass spectrometry (e.g., MS, MS/MS, MALDI, MS-TOF, QTOF), non-drug analyte(s) not elsewhere specified, qualitative or quantitative, each specimen
- 83986 - PH body fluid Not Elsewhere Specified
- 83992 - Phencyclidine (PCP)
- 84132 - Potassium; serum, plasma or whole blood
- 84146 - Prolactin
- 84311 - Spectrophotometry Analyte Not Elsewhere Specified
- 84436 - Thyroxine; total
- 84439 - Thyroxine, free
- 84443 - Thyroid stimulating hormone (TSH)
- 84520 - Urea nitrogen; quantitative
- 84703 - Gonadotropin, chorionic (Hcg), qualitative
- 85007 - Blood count; blood smear, microscopic examination with manual differential WBC count
- 85008 - Blood count; blood smear, microscopic examination without manual differential WBC count
- 85009 - Blood count; manual differential WBC count, buffy coat
- 85013 - Blood count; spun microhematocrit
- 85014 - Blood count; hematocrit (Hct)
- 85018 - Blood count; hemoglobin (Hgb)
- 85025 - Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count
- 85027 - Blood count; complete (CBC), automated (Hgb), Hct, RBC, WBC, and platelet count)
- 85048 - Blood count, leukocyte (WBC), automated
- 85651 - Sedimentation rate, erythrocyte; non-automated
- 85652 - Sedimentation rate, erythrocyte; automated
- 86580 - Skin test, tuberculosis, intradermal
- 86592 - Syphilis test; qualitative (e.g., VDRL, RPR, ART)
- 86593 - Syphilis test; quantitative
- 86689 - Antibody; HTLV or HIV antibody, confirmatory test (e.g., Western Blot)
- 86701 - Antibody; HIV-1
- 86702 - Antibody; HIV-2
- 86703 - Antibody; HIV-1 and HIV-2, single result

- 87390 - Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; HIV-1
- 87391 - Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; HIV-2
- 70450 - Computed tomography, head or brain, without contrast material
- 70460 - Computed tomography, head or brain; with contrast material(s)
- 70470 - Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections
- 70551 - Magnetic resonance (e.g., proton) imaging, brain (including brain stem); without contrast material
- 70552 - Magnetic resonance (e.g., proton) imaging, brain (including brain stem); with contrast material(s)
- 70553 - Magnetic resonance (e.g., proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences
- 80305 - Presumptive drug screenings - max of 3 in 7 days; max 12 in 1 month
- 80306 - Presumptive drug screenings - max of 3 in 7 days; max 12 in 1 month
- 80307 - Presumptive drug screenings - max of 3 in 7 days; max 12 in 1 month
- 93000 - Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report
- 93005 - Electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpretation and report
- 93010 - Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only
- 93040 - Rhythm ECG, 1-3 leads; with interpretation and report
- 93041 - Rhythm ECG, 1-3 leads; tracing only without interpretation and report
- 93042 - Rhythm ECG, 1-3 leads; interpretation and report only
- 95819 - Electroencephalogram (EEG); including recording awake and asleep
- G0480 - Definitive Drug Screenings - max 1 in 7 days; max 4 in 1 month
- G0481 - Definitive Drug Screenings - max 1 in 7 days; max 2 in 1 month
- G0482 - Definitive Drug Screenings - max 1 in 30 days; max 6 in 12 months
- G0483 - Definitive Drug Screenings - max 1 in 30 days; max 6 in 12 months

Billing Limitations

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

Medical Management

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

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

CPT Codes

- 99202 - Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
- 99203 - Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
- 99204 - Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
- 99205 - Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
- 99211 - Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified Health care professional
- 99212 - Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.
- 99213 - Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
- 99214 - Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

- 99215 - Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
- 99304 - Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.
- 99305 - Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.
- 99306 - Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 50 minutes must be met or exceeded.
- 99307 - Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.
- 99308 - Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
- 99309 - Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
- 99310 - Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
- 99315 - Nursing facility discharge management; 30 minutes or less total time on the date of the encounter
- 99316 - Nursing facility discharge management; more than 30 minutes total time on the date of the encounter
- 99341 - Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
- 99342 - Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When

using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

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

HCPCS Codes

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

Billing Limitations

For medical management services the following billing limitations apply:

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

4. Transportation provided to the AHCCCS enrolled member is not included in the rate and should be billed separately using the appropriate transportation procedure codes.
5. Medical management using CPT codes is not reimbursable when billed with a clinic or TRBHA facility ID as the servicing provider. The servicing provider NPI must belong to the individual person delivering the service.
6. T1002 and T1003 are timed codes up to 15 minutes. This distinction exempts these specific codes from Core Billing Limitation #10 and requires calculation of actual minutes of service up to 15 minutes per unit.

