

Crisis Service FAQs

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Q1: Who is responsible for the delivery of crisis services to state only members that are Non-Medicaid/KidsCare eligible (Non-Title XIX/Title XXI)?

A: RBHAs remain responsible for the provision of behavioral health crisis services for **up to 72 hours for state only or Non-Title XIX/XXI individuals.**

RBHAs continue to serve the same geographic service areas they serve today with no AHCCCS Complete Care (ACC) plan or American Indian Health Program (AIHP) involvement.

Q2: Who is responsible for the delivery of crisis services for Medicaid/KidsCare members (Title XIX/Title XXI)?

A: RBHAs are responsible for the provision of crisis services to all individuals within their assigned GSAs, including individuals in the Federal Emergency Services Program (FESP).

Crisis services include, but are not limited to; crisis telephone response, mobile crisis response and facility-based stabilization (including observation and detox not to exceed 24 hours), and all other associated covered services delivered by the crisis service provider in these settings, during the first **24 hours of a crisis episode for TXIX/XXI individuals and up to 72 hours for NTXIX/NTXXI individuals.**

A member's plan of enrollment is responsible for all other medically necessary services after the initial 24 hours covered by the RBHA, or upon resolution of the crisis episode, or discharge from a crisis stabilization setting, whichever occurs first. The plan of enrollment is responsible for

ensuring timely follow up and care coordination for assigned members upon resolution of the crisis, or in transitioning a member from crisis to another level of care, irrespective of whether the member received services within, or outside the Contractor’s GSA. The plan of enrollment shall ensure continuing stabilization and the provision of appropriate ongoing treatment and services.

RBHAs remain responsible for any costs associated with follow up phone calls related to the crisis episode post-24 hours. The crisis provider is able to make follow-up phone calls post-crisis as they do today; however, this does not take away from all care coordination and discharge requirements for the plan of enrollment.

The RBHAs will continue to be responsible for notifying the plan of enrollment within 24 hours (7 days a week) of a member engaging in crisis services so that subsequent services can be coordinated and covered through the member’s plan of enrollment. The plan of enrollment should be provided clinical recommendations related to the need for any follow up and continuing services, (with the exception of phone calls, as noted above).

Q3: What services are considered a crisis service and when is the RBHA and plan of enrollment responsible?

A: AHCCCS recognizes that the processes and practices currently in place may be different depending on the area, hospital, crisis service provider and/or RBHA. Crisis services covered by the RBHA include: crisis telephone response, mobile crisis teams and facility-based stabilization (including observation and detox not to exceed 24 hours), and all other associated covered services delivered by the crisis service provider in those settings. See table below for behavioral health services/assessment responsibility by specific service codes by population and various settings. Please note that this table includes common crisis service codes but is not meant to serve as a comprehensive listing of potential services delivered by a crisis provider (including, but not limited to, Medication Assisted Treatment).

Service	Population	Setting	Codes	Responsible Party
Crisis services within first 24 hours	Medicaid, KidsCare and State Only	All providers/settings permitted to bill these codes except observation crisis stabilization units	H2011, S9484, S9485	RBHA
Crisis services within first 24 hours	Medicaid, KidsCare and State Only	Observation crisis stabilization units	S9484, S9485, H0031, H0038, 90791, T1002, T1016	RBHA
Crisis phones	Medicaid, KidsCare and State Only	Telephonic	(T1016) Replaced with H0030 effective 7/1/20	RBHA
Assessments	Medicaid, KidsCare	ED/Medical Floor	H0031, 90791, 90792	Plan of enrollment

ED visits	Medicaid, KidsCare	ED	99281 -99285 (Not considered "crisis services")	Plan of enrollment
ED visits	State Only	ED	99281 -99285 (Are considered "crisis services")	RBHA
Assessments for pre-petition screening (for consideration for COE referral)	Medicaid, KidsCare and State Only	All		County or county designation
SMI assessments for SMI determination	Medicaid, KidsCare	All		Plan of enrollment
SMI assessments for SMI determination	State Only	All		RBHA

Q4: What entity is responsible for Crisis Observation and Stabilization Unit services and all other necessary covered services to Title XIX/Title XXI members after the 24 hour crisis period?

