MEDICAID

COVERED BEHAVIORAL HEALTH

SERVICES GUIDE

GMH/SA Dual Eligible Enrolled Members

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I.  Introduction

A.  Purpose
The University of Arizona Health Plan (UAHP) has developed a comprehensive array of covered behavioral health services to assist, support and encourage each General Mental Health /Substance Abuse (GMH/SA) Dual Eligible person to achieve and maintain the highest possible level of health and self-sufficiency. The goals that influenced how covered services were developed include:

- Align services to support a person/family centered service delivery model.
- Focus on services to meet recovery goals.
- Increase provider flexibility to better meet individual person/family needs.
- Eliminate barriers to service.
- Recognize and include support services provided by non-licensed individuals and agencies.
- Streamline service codes.
- Maximize Title XIX/XXI funds
- These covered services have been developed by the ADHS/DBHS and continue to be the Arizona Health Care Cost Containment System (AHCCCS) approved Medicaid behavioral health covered service array for GMH/SA dual eligible members

In addition, maximization of Title XIX/XXI funds is dependent on claims being submitted correctly. There are three critical components that must be in place to successfully bill for Title XIX/XXI reimbursement:

- The person receiving the service must be Title XIX/XXI eligible.
- The individual or agency submitting the bill must be an AHCCCS registered provider.
- The service must be a recognized Title XIX/XXI covered behavioral health service and be billed using the appropriate billing code.

These individual components are addressed in depth in this service guide.

B.  Organizing Principles

UAHP has organized its array of covered behavioral health services into a continuum of service domains for the purpose of promoting clarity of understanding through the consistent use of common terms that reach across populations. The individual domains are:

- Treatment Services
- Rehabilitation Services
- Medical Services
- Support Services
- Crisis Intervention Services
- Inpatient Services
- Residential Services
- Behavioral Health Day Programs
- Prevention Services
This continuum not only applies to delivering services but also serves as the framework for program management and reporting.

Within each domain, specific services are defined and described including identification of specific provider qualifications/service standards and limitations. Additionally, code specific information (both service descriptions and billing parameters) is provided.

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 UAHP should be referenced in the following manuals:

- UB04 Manual
- First Data Bank (i.e., pharmacy information)

C. General Guidelines

In order to appropriately utilize the array of covered services to improve a person’s functioning and to be able to effectively bill for those services provided, there are a number of general principles/guidelines that are important to understand. While Section II discusses the delivery of specific services, there are overarching themes that apply to the delivery of all services, which must be understood. This discussion is divided into three subsections:

- Provision of Services
- Provider Qualifications and Registration
- Billing for Services

These guidelines provide an overview of key covered services components. More detailed descriptions and requirements can be found in UAHP Provider Manual Integrated Behavioral Health Section.

D. Provision of Services

1. Eligibility and Funding Source

Factors that may impact the provision and availability of behavioral health services are the eligibility status of the person being served as well as the funding source and fund availability. UAHP is responsible for providing services to persons assigned to the behavioral health category as General Mental Health/Substance Abuse and is eligible for Medicaid and Medicare. The member must be enrolled with UAHP AHCCCS Health Plan and/or UAHP University Care Advantage, Maricopa Care Advantage or another Medicare plan.
2. **Family Members**

For purposes of service coverage and this guide, family is defined as:

“The primary care giving unit and is inclusive of the wide diversity of primary care giving units in our culture. Family is a biological, adoptive or self-created unit of people residing together consisting of adult(s) and/or child(ren) with adult(s) performing duties of parenthood for the child(ren). Persons within this unit share bonds, culture, practices and a significant relationship. Biological parents, siblings and others with significant attachment to the individual living outside the home are included in the definition of family.”

In many instances it is important to provide behavioral health services to the family member as well as the person seeking services. For example, family members may need help with parenting skills, education regarding the nature and management of the mental health disorder, or relief from care giving. Many of the services listed in the service array can be provided to family members, regardless of their enrollment or entitlement status as long as the enrolled person’s treatment record reflects that the provision of these services is aimed at accomplishing the service plan goals (i.e., they show a direct, positive effect on the individual). This also means that the enrolled person does not have to be present when the services are being provided to family members.

For situations in which a family member is determined to have extensive behavioral health needs, (e.g., substance abusing parent) the family member her/himself should be encouraged to receive behavioral health services through their health insurance provider.

**E. Provider Qualifications and Registration**

Any person or agency may participate as an AHCCCS provider if the person or agency is qualified to render a covered service and meets the AHCCCS requirements for provider participation. These requirements include:

- Obtaining any necessary license or certification (including Centers for Medicare and Medicaid Services - CMS certification for tribal providers).
- Meeting provider standards as set forth in this service guide for the covered service, which the provider wishes to deliver.
- Registering with AHCCCS as an AHCCCS provider.
- Credentialing with the UAHP

For some services, individual providers are required to register, render and bill for the service. In other instances, individual providers are required to be affiliated with an agency that in turn is responsible for billing for the service. Individual
provider qualification and provider billing requirements are discussed for each service in Section II of this guide.

1. AHCCCS Registered Providers

For most covered behavioral health services, a provider must be registered with the AHCCCS Administration as a Title XIX/XXI provider.

A provider’s AHCCCS ID number will be terminated for inactivity if the provider has not submit a claim or encounter to the AHCCCS Administration within the past 24 months, effective January 2014.

A new registration packet will be required to reactivate providers who reapply following termination for inactivity. Providers should refer to Chapter 3 of the AHCCCS Fee-for-Service Provider Manual for information on provider participation.

Category of Service

For all provider types there are mandatory and occasionally optional AHCCCS Categories of Services (COS). In addition to the provider type, the COS will determine the specific services for which the provider can bill. For purposes of behavioral health, the following COSs are relevant:

01 – Medicine
06 – Physical Therapy
09 – Pharmacy
10 – Inpatient Hospital
12 – Pathology & Laboratory
13 – Radiology
14 – Emergency Transportation
16 – Outpatient Facility Fees
26 – Respite Care Services
31 – Non-Emergency Transportation
39 – Habilitation
47 – Mental Health Services

In order to qualify for some of these COSs the providers may have to meet additional licensing/certification requirements. It is important for providers when registering to make sure they qualify and register for the necessary COS that will allow them to bill the desired service codes. Providers should reference UAHP Allowable Procedure Code Matrix (See Section 22-Forms and Resources) to identify the applicable COS associated with each procedure code.

Additional information as well as registration materials may be obtained by calling the AHCCCS Provider Registration Unit at:
Effective Date:  October 1, 2015

AHCCCS Provider Registration materials are also available on the AHCCCS Web site at [www.ahcccs.state.az.us](http://www.ahcccs.state.az.us).

2. **Tribal Provider Certification and Registration**

In addition to registering with AHCCCS and in lieu of Division of Licensing Services (DLS), tribal providers must be certified by the Center for Medicare and Medicaid Services (CMS) to provide services. Tribal providers must submit completed certification forms indicating that the provider meets the same standards as other comparable providers. AHCCCS will review the provider application and submit the CMS certification to CMS for approval.

Additional information regarding tribal provider certification and registration can be found in the AHCCCS IHS/Tribal Provider Billing Manual.

3. **Individuals Employed by or Under Contract with Licensed DLS Agencies**

For licensed DLS residential and outpatient clinics, there are three (3) types of individual providers who are not allowed to bill independently for services. These include:

- **Behavioral Health Professionals:** Only a subset of behavioral health professionals as defined in [9 A.A.C. 10](#) must be affiliated with an Outpatient Clinic. This primarily includes social workers, counselors, marriage and family therapists, and substance abuse counselors who are licensed by the Arizona Board of Behavioral Health Examiners pursuant to [ARS Title 32, Chapter 33](#) or other recognized licensing boards and who either are not allowed to practice independently or do not meet the AHCCCS registration criteria as an independent biller (Provider Types 08, 11, 12, 18, 19, 31, 85, 86, 87 and A4).

- **Behavioral Health Technicians** as defined in [9 A.A.C. 10](#).

- **Behavioral Health Paraprofessionals** as defined in [9 A.A.C. 10](#).

4. **Community Service Agencies**

Non-DLS licensed agencies can become a Community Service Agency (CSA) and provide rehabilitation and support services. To provide these services, individual providers have to meet certain qualifications and have to be associated with a CSA.
In addition to meeting specific provider requirements set forth in this guide for the services they will be providing, these providers will need to submit certain documentation as part of their registration packet. Please refer to the description of documentation-requirements is described in ADHS/DBHS Policy and Procedures Manual, Policy 406. UAHP will require contracted providers to adhere to these requirements.

5. Habilitation Providers

A Habilitation Provider is a Home and Community Based Service (HCBS) provider certified through the Arizona Department of Economic Security/Division of Developmental Disabilities (ADES/DDD) and registered with the AHCCCS Administration. UAHP must ensure adequate liability insurance before contracting with a Habilitation Provider, regardless if the provider is an ADES certified individual or agency.

Prior to the delivery of behavioral health services, the Habilitation Provider must receive an orientation to the unique characteristics and specific needs of the eligible person under their care. Habilitation Providers must be informed regarding whom to contact in an emergency, significant events or other incidents involving the eligible person. The behavioral health provider is responsible for the timely review and resolution of any known issues or complaints involving the eligible person and a Habilitation Provider.

A Habilitation Provider (Provider Type 39) who is ADES/HCBS certified to provide habilitation services must contact ADES HCBS Certification to add Category of Service 47 (Mental Health) to their profile. Only the following COS 47 and COS 26 codes are available to Provider Type 39:

- H2014 – Skills training and development
- H2014 HQ – Skills training and development, group
- S5150 and S5151 – Unskilled respite (COS 26)
- T1019 and T1020 – Personal care services
- H2017 – Psychosocial rehabilitation service
- S5110 – Home care training, family

The Adult Recovery Team as part of the service planning process must periodically review services provided by Habilitation Providers.

F. Billing for Services

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 UAHP Medicaid Covered Behavioral Health Services Guide is provided for general information purposes only. Providers shall conform all billing practices to comply with all federal, state and local laws, rules, regulations, standards, and executive orders, all AHCCCS and/or contractor provider manuals, policy guidelines, and standards (including reference tables), ICD 9 or ICD10, whichever is in effect on the date of service, CPT, HCPCS, CDT, and Health Insurance Portability and Accountability Act Transactions and Code Sets (HIPAA TCS) compliance standards, notwithstanding anything contained in this guide, whether expressed or implied.

1. a. AHCCCS Allowable Codes

To bill AHCCCS allowable codes the provider must be an AHCCCS registered provider.

AHCCCS allowable codes can be further subdivided into the following categories:

(1.) CPT

Physicians’ Current Procedural Terminology (CPT) contains nationally recognized service codes. For more information regarding these codes see the Physicians’ Current Procedural Terminology (CPT) Manual, which contains a systematic listing and coding of procedures and services, such as surgical, diagnostic or therapeutic procedures.

(2.) HCPCS

Healthcare Procedure Coding System (HCPCS) contains nationally recognized service codes. For more information regarding these codes see the Healthcare 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. A subset of the HCPCS codes are not Title XIX/XXI reimbursable; these are identified in the UAHP Allowable Procedure Code Matrix, where COS is S (See Section 22-Forms and Resources).

(3.) National Drug Codes (NDC)

These nationally recognized drug codes are used to bill for prescription drugs. Information regarding these pharmacy-related codes can be found in the First Data Bank.

(4.) 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.
2. Billing Provider Types

UAHP Allowable Procedure Code Matrix provides a listing of the service codes that can be billed by each provider type (See Section 22-Forms and Resources).

a. AHCCCS Provider Billing Types

All AHCCCS reimbursable service codes must be billed by an AHCCCS registered provider. AHCCCS provider billing types relevant to behavioral health providers include the following:

02 – Level I Hospital
03 – Pharmacy
04 – Laboratory
06 – Emergency Transportation
08 – Physician (Allopathic)*
11 – Psychologist*
12 – Certified Registered Nurse Anesthetist*
18 – Physician Assistant*
19 – Nurse Practitioner*
28 – Non-emergency Transportation
29 – Rural Health Clinics (RHCs)
31 – Physician (Osteopathic)*
39 – Habilitation Provider
71 – Level I Psychiatric Hospital (IMD)
72 – Tribal Regional Behavioral Health Authority/Regional Behavioral Health Authority (T/RBHA)
73 – Out-of-state, One Time Fee For Service Provider
77 – Behavioral Health
   Outpatient Clinic
78 – Level I Residential Treatment Center – Secure (non-IMD)
85 – Licensed Clinical Social Worker*
86 – Licensed Marriage/Family Therapist*
87 – Licensed Professional Counselor*
97 – Air Transport Providers
A3 – Community Service Agency
A4 – Licensed Independent Substance Abuse Counselor*
A5 – Behavioral Health Therapeutic Home
A6 – Rural Substance Abuse Transitional Agency
B1 – Level I Residential Treatment Center – Secure (IMD)
B2 – Level I Residential Treatment Center – Non-Secure (non-IMD)
B3 – Level I Residential Treatment Center – Non-Secure (IMD)
B5 – Level I Subacute Facility (non-IMD)
B6 – Level I Subacute Facility (IMD)
B7 – Crisis Services Provider
B8 – Behavioral Health Residential Facility
C2 – Federally Qualified Health Centers (FQHCs)  
IC – Integrated Clinics  

* These individuals are referred to as “Independent Billers”.

In addition to having the correct provider type, providers also have to be registered to provide the COS in which the service code is classified.

3. **Modifiers**

In some instances, in order to clearly delineate the service being provided, a “modifier” must be submitted along with the service code. In these circumstances codes are assigned modifiers as described in the text of this guide and in UAHP Allowable Procedure Code Matrix (See Section 22-Forms and Resources). For example, there is a single code for counseling, but reimbursement for counseling provided in the office, the home or in 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 to further define a procedure code. The following is a list of modifiers used in this guide:

- GT- Via interactive audio and video telecommunication systems- The physical location of the provider, when providing services via telecommunication, is the location used as the billable place of service.
- HB- Adult Program, Non Geriatric
- HC- Adult Program, Geriatric
- HG- Opioid addiction treatment program
- HK- Specialized mental health programs for high risk populations
- HN- Bachelor’s degree program (for staff not designated as behavioral health professionals)
- HO- Master’s degree level (for behavioral health professionals)
- HQ- Group setting
- HR- Family/couple with client present
- HS- Family/couple without client present
- HT- Multi-disciplinary team
- TF- Intermediate level of care
- TG- Complex/high level of care
- TN- Rural

4. **Place of Service (POS) Codes**

Accurate 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 their descriptions: [http://www.cms.gov/physicianfeesched/downloads/Website_POS_database.pdf](http://www.cms.gov/physicianfeesched/downloads/Website_POS_database.pdf). To determine which POS codes are available for use with specific service codes,
please reference the UAHP Allowable Procedure Code Matrix in Section 22-Forms and Resources).

5. **Group Payment ID**

An organization may act as the financial representative for any AHCCCS registered provider or group of providers who have authorized this 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 and encounters to the UAHP 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. If a provider has multiple locations, the provider may be affiliated with multiple group payment associations.

6. **Diagnosis Codes**

Covered behavioral health services may be provided to persons regardless of their diagnosis or even in the absence of any diagnosis at the time of services, so long as there are documented behaviors or symptoms that require treatment. This means that a diagnosis is not necessary prior to providing services to the UAHP GMH/SA Dual eligible member. Likewise, the provision of covered services is not limited by a person’s diagnosis (e.g., any of the covered services may be provided to address both mental illness and substance abuse disorders, at-risk behaviors/conditions or family members impacted by the person’s disorder). While a diagnosis is not needed to receive treatment, a diagnostic code is needed for service code billing.