Electroconvulsive Therapy

Electroconvulsive therapy is a medical service. A description may be found in AMPM Policy 310-B.

CPT Codes

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

Revenue Codes

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

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

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

Transcranial Magnetic Stimulation (TMS)

Transcranial Magnetic Stimulation therapy is a medical service. A description may be found in AMPM Policy 310-B.

CPT Codes

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

Support Services

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

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

Case Management

Case management is a supportive service provided to improve treatment outcomes and meet members' service or treatment plan goals. AHCCCS Medical Policy Manual Chapter 500, Policy 570, Provider Case Management provides detailed clinical guidelines for case management. This document may be found in the following location: AMPM Policy 570.

In addition, a definition of indirect contact may be found in AMPM Policy 310-B.

HCPCS Code

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

Billing Limitations

1. See general core billing limitations.
2. Case management services provided by an ADHS licensed inpatient, behavioral health residential facility or in a therapeutic/medical day program setting are included in the rate for those settings and cannot be billed separately. However, providers other than the inpatient, residential facility, or day program can bill case management services provided to the member residing in and/or transitioning out of the inpatient or residential settings, or who is receiving services in a day program.
3. A provider may not bill case management for any time associated with a therapeutic interaction, nor simultaneously bill case management with any other services. Case management should be documented and billed as a separate service from any other therapeutic service.
4. When multiple providers bill for case management services during the same time period (e.g., staffing), each provider must complete unique documentation of the specific case management service they provided.

5. Billing for case management is limited to individual providers who are directly involved with service provision to the members (e.g., when a clinical team comprised of multiple providers, physicians, nurses etc. meet to discuss current case plans).
    a. Outreach and communication needing to be clinical in nature and directly related to member needs and access to services.
    b. Email and voicemail counted and billed as case management shall contain substantive clinical notes and or communication and do not include administrative or quick check-ins.
    c. When billing multiple units/types of case management for the same member on the same day providers shall ensure all services are rolled up together vs billed as separate service/units (see core billing limitations #11).
6. Transportation provided to the member is not included in the rate and should be billed separately using the appropriate transportation procedure codes.
7. For Case Management codes:
    a. The provider should bill all time spent in direct or indirect contact with the member, family and/or other parties involved in implementing the treatment or service plan. Indirect contact includes telephone calls, and/or collateral contact with the member, family, and/or other parties involved.
    b. Written electronic communication (email) and leaving voice messages are allowable as case management functions. These functions are not to be the predominant means of providing case management services and require specific documentation as specified below.
        i. Written electronic communication (email) must be about a specific individual and be sufficient to justify a case management service to be allowable as case management, as long as documentation exists in the medical record.
        ii. When voice messages are used, the case manager must have sufficient documentation justifying a case management service was actually provided. Leaving a name and number asking for a return call is not sufficient to bill case management.
        iii. When leaving voice messages, a signed document in the member chart granting permission to leave specific information is required.
    c. See the AMPM Policy 570 for more case management guidance related to case load, responsibilities, and complex member needs.
8. Case management activities that do not meet the threshold required under Core Billing Limitation #10 but do meet the allowability of Behavioral Health Outreach services described below shall be billed using H0023. If multiple case management activities are provided on the same day for the same member by the same provider and can appropriately be coded and billed as described in Core Billing Limitation #10, T1016 shall be used to support the approved activities for one or more units based on the total time spent providing services.
9. T1016 cannot be billed on the same day by the same provider as H0023.

Behavioral Health Outreach Services (planned approach to reach a targeted population)

Behavioral Health Outreach Service involves a planned approach to reach a specific population with mental health and substance abuse education, support, and treatment services. The goal is to engage individuals who might not seek help on their own and connect them to necessary care. For the purpose of this guidance document, the H0023 code may be used to support required activities outlined in AMPM Policy 570 and AMPM Policy 1040. Specific populations include members with an SMI or SED determination, members with a Substance Use Disorder (SUD) or behavioral health condition and members identified as high need and/or high cost. The goals of this service include increasing awareness and understanding of mental health problems, reducing stigma associated with seeking help and connecting individuals to appropriate care and treatment services through care coordination.

Behavioral Health Outreach Service aims to address:

1. Mental health disorders such as depression, anxiety, and bipolar disorders.
2. Substance abuse and addiction issues.
3. Individuals exhibiting signs of mental health disorders or substance abuse.
4. High-risk populations with limited access to healthcare.

