310-B – TITLE XIX/XXI BEHAVIORAL HEALTH SERVICE BENEFIT

EFFECTIVE DATES: 10/01/94, 10/01/19, 10/01/20, 10/01/21, 10/01/22, 12/03/24, 07/22/25

APPROVAL DATES: 10/01/99, 10/01/01, 05/01/06, 10/01/06, 06/01/07, 05/01/09, 07/01/10, 10/01/10, 05/01/11, 10/01/11, 02/01/14, 03/01/14, 05/02/19, 02/06/20, 05/04/21, 09/15/22, 09/06/24, 09/06/24, 04/21/25

I. PURPOSE

This Policy applies to ACC, ACC-RBHA, ALTCS E/PD, DCS CHP (CHP), and DES DDD (DDD) Contractors; Fee-For-Service (FFS) Programs including American Indian Health Program (AIHP), Tribal ALTCS, TRBHA, and all FFS populations, excluding Federal Emergency Services Program (FESP). (For FESP, refer to AMPM Chapter 1100). This Policy describes Title XIX/XXI behavioral health services. Adult Recovery Team (ART) and Child and Family Team (CFT) are optional resources and are not a requirement for the Fee-For-Service Programs.

II. DEFINITIONS

Refer to the AHCCCS Contract and Policy Dictionary for common terms found in this Policy.

III. POLICY

AHCCCS covers Title XIX/XXI behavioral health services (behavioral health and/or substance use) within certain limits for members when medically necessary as specified in 42 CFR 440.130(d). Behavioral health services are authorized under Rehabilitative Services Benefit in the AHCCCS State Plan and 42 CFR 440.130(d). These behavioral health service categories/subcategories and other behavioral health service requirements are listed below and further described in the AHCCCS Covered Behavioral Health Services Guide (CBHSG).

For information and requirements regarding block grants, discretionary grants, and Non-Title XIX/XXI services and funding refer to AMPM Policy 320-T1 and AMPM Policy 320-T2.

A. GENERAL REQUIREMENTS

All applicable Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), and Uniform Billing (UB-04) revenue codes for Title XIX/XXI services are listed on the Medical Coding Resources page of the AHCCCS website. The Providers are required to utilize national coding standards including the use of applicable modifier(s).

1. The ICD Diagnostic Codes
   For outpatient behavioral health services, services are considered medically necessary regardless of a member's diagnosis, with documented behaviors and/or symptoms that will benefit from behavioral health services, and a valid ICD-10-CM diagnostic code is utilized.

2. Service and Treatment Planning
   The services shall be provided timely as specified in AMPM Policy 320-O and ACOM Policy 417. The provision of services shall not be delayed or pended to have all team members (i.e., CFT/ART) present for a service planning meeting or until all are able to sign off on the service plan.

   The Contractor shall require subcontractors and providers to make available and offer the option of having a Peer and Recovery Support Specialist (PRSS) or a Credentialed Family Support Partner (CFSP) for child or adult members and their families, to participate in service or treatment planning, and to provide covered services when appropriate.

3. Access to MOUD and MAT Services
   The Contractor and providers shall establish policies and procedures to ensure members prescribed any amount or type of medication as a component of Medications for Opioid Use Disorder (MOUD) and/or Medication Assisted Treatment (MAT) are not excluded from services, or admission to any treatment program or facility indicated within their service or treatment plan.

   The services and any applicable limitations shall be in compliance with the Arizona Opioid Epidemic Act, SB 1001, 53rd Leg., 1st Spec. Sess. (Ariz. 2018) (codified in scattered sections of the Arizona Revised Statutes).

4. Emergency Behavioral Health Services
   Prior Authorization (PA) is not required for emergency behavioral health services (AAC R9-22-210.01), including crisis intervention services. Refer to AMPM Policy 590 for behavioral health crisis services and care coordination requirements.

5. Clinical Oversight and Supervision
   The Behavioral Health Professionals (BHPs) shall be responsible for directing and overseeing the clinical care and treatment for members they are directly treating, and the services and support provided by Behavioral Health Technicians (BHTs) and Behavioral Health Paraprofessionals (BHPPs) for whom the BHP is providing supervision or clinical oversight. Refer to AAC R9-10 et seq. for specific requirements regarding oversight and supervision.

6. For qualifications, oversight, supervision and service provision requirements for BHTs and BHPPs providing supportive services for a Community Service Agency (CSA) refer to AMPM Policy 965.

7. Behavioral Health Services to Family Members
   Behavioral health services can be provided to the member's family members, regardless of the family member's Title XIX/XXI entitlement status, as long as the member's service plan reflects that the provision of these services are aimed at accomplishing the member's service plan goals (i.e., they show a direct, positive effect on the member). The member does not have to be present when the services are being provided to family members.

8. Indirect Contact
   Indirect contact with a member includes email or phone communication specific to a member's services, obtaining collateral information, and/or picking up and delivering medications. Refer to the AHCCCS Medical Coding Resources webpage, AHCCCS Behavioral Health Services Matrix, AHCCCS Covered Behavioral Health Services Guide, or AHCCCS Fee-For-Service Provider Billing Manual (Chapter 19) and the AHCCCS IHS/Tribal Provider Billing Manual (Chapter 12 for IHS/638 providers) for additional guidance.