The ICD-10 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 person’s condition, there are a number of very general ICD-10 codes that can be used for those cases in which no specific diagnosis has been established at the time of the service.

If a code of 799.9 is assigned under the DSM-IV criteria and is not changed to a more specific diagnostic or descriptive “V” code before a claim is submitted to the AHCCCS PMMIS data system reads it as if it were an ICD-10-CM code, that is, the clinician does not know what the specific problem is. This diagnosis code will be denied for any inpatient or laboratory service. Further, it is difficult to gather meaningful data regarding populations, trends and program effectiveness when the primary diagnostic code is 799.9.
Providers are strongly encouraged to limit the use of 799.9 and to use instead codes which more clearly describe the person’s situation. An individual who presents to the mental health system for services but who does not have a diagnosis on Axis I or II will very likely have a situation that is described by a “V” code (e.g., V61.20, counseling for parent-child problem, unspecified; V61.21, counseling for victim of child abuse, etc.).

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 principle ICD-10 mental health or substance abuse diagnosis. Although a patient may have other diagnosis codes (e.g., a “V” code or other ICD-10 diagnostic code), the encounter/claim for inpatient psychiatric service must indicate a principle mental health or substance abuse diagnosis to adjudicate successfully. The exception is the use of ICD-10 diagnostic codes 648.33 and 648.43 as principle diagnoses for complications of pregnancy while an individual is receiving inpatient psychiatric services.

Although ICD-10 and DSM-V diagnosis codes are substantially alike, DSM-V codes must not be used. Areas of differences include:

- Two ICD-10 codes (i.e., 312.8 and V61.) require a 5th digit. See ICD-10-CM manual to determine appropriate 5th digit.

ICD-10 codes should be used at their highest level of specificity (i.e., highest number of digits possible).

ICD-10 codes are the industry standard and are required for Medicaid/Medicare billing purposes.

7. 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. The specific billing limitations are set forth in Section II of this guide.

a. General Core Billing Limitations

General core billing limitations include the following:

1. A provider can only bill for their time spent in providing the actual service. For all services, the provider may not bill any time associated with note taking and/or medical record upkeep as this time has been included in the rate.

2. For all services except case management and assessment services, the provider may not bill any time associated with phone calls, leaving voice
messages, sending emails and/or collateral contact with the enrolled person, family and/or other involved parties as this time is included in the rate calculation.

3. The provider may only bill the time spent in face-to-face direct contact; however, when providing assessment or case management services, the provider may also bill indirect contact. Indirect contact includes phone calls, leaving voice messages and sending emails (with limitations), picking up and delivering medications, and/or collateral contact with the enrolled person, family and/or other involved parties.

4. A provider should bill all time spent in directly providing the actual service, regardless of the assumptions made in the rate model. Providers must indicate begin and end times on all progress notes.

5. A professional who supervises the Behavioral Health Professional, Behavioral Health Technician and/or Behavioral Health Paraprofessional providing the service may not bill this supervision function as a HCPCS/CPT code. Employee supervision has been built into the service code rates. Supervision means direction or oversight of behavioral health services provided by a qualified individual in order to enhance therapeutic competence and clinical insight and to ensure client welfare by guiding, evaluating, and advising how services are provided.

6. If the person and/or family member(s) misses their appointment, the provider may not bill for the service.

7. Parents (including natural parent, adoptive parent and stepparent) may only provide personal care services if the adult child receiving services is 21 years or older and the parent is not the adult child’s legal guardian. Under no circumstances may the spouse be the personal care services provider. UAHP is responsible for monitoring that personal care services are provided by appropriate personnel.

8. Parents (including natural parent, adoptive parent and stepparent) who are certified Habilitation providers may only encounter/bill for applicable covered behavioral health services delivered to their adult children who are 21 years or older.

9. When necessary, covered services, in addition to those offered through a DLS Level I Behavioral Health facility, may be delivered to the enrolled person. See the billing limitation section associated with each specific service for additional information.

10. For services with billing units of 15 minutes, the first unit of service can be encountered/billed when 1 or more minutes are spent providing the service.
To encounter/bill subsequent units of the service, the provider must spend at least one half of the billing unit for the subsequent units to be encountered/billed. If less than one half of the subsequent billing unit is spent providing the service, then only the initial unit of service can be encountered/billed.

11. More than one provider agency may bill for certain services provided to a behavioral health recipient at the same time if indicated by the person’s clinical needs. Please refer to the billing limitations for each service for applicability.

12. If otherwise allowed, service codes may be billed on the same day as admission to and discharge from inpatient services (e.g., billing Crisis Intervention Service (H2011) on the same day of admission to Inpatient Hospital (0114)).

13. A single provider cannot bill for any other covered service while providing transportation to client(s).

14. Payment for services related to Provider-Preventable Conditions is prohibited, in accordance with 42 CFR Section 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 AHCCCS Medical Policy Manual (AMPM), Chapter 900, Policy 960.

15. CPT codes are restricted to independent practitioners with specialized behavioral health training and licensure. Please refer to the UAHP Allowable Procedure Code Matrix to identify providers who can bill using CPT codes (See Section 22-Forms and Resources).

7. Core Provider Travel Billing Limitations

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 HCPCS code A0160.

When a provider is traveling to one destination and returns to the office, the 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:
1. 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.

2. 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 provider code A0160 (40 miles minus 25 miles).

3. If Provider C travels to multiple out-of-office settings (in succession), he/she must calculate provider travel mileage by segment. For example:
   - First segment = 15 miles; 0 travel miles are billed
   - Second segment = 35 miles; 10 travel miles are billed
   - Third segment = 30 miles; 5 travel miles are billed
   Total travel miles billed = 15 miles are billed using provider code A0160.
   The provider may bill for travel miles in excess of 25 miles for the return trip to the provider office.

4. Providers may not bill for travel for missed appointments.

8. Telehealth Services

While telehealth services is not a treatment service (“modality”) does recognize real time telehealth services as an effective mechanism for the delivery of certain covered behavioral health services. The following types of covered behavioral health services may be delivered to persons utilizing telehealth services technology:

- Diagnostic consultation and assessment
- Psychotropic medication adjustment and monitoring
- Individual and family counseling
- Case management

A complete listing of the services that can be billed utilizing telehealth services can be found in UAHP Allowable Procedure Code Matrix in Section 22-Forms and Resources. Services provided through telehealth should be billed/encountered as any other specialty consultation with the exception that the ‘GT’ modifier must be used to designate the service being billed as telehealth services.

9. Reimbursement

Providers should refer to their contacted rates in their UAHP contract. Providers can view rates on the AHCCCS website at:
II. Service Descriptions

II. A. Treatment Services

Treatment services are provided by or under the supervision of behavioral health professionals to reduce symptoms and improve or maintain functioning. These services have been further grouped into the following three subcategories:

- Behavioral Health Counseling and Therapy
- Assessment, Evaluation and Screening Services
- Other Professional

II. A. 1. Behavioral Health Counseling and Therapy

General Information

General Definition

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 person, 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.

Service Standards/Provider Qualifications

Behavioral Health Counseling and Therapy services must be provided by individuals who are qualified behavioral health professionals or behavioral health technicians as defined in 9 A.A.C. 10.

For behavioral health counseling and therapy services that are billed by a behavioral health agency, the agency must be licensed by DLS and meet the requirements for the provision of behavioral health counseling and therapy services as set forth in 9 A.A.C. 10.

Code Specific Information

CPT Codes

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION-Individual Counseling and Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>90832</td>
<td>Psychotherapy, 30 minutes with patient and/or family member.</td>
</tr>
<tr>
<td>90833</td>
<td>Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service (list separately in addition to the code for primary procedure).</td>
</tr>
<tr>
<td>CODE</td>
<td>DESCRIPTION</td>
</tr>
<tr>
<td>--------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>90834</td>
<td>Psychotherapy, 45 minutes with patient and/or family member.</td>
</tr>
<tr>
<td>90836</td>
<td>Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service (list separately in addition to the code for primary procedure).</td>
</tr>
<tr>
<td>90837</td>
<td>Psychotherapy, 60 minutes with patient and/or family member.</td>
</tr>
<tr>
<td>90838</td>
<td>Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service (list separately in addition to the code for primary procedure).</td>
</tr>
<tr>
<td>90845</td>
<td>Medical psychoanalysis - No units specified</td>
</tr>
<tr>
<td>90880</td>
<td>Hypnotherapy</td>
</tr>
</tbody>
</table>

### CODE DESCRIPTION - Family Counseling and Therapy

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>90846</td>
<td>Family psychotherapy (without the patient present)</td>
</tr>
<tr>
<td>90847</td>
<td>Family psychotherapy (conjoint psychotherapy, with patient present)</td>
</tr>
<tr>
<td>90849</td>
<td>Multiple-family group psychotherapy</td>
</tr>
</tbody>
</table>

### CODE DESCRIPTION - Group Counseling and Therapy

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>90853</td>
<td>Group psychotherapy (other than of a multiple-family group)</td>
</tr>
</tbody>
</table>

**HCPCS Codes**

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

- **H0004 - Individual Behavioral Health Counseling and Therapy -- Office:**
  Counseling services (see general definition above for behavioral health counseling and therapy) provided face-to-face at the provider’s work site to an individual person.

  **Billing Unit:** 15 minutes

- **H0004 - Individual Behavioral Health Counseling and Therapy – Home:**
  Counseling services (see general definition above for counseling and therapy)
provided face-to-face to an individual person at the person’s residence or other out-of-office setting.

Billing Unit: 15 minutes

- **H0004 HR - Family Behavioral Health Counseling and Therapy – 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 place of service**

  Billing Unit: 15 minutes per family

- **H0004 HS - Family Behavioral Health Counseling and Therapy – Office, Without Client Present:** Counseling services (see general definition above for counseling and therapy) provided face-to-face to members of a person’s family at the provider’s work site. **HS modifier required and must specify place of service**

  Billing Unit: 15 minutes per family

- **H0004 HR – Family Behavioral Health Counseling and Therapy – Out-of-Office, With Client Present:** Counseling services (see general definition above for counseling and therapy) provided face-to-face to members of a person’s family at the family’s residence or other out-of-office setting. **HR modifier required and must specify place of service**

  Billing Unit: 15 minutes per family

- **H0004 HS – Family Behavioral Health Counseling and Therapy - Out-of-Office, Without Client Present:** Counseling services (see general definitions above for counseling) provided face-to-face to members of a person’s family at the family’s residence or other out-of-office setting. **HS modifier required and must specify place of service**

  Billing Unit: 15 minutes per family

- **H0004 HQ - Group Behavioral Health Counseling and Therapy:** Counseling services (see general definition above for counseling and therapy) provided to a group (of any size) of persons, which occurs at a provider’s worksite. For example, if eight persons participated in group counseling for 60 minutes, the provider would bill four units for each person for a total of 32 units. **HQ modifier required and must specify place of service**
Billing Unit: 15 minutes per each person in the group

Billing Limitations

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

1. See general core billing limitations in Section I.

2. Provider travel time 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 core provider travel billing limitations in Section I.

3. Transportation provided to persons 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 behavioral health counseling and therapy services provided to a behavioral health recipient at the same time if indicated by the person’s clinical needs.

5. Generally, H0004 HQ (Group Behavioral Health Counseling and Therapy) may not be billed on the same day as Level I Residential Treatment Center (0114, 0124, 0134, 0154, 0116, 0126, 0136 or 0156) or Behavioral Health Short-Term Residential (H0018) Services. However, based on behavioral health recipient needs, certain specialized group behavioral health counseling and therapy services may be billed on the same day as Level I Residential Treatment Center or Behavioral Health Short-Term Residential Services and be provided in the residential setting or other places of service listed for H0004 HQ. The clinical rationale for providing specialized group behavioral health counseling and therapy services must be specifically documented in the Service Plan and Progress Note. II. A. 2. Assessment, Evaluation and Screening Services

General Information

General Definition

Gathering and assessment of historical and current information which includes face-to-face contact with the person and/or the person’s family or other informants, or group of individuals resulting in a written summary report and recommendations.

Service Standards/Provider Qualifications:
Behavioral health professionals or behavioral health technicians (as defined in 9 A.A.C. 10) must meet the UAHP credentialing requirements in order to provide assessment and evaluation services.

For behavioral health screening, assessment and evaluation services that are billed by a behavioral health agency, the agency must be licensed by DLS and meet the requirements for the provision of behavioral health assessment, evaluation and screening services as set forth in 9 A.A.C. 10.

**Code Specific Information**

**CPT Codes**

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION- Assessment, Evaluation and Screening Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>90791</td>
<td>Psychiatric diagnostic evaluation</td>
</tr>
<tr>
<td>90792</td>
<td>Psychiatric diagnostic evaluation with medical services</td>
</tr>
<tr>
<td>96101</td>
<td>Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology (e.g., MMPI, Rorshach WAIS), per hour of the psychologist’s or physician’s time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report</td>
</tr>
<tr>
<td>96102</td>
<td>Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology (e.g., MMPI, Rorshach and WAIS), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face</td>
</tr>
<tr>
<td>96103</td>
<td>Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology (e.g., MMPI, Rorshach, WAIS), administered by a computer, with qualified health care professional interpretation and report.</td>
</tr>
<tr>
<td>96110</td>
<td>Developmental screening, with interpretation and report, per standardized instrument form.</td>
</tr>
<tr>
<td>96111</td>
<td>Developmental testing, (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments) with interpretation and report.</td>
</tr>
<tr>
<td>96116</td>
<td>Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment (e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial...</td>
</tr>
</tbody>
</table>
abilities), per hour of the psychologist’s or physician’s time, both face-to-face time with the patient and time interpreting test results and preparing the report

96118 Neuropsychological testing (e.g., Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist’s or physician’s time, both face-to-face time administering tests to the patient and time interpreting test results and preparing the report

96119 Neuropsychological testing (e.g., Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face

96120 Neuropsychological testing (e.g., Wisconsin Card Sorting Test), administered by a computer, with qualified health care professional interpretation and report

99241 Office consultation for a new or established patient, which requires these 3 key components: A problem focused history; a problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are self-limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

99242 Office consultation for a new or established patient, which requires these 3 key components: an expanded problem focused history; an expanded problem focused examination; and, straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

99243 Office consultation for a new or established patient, which requires these 3 key components: a detailed history; a detailed examination; and, medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.
Office consultation for a new or established patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and, medical decision-making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

Office consultation for a new or established patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 80 minutes face-to-face with the patient and/or family.

Initial nursing facility care, per day, for the evaluation and management of a patient which requires these 3 key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually the problem(s) requiring admission are of low severity. Physicians typically spend 25 minutes at the bedside and on the patient’s facility floor or unit.

Initial nursing facility care, per day, for the evaluation and management of a patient which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 35 minutes at the bedside and on the patient’s facility floor or unit.

Initial nursing facility care, per day, for the evaluation and management of a patient which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs.
Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 45 minutes at the bedside and on the patient’s facility floor or unit.

**99307**

Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a problem focused interval history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the patient is stable, recovering or improving. Physicians typically spend 10 minutes at the bedside and on the patient’s facility floor or unit.

**99308**

Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: an expanded problem focused interval history; an expanded problem focused examination; medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 15 minutes at the bedside and on the patient’s facility floor or unit.

**99309**

Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a detailed interval history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the patient has developed a significant complication or a significant new problem. Physicians typically spend 25 minutes at the bedside and on the patient’s facility floor or unit.