Specific activities may include:

1. Completing a preliminary health assessment or questionnaire.
2. Gathering personal and medical history in preparation of an appointment or to coordinate care with partnering providers (e.g., A case manager or clinical team member at a behavioral health or health home provider may need to gather information and send it to a specialty provider for treatment planning or referral purposes, or to a hospital, behavioral health inpatient provider, residential provider, or crisis provider for discharge planning or care coordination).
3. Outreach and communication shall be clinical in nature and directly related to member needs and access to services.
4. Email and voicemail counted and billed as Behavioral Health Outreach Services shall contain clinical notes and/ or communication supporting the need and description of services provided and do not include administrative or quick check-ins.
5. Coordinating transportation for a member to ensure the member is able to get to and return home from a covered provider appointment.
6. Post-crisis contact follow up with a member to support ongoing stabilization and connection to outpatient services and community resources.

HCPCS Code

- H0023 - Behavioral health outreach (1 unit per day per member); Service targeting specific, at-risk individuals in a given population who are in need of assistance with mental health issues.

Billing Limitations

1. See general core billing limitations.
2. Behavioral health outreach services provided by an ADHS licensed inpatient, behavioral health residential facility, or in a therapeutic/medical day program setting are included in the rate for those settings and cannot be billed separately. However, providers other than the inpatient, residential facility, or day program can bill behavioral health outreach services provided to the member residing in and/or transitioning out of the inpatient or residential settings, or who is receiving services in a day program. For IHS/638 providers and tribal health programs operated under PL 93-638, see the AHCCCS IHS/Tribal Billing Manual.
3. A provider may not bill H0023 for any time associated with a therapeutic interaction, nor simultaneously bill H0023 with any other services. Behavioral health outreach services should be documented and billed as a separate service from any other service.
4. Billing for behavioral health outreach is limited to behavioral health providers who are responsible for care coordination and case management for the members.
5. For behavioral health outreach codes:
    a. The provider should bill all time spent in direct or indirect contact with the member, family, and/or other parties involved in implementing the treatment or service plan. Indirect contact includes telephone calls, and/or collateral contact with the members, family, and/or other parties involved.
    b. Written electronic communication (email) and leaving voice messages are allowable as behavioral health outreach functions. These functions are not to be the predominant means of behavioral health outreach services and require specific documentation as specified below.
        i. Written electronic communication (email) must be about a specific individual and be sufficient to justify a behavioral health outreach service to be allowable, as long as documentation exists in the medical record.
        ii. When voice messages are used, the provider must have sufficient documentation justifying a behavioral health outreach service was actually provided.
        iii. When leaving voice messages, a signed document in the member chart granting permission to leave specific information is required.
6. See the AMPM Policy 570 for more case management guidance related to case load, responsibilities, and complex member needs.

Personal Care Services

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

1. Personal care services may be provided in an unlicensed setting such as a member's own home or community setting. Parents (including natural parent, adoptive parent, and stepparent) may be eligible to provide personal care services if the member receiving services is 21 years or older and the parent is not the member's legal guardian. Personal care services provided by a member's spouse are not covered, and

HCPCS Codes

- T1019 - Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant): Personal care services (see general definition above) provided to a member for a period of time (up to 11¾ hours).
- T1020 - Personal care services, per diem, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant): Personal care services (see general definition above) provided to a member, for 12 or more hours.

Billing Limitations

For personal care services the following limitations apply:

1. See general core billing limitations.
2. Personal care services provided in an ADHS licensed inpatient, residential or day program setting are included in the rate for those settings and cannot be billed separately, with certain exceptions. For exceptions see the section Modifiers of this Guide.
3. Transportation (emergency and non-emergency) provided to members and/or family members is not included in the rate and should be billed separately using the appropriate transportation procedure codes.
4. Personal Care Services (T1019) and Personal Care Services (T1020) cannot be billed on the same day.
5. A BHRF would have to have a license from ADHS to provide personal care service (using TF modifier) and is included in the rate.
6. A Community Service Agency cannot provide personal care services.

Home Care Training to Home Care Family (Family Support)

Home care training family services (family support) with family member(s) directed toward restoration, enhancement, or maintenance of the family functions to increase the family's ability to effectively interact and care for the individual in the home and community. May involve support activities such as assisting the family with adjusting to the member's needs, developing skills to effectively interact and/or guide the member, understanding the causes and treatment of behavioral health challenges, understanding effective utilization of the delivery system, or planning for ongoing and future support(s) for the member and the family.

Home care training family services (family support) must be provided by BHPs, BHTs, or BHPPs. See AMPM Policy 964 for training and credentialing standards for Credentialed Family Support Partners (CFSP) providing parent/family support services.

HCPCS Code

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

Billing Limitations

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

1. See general core billing limitations.
2. Family support services provided in an ADHS licensed inpatient, residential or day program setting are included in the rate for those settings and cannot be billed separately, with certain exceptions. For exceptions see section Behavioral Health Counseling and Therapy under Billing Limitations of this Guide. 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 member residing in and/or transitioning out of the inpatient, residential settings, behavioral health therapeutic home or who is receiving services in a day program.
3. S5110 shall be paired with the CG modifier when the service is provided by a credentialed Family Support provider.
4. Transportation provided to members and/or family members is not included in the rate and should be billed separately using the appropriate transportation procedure codes. See AMPM Policy 310-BB for additional guidance on transportation.