A: The plan of enrollment is responsible for all medically necessary covered services for Medicaid/KidsCare (Title XIX/Title XXI) members after the initial 24 hours covered by the RBHA, or upon resolution of the crisis episode, or discharge from a crisis stabilization setting, whichever occurs first.

Q5: How will crisis services be handled for members crossing GSAs?

A: The RBHA located in the RBHA GSA where the crisis occurs is responsible for the first 24 hours of crisis services.

The [RBHA geographic service areas \(GSA\)](#) remain the same on October 1, 2018 and are different than the ACC GSAs or the statewide AIHP. All Central GSA crisis service is provided by Mercy Care RBHA (formerly known as Mercy Maricopa Integrated Care – MMIC). All Northern GSA crisis service, including Gila County, is provided by Health Choice Arizona RBHA (formerly known as Health Choice Integrated Care – HCIC). All Southern GSA crisis services, including Pinal County, will remain with Arizona Complete Health- Complete Care Plan RBHA (formerly known as Cenpatico Integrated Care - CIC).

Q6: If a RBHA covers crisis services for an individual that is not Medicaid/KidsCare eligible (Non-TXIX/XXI) at the time of service delivery, and the person is later determined Medicaid/KidsCare eligible (TXIX/XXI), what will occur?

All crisis services up to 72 hours for NTXIX/XXI individuals are covered by the RBHA.

For newly enrolled TXIX ACC or AIHP members that are assigned to a RBHA for Non-TXIX services, the RBHAs will be responsible for any behavioral health services during prior period coverage (the time period starting with the effective date of eligibility when a member is TXIX eligible for covered services but is not yet enrolled in a plan). If services were provided utilizing Non-TXIX funding during the prior period coverage time-period, and the member subsequently becomes eligible for TXIX coverage that overlays this time period, the RBHA will be responsible for

reclassifying the services as funded by TXIX. The plan of enrollment or AIHP will be responsible for behavioral health (non-crisis related) starting on the day AHCCCS is notified of a member's TXIX eligibility.

Q7: What entity is responsible for the cost of SMI assessments and determinations?

A: The member's plan of enrollment is responsible for SMI assessments, including urgent evaluations when a member is hospitalized, which will be reviewed and used by the AHCCCS vendor in determining member SMI eligibility status. RBHAs are responsible for assessments for Non-TXIX/XXI members and for individuals who are incarcerated with suspended Medicaid eligibility with upcoming release dates.

The AHCCCS administration pays the SMI determination vendor directly for the SMI determinations.

Q8: Please provide billing clarification for crisis stabilization codes S9484 and S9485.

A: The following guidance should be used as the most current directive for billing crisis stabilization codes effective October 1, 2018.

Billing instructions for Crisis Intervention Mental Health Services (Stabilization) - S9484 and S9485:

A single provider cannot bill both codes for the same crisis episode, for the same member, regardless of the number of responsible payors.

S9484 – The billing unit is one hour and may only be billed if the services delivered are 5 hours or less in duration within a single crisis episode, regardless of the number of responsible payors.

S9485 – The billing unit is per diem and may only be billed if the service duration is more than 5 hours in a single crisis episode. A provider can only bill one S9485 claim for a member per crisis episode, regardless of the number of responsible payors. The claim should be billed to the RBHA based on the expectation that this service be limited to 24 hours in duration which supports up to one per diem unit being billed.

Example: If an individual comes in at 9 p.m., and is still present at the crisis stabilization facility at 2 p.m. the following day, only one per diem S9485 service will be billed to the RBHA. If that same individual had instead been discharged from the crisis stabilization program at 1 a.m. the following day, 4 hours of S9484 would be billed to the RBHA for that episode.

The member's plan of enrollment may be billed using either code for services provided to members awaiting an inpatient placement after 24 hours in the crisis stabilization unit.

Q9: For the American Indian Health Program, under the Division of Fee for Service Management, how will crisis services be billed?

A: For AIHP members, for the first 24 hours, crisis services should be billed to the RBHA. Services up to and including the fifth hour should be billed using the hourly code of S9484. Services over the fifth hour, up to and including the 24th hour, should be billed per diem using S9485.