**99310**

Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a comprehensive interval history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 35 minutes at the bedside and on the patient’s facility floor or unit.
99315  Nursing facility discharge day management. (30 minutes or less)
99316  Nursing facility discharge day management. (More than 30 minutes)
99318  Evaluation and management of a patient involving an annual nursing facility assessment, which requires these 3 key components: a detailed interval history; a comprehensive examination; and medical decision making that is of low to moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the patient is stable, recovering, or improving. Physicians typically spend 30 minutes with the patient and/or family or caregiver. (Do not report 99318 on the same day of service as nursing facility services codes 99304-99316).

**HCPCS Codes**

Except for assessment, evaluation and screening provided by those independently registered individual behavioral health professionals billing CPT codes, all other assessment, and evaluation and screening services should be billed using the following HCPCS codes.

- **H0001 – Alcohol and/or drug assessment**

  Provider Qualifications:
  UAHP credentialed behavioral health professionals and behavioral health technicians.

- **H0002 - Behavioral Health Screening to Determine Eligibility for Admission:**
  Information gathered using a standardized screening tool or criteria including those behavioral health screening activities associated with DUI 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 person’s service plan. May also include the preliminary collection of information necessary to complete a supported employment assessment.

  Provider Qualifications:
  Behavioral health technician or behavioral health professional as defined in 9 A.A.C. 10.

- **H0031 - Mental Health Assessment –By Non-Physician-:** Gathering and assessment of information necessary for assessment of a person, resulting in a written summary report. Recommendations, which may be in response to specific questions posed in an assessment request, are made to the person, family, referral source, provider, or courts, as applicable. May also include the review and modifications to the person’s
service plan, comprehensive assessments, a rehabilitative employment support assessment and DES-DDD Positive Support Plans.

**Provider Qualifications:**
UAHP credentialed behavioral health professionals and behavioral health technicians

- **H0031 HK -Mental Health Assessment-By Board Certified Behavior Analysts:**
  See definition of mental health assessment above.

  **Provider Qualifications:**
  Board Certified Behavior Analysts

  **Billing Provider Type:**
  Behavioral Health Outpatient Clinic (77)

**Billing Limitations**

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

1. See general core billing limitations in Section I.

2. Where applicable, travel time by the provider is included in the rates. See core provider travel billing limitations in Section I.

3. Transportation (emergency and non-emergency) provided to persons and/or family members is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

4. Rehabilitative employment support assessments may only be provided when the assessment service is not available through federally funded Rehabilitation Act Program Administered by Arizona Department of Economic Security/Rehabilitation Service Administration (ADES/RSA) or the Tribal Rehabilitation Services Administrations.

5. 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.

II. A. 3. Other Professional

General Information

In addition to behavioral health counseling therapy and assessment, evaluation and screening, there are a number of 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.

Code Specific Information

CPT Codes

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION-Other Professional</th>
</tr>
</thead>
<tbody>
<tr>
<td>90875</td>
<td>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); approximately 20-30 minutes</td>
</tr>
<tr>
<td>90876</td>
<td>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); approximately 45-50 minutes</td>
</tr>
<tr>
<td>90899</td>
<td>Unlisted psychiatric services or procedure (Psychiatric services without patient face to face contact)</td>
</tr>
<tr>
<td>90901</td>
<td>Biofeedback training by any modality</td>
</tr>
<tr>
<td>99199</td>
<td>Unlisted special service, procedure or report</td>
</tr>
</tbody>
</table>

HCPCS Codes

Except for alcohol and/or drug services provided by behavioral health professionals allowed to bill CPT codes, all other alcohol and/or drug behavioral health services should be billed using the following HCPCS codes.

- **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 Unit:** Per Diem
Billing Limitations

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

1. See general core billing limitations in Section I.

2. Where applicable, travel time by the provider is included in the rates. See core provider travel billing limitations in Section I.

3. Transportation provided to persons and/or family members is not included in the rate and should be billed separately using the appropriate transportation procedure codes.
II. B. Rehabilitation Services

Rehabilitation services include the provision of educating, coaching, training and demonstrating. Other services include securing and maintaining employment to remediate residual or prevent anticipated functional deficits. Except for cognitive rehabilitation, which is billed using a CPT code, rehabilitation services are billed using HCPCS codes. Rehabilitation services include:

- Skills Training and Development and Psychosocial Rehabilitation Living Skills Training
- Cognitive Rehabilitation
- Behavioral Health Prevention/Promotion Education and Medication Training and Support (Health Promotion)
- Psychoeducational Service (Pre-Job Training and Job Development) and Ongoing Support to Maintain Employment (Job Coaching and Employment Support)
II. B. 1. Skills Training and Development and Psychosocial Rehabilitation Living Skills Training

General Information

General Definition

Teaching independent living, social, and communication skills to persons and/or their families in order to maximize the person’s ability to live and participate in the community and to function independently. Examples of areas that may be addressed include self-care, household management, social decorum, same- and opposite-sex friendships, and avoidance of exploitation, budgeting, recreation, development of social support networks and use of community resources. Services may be provided to a person, a group of individuals or their families with the person(s) present.

Service Standards/Provider Qualifications

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 para-professionals as defined in 9 A.A.C. 10. This may also include Licensed Practical Nurses (LPNs) who have training in providing these services as required by the person’s service plan.

Code Specific Information

HCPCS Codes

Skills training and development and psychosocial rehabilitation living skills training services should be billed using the following codes:

- **H2014 –Skills Training and Development – Individual**: See general definition above.

  **Billing Unit**: 15 minutes

- **H2014 HK –Skills Training and Development-By Board Certified Behavior Analysts**: See general definition above.

  **Billing Provider Type**: Behavioral Health Outpatient Clinic (77)

  **Billing Unit**: 15 minutes

- **H2014 HQ –Skills Training and Development – Group**: See general definition above. If eight persons participated in group skills training and development session
for 60 minutes, the provider would bill four units for each person for a total of 32 units.

**Billing Unit:** 15 minutes per person

- **H2017—Psychosocial Rehabilitation Services (Living Skills Training):** See general definition above.

  **Billing Unit:** 15 minutes per person

**Billing Limitations**

For skills training and development services the following billing limitations apply:

1. See general core billing limitations in Section I.

2. Where applicable, travel time by the provider is included in the rates.

3. Transportation provided to persons and/or family members is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

4. Service code H2014, Skills Training and Development, may be billed up to 8 hours. Service code H2017, Psychosocial Rehabilitation, cannot be billed if under 8 hours are needed and should be billed for the length of the service. Service codes H2014, Skills Training and Development and Service code H2017, Psychosocial Rehabilitation cannot be billed on the same day, with certain exceptions. For exceptions see section Home Care Training to Home Care Client under Billing Limitations.

4. More than one provider agency may bill for skills training and development services provided to a behavioral health recipient at the same time if indicated by the person’s clinical needs.
II. B. 2. Cognitive Rehabilitation

General Information

General Definition

The facilitation of recovery from cognitive impairments in order to achieve independence or the highest level of functioning possible. 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. Treatment may include techniques such as auditory and visual attention directed tasks, memory training, and training in the use of assistive technology, and anger management. 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.

Service Standards/Provider Qualifications
Cognitive rehabilitation services must be provided by individuals who are qualified behavioral health professionals as defined in 9 A.A.C. 10 and who can bill independently using the appropriate CPT codes.

Code Specific Information

CPT Codes

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION-Cognitive Rehabilitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>97532</td>
<td>Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one on one) patient contact by the provider, each 15 minutes.</td>
</tr>
</tbody>
</table>
II. B. 3. Behavioral Health Prevention/Promotion Education and Medication Training and Support Services (Health Promotion)

General Information

General Definition
Education and training are single or multiple sessions provided to an individual or a group of people and/or their families related to the enrolled person's treatment plan. Education and training 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, HIV education, parenting skills education and healthy lifestyles (e.g., diet, exercise). DUI health promotion education and training must be approved by DLS.

Service Standards/Provider Qualifications

Behavioral health prevention/promotion education services may be provided by individuals who are qualified behavioral health professionals or behavioral health technicians as defined in 9 A.A.C. 10 or who are educators or subject matter experts. This may also include other medical personnel, such as Licensed Practical Nurses (LPNs) or Registered Nurses (RNs) who are not allowed to bill independently using CPT codes. All individual providers must be appropriately licensed/certified/trained in the area in which they are providing training.

Code Specific Information

HCPCS Codes

Behavioral health prevention/promotion education and medication training and support services should be billed using the following codes:

- **H0025 - Behavioral Health Prevention Education Service:** (delivery of services with target population to affect knowledge, attitude and/or behavior). See general definition above.
  
  **Billing Unit:** 30 minutes

- **H0034 – Medication Training and Support:** (Health promotion) Education and training provided to a person and/or their family related to the enrolled person’s medication regime.
  
  **Billing Unit:** 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 in Section I.

2. Where applicable, travel time by the provider is included in the rates. See core provider travel billing limitations in Section I.

3. Transportation provided to persons 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 behavioral health prevention/promotion education and medication training and support services provided to a behavioral health recipient at the same time if indicated by the person’s clinical needs.
II. B. 4. Psychoeducational Services and Ongoing Support to Maintain Employment

General Information

General Definition

Psychoeducational services and ongoing support to maintain employment services are designed to assist a person or group to choose, acquire, and maintain a job or other meaningful community activity (e.g., volunteer work).

Service Standards/Provider Qualifications

Psychoeducational services and ongoing support to maintain employment services may be provided individually. These services must be provided using tools, techniques and materials which meet the individual’s needs and are appropriate for the person’s age and mental and physical status. While the goal may be for persons to achieve full time employment in a competitive, integrated work environment, there may be persons for whom this goal is not applicable. Therefore, these services need to be tailored to support persons in a variety of settings (e.g., part time job, unpaid work experience or in meaningful volunteer work). Some individuals may not be ready to identify an educational or employment goal, and will need assistance in exploring their strengths. Some individuals may desire to focus on socialization goals, which should also be addressed in rehabilitation services, and are often the first step to moving towards competitive employment and further independent involvement in the community.

Code Specific Information

HCPCS Codes

- **H2027 – Psychoeducational Services (Pre-Job Training and Development):**
  Services which prepare a person to engage in meaningful work-related activities may include: career/educational counseling, job shadowing, assistance in the use of educational resources, training in resume preparation, job interview skills, study skills, work activities, professional decorum and dress, time management, and assistance in finding employment.

  **Provider Qualifications:**

  Behavioral health professionals, behavioral health technicians and behavioral health paraprofessionals with one year of experience in providing rehabilitation services to persons with disabilities.

  For Community Service Agencies, please see ADHS/DBHS Procedures Manual Policy 406.
Billing Unit: 15 minutes

- **H2025 – Ongoing Support to Maintain Employment:** Includes support services that enable a person to complete job training or maintain employment. Services may include monitoring and supervision, assistance in performing job tasks, work-adjustment training, and supportive counseling.

  **Provider Qualifications:**

  Behavioral health professionals, behavioral health technicians and behavioral health parapersons with one year of experience in providing rehabilitation services to persons with disabilities.

  **Billing Unit:** 15 minutes

- **H2026 – Ongoing Support to Maintain Employment:** See definition above.

  **Provider Qualifications:**

  Behavioral health professionals, behavioral health technicians and behavioral health parapersons with one year of experience in providing rehabilitation services to persons with disabilities.

  **Billing Unit:** Per Diem

**Billing Limitations**

For psychoeducational services and ongoing support to maintain employment services the following billing limitations apply:

1. See general core billing limitations in Section I.

2. Where applicable, travel time by the provider is included in the rates. See core provider travel billing limitations in Section I.

3. Transportation provided to persons is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

4. Psychoeducational 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 DES-RSA, which is required to be the primary payer for Title XIX eligible persons.
5. Service code H2025, Ongoing Support to Maintain Employment, may be billed up to 8 hours. Service code H2026, Ongoing Support to Maintain Employment (per diem), cannot be billed if under 8 hours are needed and should be billed for the length of the service. Service codes H2025, Ongoing Support to Maintain Employment and Service code H2026, Ongoing Support to Maintain Employment (per diem) cannot be billed on the same day.

6. More than one provider agency may bill for psychoeducational services and ongoing support to maintain employment services provided to a behavioral health recipient at the same time if indicated by the person’s clinical needs.

7. Peer employment training is not a billable service for costs associated with training an agency’s own employees.

II. C. Medical Services

Medical services are provided or ordered by a licensed physician, nurse practitioner, physician assistant, or nurse to reduce a person’s symptoms and improve or maintain functioning. These services have been further grouped into the following four subcategories:

- Medication
- Laboratory, Radiology and Medical Imaging
- Medical Management (including medication management)
- Electroconvulsive Therapy (ECT)

II. C. 1. Medication Services

General Information

General Definition

Drugs prescribed by a licensed physician, nurse practitioner or physician assistant to prevent, stabilize or ameliorate symptoms arising from a behavioral health condition or its treatment.

Service Standards/Provider Qualifications

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, or physician assistant.

UAHP maintains a minimum list of medications to ensure the availability of necessary, safe and cost effective medications for persons with behavioral health disorders. These
medications must be made available to persons in accordance with the UAHP Prescription Drug List at- http://uahealthplans.com/ProviderResourcePage.aspx

**Code Specific Information**

**National Drug Codes**

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

**CPT Codes**

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION-Medication Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>96372</td>
<td>Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular</td>
</tr>
</tbody>
</table>

**HCPCS Codes**

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION-Medication Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>J0515</td>
<td>Injection, Benztropine Mesylate, per 1mg</td>
</tr>
<tr>
<td>J1200</td>
<td>Injection, Diphenhydramine HCL, up to 50 mg</td>
</tr>
<tr>
<td>J1630</td>
<td>Injection, Haloperidol, up to 5 mg</td>
</tr>
<tr>
<td>J1631</td>
<td>Injection, Haloperidol Decanoate, per 50 mg</td>
</tr>
<tr>
<td>J2680</td>
<td>Injection, Fluphenazine Decanoate, up to 25 mg</td>
</tr>
<tr>
<td>J2794</td>
<td>Injection, Risperidone (Risperidal Const), long-acting, 0.5 mg</td>
</tr>
<tr>
<td>J3410</td>
<td>Injection, Hydroxyine HCL, up to 25 mg</td>
</tr>
</tbody>
</table>

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, (see 42 CFR Part 8), state regulations (9 A.A.C. 10) and ADHS/DBHS guidelines related to opioid agonist administration.

- **H2010 HG –Comprehensive Medication Services**: 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).
Billing Unit: 15 minutes

- **H0020 HG – Alcohol and/or Drug Services; Methadone Administration and/or Services (provision of the drug by a licensed program):** Administration of prescribed opioid agonist drugs for a person to take at home 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).

  **Billing Unit:** 1 dose 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.

**Billing Limitations**

For medication services the following billing limitations apply:

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

2. In certain circumstances, the member’s primary care provider may prescribe psychotropic medications for the treatment of depression, anxiety and attention deficit hyperactivity disorder.

3. 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.

4. UAHP does not cover items relating to medical marijuana. This includes application fees or the drug itself.

5. Transportation provided to UAHP GMH/SA Dual Eligible member is not included in the rate and should be billed separately using the appropriate transportation procedure codes.
II. C. 2. Laboratory, Radiology and Medical Imaging

General Information

General Definition

Medical tests ordered for diagnosis, screening or monitoring of a behavioral health condition. 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, 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 A.R.S. Title 36, Chapter 4. (Also see requirements related to federal Clinical Laboratory Improvement Amendments in 9 A.A.C.14-101 and the federal code of regulations 42 CFR 493, Subpart A).

