ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Skills Training and Development

HCPCS H2038 Per Diem

DFSM Provider Education and Training

8/10/2026

Webinar Disclaimer

This webinar and associated materials presented are not comprehensive. This training does not take the place of reading the AHCCCS Medical Policy Manual, Covered Behavioral Health Services Guide and the AHCCCS Fee-for-Services and IHS/638 Providers Billing manuals.

- For training questions or requests, email the DFSM Provider Training team at ServiceNow@azahcccs.gov and assign to “Provider Training” .

Topics Covered Include:

This training provides an overview of **HCPCS H2038 (Skills Training and Development, Per Diem)** and key billing requirements for AHCCCS Fee-for-Service providers.

- Understanding Skills Training and Development services.
- When to use HCPCS H2038 versus H2014.
- Participating provider reporting requirements.
- Proper claim formatting and provider identification.
- Documentation requirements to support services billed.
- Appropriate use of the HQ modifier for group services.
- Resources and policy references for additional guidance.

Skills Training and Development, Per Diem HCPCS Code - H2038

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What is Skills Training and Development

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.

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

Completing the Participating Provider Details

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Difference Between Participating Provider and Supervising Provider

- If the H2038 was performed by a BHT, BHPP, the claim must be submitted with the facility NPI listed as the service provider.
- If the services were performed by a participating provider, the provider's details must be entered in the ***Additional Information field*** on the claim submission.

Billing Information: *Billing for behavioral health services performed by BHTs and BHPPs, refer to the FFS Provider Billing Manual, Chapter 19.*

Completing the Participating Provider Details

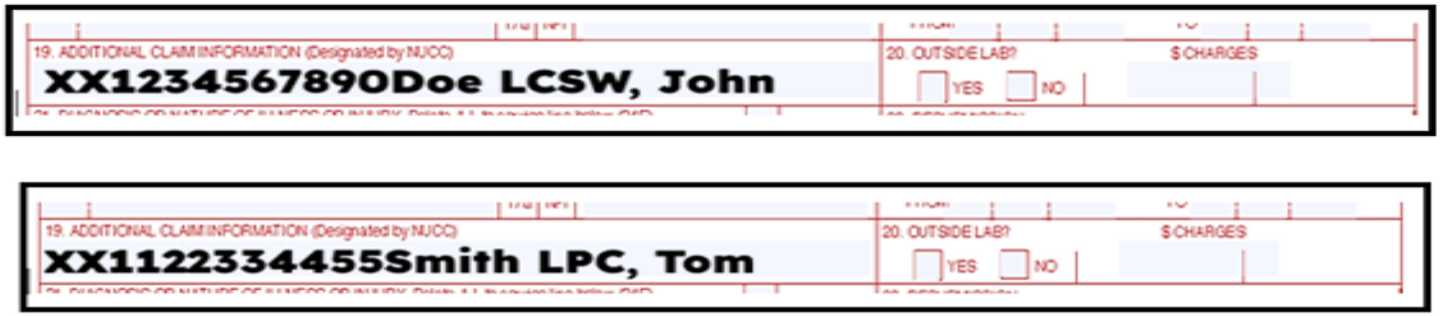
AHCCCS Fee-for-Service recognizes two participating provider qualifier codes: (XX) and (9999999999).

Additional information and examples on proper qualifier code formatting are provided below.

Participating Provider Qualifier Codes
XXNPI - Provider type who is registered with AHCCCS and has a valid NPI.
9999999999 - Practitioner who does not meet the criteria to be registered with AHCCCS under their own individual NPI.

Formatting Requirement Provider with a NPI Number

In this example the participating provider is registered with AHCCCS and has an individual NPI number. The qualifier code 'XX' is used, followed by the provider's NPI.



Formatting Requirements - For Participating Providers Who Do Not Qualify for an NPI Number

When the individual does not have a license, but is performing within the scope of their practice and education and under the appropriate clinical oversight or supervision of a AHCCCS registered Behavioral Health Professional (BHP), as specified in A.C.C. R9-10-1011 and identified in AMPM Policy 310-B. The participating provider shall be reported using the qualifier code: (10-9) 9999999999 Last Name, First Name.

Provider credentials (e.g., BHT, BHPP, or PRSS) may be included after the last name.

Understanding the Difference Billing H2038 and H2014

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HCPCS H2038 Skills Training and Development

Providers billing H2038 must maintain thorough documentation to substantiate the necessity and scope of the services provided. The treatment plan, including clearly defined goals, measurable objectives, and timeframes relevant to the patient. Treatment plan must include code being billed H2014 or H2038 and frequency of service. Providers should regularly re-assess the patient's progress and adjust the treatment plan accordingly.

The progress notes should accurately reflect the duration, setting, and type of interaction involved such as face-to-face or telehealth and must include client's specific individual responses to service.

Difference Between H2014 and H2038

The primary difference between HCPCS codes **H2014** and **H2038** is the billing unit and time frame used for skills training and development services.

Both HCPCS codes cover the same underlying behavioral health habilitation or psychosocial rehabilitation activities, ***but they measure duration differently.***

HCPCS Codes H2014 and H2038

Reporting timed procedure codes accurately is a critical component of submitting a claim that meets clean claim and compliant requirements. Most Procedure Code descriptions provide the time or time range associated with the service rendered.

- Use H2014 - Skills training and development, ***per 15 minutes (up to 5 hours per day) when billing for skills training services provided in 150minute increments.***
- Use H2038 – Skills training and development, **per diem (5 hours in duration minimum)** when the member receives at least 5 hours of services in one day, allowing billing as a per diem service.