Self-Help/Peer Services (Peer Support)

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

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

See the AHCCCS Office of Individual and Family Affairs Peer Support website, along with the Peer Support FAQ page for additional information.

HCPCS Codes

- **H0038** - Self-help/peer services, per 15 minutes: Self-help/peer services (see general definition above) provided to an individual person for a short period of time, up to 5 hours per day.
- **H2016** – Comprehensive Community Support Services, per diem, more than 5 hours per day.

Billing Limitations

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

1. See general core billing limitations.
2. Self-help/peer services provided in an ADHS DLS licensed inpatient, residential or day program setting are included in the rate for those settings and cannot be billed separately, with certain exceptions. However, providers other than the inpatient, residential facility or day program can

bill self-help/peer services provided to the member residing in and/or transitioning out of the inpatient or residential settings or who is receiving services in a day program.

3. Transportation provided to members 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 H0038 self-help/peer services provided to a member on the same day only when indicated by the member's clinical needs as documented in their comprehensive assessment and service plan.
5. H0038 provided to a member who is residing in a residential or inpatient setting by a provider of choice that is not the facility shall be limited to individual self-help/peer services to support the member with treatment and the discharge plan. For example, if a member is residing in and receiving services in a BHRF, a Peer Support provider of choice would be invited to attend and participate in the monthly treatment planning meeting to support the member in understanding treatment goals and discharge plans. This would be the same for a member receiving inpatient services, the Peer Support provider of choice would be invited to attend and participate in scheduled discharge planning meetings to support the member in understanding treatment goals and the discharge plan.
6. Only individuals holding a PRSS credential may deliver peer support services. Providers of peer support services shall maintain documentation of PRSS credentials per AMPM Policy 963.
7. Providers must have evidence of credentialing on file for all individuals delivering Medicaid reimbursable peer support services.
8. H0038 must be paired with the HQ modifier when providers are serving two or more members at the same time.
9. The HQ modifier is not applicable to H2016, these rates are developed with the understanding and methodology supporting group programming.
10. H0038 and H2016 are not subject to the group limit specified in Core Billing Limitation #24 if the service is being provided in person at an AHCCCS registered provider site. Groups that meet this exception shall not exceed a 1:20 ratio.

Unskilled Respite Care

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

Respite services are limited to 600 hours per year (October 1 through September 30) per member and are inclusive of both behavioral health and ALTCS respite care.
Respite may include a range of activities to meet the social, emotional, and physical needs of the member during the respite period. These services may be provided on a short-term basis (i.e., for a few hours during the day) or for longer periods of time involving overnight stays. Respite services can be planned or

unplanned. If unplanned respite is needed, behavioral health providers will assess the situation with the caregiver and recommend the appropriate setting for respite. CSAs cannot provide respite services.

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

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

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

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

Revenue Codes

Respite services provided in an ADHS licensed facility should be billed using the applicable revenue codes listed in Inpatient Services of this Guide for the facility type.

HCPCS Codes

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

Billing Limitations

1. See general core billing limitations.
2. Respite services billed using the two HCPCS codes S5150 and S5151 are limited to no more than 600 hours of respite services per year (October 1 through September 30) per member.
3. Transportation provided to members and/or family members is not included in the rate and should be billed separately using the appropriate transportation procedure codes.
4. Respite services cannot be billed for members who are residing and receiving treatment in a DHS licensed Behavioral Health Inpatient Facility, Behavioral Health Residential Facility, group home or nursing home.
5. A Community Service Agency cannot provide respite services.
6. S5150 and S5151 cannot be billed on the same date for the same member.
7. S5151 must not be billed with any other per diem code.

8. When respite services are provided to more than one member at a time the following modifiers shall be paired with the S5150 or S5151 codes:
    a. UN - For two members served,
    b. UP - For three members served,
    c. UQ - For four members served,
    d. UR - For five members served, and
    e. US - For six or more members served.

Transportation

Transportation services involve the transporting of a member from one place to another to facilitate the receipt of, or benefit from, medically necessary covered behavioral health services, allowing the member to achieve their service plan goals. The service may also include the transportation of a member's family/caregiver with or without the presence of the member, if provided for the purposes of carrying out the member's service plan (e.g., counseling, family support, case planning meetings). Urban transport is defined as those originating within the Phoenix or Tucson metropolitan areas. All other means of transport are defined as rural.

Additional information regarding the transportation benefit can be found in AMPM Policy 310-BB.

Details pertaining to the billing of transportation services may be found in the AHCCCS Fee-For-Service Provider Billing Manual Chapter 14 Transportation.
For specific details pertaining to the billing of transportation services for members enrolled with an MCO, see the specific MCO website.