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

Code Specific Information

CPT Codes

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION-Laboratory, Radiology and Medical Imaging</th>
</tr>
</thead>
<tbody>
<tr>
<td>36415</td>
<td>Collection of venous blood by venipuncture</td>
</tr>
<tr>
<td>80048</td>
<td>Basic metabolic panel, this panel must include the following: calcium total, carbon dioxide, chloride, creatinine, glucose, potassium, sodium, urea nitrogen (BUN)</td>
</tr>
<tr>
<td>80050</td>
<td>General health panel, this panel must include the following: comprehensive metabolic panel, blood count complete (CBC) automated and automated differential WBC count or blood count, complete (CBC) automated and appropriate manual differential WBC count, thyroid stimulating hormone (TSH).</td>
</tr>
<tr>
<td>80051</td>
<td>Electrolyte panel, this panel must include the following: carbon dioxide, chloride, potassium, sodium.</td>
</tr>
</tbody>
</table>
Comprehensive metabolic panel, this panel must include the following: albumin, bilirubin total, calcium total, carbon dioxide (bicarbonate), chloride, creatinine, glucose, phosphatase alkaline, potassium, protein total, sodium, transferase alanine amino (ALT) (SGPT), transferase aspartate amino (AST) (SGOT), urea nitrogen (BUN).

Lipid panel, this panel must include the following: cholesterol serum total, lipoprotein direct measurement, high density cholesterol (HDL cholesterol), triglycerides.

Hepatic function panel, this panel must include the following: albumin, bilirubin total, bilirubin direct, phosphatase alkaline, protein total, transferase alanine amino (ALT) (SGPT), transferase aspartate amino (ALT) (SGOT).

Drug screen qualitative; multiple drug classes chromatographic method, each procedure

Drug screen, qualitative; single drug class method (i.e. immunoassay, enzyme assay), each drug class

Drug confirmation, each procedure

Amitriptyline

Benzodiazepines

Carbamazepine; total

Desipramine

Dipropylacetic acid (valproic acid)

Doxepin

Imipramine

Lithium

Nortriptyline

Quantitation of drug, Not Elsewhere Specified (NOS)

Dexamethasone suppression panel, 48 hour, this panel must include the following: free cortisol urine, cortisol, volume measurement for
timed collection.

81000  Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, and 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, and 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, and 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

82055  Alcohol (ethanol), any specimen except breath

82075  Alcohol (ethanol); breath

82145  Amphetamine or methamphetamine, chemical, quantitative

82205  Barbiturate, not elsewhere specified

82382  Catechloamines, total urine

82465  Cholesterol, serum or whole blood, total

82520  Cocaine or Metabolite

82530  Cortisol, free

82533  Cortisol, total
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>82542</td>
<td>Column chromatography/mass spectrometry (EG, GC/MS, or HPLC/MS), analyte not elsewhere specified; quantitative, single stationary and mobile phase</td>
</tr>
<tr>
<td>82565</td>
<td>Creatinine; blood</td>
</tr>
<tr>
<td>82570</td>
<td>Creatinine (other source)</td>
</tr>
<tr>
<td>82575</td>
<td>Creatinine, clearance</td>
</tr>
<tr>
<td>82607</td>
<td>Cyanocobalamin (Vitamin B12)</td>
</tr>
<tr>
<td>82742</td>
<td>Flurazepam</td>
</tr>
<tr>
<td>82746</td>
<td>Folic acid; serum</td>
</tr>
<tr>
<td>82947</td>
<td>Glucose, quantitative, blood (except reagent strip)</td>
</tr>
<tr>
<td>82948</td>
<td>Glucose, blood, reagent strip</td>
</tr>
<tr>
<td>82977</td>
<td>Glutamyltransferase (GGT)</td>
</tr>
<tr>
<td>83840</td>
<td>Methadone</td>
</tr>
<tr>
<td>83925</td>
<td>Opiate(s), drug and metabolites, each procedure</td>
</tr>
<tr>
<td>83992</td>
<td>Phencyclidine (PCP)</td>
</tr>
<tr>
<td>84022</td>
<td>Phenothiazine</td>
</tr>
<tr>
<td>84132</td>
<td>Potassium; serum, plasma or whole blood</td>
</tr>
<tr>
<td>84146</td>
<td>Prolactin</td>
</tr>
<tr>
<td>84436</td>
<td>Thyroxine; total</td>
</tr>
<tr>
<td>84439</td>
<td>Thyroxine, free</td>
</tr>
<tr>
<td>84443</td>
<td>Thyroid stimulating hormone (TSH)</td>
</tr>
<tr>
<td>84520</td>
<td>Urea nitrogen, blood (BUN); quantitative</td>
</tr>
<tr>
<td>84703</td>
<td>Gonadotropin, chorionic (hCG), qualitative</td>
</tr>
<tr>
<td>85007</td>
<td>Blood count; blood smear, microscopic examination with manual differential WBC count</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>85008</td>
<td>Blood count; blood smear, microscopic examination without manual differential WBC count</td>
</tr>
<tr>
<td>85009</td>
<td>Blood count; manual differential WBC count, buffy coat</td>
</tr>
<tr>
<td>85013</td>
<td>Blood count; spun microhematocrit</td>
</tr>
<tr>
<td>85014</td>
<td>Blood count; hematocrit (Hct)</td>
</tr>
<tr>
<td>85018</td>
<td>Blood count; hemoglobin (Hgb)</td>
</tr>
<tr>
<td>85025</td>
<td>Blood count; complete (CBC), automated (Hgb), Hct, RBC, WBC, and platelet count) and automated differential WBC count</td>
</tr>
<tr>
<td>85027</td>
<td>Blood count; complete (CBC), automated (Hgb), Hct, RBC, WBC, and platelet count)</td>
</tr>
<tr>
<td>85048</td>
<td>Blood count, leukocyte (WBC), automated</td>
</tr>
<tr>
<td>85651</td>
<td>Sedimentation rate, erythrocyte; non-automated</td>
</tr>
<tr>
<td>85652</td>
<td>Sedimentation rate, erythrocyte; automated</td>
</tr>
<tr>
<td>86580</td>
<td>Skin test, tuberculosis, intradermal</td>
</tr>
<tr>
<td>86592</td>
<td>Syphilis test; qualitative (e.g., VDRL, RPR, ART)</td>
</tr>
<tr>
<td>86593</td>
<td>Syphilis test; quantitative</td>
</tr>
<tr>
<td>86689</td>
<td>Antibody; HTLV or HIV antibody, confirmatory test (e.g., Western Blot)</td>
</tr>
<tr>
<td>86701</td>
<td>Antibody; HIV-1</td>
</tr>
<tr>
<td>86702</td>
<td>Antibody; HIV-2</td>
</tr>
<tr>
<td>86703</td>
<td>Antibody; HIV-1 and HIV-2, single result</td>
</tr>
<tr>
<td>87390</td>
<td>Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; HIV-1</td>
</tr>
<tr>
<td>87391</td>
<td>Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; HIV-2</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>70450</td>
<td>Computed tomography, head or brain, without contrast material</td>
</tr>
<tr>
<td>70460</td>
<td>Computed tomography, head or brain; with contrast material(s)</td>
</tr>
<tr>
<td>70470</td>
<td>Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections</td>
</tr>
<tr>
<td>70551</td>
<td>Magnetic resonance (e.g., proton) imaging, brain (including brain stem); without contrast material</td>
</tr>
<tr>
<td>70552</td>
<td>Magnetic resonance (e.g., proton) imaging, brain (including brain stem); with contrast material(s)</td>
</tr>
<tr>
<td>70553</td>
<td>Magnetic resonance (e.g., proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences</td>
</tr>
<tr>
<td>93000</td>
<td>Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report</td>
</tr>
<tr>
<td>93005</td>
<td>Electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpretation and report</td>
</tr>
<tr>
<td>93010</td>
<td>Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only</td>
</tr>
<tr>
<td>93040</td>
<td>Rhythm ECG, one to three leads, with interpretation and report</td>
</tr>
<tr>
<td>93041</td>
<td>Rhythm ECG, one to three leads, tracing only, without interpretation and report</td>
</tr>
<tr>
<td>93042</td>
<td>Rhythm ECG, one to three leads, interpretation and report only</td>
</tr>
<tr>
<td>95819</td>
<td>Electroencephalogram (EEG) including recording awake and asleep</td>
</tr>
</tbody>
</table>

**Billing Limitations**

For laboratory, radiology and medical imaging the following billing limitation applies:

Laboratory, radiology, and medical imaging services provided in an inpatient hospital setting are included in the per diem rate and cannot be billed separately.
II. C. 3. Medical Management

General Information

General Definition

Assessment and management services that are provided by a licensed medical professional (i.e., physician, nurse practitioner, physician assistant or nurse) to a person 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.

Service Standards/Provider Qualifications

Appropriately licensed physicians, nurse practitioners, physician assistants, and nurses must provide medical management services. Psychiatric consultation services are provided for AHCCCS primary care providers who wish to prescribe psychotropic medications in accordance DLS licensed agencies must operate within the scope of services authorized through the agency’s license.

Code Specific Information

CPT Codes

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION-Medical Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a problem-focused history; a problem-focused examination; straightforward medical decision-making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are self-limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99202</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: an expanded problem-focused history; an expanded problem-focused examination; straightforward medical decision-making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.</td>
</tr>
</tbody>
</table>
Office or other outpatient visit for the evaluation and management of new patient, which requires these 3 key components: a detailed history; a detailed examination; and, medical decision-making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

Office or other outpatient visit for the evaluation and management of new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and, medical decision-making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.

Office or other outpatient visit for the evaluation and management of new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and, medical decision-making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a problem-focused history; a problem-focused examination; straightforward medical decision-making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are self-limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.
an established patient, which requires at least 2 of these 3 key components: an expanded problem-focused history; an expanded problem-focused examination; medical decision-making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

99214 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a detailed history; a detailed examination; medical decision-making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

99215 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a comprehensive history; a comprehensive examination; and medical decision-making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

99304 Initial nursing facility care, per day, for the evaluation and management of a patient which requires these three key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually the problem(s) requiring admission are of low severity. Physicians typically spend 25 minutes at the bedside and on the patient’s facility floor or unit.

99305 Initial nursing facility care, per day, for the evaluation and management of a patient which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided
consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 35 minutes at the bedside and on the patient’s facility floor or unit.

99306

Initial nursing facility care, per day, for the evaluation and management of a patient which requires these 3 key components: a comprehensive history; a comprehensive examination, and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 45 minutes at the bedside and on the patient’s facility floor or unit.

99307

Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a problem focused interval history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually the patient is stable, recovering, or improving. Physicians typically spend 10 minutes at the bedside and on the patient’s facility floor or unit.

99308

Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: an expanded problem focused interval history; an expanded problem focused examination; medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 15 minutes at the bedside and on the patient’s facility floor or unit.

99309

Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a detailed interval history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the patient has developed a significant complication or a significant new problem. Physicians typically spend 25 minutes at the bedside and on the patient’s facility floor or unit.
99310 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a comprehensive interval history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 35 minutes at the bedside and on the patient’s facility floor or unit.

99315 Nursing facility discharge day management. (30 minutes or less)

99316 Nursing facility discharge day management. (more than 30 minutes)

99318 Evaluation and management of a patient involving an annual nursing facility assessment, which requires these 3 key components: a detailed interval history; a comprehensive examination; and medical decision making that is of low to moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the patient is stable, recovering, or improving. Physicians typically spend 30 minutes with the patient and/or family or caregiver. (Do not report 99318 on the same day of service as nursing facility services codes 99304-99316.)

99324 Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: a problem focused history; a problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 20 minutes with the patient and/or family or caregiver.

99325 Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: an expanded problem focused history; an expanded problem focused examination; and medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes with the patient and/or family or caregiver.
99326  Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: a detailed history; a detailed examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes with the patient and/or family or caregiver.

99327  Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of high severity. Physicians typically spend 60 minutes with the patient and/or family or caregiver.

99328  Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention. Physicians typically spend 75 minutes with the patient and/or family or caregiver.

99334  Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a problem focused interval history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are self-limited or minor. Physicians typically spend 15 minutes with the patient and/or family or caregiver.

99335  Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: an expanded problem focused interval history; an expanded problem focused examination; medical decision making of
low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 25 minutes with the patient and/or family or caregiver.

99336
Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a detailed interval history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes with the patient and/or family or caregiver.

99337
Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a comprehensive interval history; a comprehensive examination; and medical decision making of moderate to high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 60 minutes with the patient and/or family or caregiver.

99341
Home visit for the evaluation and management of a new patient which requires these 3 key components: a problem-focused history; a problem-focused examination; straightforward medical decision-making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.

99342
Home visit for the evaluation and management of a new patient which requires these 3 key components: an expanded problem-focused history; an expanded problem-focused examination; and medical decision-making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of moderate
severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

99343 Home visit for the evaluation and management of a new patient which requires these 3 key components: a detailed history; a detailed examination; and decision-making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.

99344 Home visit for the evaluation and management of a new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision-making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

99345 Home visit for the evaluation and management of a new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision-making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention. Physicians typically spend 75 minutes face-to-face with the patient and/or family.

99347 Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a problem focused interval history; a problem-focused examination; straightforward medical decision-making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are self-limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

99348 Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: an expanded problem focused interval history; an expanded problem focused examination; medical decision-making of low complexity. Counseling and/or coordination of care with other providers or
agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

99349
Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a detailed interval history; a detailed examination; medical decision-making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

99350
Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a comprehensive interval history; a comprehensive examination; medical decision-making of moderate to high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

99354
Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service; first hour. (List separately in addition to code for office or other outpatient evaluation and management service)

99355
Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service; each additional 30 minutes (list separately in addition to code for prolonged physician service 99354)

99358
Prolonged evaluation and management service before and/or after direct (face-to-face) patient care (e.g., review of extensive records and tests, communication with other professionals and/or the patient/family); first hour (list separately in addition to code(s) for other physician service(s) and/or inpatient or outpatient evaluation and management service).

99359
Prolonged evaluation and management service before and/or after direct (face-to-face) patient care (e.g., review of extensive records
and tests, communication with other professionals and/or the patient/family); each additional 30 minutes (list separately in addition to code for prolonged physician service 99358)

99499  Unlisted evaluation and management service.

HCPCS Codes

- **T1002 - RN Services:** Medical management services (including medication monitoring) related to the treatment of a behavioral health disorder. As allowed by the individual provider’s scope of practice may include such activities as the measurement of vital signs, assessment and monitoring of physical/medical status, review of the effects and side effects of medications and administration of medications.

  **Provider Qualifications:**
  Licensed registered nurse (within the scope of their license)

  **Billing Unit:** 15 minutes

- **T1003 – LPN Services:** Medical management services (including medication monitoring) related to the treatment of a behavioral health disorder. As allowed by the individual provider’s scope of practice may include such activities as the measurement of vital signs, assessment and monitoring of physical/medical status, review of the effects and side effects of medications and administration of medications.

  **Provider Qualifications:**
  Licensed practical nurse (within the scope of their license)

  **Billing Unit:** 15 minutes

**Billing Limitations**

For medical management services the following billing limitations apply:

1. 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 inclusive of the higher level of service.

2. Where applicable, travel time by the provider is included in the rate for RN and LPN services (T1002 and T1003)
3. Nursing services provided in a DLS licensed inpatient, residential or medical day program setting are included in the rate and cannot be billed separately.

4. Transportation provided to the GMH/SA dual enrolled member is not included in the rate and should be billed separately using the appropriate transportation procedure codes.
II. C. 4. Electroconvulsive Therapy

General Information

General Definition

The application of alternating current at or slightly above the seizure threshold through the use of electrodes attached to the scalp of a person who has received short-acting general anesthetic and muscle depolarizing medication.

Service Standards/Provider Qualifications

Electroconvulsive therapy services must be provided by a licensed physician with anesthesia support in a hospital.