9. Room and Board
   Room and Board (R&B) is covered only for Inpatient Hospitals, Intermediate Care Facilities for individuals with Intellectual Disability (ICF/IID), and Nursing Facilities (NF).

10. Referrals
    A referral may be made, but is not required, to initiate behavioral health services. A member may directly contact their enrolled health plan's member services department to initiate services or to identify a contracted service provider. If behavioral health services are not available within the service array of a provider currently serving the member or an in-network provider, a referral may be made to any provider who does offer the necessary services.

11. Transportation
    Refer to AMPM Policy 310-BB, the AHCCCS Fee-For-Service Provider Billing Manual (Chapter 14), and the AHCCCS IHS/Tribal Provider Billing Manual (Chapter 11) for additional information.

12. Provider Travel
    Provider travel is the cost associated with certain provider types traveling to provide a covered behavioral health service as specified in the Behavioral Health Services Matrix. This is different than transportation, which is provided to take a member to and from a covered behavioral health service.

    Certain behavioral health providers are eligible to bill for provider travel services, as outlined below.

    The mileage cost of the first 25 miles of provider travel is included in the rate calculated for each service therefore, provider travel mileage may not be billed separately except when it exceeds 25 miles. In these circumstances, providers bill the additional miles traveled in excess of 25 miles using the appropriate HCPCS code as specified in the AHCCCS Medical Coding Resources Page located on the AHCCCS website.

    When a provider is traveling to one destination and returns to the office, 25 miles is assumed to be included in the round trip. If a provider is traveling to multiple out-of-office settings, each segment of the trip is assumed to include 25 miles of travel.

    The following examples demonstrate when to bill for additional miles:
    a. If Provider A travels a total of 15 miles (to the out-of-office setting in which the service is delivered and back to the provider's office), travel time and mileage is included in the rate and may not be billed separately,

b. If Provider B travels a total of 40 miles (to the out-of-office setting in which the service is delivered and back to the provider's office), the first 25 miles of provider travel are included in the rate, but the provider may bill 15 miles using the appropriate HCPCS code as specified in the AHCCCS Medical Coding Resources Page, if Provider C travels to multiple out-of-office settings (in succession), the provider shall calculate provider travel mileage by segment. For example:
   i. First segment = 15 miles, 0 travel miles are billed,
   ii. Second segment = 35 miles, 10 travel miles are billed,
   iii. Third segment = 30 miles, 5 travel miles are billed, and
   iv. Total travel miles billed = 15 miles are billed using the appropriate HCPCS code as specified in the AHCCCS Medical Coding Page. The provider may bill for travel miles in excess of 25 miles for the return trip to the provider office.

c. The Providers may not bill for travel for missed appointments.
   Provider Travel Limitations - If a provider travels to provide services to a member and the member misses the appointment, the intended service may not be billed. This applies for time spent conducting outreach without successfully finding the member and for time spent driving to do a home visit and the member is not home.

B. TITLE XIX/XXI BEHAVIORAL HEALTH SERVICES CATEGORIES/SUBCATEGORIES

Covered behavioral health services are provided by, or under the direction and clinical oversight of, a BHP to reduce symptoms and improve or maintain functioning in accordance with each member's treatment or service plan. These services have organized into categories and subcategories based on the type of service. Additional examples, definitions, billing guidance, and requirements are outlined in the AHCCCS Medical Policy Manual, the AHCCCS CBHSG, and on the AHCCCS Medical Coding Resources website.

1. Outpatient Treatment Services
   The following treatment services are covered under the behavioral health benefit:
   a. Assessment, evaluation (non-court ordered), and screening services (Refer to AMPM Policy 320-O),
   b. Behavioral health counseling, therapy, and psychotherapy,
   c. Behavioral analysis services,
   d. Partial Hospitalization Programs,
   e. Intensive Outpatient Programs,
   f. Behavioral Health Day Programs,
   g. Rehabilitation services, and
   h. Other services.

Refer to AMPM Policy 320-U for court-ordered evaluation responsibilities.

2. Medical Services
   The Medical services are provided or ordered within the scope of practice by a licensed physician, nurse practitioner, physician assistant, or nurse to reduce a member's symptoms and improve or maintain functioning. These services fall into one of the following four subcategories:
   a. Medication,
   b. Laboratory, radiology, and medical imaging services,

c. Medical Management (MM) services, and
d. Electroconvulsive Therapy (outpatient) and Transcranial Magnetic Stimulation (outpatient).

3. Support Services
The Support services are provided to facilitate the delivery of, or enhance the benefit received from, other behavioral health services. Support services are classified into the following subcategories:
a. Case Management (provider level),
b. Personal care services,
c. Home care training to home care family (family support),
d. Self-Help/Peer Services (Peer and Recovery Support),
e. Life skills,
f. Employment services,
g. Unskilled respite care (respite),
h. Transportation, and
i. Housing Support Services.

4. Crisis Intervention Services

5. Outpatient Residential Treatment Services
a. Behavioral Health Residential Facility (BHRF) Services,
b. Adult Behavioral Health Therapeutic Homes (ABHTH), and
c. Therapeutic Foster Care (TFC) (for children).

6. Inpatient Services
Inpatient services (including room and board) are further classified into the following subcategories:
a. Hospital,
b. Subacute Facilities, and
c. Residential Treatment Centers (RTCs).