Housing Support Services

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

Providers should ensure staff providing these services are knowledgeable in and can provide services consistent with evidence-based practice. Specific details on permanent supportive housing service delivery and housing practices can be found in AMPM Policy 930 and the AHCCCS Medical Policy Manual (AMPM) Chapter 1700 - Health Related Social Needs for additional information on Housing Support Services.

Crisis Intervention Services

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

Requirements for crisis care coordination and crisis providers as applicable to AHCCCS Contracted health plans are found in AMPM Policy 590.

CPT Codes

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

HCPCS Codes

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

Billing Limitations

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

1. See general core billing limitations.
2. Emergency crisis intervention services are the responsibility of the ACC-RBHA or TRBHA and should be billed to the ACC-RBHA or TRBHA in the GSA where the crisis occurred. Emergency crisis coverage is limited to the first 24 hours for Title XIX/XXI members, 72 hours for Non-Title XIX/XXI or until the crisis has resolved, whichever occurs first. See the AMPM Policy 590 for care coordination requirements.
3. Transportation provided to the member receiving the crisis intervention services is not included in the rate and should be billed separately using the appropriate transportation procedure codes.
4. Services provided in the jail setting are not Title XIX/XXI reimbursable.

5. If a member receives service code S9484 or S9485 at a Level I inpatient hospital or subacute facility, then the member 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 member by the same provider.
6. Medical supplies provided to a member while in a crisis services setting and provided by the crisis service provider type are included in the rate and should not be billed separately.
7. Meals are included in the rate and should not be billed separately.
8. Laboratory and radiology services are not included in the rate and should be billed separately.
9. Medications are not included in the rate and should be billed separately.
10. When billing for emergency crisis intervention services, billing for the first 24 hours or until the crisis is resolved will be billed to the applicable ACC-RBHA or TRBHA, crisis service providers must identify those services by appending a modifier ET (Emergency Services) to those line items and crisis providers must be contracted with the applicable ACC-RBHA or TRBHA to bill for crisis services. The reporting of the ET modifier paired with an applicable crisis intervention HCPCS allows AHCCCS and ACC-RBHAs to accurately monitor community need for emergency crisis intervention services. Only providers contracted with an ACC-RBHA for crisis intervention services may bill an ACC-RBHA for emergency crisis intervention services.

Outpatient Residential Treatment

Outpatient residential treatment services are provided by or under the direction and clinical oversight of BHPs to reduce symptoms and improve or maintain functioning. BHPs are required to be reported by all PTs 77 & IC, per AMPM Policy 610.

Behavioral Health Residential Facility Services (BHRF)

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

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

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

In the case a specialized treatment need is identified while a member is in a BHRF level of care, the treatment team, inclusive of all team members involved outside the BHRF, must meet to establish, based on clinical best practice, the appropriateness of service provision, timeline for most appropriate implementation of service, and if established, the clinical need for the service to be initiated while the member is in BHRF care. For example, a member who has been engaged in Eye Movement Desensitization and Reprocessing (EMDR) Treatment and is responding well to treatment or who has selected a peer support provider that they trust to participate in treatment and discharge planning meetings prior to entering a BHRF, may continue with treatment and services if the continuation of treatment/service is indicated by the treatment provider, member, and clinical team (including documentation within the comprehensive service plan) indicating the service will continue to positively benefit the member while they are in BHRF care. This would be the same for newly identified needs, including medical treatment and outpatient behavioral health treatment services that are beyond the scope of the BHRF.

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

HCPCS Codes

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

Billing Limitations

1. See general core billing limitations.
2. H0018 is a comprehensive service code inclusive of all services provided by the BHRF provider within the BHRF approved scope of work including, intake and discharge screening and assessment, group and individual counseling and therapy, BHRF treatment plan development and updates, care coordination, skills training and development, behavioral health prevention/promotion education, rehabilitation services and supportive services. See AMPM Policy 320-V.
3. A member may receive behavioral health services not provided by the BHRF based on the member's medical necessity and shall be documented in the BHRF treatment plan and the clinical teams comprehensive service plan. See AMPM Policy 320-V and the AHCCCS Same Day Disallow Table for services that cannot be billed on the same day for additional reference.
4. Sober living facilities are not behavioral health residential treatment facilities. Sober living facilities are not a covered service for AHCCCS.
5. Room and board is not a Medicaid covered service for members residing in behavioral health residential facilities and is not included in the H0018 rate.
6. H0018 may only be provided by ADHS licensed behavioral health agency pursuant to licensure requirements set forth in AAC Title 9, Chapter 10, Article 7, or tribal owned and operated program located on tribal land that meet the certification requirements of the Centers for Medicare and Medicaid Services and have an active B8 Provider registration with AHCCCS.
7. In addition to being licensed by ADHS as a Behavioral Health Residential Facility, in order to provide personal care services, a BHRF shall be authorized by ADHS to provide personal care services as specified in AAC Title 9, Chapter 10, Article 7.
8. H0018 may be paired with the U9 modifier at intake and during discharge planning (limit 2 per member per admission) when using the ASAM CONTINUUM® assessment tool to determine the appropriate level of care.
9. Admission to a BHRF requires prior and continued authorization.