Code Specific Information

CPT Codes

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION-Electroconvulsive Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>00104</td>
<td>Anesthesia for electroconvulsive therapy.</td>
</tr>
<tr>
<td>90870</td>
<td>Electroconvulsive therapy (includes necessary monitoring).</td>
</tr>
</tbody>
</table>

Revenue Codes

In addition to the CPT codes billed for the professional services, hospitals (02), free standing psychiatric facilities (71) or subacute facilities (B5, B6) may bill Revenue Code 0901 – electro shock treatment for the facility based costs associated with providing electroconvulsive therapy to a person in the facility. The rate for revenue code 0901 is set by report.

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

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.
II. D. 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)
- Home Care Training to Home Care Client (HCTC)
- Unskilled Respite Care
- Supported Housing
- Sign Language or Oral Interpretive Services
- Non-Medically Necessary Covered Services (Flex Fund Services)
- Transportation
II. D. 1. Case Management

General Information

General Definition

Case management is a supportive service provided to enhance treatment goals and effectiveness. Activities may include:

- Assistance in maintaining, monitoring and modifying covered services;
- Brief telephone or face-to-face interactions with a person, family or other involved party for the purpose of maintaining or enhancing a person’s functioning;
- Assistance in finding necessary resources other than covered services to meet basic needs;
- Communication and coordination of care with the person’s family, behavioral and general medical and dental health care providers, community resources, and other involved supports including educational, social, judicial, community and other State agencies;
- Coordination of care activities related to continuity of care between levels of care (e.g., inpatient to outpatient care) and across multiple services (e.g., personal assistant, nursing services and family counseling);
- Outreach and follow-up of crisis contacts and missed appointments;
- Participation in staffings, case conferences or other meetings with or without the person or their family participating; and
- Other activities as needed.

Case management **does not** include:

- Administrative functions such as authorization of services and utilization review;
- Other covered services listed in the UAHP Covered Behavioral Health Services Guide.

Service Standards/Provider Qualifications

Case management services must be provided by individuals who are qualified *behavioral health professionals, behavioral health technicians, or behavioral health paraprofessionals* as defined in [9 A.A.C. 10](#).

If case management services are not provided by behavioral health professionals, these services must be provided under their direction or supervision.

Code Specific Information

CPT Codes
<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>98966</td>
<td>Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.</td>
</tr>
<tr>
<td>98967</td>
<td>Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion.</td>
</tr>
<tr>
<td>98968</td>
<td>Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion.</td>
</tr>
<tr>
<td>99367</td>
<td>Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician.</td>
</tr>
<tr>
<td>99368</td>
<td>Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by nonphysician qualified health care professional.</td>
</tr>
<tr>
<td>99441</td>
<td>Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.</td>
</tr>
<tr>
<td>99442</td>
<td>Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion.</td>
</tr>
</tbody>
</table>
99443  Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion.

90887  Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient.

90889  Preparation of report of patient's psychiatric status, history, treatment, or progress (other than legal or consultative purposes) for other physicians, agencies, or insurance carriers.

HCPCS Codes:

- **T1016 HO – Case Management by Behavioral Health Professional - Office**: Case management services (see general definition above for case management services) provided at the provider’s work site.

  Provider Qualifications:
  Behavioral health professional

  Billing Unit:  15 minutes

- **T1016 HO – Case Management by Behavioral Health Professional - Out-of-Office**: Case management services (see general definition above for case management services) provided at a person’s place of residence or other out-of-office setting.

  Provider Qualifications:
  Behavioral health professional

  Billing Unit:  15 minutes

- **T1016 HN – Case Management - Office**: Case management services (see general definition above for case management services) provided at the provider’s work site.

  Provider Qualifications:
  Behavioral health technician or Behavioral health paraprofessional

  Billing Unit:  15 minutes
- **T1016 HN – Case Management - Out-of-Office:** Case management services (see general definition above for case management services) provided at a person’s place of residence or other out-of-office setting.

**Provider Qualifications:**
Behavioral health technician or behavioral health paraprofessional

**Billing Unit:** 15 minutes

**Billing Limitations**

For case management services the following billing limitations apply:

1. Case management services provided by a DLS licensed inpatient, residential 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 person residing in and/or transitioning out of the inpatient or residential settings or who is receiving services in a day program.

2. A single provider may not bill case management for any time associated with a therapeutic interaction, nor simultaneously with any other services.

3. Multiple provider agencies may bill for this service during the same time period when more than one provider is simultaneously providing a case management service (e.g., a staffing). In addition, more than one individual within the same agency may bill for this service (e.g., individuals involved in transitioning a person from a residential level of care to a higher (subacute) or lower (outpatient) level of care, staff from each setting may bill case management when attending a staffing.

4. Billing for case management is limited to individual providers who are directly involved with service provision to the person (e.g., when a clinical team comprised of multiple providers, physicians, nurses etc. meet to discuss current case plans).

5. Transportation provided to a GMH/SA dual enrolled member is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

6. For Case Management codes:
   - See general core billing limitations in Section I.
- Where applicable, travel time by the provider is included in the rates. See core provider travel billing limitations in Section I.
- The provider should bill all time he/she spent in direct or indirect contact with the person, family and/or other parties involved in implementing the treatment/service plan. Indirect contact includes telephone calls, picking up and delivering medications, and/or collateral contact with the person, family and/or other involved parties.
- Written electronic communication (email) and leaving voice messages are allowable as case management functions. These functions are not to become the predominant means of providing case management services and require specific documentation as specified below.
- Written electronic communication (email) must be about a specific individual and is allowable as case management, as long as documentation (a paper copy of the email) exists in the case record.
- 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.
- When leaving voice messages, a signed document in the client chart granting permission to leave specific information is required.

7. When a provider is picking up and dropping off medications for more than one behavioral health recipient, the provider must divide up the time spent and bill the appropriate case management code for each involved behavioral health recipient.

8. In accordance with other case management restrictions, UAHP providers shall be permitted to encounter behavioral health case management for services provided within 60 days of planned discharge from the Arizona State Hospital for the purposes of coordinating care between inpatient and outpatient providers.
II. D. 2. Personal Care Services

General Information

General Definition

Personal care services involve the provision of support activities to assist a person in carrying out daily living tasks and other activities essential for living in a community. May include assistance with homemaking (e.g., cleaning, food preparation in accordance with requirements in 9 A.A.C. 10, essential errands), personal care (e.g., bathing, dressing, oral hygiene), and general supervision and appropriate intervention (e.g., assistance with self-administration of medications, in accordance with requirements in 9 A.A.C. 10, and monitoring of individual’s condition and functioning level). Services may involve hands-on assistance, such as performing the task for the person or cueing the person to perform the task.

Personal Care Services in a Behavioral Health Residential Facility

Personal Care Services (A.R.S 36-401.36) means assistance with activities of daily living that can be performed by persons without professional skills or professional training and includes the coordination or provision of intermittent nursing services and the administration of medications and treatments by a nurse who is licensed pursuant to Title 32 Chapter 15 or as otherwise provided by law.

Personal Care Services also includes Supervisory Care Services which means the general supervision, including daily awareness of resident functioning and continuing needs, the ability to intervene in a crisis and assistance in the self-administration of prescribed medications.

Service Standards/Provider Qualifications

Personal care services may be provided by a licensed behavioral health agency utilizing individuals who are qualified as behavioral health professionals, behavioral health technicians, or behavioral health paraprofessionals as defined in 9 A.A.C. 10.

“Personal care,” as defined in A.R.S. § 36-401.36 may be provided by licensed behavioral health facilities in accordance with the Integrated Licensing rules. “Personal care,” as defined in the UAHP Covered Behavioral Health Services Guide, is not inclusive of those services defined in A.R.S. § 36-40.

Personal care services provided by a Behavioral Health Residential Facility must be approved by the ADHS Bureau of Residential Facilities Licensing.

Code Specific Information

HCPCS Codes
- **T1019 – Personal Care Services**, not for an inpatient or resident of a hospital, nursing facility, Intermediate Care Facility for the Mentally Retarded (ICF/MR) or Institution of Mental Disease (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 person for a period of time (up to 11½ hours).

  **Billing Unit:** 15 minutes

- **T1020 – Personal Care Services**, not for 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 person for 12 or more hours.

  **Billing Unit:** Per Diem

**Billing Limitations**

For personal care services the following billing limitations apply:

1. See general core billing limitations in Section I.

2. Personal Care Services provided in a Behavioral Health Residential Facility require a Prior Authorization.

3. Where applicable, travel time by the provider is included in the rates. See core provider travel billing limitations in Section I.

4. Personal care services provided in a DLS 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 on Modifiers. This service is also included in the HCTC service rate and cannot be billed separately for persons receiving HCTC services. See also section on Home Care Training to Home Care Client under Billing Limitations.

5. Transportation (emergency and non-emergency) provided to persons and/or family members is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

6. Personal Care Services (T1019) and Personal Care Services (T1020) cannot be billed on the same day.
7. More than one provider agency may bill for personal care services provided to a behavioral health recipient at the same time if indicated by the person’s clinical needs.

8. A Community Service Agency cannot provide assistance with self-administration of medications.
II. D. 3. Home Care Training Family (Family Support)

General Information

General Definition

Home care training family services (family support) involve face-to-face interaction with family member(s) directed toward restoration, enhancement, or maintenance of the family functioning to increase the family’s ability to effectively interact and care for the person in the home and community. May involve support activities such as assisting the family to adjust to the person’s disability, developing skills to effectively interact and/or guide the person, understanding the causes and treatment of behavioral health issues, understanding and effectively utilizing the system, or planning long term care for the person and the family.

Service Standards/Provider Qualifications

Home care training family services (family support) must be provided by behavioral health professionals, behavioral health technicians, or behavioral health para-professionals as defined in 9 A.A.C. 10.

Code Specific Information

HCPCS Codes

- S5110 – Home Care Training, Family; (Family Support): See general definition above.

  Billing Unit: 15 minutes

Billing Limitations

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

1. See general core billing limitations in Section I.

2. Where applicable, travel time by the provider is included in the rates. See core provider travel billing limitations in Section I.

3. Family support services provided in a DLS 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. This service is also included in the HCTC service rate and cannot be billed.
separately by the behavioral health therapeutic home, with certain exceptions. For exceptions see section Home Care Training to Home Care Client under Billing Limitations. 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 person residing in and/or transitioning out of the inpatient, residential settings, behavioral health therapeutic home or who is receiving services in a day program.

4. Transportation provided to persons and/or family members is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

5. More than one provider agency may bill for home care training family services (family support) services provided to a behavioral health recipient at the same time if indicated by the person’s clinical needs.
II. D. 4. Self-Help/Peer Services (Peer Support)

General Information

General Definition

This may involve assistance with more effectively utilizing the service delivery system (e.g., assistance in developing plans of care, identifying needs, accessing supports, partnering with professionals, overcoming service barriers) or understanding and coping with the stressors of the person’s disability (e.g., support groups), coaching, role modeling and mentoring.

Self-help/peer services are intended for enrolled persons and/or their families who require greater structure and intensity of services than those available through community-based recovery fellowship groups and who are not yet ready for independent access to community-based recovery groups (e.g., Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Dual Recovery). These services may be provided to a person, group or family and are aimed at assisting in the creation of skills to promote long-term, sustainable recovery.

Service Standards/Provider Qualifications

Individuals providing self-help/peer services must be employed by or contracted with a Community Service Agency or a licensed facility allowed to bill the procedure code. Community Service Agencies providing this service must be Title XIX certified by ADHS.

Self-help/peer services are provided by those who have personal experience with mental illness and substance abuse and are qualified as behavioral health professionals, behavioral health technicians, or behavioral health para-professionals as defined in 9 A.A.C. 10. A family member, as referenced in these provider qualifications, is defined as a parent or caregiver who has raised or is currently raising a child with emotional, behavioral or mental health challenges and has experience navigating the children’s behavioral health system.

Code Specific Information

HCPCS Codes

- **H0038 – Self-Help/Peer Services**: Self-help/peer services (see general definition above) provided to an individual person for a short period of time (up to 2 ¾ hours).

  **Billing Unit**: 15 minutes
**H0038 HQ – Self-Help/Peer Services - Group:** Self-help/peer services (see general definition above) provided to a group of individuals and/or their families.

**Billing Unit:** 15 minutes

**H2016 – Comprehensive Community Support Services (Peer Support):** Self-help/peer services (see general definition above) provided to a person for a period of time, 3 or more hours in duration.

**Billing Unit:** Per Diem

**Billing Limitations**

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

1. See general core billing limitations in Section I.

2. Where applicable, travel, time by the provider is included in the rates. See core provider travel billing limitations in Section I.

3. Self-help/peer services provided in a 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 person residing in and/or transitioning out of the inpatient or residential settings or who is receiving services in a day program.

4. Transportation provided to persons and/or family members is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

5. Self Help/Peer Services (H0038) and Comprehensive Community Support Services (H2016) cannot both be billed on the same day.

6. More than one provider agency may bill for self-help/peer services provided to a behavioral health recipient at the same time if indicated by the person’s clinical needs.
II. D. 5. Home Care Training to Home Care Client

General Information

General Definition

Home Care Training to Home Care Client (HCTC) services are provided by a behavioral health therapeutic home to a person residing in their home in order to implement the in-home portion of the person’s behavioral health service plan. HCTC services assist and support a person in achieving their service plan goals and objectives. It also helps the person remain in the community setting, thereby avoiding residential, inpatient or institutional care. These services include supervision and the provision of behavioral health support services such as personal care (especially prescribed behavioral interventions), psychosocial rehabilitation, skills training and development, transportation of the person to therapy or visitations and/or the participation in treatment and discharge planning. (See HCTC billing limitations below)

Service Standards/Provider Qualifications

Provider of Services to Adults

Behavioral health therapeutic homes providing HCTC services to adults must meet the following qualifications:

- Be a DLS licensed Behavioral Health Therapeutic Home (9 A.A.C. 10); or
- Be licensed by federally recognized Indian Tribes that attest to CMS (via AHCCCS) that they meet equivalent requirements.

For all providers of HCTC services, prior to providing a service for an adult UAHP must ensure that:

a. The behavioral health therapeutic home providers have successfully completed pre-service training in the type of care and services required for the individual being placed in the home.

b. The behavioral health therapeutic home providers have access to crisis intervention and emergency consultation services.

c. A Clinical Supervisor has been assigned to oversee the care provided by the behavioral health therapeutic home provider.

Code Specific Information

HCPCS Codes
- S5109 HB–Home Care Training to Home Care Client (Adult) – Age 18-64 years
- S5109 HC–Home Care Training to Home Care Client (Adult geriatric) – Age 65 years and older

Billing Unit: Per Session

Billing Limitations

For HCTC services the following billing limitations apply:

1. Personal care services, skills training and development and home care training family services (family support) are provided by the behavioral health therapeutic home provider and are included in the HCTC rate. Counseling, evaluation, support and rehabilitation services provided to the GMH/SA Dual Eligible member may be billed using the appropriate procedure code.

2. The HCTC procedure code does not include any professional services; therefore, professional services provided should be billed by the appropriate provider using the applicable CPT codes.

3. The HCTC procedure code does not include day program services, this service should be billed by the appropriate provider using the applicable procedure code.

4. A licensed professional who supervises and trains the behavioral health therapeutic home provider may not bill for these functions. Employee supervision and training has been built into the procedure code rate.

5. Pre-training activities associated with the HCTC setting is included in the rate. This service may not be billed outside the HCTC procedure code rate by either the licensed professional or behavioral health therapeutic home provider.

6. Prescription drugs are not included in the rate and should be billed by appropriate providers using the applicable NDC procedure codes.

