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Important Notice:

In 2019, information contained within the AHCCCS Covered Behavioral Health Services Guide (CBHSG) will be transitioned into the following areas:

- [AMPM 310-B, Behavioral Health Services Benefit](#)
- [AMPM 320-T, Non-Title XIX/XXI Behavioral Health Services Benefit](#)
 - Non-Title XIX/XXI service information will be transferred to AMPM 320-T.
- The Provider Billing Manuals
 - Billing information for Fee-For-Service providers will be transferred to the Provider Billing Manuals.
 - [Chapter 19, Behavioral Health Services, of the Fee-For-Service Provider Billing Manual](#)
 - [Chapter 12, Behavioral Health Services, of the IHS/Tribal Provider Billing Manual](#)
- Appropriate Policies as necessary.
 - i.e. Service benefit information, including transportation and transportation billing information pertinent to MCOs and FFS providers, will be transferred to AMPM 310-BB.

Behavioral Health Services

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

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

- Inpatient hospital services
- Behavioral Health Inpatient Facilities (BHIF)
- Behavioral Health Residential Facilities (BHRF)
- Partial care (supervised day program, therapeutic day program, medical day program)
- Individual therapy and counseling
- Group and/or family therapy and counseling

- Emergency/crisis behavioral health services
- Behavior management (behavioral health personal assistance, family support, peer support)
- Evaluation and diagnosis
- Psychotropic medication, including adjustment and monitoring of medication
- Psychosocial Rehabilitation (living skills training; health promotion; pre-job training, education and development; job coaching; and employment support)
- Laboratory and Radiology Services for medication regulation and diagnosis
- Screening
- Case Management Services
- Emergency Transportation
- Non-Emergency Transportation
- Respite Care (with limitations)
- Therapeutic foster care services

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

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

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

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

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

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

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

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

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

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

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

ALTCS/Tribal ALTCS EPD

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

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

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

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

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

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

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

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

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

Definitions

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

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

Behavioral Health Entity

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

Behavioral Health Entities can be one of the following:

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

Enrolled Health Plan

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

- For members who elect AIHP, the enrolled health plan is AIHP. This includes AIHP members with or without a CRS designation.
- For members who elect an ACC plan, the enrolled health plan is the [ACC plan](#).
- For members enrolled in DDD, the enrolled health plan is DDD. This includes DDD members with or without a CRS designation.
- For members enrolled in CMDP, the enrolled health plan is CMDP. This includes CMDP members with or without a CRS designation.
- For members with an SMI designation who elect a TRBHA or non-integrated RBHA for behavioral health services, the enrolled health plan is the elected ACC plan or AIHP.

Medication Assisted Treatment (MAT)

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

Principal Diagnosis

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

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

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

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

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

For further information on requirements for providers in determining payment responsibility and a member's eligibility, please refer to AMPM Chapter 650, Behavioral Health Provider

Requirements for Assisting Individuals with Eligibility Verification and Screening/Application for Public Health Benefits.

Inpatient Facility Payment Responsibility

Facility Claims

1. If the principal diagnosis on the claim is a behavioral health diagnosis, then payment of the facility claim is the responsibility of the behavioral health entity for both behavioral and physical health services.
2. If the principal diagnosis on the claim is a physical health diagnosis, then payment of the facility claim is the responsibility of the enrolled health plan for both behavioral and physical health services.
3. When the principal diagnosis on an inpatient claim is a behavioral health diagnosis, the assigned behavioral health entity shall not deny payment of the inpatient facility claim for lack of authorization or medical necessity when the member's enrolled health plan authorized and/or determined medical necessity of the stay, such as when the admitting diagnosis is a physical health diagnosis.
4. The enrolled health plan must coordinate with the assigned behavioral health entity when both physical and behavioral health services are rendered during an inpatient stay. The enrolled health plan must be notified of the stay. Such coordination shall include, but is not limited to, communication/collaboration of authorizations and determinations of medical necessity.

Professional Claims

1. Payment responsibility for professional services associated with an inpatient stay is determined by the principal diagnosis on the professional claim.
2. Payment responsibility for the inpatient facility claim and payment responsibility for the associated professional services is not necessarily the same entity.
3. Payment of the professional claim shall not be denied by the responsible entity due to lack of authorization/notification of the inpatient stay regardless of the entity that authorized the inpatient stay.

Emergency Department Payment Responsibility

Facility Claims

1. Payment of a facility claim for an emergency department visit, not resulting in an inpatient admission, is the responsibility of the enrolled health plan regardless of the principal diagnosis on the facility claim.