After the first 24 hours, i.e., the 25th hour forward, crisis services should be billed to AIHP. Services up to and including the fifth hour should be billed using the hourly code of S9484. Services over the fifth hour, up to and including the 24th hour, should be billed per diem using S9485.

In situations where the crisis services overlap days, the per diem code can span the two dates. The crisis provider would bill the first per diem as described above for dates of service 1 and 2, and the second per diem for dates of service 2 and 3, if applicable. The crisis provider may also bill hourly as described above, if applicable, in addition to the per diem.

Example:

Crisis services were initiated at 3 p.m. on Monday (day 1) and ended at 6 p.m. on Tuesday (day 2). The per diem code S9485 should be billed once to the RBHA for the first 24 hour time period. This date span is from 3 p.m. Monday to 3 p.m. Tuesday. On Tuesday (day 2), the hourly code S9484 should be billed to AIHP for the 3 hours (from 3 p.m. to 6 p.m.) beyond the initial 24 hours of crisis.

Crisis services were initiated at 3 p.m. on Monday (day 1) and ended at 11 p.m. on Tuesday (day 2). The per diem S9485 should be billed once to the RBHA for the first 24 hour time period. This date span is from 3 p.m. Monday to 3 p.m. Tuesday. On Tuesday (day 2) the per diem code should be billed to AIHP since the crisis services (from 3 p.m. to 11 p.m.) extended beyond 5 hours.

For mobile services, H2011 should be used and the HT modifier added for the two-person multi-disciplinary team.

Q10: Which entity is responsible for providing crisis and non-crisis related transportation? Specifically address transportation to and from a Crisis Observation and Stabilization Unit.

A: **Effective 10/1/20**, all emergent transportation and all other applicable non-crisis related NEMT, to and from providers for services, shall be covered by the member's health plan of enrollment. Crisis related non-emergency medical transportation (NEMT), including transportation provided by mobile teams, transportation for NTXIX/XXI individuals, and (where contracted) Title 36-related transportation, remain the responsibility of the RBHA.

In instances where it is necessary to transport an AHCCCS enrolled member **to** a crisis services provider, RBHAs are responsible for the provision of crisis-related NEMT only. Emergent transportation **to** and **from** a crisis services provider and NEMT **from** the crisis service provider to another level of care, or other location, is the responsibility of the member's plan of enrollment, regardless of the timing within the crisis episode. Refer to ACOM 432.

B: (RBHAs): if clinically appropriate, crisis mobile teams are responsible for providing or coordinating transportation for individuals to a higher level of care. In these cases, crisis mobile teams must provide transportation to the nearest appropriate facility capable of stabilizing, triaging and determining medical necessity for ongoing care, in accordance with AMPM 310-BB.

Q11: Provide guidance regarding the use of HCPCS H0030 (Behavioral Health Hotline Service).

Effective 7/1/20, AHCCCS activated HCPCS code H0030, Behavioral Health Hotline Service (each 15 minutes) to replace the use of T1016 (Case Management) for billing crisis related telephone services.

Additional billing guidance is available via the AHCCCS medical coding resources webpage (B-2 Matrix): <https://www.azahcccs.gov/PlansProviders/MedicalCodingResources.html>

Provider Type	Code	Description	Category of Service	Modifier	Places of Service / Bill Type
77	H0030	Behavioral health hotline service (Per 15 minutes per AHCCCS Policy) Eff 7/1/2020	47	HN HO ET	02 04 12 14 16 18 99

Provide guidance on using H0030 (Behavioral Health Hotline Service) vs T1016 (Case Management):

H0030 is intended to replace the use of T1016 when billing for crisis related telephone services. This includes all incoming and outgoing calls to/from the crisis line(s), provided the services align with the below code description:

Behavioral health hotline is a telephone service that provides crisis intervention and emergency management such as mental health referrals, treatment information, and other verbal assistance.

All other services provided through the crisis line(s) which do not align with this description should be billed to T1016, or other applicable billing code(s).

Can H0030 be billed for crisis related telehealth services?

No. Place of Service 02 is used to identify services provided by telephone only and is not applicable for telehealth audio/video.

Use of Pseudo-Codes with H0030:

The use of pseudo-codes assigned to each RBHA for unidentified individuals (i.e. when enrollment/eligibility status unknown) is allowable when submitting encounters for H0030.