7. Over-the-counter drugs and non-customized medical supplies are included in the rate and should not be billed separately.

8. Emergency transportation provided to a GMH/SA Dual Eligible member is not included in the rate and should be billed separately by the appropriate provider using the applicable transportation procedure codes.

9. Non-emergency transportation is included in the rate and cannot be billed separately.

10. Any medical services provided to persons, excluding those medical services included in the UAHP covered service array as set forth in this guide should be billed to the member’s health plan.
11. HCTC services cannot be encountered/billed on the same day as Unskilled Respite Care (S5151).

12. Based on behavioral health recipient needs, Personal Care Services (T1019), Skills Training and Development (H2014/H2014HQ), Home Care Training Family Services (S5110) and Psychosocial Rehabilitation Services (H2017) may be provided and billed on the same day that HCTC services are furnished. The clinical rationale for providing these additional services must be specifically documented in the Service Plan and Progress Note.
II. D. 6. Unskilled Respite Care

General Information

General Definition

"Respite" means short term behavioral health services or general supervision that provides rest or relief to a family member or other individual caring for the behavioral health recipient. Respite services are designed to provide an interval of rest and/or relief to the family and/or primary care givers and may include a range of activities to meet the social, emotional and physical needs of the behavioral health recipient during the respite period. These services may be provided on a short-term basis (i.e., 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, agency personnel will assess the situation with the caregiver and recommend the appropriate setting for respite.

Licensed programs providing respite must develop and implement policy and procedures demonstrating the following:

- A respite admission does not cause the agency to exceed the licensed capacity identified on the agency's license,
- A behavioral health recipient being admitted for respite meets the admission requirements in 9 A.A.C. 10,
- A behavioral health recipient being admitted for respite receives an assessment and treatment plan for the period of time the person is receiving respite from the agency, and
- A behavioral health recipient's treatment plan addresses how the person will be oriented to and integrated into the daily activities at the agency.

The setting in which respite services are received should be the most conducive to the behavioral health recipient’s situation. A behavioral health recipient in need of assistance in the self-administration of medication while receiving respite services must be able to get the assistance from a provider meeting the requirements in 9 A.A.C. 10. A behavioral health recipient’s clinical team must consider the appropriateness of the setting in which the recipient receives respite services. Safety of the behavioral health recipient and the provider must be considered when the recipient has exhibited behavior requiring an emergency safety response (see 9 A.A.C. 10). When respite services are provided in a home setting, household routines and preferences should be respected and maintained when possible. It is essential that the respite provider receive orientation from the family/caregiver regarding the behavioral health recipient’s needs as well as the individual service plan (ISP). At all times the respite provider shall respect and maintain the confidentiality of the family/caregiver.

Respite services, including the goals, setting, frequency, duration and intensity of the service, are defined in the behavioral health recipient’s service plan. Respite services are
not a substitute for other medically necessary covered services. The treatment team will also explore the availability and use of informal supports and other community resources to meet the caregiver’s respite needs.

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.

Parents receiving behavioral health services may receive necessary respite services for their non-enrolled children as indicated in their service plan. Non-enrolled siblings of a child receiving respite services are not eligible for behavioral health respite benefits.

**Service Standard/Provider Qualifications**

Respite services may be provided in a variety of settings (for licensed providers, this would include settings listed in 9 A.A.C. 10). Each provider type must meet licensing or certification requirements and other local authorities (i.e., county, city, etc.). The type of setting in which respite services are provided must ensure the behavioral health recipient’s current service plan can be appropriately supported and services provided are within the respite provider’s qualifications and experience.

Licensed providers must meet all applicable qualifications, as described in 9 A.A.C. 10.

**Code Specific Information**

**Revenue Codes**

Respite services provided in a DLS licensed Level I facility should be billed using the applicable revenue codes listed in Section II. F. Inpatient Services for the facility type.

**HCPCS Codes**

- **S5150– Unskilled respite care: - not hospice:** Unskilled respite services (see general definition above) provided to a person for a short period of time (up to 12 hours in duration).

  **Billing Unit:** 15 minutes

- **S5151– Unskilled respite care - not hospice:** Unskilled respite services provided to a person for more than 12 hours in duration.

  **Billing Unit:** Per Diem

**Billing Limitations**
For respite services, the following billing limitations apply:

1. See general core billing limitations in Section I.

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 1st through September 30th) per person. UAHP must ensure the accurate tracking of respite service limitations for their enrolled members.

3. For Behavioral Health Residential facilities providing respite services, room and board may be billed in addition to the per diem rate.

4. Where applicable, travel time by the provider is included in the rates. See core provider travel billing limitations in Section I.

5. Transportation provided to persons and/or family members is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

6. Respite services cannot be billed for persons who are residing and receiving treatment in a DLS licensed Level I facility, ADES group home or nursing home.

7. A Community Service Agency cannot provide respite services.

II. D. 7. Sign Language or Oral Interpretive Services

General Definition

Sign Language and oral interpretation services are required to be made available to members free of charge; services for all non-English languages and the hearing impaired must be available to potential members, free of charge, when oral information is requested.

Sign language or oral interpretive services are required by Medicaid regulations and as defined in 9 A.A.C. 21 and must be paid for with Title XIX and Title XXI Administrative Capitation Funds or grant funding for services provided with grant funding. Sign language or oral interpretive services are provided to persons and/or their families with limited English proficiency or other communication barriers (e.g., sight or sound) during instructions on how to access services, counseling, and treatment activities that will ensure appropriate delivery of mental health services for individuals.

Service Standards/Provider Qualifications

Oral interpretive services must be provided by: qualified interpreter staff, qualified bilingual staff, contracted qualified interpreters, telephone interpretation services or from a qualified individual provider office, agency, or facility. Sign language services are to
be provided by license interpreters for the deaf and the hard of hearing pursuant to A.R.S. § 36-1946.

Code Specific Information

Encounters are to be submitted to UAHP for sign language or oral interpretive services, utilizing the T1013 code requirements as described below.

State Funded HCPCS Codes

- **T1013 –Sign Language or Oral Interpretive Services:** (see general definition above)

  **Billing Unit:** 15 minutes

Billing Limitations

For interpreter services the following billing limitation applies:

1. The sign language or oral interpretive service code must be billed in combination with a code for a behavioral health service that cannot be delivered effectively without the availability of sign language or interpreter services.

2. For DLS licensed inpatient and residential facilities, sign language or oral interpretive services are included in the per diem rate, however, these services must be documented and encountered separately by the facility with a zero dollar bill value (0.00).

II. D. 10. Transportation

General Information

General Definition

Transportation services involve the transporting of a person from one place to another to facilitate the receipt of, or benefit from, medically necessary covered behavioral health services, allowing the person to achieve their service plan goals. The service may also include the transportation of a person’s family/caregiver with or without the presence of the person, if provided for the purposes of carrying out the person’s service plan (e.g., counseling, family support, case planning meetings). Urban transports are defined as those originating within the Phoenix or Tucson metropolitan areas. All other transports are defined as rural. Odometer readings or other UAHP approved documentation methods that clearly and accurately support mileage may be used when billing transportation services.
Service Standards/Provider Qualifications

Transportation services may be provided by:

- Non-emergency transportation providers (e.g., vans, buses, taxis) who are registered with AHCCCS as a non-emergency transportation provider and have proof of insurance, drivers with valid driver’s licenses and any other insurance as required by state law.
- Emergency transportation providers (e.g., air or ground ambulance) who are registered with AHCCCS as emergency transportation providers and have been granted a certificate of necessity by the Arizona Department of Health Services/Bureau of Emergency Medical Services (A.R.S. 36-2233).

In most instances, transportation services should be provided by non-emergency transportation providers. Transportation services furnished by a ground or air ambulance provider should be provided in situations in which the person’s condition is such that the use of any other method of transportation is contraindicated and medically necessary behavioral health services are not available in the hospital from which the person is being transported.

Emergency transportation service shall not require prior authorization.

Non-emergency transportation must be provided for persons and/or families who are unable to arrange or pay for their transportation or who do not have access to free transportation in order to access medically necessary covered behavioral health services.

Record Keeping for Non-Emergency Transportation Providers

UAHP has added the following guidance based on AHCCCS’ established guidelines for documentation of non-emergency transportation services.

1. Complete Service Provider's Name and Address
2. Name and signature of the driver who provided the service
3. Vehicle Identification (car, van, wheelchair van, etc.)
4. Recipient (being transported) name
5. Recipient's AHCCCS ID
6. Complete date of service, including month, day and year
7. Complete address of the pick-up site
8. Complete address of drop off destination
9. Type of trip - round trip or one way

10. Escort (if any) must be identified by name and relationship to the member being transported

11. Signature of recipient, verifying services were rendered

It is the provider's responsibility to maintain documentation that supports each transport provided. Transportation providers put themselves at risk of recoupment of payment IF the required documentation is not maintained or covered services cannot be verified.

Code Specific Information

HCPCS Codes-Emergency Transportation Providers Only

- A0382 – Basic Life Support (BLS) routine disposable supplies
- A0398 – Advanced Life Support (ALS) routine disposable supplies
- A0420 – Ambulance waiting time (ALS or BLS), one-half (½) hour increments
- A0422 – Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining situation
- A0888 – Non-covered ambulance mileage, per mile (e.g., for miles traveled beyond closest appropriate facility)
- A0426 – Ambulance service, ALS; non-emergency transport, level 1 (ALS 1)
- A0427 – Ambulance service, ALS; emergency transport, level 1 (ALS 1-emergency)
- A0428 – Ambulance service, BLS base rate, non-emergency transport (BLS)
- A0429 – Ambulance service, BLS base rate, emergency transport (BLS-emergency)
- A0434 – Specialty Care Transport (SCT) (this code may be used only by TRBHAs)
- A0430 – Ambulance service, conventional air services, transport, one-way (fixed wing)
- A0431 – Ambulance service, conventional air services, transport, one way (rotary wing)
- A0435 – Fixed wing air mileage, per statute mile
- A0436 – Rotary wing air mileage, per statute mile

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HCPCS Codes-Non-Emergency Transportation Providers Only

- A0090* – Non-emergency transportation, per mile - vehicle provided by individual (family member, self, neighbor) with vested interest
**This code must be used by friends/relatives/neighbors when transporting a client.**

- A0100 – Non-emergency transportation; taxi
- A0110 – Non-emergency transportation and bus, intra- interstate carrier (may be used to encounter and/or bill for bus passes)
- A0170 – Transportation ancillary; parking fees, tolls, other
- A0180 – Non-emergency transport; ancillary: lodging-recipient
- A0190 – Non-emergency transport; ancillary: meals-recipient
- A0200 – Non-emergency transport; ancillary lodging-escort
- A0210 – Non-emergency transport; ancillary meals-escort
- A0120* – Non-emergency transportation; mini-bus, mountain area transports or other transportation systems

*This code may be used for vans or cars.

- A0120 TN* - Non-emergency transportation; mini-bus, mountain area transports - Rural

* This code may be used for vans or cars.

- A0130 – Non-emergency transport; wheel-chair van
- A0130 TN – Non-emergency transport; wheel-chair van - Rural
- A0140 – Non-emergency transport; and air travel (private or commercial), intra- or interstate
- A0160 – Non-emergency transportation per mile-case worker or social worker
- T2003 – Non-emergency transportation; encounter/trip

**HCPCS Codes-Emergency and Non-emergency Transportation Providers**

- S0209 – Wheelchair van mileage, per mile
- S0209 TN – Wheelchair van mileage, per mile- Rural
- S0215 – Non-emergency transportation mileage, per mile
- S0215 TN – Non-emergency transportation mileage, per mile - Rural
- T2005 – Non-emergency transportation; stretcher van
- T2005 TN - Non-emergency transportation; stretcher van – Rural
- T2007 – Transportation waiting time, air ambulance and non-emergency vehicle, ½ hour increments
A0425 – Ground mileage, per statute mile
T2049 – Non-emergency transportation; stretcher van, mileage; per mile
T2049 TN - Non-emergency transportation; stretcher van, mileage; per mile – Rural
A0999 – Unlisted ambulance service. Determine if an alternative national HCPCS Level II code or a CPT code better describes the service. This code should be used only if a more specific code is unavailable.

Billing Limitations

For transportation services the following billing limitations apply:

1. See core transportation billing limitations in Section I.

2. Emergency transportation required to manage an emergency medical condition and includes the transportation of a person to the same or higher level of care for immediate medically necessary treatment at the nearest appropriate facility is covered for UAHP GMH/SA dual eligible members and is the responsibility of UAHP.

3. Depending on the setting and the service being provided, certain transportation costs may be included as part of a provider’s rate and cannot be billed separately.

4. Like all other non-emergency transportation, A0090 may only be billed if a person and/or family is unable to arrange or pay for their transportation or does not have access to free transportation in order to obtain medically necessary covered behavioral health services.

5. When providing transportation to multiple clients, the provider bills a base rate for each client and the loaded mileage for each person transported. Loaded mileage is the actual number of miles each enrolled person is transported in the vehicle beginning when the enrolled person is picked up and ending when the enrolled person is dropped off.

6. For most transports, the provider should bill the applicable base rate code and the number of loaded miles using the appropriate mileage code. Loaded mileage is the distance traveled while a person and/or family is being transported.

7. The following provider types may bill A0120, S0215, S0215 TN or A0120 TN, when providing crisis intervention – (H2011 HT) or crisis intervention service via two-person team or crisis intervention service (H2011):
   -Level I Hospital (02)
   -Out-of-state, One Time Fee For Service Provider (73)
   -Behavioral Health Outpatient Clinic (77)
8. More than one provider agency may bill for transportation services provided to a behavioral health recipient at the same time if indicated by the person’s clinical needs.

9. A provider may bill for transportation services provided to a behavioral health recipient in order to receive a Medicare covered service.
II. E. Crisis Intervention Services

Beginning July 1, 2010, “crisis” is defined as: “A Crisis is when a person presents with a sudden, unanticipated, or potentially dangerous behavioral health condition, episode or behavior.” Crisis intervention services are provided to a person for the purpose of stabilizing or preventing a sudden, unanticipated, or potentially dangerous behavioral health condition, episode or behavior. Crisis intervention services are provided in a variety of settings (see places of service below) or over the telephone. These intensive and time limited services may include screening, (e.g., triage and arranging for the provision of additional crisis services) counseling to stabilize the situation, medication stabilization and monitoring, observation and/or follow-up to ensure stabilization, and/or other therapeutic and supportive services to prevent, reduce or eliminate a crisis situation.

The Integrated Regional Behavioral Health Authorities are responsible for all Crisis Hotline services, mobile Crisis Services and 23 hour Crisis Services.

UAHP providers can bill for the following crisis services:

**CPT Codes:**

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION-Crisis Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>99281</td>
<td>Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: a problem-focused history; a problem-focused examination; and straightforward medical decision-making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are self-limited or minor.</td>
</tr>
<tr>
<td>99282</td>
<td>Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: an expanded problem-focused history; an expanded problem-focused examination; and medical decision-making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of low to moderate severity.</td>
</tr>
<tr>
<td>99283</td>
<td>Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: an expanded problem-focused history; an expanded problem-focused examination; and medical decision-making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of moderate to severe severity.</td>
</tr>
</tbody>
</table>
and/or family’s needs. Usually the presenting problem(s) are of moderate severity.

99284 Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: a detailed history; a detailed examination; and medical decision-making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually the presenting problem(s) are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.

99285 Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient’s clinical condition and/or mental status; a comprehensive history; a comprehensive examination; and medical decision-making of high complexity. Usually the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.
II. F. Inpatient Services

Inpatient services (including room and board) are provided by a DLS licensed Level I behavioral health agency and include the following subcategories:

- Hospitals
- Subacute Facilities
- Residential Treatment Centers (RTC) (only for GMH/SA dual eligible members age 18-20)

These facilities provide a structured treatment setting with 24 hour supervision and an intensive treatment program, including medical support services.