Professional Fees

1. Payment responsibility for professional services associated with the emergency department visit is determined by the principal diagnosis on the professional claim.
2. Payment responsibility for the emergency department visit and professional services may not necessarily be the same entity.
3. Payment of the professional claim shall not be denied by the responsible entity due to lack of authorization/notification of the emergency department visit.

Primary Care Provider Payment Responsibility

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

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

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

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

Transportation Payment Responsibility

When the enrolled health plan is ACC or AIHP and the member is assigned to a RBHA, the enrolled health plan is responsible for payment of medically necessary transportation services (emergent and non-emergent) when the diagnosis code on the claim is for physical health, regardless of which entity scheduled the appointment.

There are unspecified diagnoses designated for physical health (R68.89) and behavioral health (F99). These unspecified diagnoses, when permitted, will tell the system who is the responsible payer. If a member is enrolled with a RBHA and submits a claim to AHCCCS with the unspecified diagnosis code F99, the claim may deny since the claim would need to be sent to the RBHA.

Additional Information

For further information regarding payment responsibility for transportation, outpatient services, physician services, and therapies associated with behavioral health, or for additional information on inpatient and emergency department payment responsibilities, please see ACOM Policy 432 Attachment A, the Matrix of Financial Responsibility by Responsible Party Matrix.

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

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

General Billing Information

Place of Service

To determine which place of service codes are available with specific service codes, please reference the Behavioral Health Services Matrix at:

<https://www.azahcccs.gov/PlansProviders/Downloads/MedicalCodingResources/BehavioralHealthServicesMatrix.xlsx>

Common Modifiers for the Billing of Behavioral Health Services

For additional information on modifiers please reference the Behavioral Health Services Matrix at

<https://www.azahcccs.gov/PlansProviders/Downloads/MedicalCodingResources/BehavioralHealthServicesMatrix.xlsx>

Emergency Services

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

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

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

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

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

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

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

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

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

Crisis Services

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

Crisis services include mobile team services, telephone crisis response, and urgent care inpatient services including those provided at a hospital, sub-acute and/or residential treatment center. Crisis stabilization services will continue to include related transportations and facility charges.

First 24 Hours of Crisis Services

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

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

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

After the First 24 Hours of Crisis Services

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

The health plan of enrollment is responsible for payment of¹ medically necessary covered services (which may include follow up stabilization services) post-24 hours; the RBHA will remain responsible for any costs associated with follow up phone calls related to the crisis episode post-24 hours.²

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

¹ Distinction added.

² Clarifying responsibility post the initial 24 hour time frame.

For further information regarding what services are considered a crisis service and when the RBHA and ACC health plan or AIHP are responsible for payment, please see Exhibit 12-1, Matrix of Financial Responsibility for Crisis Services.

In situations where the crisis services overlap days, the per diem code can span the two dates. Please see below for crisis billing examples.

Example 1: Crisis services were initiated at 3 p.m. on October 8th (Monday – Day 1) and ended at 6 p.m. on October 9th (Tuesday – Day 2).

- Billing for Day 1 (the first 24 hours):
 - The per diem code should be billed once to the RBHA for the first 24 hour time frame. This date span is from 3 p.m. on October 8th (Monday – Day 1) to 2:59 p.m. on October 9th (Tuesday – end of the first 24 hour time frame).
- Billing for the first 3 hours of Day 2:
 - An hourly rate for 3 hours (from 3 p.m. to 6 p.m.) should be billed to AIHP. This covers the 3 hours beyond the 24th hour on October 9th (from 3 p.m. to 6 p.m.).

Example 2: Crisis services were initiated at 3 p.m. on October 8th (Monday – Day 1) and ended at 11 p.m. on October 9th (Tuesday – Day 2).

- Billing for Day 1 (the first 24 hours):
 - The per diem code should be billed once to the RBHA for the first 24 hour time period. This date span is from 3 p.m. on October 8th (Monday – Day 1) to 2:59 p.m. on October 9th (Tuesday – end of the first 24 hour time frame).
- Billing for Day 2:
 - “Day 2” started at 3 p.m. on October 9th. Since crisis services extended beyond the 5th hour of Day 2, the provider should bill the per diem to AIHP.

Telephonic Crisis Intervention Services (Telephone Response)

- Effective 7/1/2020, HCPCS code H0030 (Behavioral Health Hotline Service) shall replace T1016 as the dedicated crisis telephone billing code. The applicable rates and modifiers for crisis telephone billing that were valid for T1016 will now be valid for H0030. This includes modifiers HO (Master’s Degree level), HN (Bachelor’s Degree level) and ET (Emergency Services).