10. H0018 may only be billed on days when the member is present overnight (present at 11:59 p.m. and 12:01 a.m. the following morning). Example: If a member is present overnight on August 2nd into August 3rd and leaves the program on August 3rd at any time before midnight and does not return until August 4th, the provider would be able to bill the per diem on August 2nd and August 4th (assuming they were present overnight) but not on August 3rd.
11. The per diem rate cannot be billed for the day of discharge.
12. Modifier U9 for an ASAM CONTINUUM® assessment can be paired with H0018 when the BHRF provider uses the ASAM CONTINUUM® assessment tool to inform intake treatment or discharge plans.
13. H0018 services are not subject to the group limit specified in core billing limitation #24 if the group services are provided in person at an AHCCCS registered provider service site to members currently residing in that facility. This exception is site specific and does not cover provider agencies with multiple service locations or co-located provider types combining treatment services. Groups shall not exceed a 1:20 ratio.

Adult Behavioral Health Therapeutic Homes (ABHTH)

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

HCPCS Code

- S5140 - Foster Care, Adult; Per Diem.

Billing Limitations

1. A licensed Collaborating Health Care Institution (CHI) who supervises and trains the adult behavioral health therapeutic home provider may not bill for these administrative functions. Employee supervision and training has been built into the procedure code rate.
2. Pre-training activities associated with the ABHTH setting are included in the rate. This service may not be billed outside the procedure code rate by either the licensed professional or the ABHTH provider.
3. Room and Board is not included in the rate.
4. Prescription drugs are not included in the rate and should be billed by appropriate providers using the applicable NDC procedure codes.
5. Over-the-counter drugs and non-customized medical supplies are included in the rate and should not be billed separately.
6. Emergency transportation provided to a member is not included in the rate and should be billed separately by the appropriate provider using the applicable transportation procedure codes.
7. Non-emergency transportation is included in the rate and cannot be billed separately.
8. Any medical services provided to members, excluding those medical services included in the covered service array as set forth in this Guide, should be billed to the member's health plan.
9. Foster Care, Adult cannot be encountered/billed on the same day as Unskilled Respite Care (S5151).

10. S5140 may only be billed on days when the member is present overnight (present at 11:59 p.m. and 12:01 a.m. the following morning). Example: If a member is present overnight on August 2nd into August 3rd and leaves the program on August 3rd at any time before midnight and does not return until August 4th, the provider would be able to bill the per diem on August 2nd and August 4th (assuming they were present overnight) but not on August 3rd.
11. The Per diem rate cannot be billed for the day of discharge.

Therapeutic Foster Care (TFC)

TFC is a covered behavioral health service that provides daily behavioral interventions within a licensed family setting. This service is designed to maximize the member's ability to live in a family setting, participate in the community, and to function independently, including assistance in the self-administration of medication and any ancillary services (such as living skills and health promotion) as appropriately indicated in the member's Service Plan as appropriate (Arizona State Plan for Medicaid). Guidelines for TFC for children are provided in AMPM Policy 320-W.

HCPCS Code

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

Billing Limitations

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

Inpatient Services

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

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

- Hospital services provide continuous behavioral health treatment with 24-hour nursing supervision and a qualified physician, nurse practitioner, or physician assistant are on site or on call which includes general psychiatric care, medical detoxification, and/or forensic services in a general hospital, or a general hospital with a distinct psychiatric unit, or a freestanding psychiatric facility. Services provided in hospitals are inclusive of all services, supplies, accommodations, staffing, and equipment, bed hold:
    - General and freestanding hospitals may provide services to members, if the hospital:
        - Meets the requirements of 42 CFR 440.10 and CFR Title 42, Chapter IV, Subchapter G, Part 482, and
        - Is licensed pursuant to ARS Title 36, Chapter 4 and AAC R9-10-Article 2.
    - Prior authorization is required for Bed Hold/therapeutic leave,
    - Bed Hold or home pass are days in which the facility reserves the member's bed, or member's space in which they have been residing, while the member is on an authorized/planned overnight leave from the facility for the purposes of therapeutic leave (i.e., home pass) to enhance psychosocial interaction or as a trial basis for discharge planning. As specified in the Arizona State Plan under Title XIX of the Social Security Act:
        - For members ages 21 and older, therapeutic leave may not exceed nine days, and bed hold days may not exceed 12 days, per contract year (October 1 through September 30), and
        - For members under 21 years of age, total therapeutic leave and/or bed hold days may not exceed 21 days per contract year (October 1 through September 30).