Service Standards/Provider Qualifications

Inpatient services may only be provided by DLS licensed behavioral health agencies that meet the general Level I licensure requirements set forth in 9 A.A.C. 10. In addition, depending on the type of services being provided, the facility may need to meet supplemental requirements as set forth in the licensing rules.

Institution for Mental Diseases (IMD)

Except for general hospitals with distinct units (Provider Type 02), all other Level I facilities with more than 16 beds (Provider Types 71, B1, B3 and B6) are considered under Title XIX/XXI to be Institutions for Mental Diseases (IMDs). An IMD is defined under 42 CFR 435.1010 as an institution with more than 16 beds that are primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and other related services.

Code Specific Information

CPT Codes

Services provided in hospitals are inclusive of all services, supplies, accommodations, staffing, and equipment. UAHP is responsible for the payment of behavioral health professional services, such as psychiatric consultations, provided in an inpatient setting (regardless of the bed or floor where the patient is located).

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION-Inpatient Services (Professional)</th>
</tr>
</thead>
<tbody>
<tr>
<td>99217</td>
<td>Observation care discharge day management (this code is to be utilized by the physician to report all services provided to a patient on discharge from “observation status” if the discharge is on other than the initial date of “observation status”). To report services to a patient designated as “observation status” or “inpatient status” and discharge on the same date, use the code for Observation or Inpatient care</td>
</tr>
</tbody>
</table>
Initial observation care, per day, for the evaluation and management of a patient which requires these 3 key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the problem(s) requiring admission to “observation status” are of low severity. Physicians typically spend 30 minutes at the bedside and on the patient’s hospital floor or unit.

Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the problem(s) requiring admission to “observation status” are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the patient’s hospital floor or unit.

Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the problem(s) requiring admission to “observation status” are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient’s hospital floor or unit.

Initial hospital care, per day, for the evaluation and management of a patient which requires these 3 key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision-making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the problem(s) requiring admission are of low severity. Physicians typically spend 30 minutes at the bedside and on the patient’s hospital floor or unit.

Initial hospital care, per day, for the evaluation and management of a patient which requires these 3 key components: a comprehensive
history; a comprehensive examination; and medical decision-making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the patient’s hospital floor or unit.

99223
Initial hospital care, per day, for the evaluation and management of a patient which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision-making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient’s hospital floor or unit.

99231
Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a problem-focused interval history; a problem-focused examination; medical decision-making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the patient is stable, recovering or improving. Physicians typically spend 15 minutes at the bedside and on the patient’s hospital floor or unit.

99232
Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: an expanded problem-focused interval history; an expanded problem-focused examination; medical decision-making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient’s hospital floor or unit.

99233
Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a detailed interval history; a detailed examination; medical decision-making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the patient is unstable or has developed a significant
complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient’s hospital floor or unit.

99234 Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these 3 key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision-making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually the presenting problem(s) requiring admission are of low severity.

99235 Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision-making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually the presenting problem(s) requiring admission are of moderate severity.

99236 Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these 3 key components: a comprehensive history; comprehensive examination; and medical decision-making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually the presenting problem(s) requiring admission are of high severity.

99238 Hospital discharge day management; 30 minutes or less.

99239 Hospital discharge day management; more than 30 minutes.

99251 Inpatient consultation for a new or established patient, which requires these 3 key components: a problem-focused history; a problem-focused examination; and straightforward medical decision-making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are self-limited or minor. Physicians typically spend 20 minutes at the bedside and on the patient’s hospital floor or unit.

99252 Inpatient consultation for a new or established patient, which requires these 3 key components: an expanded problem-focused history; an
expanded problem-focused examination; and straightforward medical decision-making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 40 minutes at the bedside and on the patient’s hospital floor or unit.

99253
Inpatient consultation for a new or established patient, which requires these 3 key components: a detailed history; a detailed examination; and medical decision-making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 55 minutes at the bedside and on the patient’s hospital floor or unit.

99254
Inpatient consultation for a new or established patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision-making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 80 minutes at the bedside and on the patient’s hospital floor or unit.

99255
Inpatient consultation for a new or established patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision-making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 110 minutes at the bedside and on the patient’s hospital floor or unit.

99307
Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a problem focused interval history; a problem focused examination; straightforward medical decision-making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the patient is stable, recovering or improving. Physicians typically spend 10 minutes at the bedside and on the patient’s facility floor or unit.

99308
Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key
components: an expanded problem focused interval history; an expanded problem focused examination; medical decision-making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 15 minutes at the bedside and on the patient’s facility floor or unit.

99309 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a detailed interval history; a detailed examination; medical decision-making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the patient has developed a significant complication or a significant new problem. Physicians typically spend 25 minutes at the bedside and on the patient’s facility floor or unit.

99310 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a comprehensive interval history; a comprehensive examination; medical decision-making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 35 minutes at the bedside and on the patient’s facility floor or unit.

99356 Prolonged physician service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; first hour (list separately in addition to code for inpatient evaluation and management service)

99357 Prolonged physician service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; each additional 30 minutes (list separately in addition to code for prolonged physician service-99356)

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.
II. F. 1. Hospital

General Information

General Definition

Provides continuous 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. Also includes 24 hour nursing supervision and physicians on site and on call.

UAHP’s responsibility for payment of behavioral health services includes per diem claims for inpatient hospital services, when the principal diagnosis on the hospital claim is a behavioral health diagnosis. The hospital claim, which may include both behavioral health and physical health services, will be paid by UAHP at the per diem inpatient behavioral health rate prescribed by UAHP and described in A.A.C. R9-22-712.61

Service Standards/Provider Qualifications:

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

- Accredited through an accrediting body approved by CMS or surveyed by DLS 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 A.R.S. 36, Chapter 4, Articles 1 and 2 and 9 A.A.C. 10; 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 Office of Medical Facility Licensing and DLS to meet such requirements.

If seclusion and restraint is provided, then the facilities must meet the requirements set forth in 9 A.A.C. 10.

Code Specific Information

Revenue Codes:

Hospitals may bill the following 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
<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0156</td>
<td>Detoxification; room and board – ward</td>
</tr>
<tr>
<td>0110</td>
<td>Room and board - private</td>
</tr>
<tr>
<td>0111</td>
<td>Medical-Surgical-Gyn - private</td>
</tr>
<tr>
<td>0112</td>
<td>OB - private</td>
</tr>
<tr>
<td>0113</td>
<td>Pediatrics - private</td>
</tr>
<tr>
<td>0120</td>
<td>Room and board - semi-private 2 beds</td>
</tr>
<tr>
<td>0121</td>
<td>Medical-Surgical-Gyn - 2 beds</td>
</tr>
<tr>
<td>0122</td>
<td>OB - 2 beds</td>
</tr>
<tr>
<td>0123</td>
<td>Pediatrics - 2 beds</td>
</tr>
<tr>
<td>0130</td>
<td>Room and board - Semi private 3 and 4 beds</td>
</tr>
<tr>
<td>0131</td>
<td>Medical-Surgical-Gyn - 3 and 4 beds</td>
</tr>
<tr>
<td>0132</td>
<td>OB - 3 and 4 beds</td>
</tr>
<tr>
<td>0133</td>
<td>Pediatrics - 3 and 4 beds</td>
</tr>
<tr>
<td>0150</td>
<td>Room and board - ward</td>
</tr>
<tr>
<td>0151</td>
<td>Medical-Surgical-Gyn - ward</td>
</tr>
<tr>
<td>0152</td>
<td>OB - ward</td>
</tr>
<tr>
<td>0153</td>
<td>Pediatrics - ward</td>
</tr>
<tr>
<td>0160</td>
<td>Room and board -general</td>
</tr>
<tr>
<td>0200</td>
<td>Intensive Care</td>
</tr>
<tr>
<td>0201</td>
<td>Intensive Care Unit - surgical</td>
</tr>
<tr>
<td>0202</td>
<td>Intensive Care Unit - medical</td>
</tr>
<tr>
<td>0203</td>
<td>Intensive Care Unit – pediatrics</td>
</tr>
<tr>
<td>0206</td>
<td>Intensive Care Unit - intermediate</td>
</tr>
<tr>
<td>0209</td>
<td>Intensive Care Unit - other</td>
</tr>
<tr>
<td>0210</td>
<td>Coronary Care</td>
</tr>
</tbody>
</table>

**Billing Provider Type:**
- Level I Hospital (02)
- Level I Psychiatric Hospital (IMD) (71)

**Billing Unit:** Per Diem

A Level I Psychiatric Hospital (71) may bill for bed hold or home pass days. Level I Hospital (02) can only bill for home pass days. These are days in which the hospital reserves the person’s space in which they have been residing while the individual is on an 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 person 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 (July 1st through June 30th). The following revenue codes must be used to bill for home pass and bed hold days:
0183 – Home pass

Billing Provider Type:
Level I Hospital (02)
Level I Psychiatric Hospital (IMD) (71)

Billing Unit: Per Diem

0189 – Bed hold

Billing Provider Type:
Level I Psychiatric Hospital (IMD) (71)

Billing Unit: Per Diem

Billing Limitations

1. Non-emergency travel for a person in a hospital/psychiatric hospital is included in the rate and should not be billed separately.

2. Emergency transportation provided to a person residing in the facility is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

3. Medical services provided to a person while in a hospital/psychiatric hospital are included in the rate and should not be billed separately.

4. Medical supplies provided to a person 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 person receiving services.

8. Medication provided/dispensed by the hospital/psychiatric hospital 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 Level I hospital, (provider type 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 from the T/RBHA, the member is medically stable, and there is a principal mental health or substance abuse diagnosis on the claim.
II. F. 2. Behavioral Health Inpatient Facility-Subacute Facility

General Information

General Definition

Continuous treatment provided in a subacute facility to a person 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 physicians 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 person to be admitted to the facility.

Service Standards/Provider Qualifications:

Subacute facilities must be accredited by The Joint Commission, COA, or CARF and licensed by DLS as a Level I facility meeting the specific requirements of 9 A.A.C. 10. Additionally, the facilities must meet the requirements set forth in 9 A.A.C. 10 for seclusion and restraint if the facility has been authorized by DLS to provide seclusion and restraint.

Code Specific Information

Revenue Codes:

Level I subacute facilities may bill the following 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

Billing Provider Type:
Level I Subacute Facility (non-IMD) (B5)
Level I Subacute Facility (IMD) (B6)

Billing Unit: Per Diem

Billing Limitations
1. See general core billing limitations in Section I.

2. The revenue codes for subacute facility services are billed per day for each person receiving services.

3. Non-emergency transportation for a person in a subacute facility is included in the rate and should not be billed separately.

4. Emergency transportation provided to a person residing in the facility is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

5. Medical services provided to a person 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 UAHP.

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.
II. F. 3. Behavioral Health Inpatient Facility-Residential Treatment Center

General Information

General Definition:

Inpatient psychiatric treatment, which includes an integrated residential program of therapies, activities, and experiences provided to persons who are GMH/SA Dual Eligible and are age 18-20 years of age and have severe or acute behavioral health symptoms. UAHP will only reimburse for this service when a member is residing in an RTC at the time the member becomes enrolled with UAHP as a GMH/SA dual eligible member. UAHP will conduct concurrent review and determine the medical necessity for this level of care. This level of care requires prior authorization and concurrent reviews for continued stays. There are two types of residential treatment centers:

Secure - a residential treatment center which generally employs security guards and uses monitoring equipment and alarms.

Non-secure – an unlocked residential treatment center setting.

Service Standards/Provider Qualifications:

Residential treatment facilities must be accredited by an accrediting body approved by CMS and licensed by DLS as a Level I facility meeting the specific requirements of 9 A.A.C. 10. Additionally, the facility must meet the requirements for seclusion and restraint set forth in 9 A.A.C. 10 and in accordance with 42 CFR 441 and 483 if the facility has been authorized by DLS to provide seclusion and restraint.

Code Specific Information

Revenue Codes:

For inpatient stays the residential treatment center may bill the following 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

Billing Provider Type:
Level I Residential Treatment Center – Secure (non-IMD) (78)
Level I Residential Treatment Center – Secure (IMD) (B1)
Level I Residential Treatment Center – Non-Secure (non-IMD) (B2)
Level I Residential Treatment Center – Non-Secure (IMD) (B3)

**Billing Unit:** Per Diem

Residential treatment centers may bill for bed hold or home pass days. These are days in which the RTC reserves the person’s space in which they have been residing while the individual is on an 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 person 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 (July 1st through June 30th). The following revenue codes must be used to bill for bed hold or home pass days:

- **0183** – home pass
- **0189** – bed hold

**Billing Provider Type:**
Level I Residential Treatment Center – Secure (non-IMD) (78)
Level I Residential Treatment Center – Secure (IMD) (B1)
Level I Residential Treatment Center - Non-Secure (non-IMD) (B2)
Level I Residential Treatment Center – Non-Secure (IMD) (B3)

**Billing Unit:** Per Diem

**Billing Limitations:**

1. See general core billing limitations in Section I.

2. This service requires a Prior Authorization Request.

3. The RTC revenue code is billed per day for each person receiving services.

4. The RTC revenue code is a “bundled” rate that includes all HCPCS procedure code services an individual receives.

5. Expenses related to the person’s education are not included in the RTC rate and should be billed separately.
6. Non-emergency transportation for a person in a RTC facility is included in the rate and should not be billed separately.

7. Emergency transportation provided to a person residing in the RTC facility is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

8. Medical supplies provided to a person while in a RTC are included in the rate and should not be billed separately.

9. 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.

10. 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.
II. G. Behavioral Health Residential Services

Residential services are provided on a 24 hour basis.

II. G. 1. Behavioral Health Residential Facility, Without Room and Board

General Information

General Definition

Residential services are provided by a licensed behavioral health agency. These agencies provide a structured treatment setting with 24 hour supervision and counseling or other therapeutic activities for persons who do not require on-site medical services, under the supervision of an on-site or on-call behavioral health professional.

Service Standards/Provider Qualifications

These services may only be provided by DLS licensed behavioral health agencies that meet the general licensure requirements set forth in 9 A.A.C. 10.

Room and board is not covered by Title XIX/XXI for persons residing in behavioral health residential facilities. (See service description on room and board.)

Code Specific Information

HCPCS Codes

- **H0018– Behavioral Health Short-Term Residential, without room and board:** Personal Care is included in the rate for this service. See general definition above.

Billing Unit: Per Diem

Billing Limitations:

1. This service requires a Prior Authorization Request.
II. G. 2. Mental Health Services NOS (Room and Board)

General Information

General Definition

Room and board means provision of lodging and meals to a person residing in a residential facility or supported independent living setting which may include but is not limited to: services such as food and food preparation, personal laundry, and housekeeping. This code may also be encountered to report bed hold/home pass days in Behavioral Health Residential facilities.

Service Standards/Provider Qualifications

The provider must meet the following requirements:

- Provide safe and healthy living arrangements that meet the needs of the person and
- Provide or ensure the nutritional maintenance for the resident.

Code Specific Information

State Funded HCPCS Codes

- **H0046 SE – Mental Health Services NOS (Room and Board):** See general definition above.

  **Billing Unit:** Per Diem

Billing Limitations

For room and board services, the following billing limitations apply:

All other fund sources (e.g., SSI) must be exhausted prior to billing this service. Outpatient Clinics may bill the Room and Board code only when providing services to persons in Supervised Independent Living settings.
II. H. Behavioral Health Day Programs

Behavioral health day program services are 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 person, group of individuals and/or families in a variety of settings.