What Providers Should Know About H2038

- H2038 must not be used for Intensive Outpatient Treatment Services **(H0015 or S9480)**
- IOP bundles multidisciplinary daily treatment, whereas code **H2038** typically specifies separate behavioral skills training
    - Behavioral health staff who are responsible for submitting claims for reimbursement should refer to the Covered Behavioral Health Services Guide for detailed information.

Documentation

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Documentation Requirements

Progress notes should reflect:

1. The specific skill(s) taught/practiced.
2. Method (modeling, coaching, rehearsal, feedback).
3. Members' active participation and response.
4. Functional progress toward measurable goals tied to the service plan; and
5. Required begin/end times for timed services.
6. Documentation cloning is strictly prohibited.

Billing Modifier HQ

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Using Behavioral Health Modifiers Correctly
HQ Modifier

Modifiers are two-character codes added to CPT® or HCPCS Level II codes to give extra details about a service or procedure without changing its definition. Correct use ensures accurate reimbursement, prevents denials, and maintains compliance.

- Modifier HQ is a HCPCS Level II modifier used to show that a procedure or service was delivered in a group setting, to multiple clients simultaneously. Groups shall not exceed a 1:20 ratio.
- HQ modifier distinguishes a service from individual services and ensures accurate reimbursement.
- HQ must be used with H2038 when 2 or more members are served at the same time.

How to Apply Modifier HQ

- **Identify the service:** Determine if it was delivered in a group setting.
- **Append HQ to the code:** If the code does not describe “group,” add HQ.
- **Document support**: Ensure medical records or EHR notes confirm the group setting and number of participants.

Compliance & Risks

- Failure to use HQ when required can lead to claim denials or delays in reimbursement as well as overpayment and required payback.

Code	Description	HQ Modifier Use
H0001	Alcohol and/or Drug Assessment Service	Ineligible to be performed in a group setting
H0002	Behavioral Health screening to determine eligibility for admission to treatment program(s)	Service ineligible to be performed in a group setting
H0004	Behavioral Health Counseling And Therapy, Per 15 Minute	HQ modifier is required when performed in a group setting.
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).	HQ modifier is not required when performed in a group setting.
H2038	Skills Training And Development, Per Diem	HQ modifier is required when performed in a group setting.
H2014	Skills Training And Development, Per 15 Minutes	HQ modifier is required when performed in a group setting.
S9480	Intensive Out-patient Psychiatric Services program, that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan).	HQ modifier is not required when performed in a group setting.
H2016	Comprehensive Community Support Services, Per Diem, 3 or more hours in duration must be met for this code.	Service ineligible to be performed in a group setting

Modifiers

When in doubt discuss billing questions with your coding team.

Modifier	Description	When to Use
HQ	Group Session	Used to indicate that a session was provided in a group setting.

- Claims should be submitted separately for each recipient receiving group therapy services.
- Each claim submission must contain the HQ modifier when performed in a group setting.

Skills Training and Development

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Who can provide Skills Training and Development

Skills training and development and psychosocial rehabilitation living skills training services must be provided by individuals as defined in *9 AAC 10 and AMPM Policy 310-B.* *This is not an all-inclusive list.*

- Behavioral health technicians, or (BHT)
- Behavioral health paraprofessionals, (BHPP)

A BHT and BHPP must be affiliated with a licensed behavioral health agency/facility, clinic, alternative residential facility or outpatient hospital.

NOTE: Affiliated settings must be AHCCCS registered providers.

AMPM 310-B
Title XIX/XXI Behavioral Health Service Benefit

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 310-B

Provider Self Disclosure

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OIG Self Disclosure Guidelines

Recommended Self-Disclosure

- Due to the audit findings, AHCCCS recommends that your organization evaluate the extent of any potential improper billing and consider making a voluntary self-disclosure to the AHCCCS Office of Inspector General (OIG), as appropriate.

Paragraph 29 of the Provider Participation Agreement states that:

- Consistent with 42 USCS § 1320a-7k(d) an overpayment must be reported and returned within sixty (60) days after the date on which the overpayment was identified. Failure to promptly return an overpayment is indicia of intent to commit fraud, waste, and abuse of the AHCCCS program.

- Click on this link to learn how to self-disclose:

https://www.azahcccs.gov/Fraud/Downloads/SelfDisclosure.pdf

AHCCCS Resources

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Available Resources

The AHCCCS Covered Behavioral Health Services Guide (CBHSG) is updated and published as needed. Refer to the CBHSG below:

- AHCCCS Covered Behavioral Health Services Guide (updated 07/01/2026)

- AHCCCS Medical Policy Manual 310B Title XXI/XXI BH Service Benefit.pdf
- AHCCS Medical Policy Manual 320-O Behavioral Health Assessment, Service, and Treatment Planning.pdf
- AHCCCS Medical Policy Manual 940 Medical Records and Communiction of Clinical Information.pdf
- Fee-for-Service Provider Billing Manual Chap. 19 Behavioral Health.pdf

This concludes the training presentation.

Thank you for your continued partnership with AHCCCS.

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Division of Fee-for-Service Provider Education and Training

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Provider Education and Training

- AHCCCS Fee-for-Service provider training focuses on claim submissions, prior authorization, Submission of documentation using the Electronic Data to attach any required documentation to the claim for review, AHCCCS FFS policies and resources on the Provider Online portal.

- Additionally, the DFSM education and training unit offers trainings with informational updates to program changes, system updates, and changes to the AHCCCS policy, AHCCCS guides and manuals.