- Behavioral Health Inpatient Facilities (BHIF):
    - BHIFs provide continuous treatment to a member who is experiencing acute and significant behavioral health symptoms. BHIFs may provide observation/stabilization services and child and adolescent residential treatment services, in addition to other behavioral health and/or physical health services, as identified under their licensure capacity,
        - Observation/Stabilization Services
          In addition to 24-hour nursing supervision and a qualified physician, nurse practitioner, or physician assistant are on site or on call, observation/stabilization services include emergency reception, screening, assessment, crisis intervention and stabilization, and counseling, and referral to appropriate level of services/care. Refer AAC R9-10-1012 for more information,

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

CPT Codes

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

- 99236 - Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 85 minutes must be met or exceeded.
- 99238 - Hospital inpatient or observation discharge day management; 30 minutes or less on the date of the encounter.
- 99239 - Hospital inpatient or observation discharge day management; more than 30 minutes on the date of the encounter.
- 99252 - Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.
- 99253 - Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
- 99254 - Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
- 99255 - Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 80 minutes must be met or exceeded.
- 99307 - Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.
- 99308 - Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
- 99309 - Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
- 99310 - Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

Revenue Codes

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

HCPCS Codes

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

Hospital

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

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

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

After the leave, the member 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 (October 1 through September 30). The following revenue codes must be used to bill for home pass and bed hold days:

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

Hospitals (PT 02) may bill the following revenue codes:

- 0114 – Psychiatric; room and board – (One Bed) private
- 0124 – Psychiatric; room and board – semiprivate two beds
- 0134 – Room & Board Three and Four Beds -Psychiatric
- 0154 – Room & Board Ward-Psychiatric
- 0116 – Room & Board Private (One Bed) - Detoxification
- 0126 – Detoxification; room and board – semiprivate two beds

- 0136 – Room & Board Three and Four Beds -Detoxification
- 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 - Semiprivate 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

Service Standards/Provider Qualifications

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

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

If seclusion and restraint is provided, then the facilities must meet the requirements set forth in AAC Title 9 Chapter 10.

Billing Limitations

1. Non-emergency transportation (NEMT) for a member in a hospital/psychiatric hospital is included in the rate and should not be billed separately. NEMT from the facility on the day of discharge remains covered because the per diem code is not paid for on the day of discharge.
2. Emergency transportation provided to a member residing in the facility is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

3. Nursing services provided to a member while in a hospital/psychiatric hospital are included in the rate and should not be billed separately.
4. Medical supplies provided to a member 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 member receiving services.
8. Medications provided/dispensed by the hospital, PT 02 or the psychiatric hospital, PT 71, 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 PT 02 cannot bill for therapeutic leave/bed hold.
11. Accommodation revenue codes 0110-0113, 0120-0123, 0130-0133, 0150-0153, 0160, 0200-0203, 0206, 0209-0210 can be billed when prior authorization is obtained, the member is medically stable, and there is a principal mental health or substance abuse diagnosis on the claim.
12. Outpatient PT 77 and IC are prohibited from billing on a UB form or using revenue codes.
13. Hospital services are not subject to the group limit specified in Core Billing Limitation #24 if the group services are provided in person at an AHCCCS registered hospital to members currently admitted. This exception is site specific and does not cover provider agencies with multiple service locations or co-located provider types combining treatment services. Groups shall not exceed a 1:20 ratio.
14. Payment for services related to provider preventable conditions is prohibited, in accordance with 42 CFR 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 AMPM Policy 960.

Subacute Facilities

Continuous treatment is provided in a subacute facility to a member 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 a qualified physician, nurse practitioner, or physician assistant are 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 member to be admitted to the facility.

Subacute facilities must be licensed by ADHS as meeting the specific requirements of AAC Title 9, Chapter 10. Additionally, the facilities must meet the requirements set forth in AAC Title 9, Chapter 10 10 for seclusion and restraint if the facility has been authorized by ADHS to provide seclusion and restraint.