Based on the level/type of staffing, day programs are grouped into the following three subcategories:

- Supervised
- Therapeutic
- Psychiatric/Medical

II. H. 1. Supervised Behavioral Health Treatment and Day Programs

General Information

General Definition

A regularly scheduled program of individual, group and/or family activities/services related to the enrolled person's treatment plan designed to improve the ability of the person 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, ongoing support to maintain employment, and self-help/peer services.

Service Standards/Provider Qualifications

Supervised behavioral health treatment and day programs may be provided by either DLS licensed behavioral health agencies or Title XIX certified Community Service Agencies. The individual staff that deliver specific services within the supervised behavioral health treatment and day programs must meet the individual provider qualifications associated with those services. Supervised behavioral health treatment and day programs provided by non-DLS licensed community service agencies must be supervised by a behavioral health technician or behavioral health para-professional.

Code Specific Information

HCPCS Codes

- **H2012 --Behavioral Health Day Treatment (Supervised):** See general definition above. Per hour, up to 5 hours in duration.

  **Billing Unit:** Per hour
- H2015 – Comprehensive Community Support Services (Supervised Day Program): See general definition above. Greater than 5 hours, up to 10 hours in duration.

  **Billing Unit:** Per 15 minutes

**Billing Limitations**

For supervised day programs and treatment, the following billing limitations apply:

1. See general core billing limitations in Section I.

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 person is not included in the rate and should be billed separately using the appropriate transportation procedure codes.
II. H. 2. Therapeutic Behavioral Health Services and Day Programs

General Definition

A regularly scheduled program 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, ongoing support to maintain employment, home care training family (family support), medication monitoring, case management, self-help/peer services, and/or medical monitoring.

Service Standards/Provider Qualifications

Therapeutic behavioral health services and day programs must be provided by an appropriately licensed DLS behavioral health agency and in accordance with applicable service requirements set forth in 9 A.A.C. 10. These programs must be under the direction of a behavioral health professional. The staff who deliver the specific services within the therapeutic day program must meet the individual provider qualifications associated with those services.

Code Specific Information

HCPCS Codes

• **H2019 – Therapeutic Behavioral Services:** See general definition above. Up to 5 ¾ hours in duration.

  Billing Unit: 15 minutes

• **H2019 TF – Therapeutic Behavioral Services:** See general definition above. Up to 5 ¾ hours in duration. **TF modifier required for intermediate level of care.** The TF modifier is used to allow UAHP to contract for an intermediate level of services (e.g., clients needing more intensive supervision, a sitter and/or 1:1 staffing).

  Billing Unit: 15 minutes

• **H2020 – Therapeutic Behavioral Services:** See general definition above.

  Billing Unit: Per Diem

Billing Limitations
For therapeutic behavioral health services and day programs, the following billing limitations apply:

1. See general core billing limitations in Section I.

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. Emergency and non-emergency transportation provided to a person is not included in the rate and should be billed separately using the appropriate transportation procedure codes.
II. H. 3. Community Psychiatric Supportive Treatment and Medical Day Programs

General Definition

A regularly scheduled program of active treatment modalities, including medical interventions, in a group setting. 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, home care training family (family support), and/or other nursing services such as medication monitoring, methadone administration, and medical/nursing assessments.

Service Standards/Provider Qualifications

Community psychiatric supportive treatment and medical day programs must be provided by an appropriately licensed DLS behavioral health agency and in accordance with applicable service requirements set forth in 9 A.A.C.10. These programs must be under the direction of a licensed physician, nurse practitioner, or physician assistant. The staff who deliver the specific services within the supervised day programs must meet the individual provider qualifications associated with those services.

Code Specific Information

HCPCS Codes

- **H0036– Community Psychiatric Supportive Treatment, face-to-face**: See general definition above.
  
  Billing Unit: 15 minutes

- **H0036 TF– Community Psychiatric Supportive Treatment, face-to-face**: See general definition above. **TF modifier required for intermediate level of care.** The TF modifier is used to allow RBHAs to contract for an intermediate level of services (e.g., clients needing more intensive supervision, a sitter and/or 1:1 staffing).
  
  Billing Unit: 15 minutes

- **H0036 TF –Community Psychiatric Supportive Treatment, face-to-face (Home)**: See general definition above. **TF modifier required for intermediate level of care.** The TF modifier is used to allow UAHP to contract for an intermediate level of services (e.g., clients needing more intensive supervision, a sitter and/or 1:1 staffing).
Billing Unit: 15 minutes

- H0037– Community Psychiatric Supportive Treatment Program: See general definition above.
  Billing Unit: Per Diem

Billing Limitations

For community psychiatric supportive treatment and medical day programs, the following billing limitations apply:

1. See general core billing limitations in Section I.

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 person is not included in the rate and should be billed separately using the appropriate transportation procedure codes.
III. Appendices
## A.1 Case Management Billing Guidelines

<table>
<thead>
<tr>
<th><strong>Paperwork completion for coordination of care</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Writing a letter on the consumer’s behalf vs. simply mailing a letter</td>
<td>Does the service fit the definition* of case management services? Is the service included or part of the behavioral health recipient’s treatment plan and thoroughly documented in the progress notes?</td>
</tr>
<tr>
<td>Mailing an invitation to the consumer vs. simply mailing an event calendar</td>
<td>This service appears to be an administrative function. Does the service fit the definition* of case management services? Is the service included or part of the behavioral health recipient’s treatment plan and thoroughly documented in the progress notes?</td>
</tr>
<tr>
<td>Mailing appointment reminders</td>
<td>This service appears to be an administrative function. Does the service fit the definition* of case management services? Is the service included or part of the behavioral health recipient’s treatment plan and thoroughly documented in the progress notes?</td>
</tr>
<tr>
<td>Preparing documentation for the consumer at the consumer’s request</td>
<td>This service appears to be an administrative function. Does the service fit the definition* of case management services? Is the service included or part of the behavioral health recipient’s treatment plan and thoroughly documented in the progress notes?</td>
</tr>
<tr>
<td>Completing an application for the consumer</td>
<td>Does the service fit the definition* of case management services? Is the service included or part of the behavioral health recipient’s treatment plan and thoroughly documented in the progress notes?</td>
</tr>
</tbody>
</table>
| Reviewing/updating consumer charts with the consumer not present | Core Billing Limitations  
A provider can only bill for his/her time spent in providing the actual service. For all services, the provider may not bill any time associated with note taking and/or medical record upkeep as this time has been included in the rate. |
| Sending faxes on consumer’s behalf | Does the service fit the definition* of case management services? Is the service included or part of the behavioral health recipient’s treatment plan and thoroughly documented in the progress notes? |
| Faxing referrals to providers | This service appears to be an administrative function. Does the service fit the definition* of case management services? Is the service included or part of the behavioral health recipient’s treatment plan and thoroughly documented in the progress notes? |
| E-mailing communication to providers or other members of the clinical team regarding the consumer | Case management Billing Limitations:  
Written electronic communication (e-mail) and leaving voice messages are allowable as case management functions. These functions are not to become the predominant means of providing case |
<table>
<thead>
<tr>
<th>Activity</th>
<th>Case Management Billing Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reading e-mails received from consumers or clinical team members</td>
<td>Case management may not be billed for simply reading e-mails. The following applies when providing case management services via e-mail communication:</td>
</tr>
<tr>
<td>management services and require specific documentation as specified below.</td>
<td>Case management Billing Limitations</td>
</tr>
<tr>
<td>Written electronic communication (e-mail) must be about a specific individual and is allowable as case management, as long as documentation (a paper copy of the e-mail) exists in the case record.</td>
<td>Written electronic communication (e-mail) and leaving voice messages are allowable as case management functions. These functions are not to become the predominant means of providing case management services and require specific documentation as specified below.</td>
</tr>
<tr>
<td>Written electronic communication (e-mail) must be about a specific individual and is allowable as case management, as long as documentation (a paper copy of the e-mail) exists in the case record.</td>
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</tr>
<tr>
<td>E-mailing consumer directly</td>
<td>Case management Billing Limitations</td>
</tr>
<tr>
<td>Case management Billing Limitations</td>
<td>Written electronic communication (e-mail) and leaving voice messages are allowable as case management functions. These functions are not to become the predominant means of providing case management services and require specific documentation as specified below.</td>
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<tr>
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</tr>
<tr>
<td>Telephone calls with family members, probation officers, etc. regarding</td>
<td>Case Management Billing Limitations</td>
</tr>
<tr>
<td>consumer</td>
<td>Written electronic communication (e-mail) and leaving voice messages are allowable as case management functions. These functions are not to become the predominant means of providing case management services and require specific documentation as specified below.</td>
</tr>
<tr>
<td>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.</td>
<td>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.</td>
</tr>
<tr>
<td>Telephone calls with family members, probation officers, etc. regarding consumer</td>
<td>When leaving voice messages, a signed document in the client chart granting permission to leave specific information would be required.</td>
</tr>
<tr>
<td>Activity</td>
<td>Case Management Billing Limitations</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Leaving a voicemail message for consumer</td>
<td>Written electronic communication (e-mail) and leaving voice messages are allowable as case management functions. These functions are not to become the predominant means of providing case management services and require specific documentation as specified below. 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. When leaving voice messages, a signed document in the client chart granting permission to leave specific information would be required.</td>
</tr>
<tr>
<td>Arranging transportation for a consumer</td>
<td>Does the service fit the definition* of case management services? Is the service included or part of the behavioral health recipient’s treatment plan and thoroughly documented in the progress notes?</td>
</tr>
<tr>
<td><strong>Transportation/Driving</strong></td>
<td></td>
</tr>
<tr>
<td>Picking up a food box for a consumer</td>
<td>Does the service fit the definition* of case management services? Is the service included or part of the behavioral health recipient’s treatment plan and thoroughly documented in the progress notes?</td>
</tr>
<tr>
<td>Picking up a food box for a consumer and bringing it back to the provider’s office and delivering to the consumer at a later time</td>
<td>Does the service fit the definition* of case management services? Is the service included or part of the behavioral health recipient’s treatment plan and thoroughly documented in the progress notes?</td>
</tr>
<tr>
<td>Picking up medication/groceries for the consumer</td>
<td>Case Management Billing Limitations</td>
</tr>
<tr>
<td></td>
<td>The provider should bill all time he/she spent in direct or indirect contact with the person, family and/or other parties involved in implementing the treatment/service plan. Indirect contact includes telephone calls, picking up and delivering medications, and/or collateral contact with the person, family and/or other involved parties. Picking up groceries for the consumer: Is the service included or part of the behavioral health recipient’s treatment plan and thoroughly documented in the progress notes?</td>
</tr>
<tr>
<td>Service delivered while driving a consumer to an appointment (i.e. provide substance abuse engagement services)</td>
<td>Case management Billing Limitations</td>
</tr>
<tr>
<td></td>
<td>The provider may not bill case management for any time associated with a therapeutic interaction nor simultaneously with any other services.</td>
</tr>
<tr>
<td>Time spent flying with consumer to a treatment</td>
<td>These services are reimbursed By Report (BR).</td>
</tr>
<tr>
<td>Program in another state</td>
<td>Please see the Covered Services Guide and the B2 matrix in Section 22-Forms and Resources</td>
</tr>
<tr>
<td>-------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Time spent conducting outreach without successfully finding the consumer</td>
<td>Core Billing Limitations</td>
</tr>
<tr>
<td></td>
<td>The provider may only bill the time spent in face-to-face direct contact; however, when providing assessment, case management services, the provider may also bill indirect contact. Indirect contact includes phone calls, leaving voice messages and sending e-mails (with limitations), picking up and delivering medications, and/or collateral contact with the enrolled person, family and/or other involved parties.</td>
</tr>
<tr>
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<td>Core Provider Travel Billing Limitations</td>
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<td></td>
<td>If a behavioral health professional, behavioral health technician or behavioral health paraprofessional travels to provide case management services or provider type 85, 86, 87 or A4 travels to provide services to a client and the client misses the appointment, the intended service may not be billed. Additionally, providers may not bill for travel for missed appointments.</td>
</tr>
<tr>
<td>Time spent driving to do a home visit when the consumer is not home</td>
<td>Core billing Limitations</td>
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<tr>
<td></td>
<td>The provider may only bill the time spent in face-to-face direct contact; however, when providing assessment, case management services, the provider may also bill indirect contact. Indirect contact includes phone calls, leaving voice messages and sending e-mails (with limitations), picking up and delivering medications, and/or collateral contact with the enrolled person, family and/or other involved parties.</td>
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<tr>
<td></td>
<td>Core Provider Travel Billing Limitations</td>
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<tr>
<td></td>
<td>If a behavioral health professional, behavioral health technician or behavioral health paraprofessional travels to provide case management services or provider type 85, 86, 87 or A4 travels to provide services to a client and the client misses the appointment, the intended service may not be billed. Additionally, providers may not bill for travel for missed appointments.</td>
</tr>
<tr>
<td>Time spent researching for various cell phone deals and service plans or similar services at the consumer’s request</td>
<td>Does the service fit the definition* of case management services? Is the service included or part of the behavioral health recipient’s treatment plan and thoroughly documented in the progress notes?</td>
</tr>
</tbody>
</table>

**Accompanying to, and participating in appointments with the person**

<table>
<thead>
<tr>
<th>Time spent waiting with a consumer for an appointment vs. the time spent waiting for the consumer while the consumer is receiving treatment</th>
<th>Waiting for a person while he/she receives services does not appear to be a case management service. The following applies when transporting a person to</th>
</tr>
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</table>
Case Management Billing Limitations

Transportation provided to an ADHS/DBHS enrolled member is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

Sitting in an appointment with a doctor or provider with the consumer to assist the consumer in advocating for their needs or to assist in coordination of care

Case Management Billing Limitations

The provider should bill all time he/she spent in direct or indirect contact with the person, family and/or other parties involved in implementing the treatment/service plan.

*Description of Behavioral Health Case Management Services: AHCCCS Behavioral Health Services Guide:

Behavioral health case management services are supportive services provided to enhance treatment compliance and effectiveness. Case management activities include assistance in accessing, maintaining, monitoring and modifying covered services; assistance in finding resources, communication and coordination of care, outreach and follow-up of crisis contacts or missed appointments.

UAHP Medicaid Behavioral Health Covered Services Guide:

Case management is a supportive service provided to enhance treatment goals and effectiveness. Activities may include:

- Assistance in maintaining, monitoring and modifying covered services;
- Brief telephone or face-to-face interactions with a person, family or other involved party for the purpose of maintaining or enhancing a person’s functioning;
- Assistance in finding necessary resources other than covered services to meet basic needs;
- Communication and coordination of care with the person’s family, behavioral and general medical and dental health care providers, community resources, and other involved supports including educational, social, judicial, community and other state agencies;
- Coordination of care activities related to continuity of care between levels of care (e.g., inpatient to outpatient care) and across multiple services (e.g., personal assistant, nursing services and family counseling);
- Outreach and follow-up of crisis contacts and missed appointments;
- Participation in staffings, case conferences or other meetings with or without the person or his/her family participating; and
- Other activities as needed.

Case Management does not include:

- Administrative functions such as authorization of services and utilization review;
- Other covered services listed in the UAHP Medicaid Behavioral Health Covered Services Guide.
B-2. Allowable Procedure Code Matrix

Please see Section 22- Forms and Resources
### B-3. Encounter/Claims Principle Behavioral Health ICD-9 Diagnostic Codes

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</table>
The submission of claims/encounters must include correct coding in accordance with the ICD-10 Coding Manual, including the use of five digits, when indicated.
B-4. Rehabilitation and Support Services Crosswalk
B-5. Billing Limitations Matrix