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

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

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

Mobile Crisis Intervention Services (Mobile Crisis Teams)

- For mobile crisis services, H2011 should be used and the HT modifier added for the two-person multi-disciplinary team.
- Mobile crisis services provided by fire, police, EMS, and/or other providers of public health and safety services or in jails are not Title XIX/XXI reimbursable.³

Facility-Based Crisis Intervention Services

- Facility-based crisis intervention services are limited to up to 24 hours per episode. After 24 hours the member, depending on their discharge plan, should be transferred and/or admitted to a more appropriate setting for further treatment (e.g. inpatient hospital, BHIF, respite) or sent home with arrangements made for follow-up services, if needed (e.g. prescription for follow-up medications, in-home stabilization services).

If a member receives facility-based crisis intervention services at an inpatient hospital or through a BHIF observation/stabilization service, and the member is subsequently admitted inpatient within the same 24 hour time frame, codes S9484 or S9485 cannot be billed within the same 24 hour time frame, as the inpatient rate is inclusive of this service.

A single provider cannot bill both codes in the first 24 hours of a crisis episode, for the same member

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.

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. 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 be billed.

The ACC Plan or other Contractor of enrollment may be billed using either code for services provided to members awaiting an inpatient placement after 24 hours in the crisis stabilization.⁴

³ Clarifying responsibility post the initial 24 hour time frame.

⁴ Added from Crisis FAQ

Medical supplies and meals provided to a member while in a facility-based crisis intervention setting are included in the rate and should not be billed separately. The following services are not included in the facility-based crisis intervention services rate and can be billed separately: medications, laboratory and radiology services.⁵

Emergent and non-emergent medical transportation from the Crisis Observation and Stabilization Unit to another level of care or other location shall be the responsibility of the enrolled health plan, regardless of the timing within the crisis episode.

Generally, the enrolled health plan is responsible for covering transportation to and from providers for services which are their responsibility. Transportation during a crisis episode to a crisis service provider will be the responsibility of the RBHA. Transportation services provided to the individual receiving the crisis intervention services is not included in the rate and should be billed separately using the appropriate transportation procedure codes.⁶

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

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

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

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

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

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

⁵ Rates clarification.

⁶ Clarifying transportation payment responsibility.

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

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

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

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

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

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

Inpatient Services

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

Billing for Inpatient and Outpatient Services

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

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

Inpatient services are billed on the UB-04 claim form and are reimbursed on a per diem basis. Inpatient services include all services provided during the inpatient stay except those provided by behavioral health independent providers. Please refer to the Billing for Professional Services section below.

Outpatient hospital services are billed on a UB-04 and reimbursed at the Outpatient Prospective Fee Schedule (OPFS) rate.

Billing for Professional Services

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

- 08 MD-physician with psychiatry and/or neurology specialty code 192 or 195
- 11 Psychologist
- 18 Physician Assistant
- 19 Registered Nurse Practitioner
- 31 DO-Physician Osteopath with psychiatry and/or neurology specialty code 192 or 195
- 77 Behavioral Health Outpatient Clinic
- 85 Licensed Independent Social Worker (LISW)
- 86 Licensed Marriage and Family Therapist (LMFT)
- 87 Licensed Professional Counselor (LPC)
- A4 Licensed Independent Substance Abuse Counselor
- BC Board Certified Behavioral Analyst
- CN Clinical Nurse Specialist

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

<https://www.azahcccs.gov/PlansProviders/Downloads/MedicalCodingResources/BehavioralHealthServicesMatrix.xlsx>

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

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

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

For BCBA and BHT criteria refer to:

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

Services must be billed on a CMS 1500 claim form with appropriate ICD diagnosis codes and CPT procedure codes. AHCCCS does not accept DSM-IV codes. Claims submitted with DSM-IV codes will be denied.

The attending physician must be listed as the provider's NPI, except when billing for BCBA, BHPP, or BHT professionals. When billing for BCBA, BHPP or BHT professional services, the clinic NPI is billed as the attending.

Services are reimbursed at the AHCCCS capped Fee-For-Service rate.

Medication Assisted Treatment (MAT)

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

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

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

Billing for Methadone Administration

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

Methadone administration must be billed with the following codes:

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

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

References

Please refer to the following chapters for additional information:

AMPM Exhibit 300-2A AHCCCS Covered Services Behavioral Health

AMPM Chapter 300, Policy 310-B Behavioral Health Services

AMPM Chapter 310-V Prescription Medications-Pharmacy Services (the section on Behavioral Health Medication Coverage)

AMPM Chapter 510 – Primary Care Providers

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

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

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

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

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

Chapter 12, Pharmacy, of the Fee-For-Service Provider Billing Manual

For the Case Manager Billing Guide refer to:

<https://www.azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/AppendixA4.pdf>

Presentation: Overview of BH Services for IHS and 638 Providers:

<https://www.azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/AppendixA3.pdf>

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

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

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

Revision History

Date	Description of changes	Page(s)
10/1/2021	Added Clinical Nurse Specialist to list of providers eligible to bill COS 47	15
7/14/2020	FESP Crisis Services information added to chapter.	10-11
7/8/2020	Link to the Behavioral Health Services Matrix updated Additional section on Crisis Service Billing for Telephonic Services added (code H0030 is replacing T1016 for telephonic crisis service billing)	8 11-12
12/7/2018	The entire chapter was restructured and formatting updated. Important Notice regarding the Covered Behavioral Health Service (CBHSG) added. List of covered behavioral health services updated. New section added called ‘Members Enrolled in an Integrated Health Plan for Physical and Behavioral Health Services.’ ALTCS/Tribal ALTCS EPD section updated, including an addition regarding where claims should be sent for BH services. (To AHCCCS DFSM). New section added called ‘Benefit Coordination for Members Enrolled with Different Entities for Physical and Behavioral Health Services.’ The referenced populations are: <ul style="list-style-type: none"> • ALTCS members enrolled with DES/DDD; • Foster care children enrolled with the Comprehensive Medical Dental Program (CMDP); and • Adults with a Serious Mental Illness (SMI) designation. 	1-18 1-2 2-3 3 4

	<p>Definitions section updated for integration. The following definitions were removed (and a reference to where they can be found in AMPM has been added): Acute Care Services Acute Care Hospital American Indian Health Program (AIHP) Behavioral Health Diagnosis Court Ordered Evaluation Court Ordered Treatment CRS Fully Integrated CRS Only CRS Partially Integrated – Acute CRS Partially Integrated – Behavioral Health (BH) Primary Care Provider</p> <p>The following definitions were updated: Behavioral Health Entity Enrolled Health Plan</p>	<p>4-5</p>
	<p>Payer responsibility section updated to read as ‘Payment Responsibility for Members Enrolled with Different Entities for their Physical and Behavioral Health Services.’ The information regarding who the payer is for inpatient facility and professional claims, ER facility and professional claims, transportation claims, and primary care provider payments has been updated.</p>	<p>5-8</p>
	<p>A General Billing Information section was added.</p>	<p>8</p>
	<p>A Place of Service section was added.</p>	<p>8</p>
	<p>A Common Modifiers for the Billing of Behavioral Health Services section was added.</p>	<p>8</p>
	<p>The Emergency Services section was updated for integration billing information.</p>	<p>8-9</p>
	<p>A Crisis Services section was added with billing examples.</p>	<p>9-10</p>
	<p>The Pre-Petition, Court Ordered Evaluations, and Court Ordered Treatment section was updated.</p>	<p>10-11</p>
	<p>A minor update to the Medication Assisted Treatment section was done. It was changed from: “To address the opioid use epidemic, the AHCCCS Administration and its Contractors shall provide coverage for medically necessary, cost-effective, and federally and state reimbursable behavioral health medications prescribed by a PCP when used to treat anxiety, depression (including postpartum depression), ADHD, and/or Opioid Use Disorder (OUD)” to “To address the opioid use epidemic, the AHCCCS Administration and its Contractors shall provide coverage for medically necessary,</p>	<p>12</p>

	cost-effective, and federally and state reimbursable behavioral health medications prescribed by a PCP within their scope of practice.” The References section was updated.	15-16
7/31/2018	Link updated on page 8 to link to the AHCCCS Behavioral Health Allowable Procedure Code Matrix	8
2/16/2018	Billing the AIR for BH services conducted by a non-AHCCCS registered behavioral health professional, like a BHT, clarification added.	10
1/17/2018	IHS Tribally Owned or Operated 638 Facilities section corrected to read as “KidsCare members enrolled with a MCO should have claims sent to the TRBHA.”	13
12/29/2017	Definitions updated Emergency Services section updated Billing for Professional Services section updated Billing for Methadone Administration section updated Medication Assisted Treatment for Opioid Use Disorder added General Requirements Regarding Payment for Physical and Behavioral Health section updated. Inpatient Facility Payment Responsibility section updated Emergency Department Payment Responsibility section updated IHS Tribally Owned or Operated 638 Facilities section updated Specific Circumstances Regarding Payment for Behavioral Health section updated Court Ordered Evaluations & Financial Responsibility section added References updated Format changes	2-7 7-8 11 10-11 11 12-14 12 12 13 13-14 15 15-16 All
10/1/2016	Behavioral Health changes effective service date 07/01/2016 and later BH Billing Matrix	9 – 16
09/17/2015	New format Changed “ICD-9” to “ICD” in preparation for 10/1/2015 ICD-10	All