Revenue Codes

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

HCPCS CodesH0014

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

Billing Provider Types

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

Billing Limitations

1. See general Core Billing Limitations section of this Guide.
2. The revenue codes for subacute facility services are billed per day for each member receiving services.
3. Non-emergency transportation for a member in a subacute facility is included in the rate and should not be billed separately.
4. Emergency transportation provided to a member residing in the facility is not included in the rate and should be billed separately using the appropriate transportation procedure codes.
5. Medical supplies provided to a member while in a subacute facility are included in the rate and should not be billed separately.
6. Laboratory, Radiology, Medical Imaging and Psychotropic Medication provided by the subacute facility are not included in the rate and should be billed separately. Laboratory, Radiology, Medical Imaging and Psychotropic Medication services related to a behavioral health condition are the responsibility of the enrolled health plan.
7. Miscellaneous costs such as insurance, housekeeping supplies, laundry, clothing, resident toiletries and expenses, and staff training materials are included in the rate and should not be billed separately.
8. Meals are included in the rate and should not be billed separately.
9. No outpatient HCPCS codes may be billed on the same day as any of the per diem rev codes listed above.
10. Subacute facility services are not subject to the group limit specified in core billing limitation #24 if the group services are provided in person at an AHCCCS registered provider service site to members currently admitted. This exception is site specific and does not cover provider agencies with multiple service locations or co-located provider types combining treatment services. Groups shall not exceed a 1:20 ratio.

Residential Treatment Centers (RTC)

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

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

Billing Provider Types

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

Revenue Codes

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

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

Residential treatment centers may bill for bed hold or home pass days. These are days in which the RTC reserves the members' space in which they have been residing while the individual is on 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 member 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 (October 1 through September 30).

Service standards for residential treatment centers may be found in AMPM 310 B

Billing Limitations

1. See general core billing limitations.
2. The RTC revenue code is billed per day for each member 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 members’ education are not included in the RTC rate and should be billed separately.
5. Non-emergency transportation for a member in an RTC facility is included in the rate and should not be billed separately.
6. Emergency transportation provided to a member 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 member while in 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.
11. Residential treatment Center services are not subject to the group limit specified in Core Billing Limitation #24 if the group services are provided in person at an AHCCCS registered provider service site to members currently admitted. This exception is site specific and does not cover provider agencies with multiple service locations or co-located provider types combining treatment services. Groups shall not exceed a 1:20 ratio.

Appendix

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

- AMPM Exhibit 300-2A, AHCCCS Covered Services Behavioral Health https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/Exhibit300-2A.pdf contains the chart that outlines which behavioral health services are covered by AHCCCS based on member enrollment category.
- AMPM Chapter 300 - Policy 310-B Title XIX/XXI Behavioral Health Service Benefit https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/310B.pdf provides a brief definition of certain behavioral health services and includes general information about service requirements and provider qualifications. It also addresses issues like referrals, provider travel, room and board, clinical supervision, and services to families.
- AMPM Chapter 300 - Policy 320-V, Behavioral Health Residential Facilities https://azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/320-V.pdf addresses behavioral health residential service requirements.
- AMPM Chapter 300 - Section 320 - Services with Special Circumstances, Policy 320-W Therapeutic Foster Care for Children https://azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/320W.pdf.
- AMPM Chapter 300 - Section 320 - Services with Special Circumstances, Policy 320-S - Behavior Analysis Services https://azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/320S.pdf specifically addresses all aspects of provision of behavior analysis services.
- AMPM Chapter 300 - Section 320 - Services with Special Circumstances 320-X-Adult Behavioral Health Therapeutic Homes https://azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/320X.pdf.
- AMPM Chapter 500 - Policy 570 - Provider Case Management provides detailed clinical guidelines for case management. This document may be found in the following location: https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/500/570.pdf.
- AMPM Chapter 500 - Policy 590, Behavioral Health Crisis Services and Care Coordination https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/500/590.pdf.
- AMPM Chapter 800 – Policy 820, Fee-For-Service Authorization Requirements https://azahcccs.gov/shared/Downloads/MedicalPolicyManual/800/820.pdf
- A definition of peer support services may be found on https://www.azahcccs.gov/AHCCCS/HealthcareAdvocacy/OIFA/peersupport.html. This web page also describes requirements for peer/recovery support specialist credentialing as well as a list of organizations that can provide this credential.
- AHCCCS Fee-For-Service Provider Billing Manual https://azahcccs.gov/PlansProviders/RatesAndBilling/FFS/providermanual.html.

- AHCCCS Provider Enrollment Policy Manual https://pepm.azahcccs.gov/PEPM/index.html#t=Introduction%2FHome.htm
- Provider Enrollment Screening Glossary, Provider Type Code Order provides AHCCCS Provider Types and applicable enrollment requirements: https://www.azahcccs.gov/PlansProviders/Downloads/apep/PEP-903.xlsx.

- For information on what HCPCS codes are eligible for the All Inclusive Rate AIR for IHS/638 Providers see AHCCCS IHS/Tribal Billing Manual.

- For information on available categories of service (COS) and how to add a new category of service to a provider profile see https://www.azahcccs.gov/PlansProviders/Downloads/APEP/PEP-906.pdf.

- For AHCCCS Rates and Billing information including FFS Fee Schedules see https://azahcccs.gov/PlansProviders/RatesAndBilling/.