GENERAL MENTAL HEALTH/SUBSTANCE ABUSE (GMH/SA) DUAL ELIGIBLE

BEHAVIORAL HEALTH PROVIDER MANUAL

For Providers contracted with
University Family Care and University Care Advantage

THE UNIVERSITY OF ARIZONA
HEALTH PLANS

2701 E. Elvira Road
Tucson, Arizona 85756

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Table of Contents

Section 1 – Introduction

University of Arizona Health Plans is an Arizona-based, locally-operated Managed Health Care Organization dedicated to ensuring that members receive ready access to high quality and culturally responsive care. UAHP is committed to bringing the best care possible to vulnerable populations through a focus on innovative programs and services. UAHP serves ten Arizona counties—Pima, La Paz, Yuma, Santa Cruz, Cochise, Greenlee, Graham, Pinal, Yavapai and Gila Counties—and recognizes that the needs of each county are uniquely based on the county's resources and challenges. UAHP tailors services to meet the needs of each community and supports local community-based efforts to effectively coordinate care. UAHP developed this Provider Manual in support of its provider agreements and in conformance with the Arizona Health Care Cost Containment System (AHCCCS) - Contractor Operations Manual (ACOM Manual) and the AHCCCS Medical Policy Manual (AMPM). UAHP's Behavioral Health Provider Manual is applicable to those members who have both Medicare and Medicaid funded health care, and have the behavioral health category of General Mental Health/Substance Abuse (GMH/SA DUAL) ONLY. Providers are obligated to adhere to and comply with all terms and conditions of the UAHP Behavioral Health Provider Manual, the provider's agreement with UAHP, and all applicable federal and State laws and regulations. In addition, providers are obligated to understand and comply with all Arizona Health Care Cost Containment System requirements. Please refer to: AHCCCS ACOM and AMPM located at www.ahcccs.gov for additional information regarding State requirements.

UAHP endorses and requires for all subcontracted providers to comply with the Arizona Adult Service System's Nine Guiding Principles.

1. Respect
Respect is the cornerstone. Meet the person where they are without judgment, with great patience and compassion.

2. Persons in recovery choose services and are included in program decisions and program development efforts. A person in recovery has choice and a voice. Their self-determination in driving services, program decisions and program development is made possible, in part, by the ongoing dynamics of education, discussion, and evaluation, thus creating the "informed consumer" and the broadest possible palette from which choice is made. Persons in recovery should be involved at every level of the system, from administration to service delivery.

3. Focus on individual as a whole person, while including and/or developing natural supports. A person in recovery is held as nothing less than a whole being: capable, competent, and respected for their opinions and choices. As such, focus is given to empowering the greatest possible autonomy and the most natural and well-rounded lifestyle. This includes access to and

involvement in the natural supports and social systems customary to an individual's social community.

4. Empower individuals taking steps towards independence and allowing risk taking without fear of failure. A person in recovery finds independence through exploration, experimentation, evaluation, contemplation and action. An atmosphere is maintained whereby steps toward independence are encouraged and reinforced in a setting where both security and risk are valued as ingredients promoting growth.

5. Integration, collaboration, and participation with the community of one's choice
A person in recovery is a valued, contributing member of society and, as such, is deserving of and beneficial to the community. Such integration and participation underscores one's role as a vital part of the community, the community dynamic being inextricable from the human experience. Community service and volunteerism is valued.

6. Partnership between individuals, staff, and family members/natural supports for shared decision making with a foundation of trust. A person in recovery, as with any member of a society, finds strength and support through partnerships. Compassion-based alliances with a focus on recovery optimization bolster self-confidence, expand understanding in all participants, and lead to the creation of optimum protocols and outcomes.

7. Persons in recovery define their own success. A person in recovery -- by their own declaration -- discovers success, in part, by quality of life outcomes, which may include an improved sense of well-being, advanced integration into the community, and greater self-determination. Persons in recovery are the experts on themselves, defining their own goals and desired outcomes.

8. Strengths-based, flexible, responsive services reflective of an individual's cultural preferences. A person in recovery can expect and deserves flexible, timely, and responsive services that are accessible, available, reliable, accountable, and sensitive to cultural values and mores. A person in recovery is the source of his/her own strength and resiliency. Those who serve as supports and facilitators identify, explore, and serve to optimize demonstrated strengths in the individual as tools for generating greater autonomy and effectiveness in life.

9. Hope is the foundation for the journey towards recovery. A person in recovery has the capacity for hope and thrives best in associations that foster hope. Through hope, a future of possibility enriches the life experience and creates the environment for uncommon and unexpected positive outcomes to be made real. A person in recovery is held as boundless in potential and possibility.

Section 2 – Covered Services and Related Program Requirements

2.1 UAHP Behavioral Health Medicaid and Medicare Covered Services

Members who are in the behavioral health category: General Mental Health/Substance Abuse (GMHS/SA) and are also eligible for both Medicare and Medicaid (AHCCCS) are considered to be GMH/SA dual eligible members. These members receive their Medicaid funded behavioral health and physical health care services from their AHCCCS Health Plan. In order to determine which entity is responsible for a member's behavioral health services, you will need to check with AHCCCS On-Line, Member Eligibility Verification, under the behavioral health tab.

GMH/SA Duals have the same covered behavioral health services regardless of their Medicare Advantage Plan or traditional Medicare plan. The table below depicts a general list of covered behavioral health services for Medicare and Medicaid. For more specific information regarding Medicaid behavioral health covered services please refer to the UAHP Covered Behavioral Health Services Guide at www.uahealthplans.com.

Medicare Behavioral Health Covered Services	Medicaid Behavioral Health Covered Services
Inpatient Psychiatric Care (190 day lifetime limit for days in a psychiatric hospital. Inpatient psychiatric days in a general hospital are not counted toward the lifetime maximum.)	**Inpatient Hospital Services** **Non-Hospital Inpatient Psychiatric Facilities Services (Level I residential treatment centers and sub-acute facilities)**
Psychiatric diagnostic interviews	**Assessment, Evaluation and Screening Services**
Individual/ Group/Family Psychotherapy	**Individual, Group and Family Therapy and Counseling**
Interactive psychotherapy	
Pharmacologic management	**Psychotropic Medication Adjustment and Monitoring**

	Laboratory and Radiology Services for Psychotropic Medication Regulation and Diagnosis
Part B Prescription Drugs	**Psychotropic Medication**
Out Patient Substance Abuse Services	**Opioid Agonist Treatment** **(Covered under Counseling Services)**
Electroconvulsive Therapy	**Electroconvulsive Therapy**
Diagnostic psychological and neuropsychological tests	**(Covered under Assessment, Evaluation and Screening Services)**
Hypnotherapy	**(Covered under Counseling Services)**
Narcosynthesis	
Biofeedback Therapy	
Individualized activity therapy (as part of a Partial Hospitalization Program that is not primarily recreational or diversionary)	**Partial Care (supervised day program, therapeutic day program and medical day program)**
Depression Screening with PCP (one per year)	
Screening and Counseling to reduce alcohol misuse. If positive screen, up to 4 brief face to face sessions per year with a qualified primary doctor in a primary care setting.	
Smoking and Tobacco use Cessation (counseling to stop smoking or tobacco use) **(2 counseling quit attempts per year. Each counseling attempt includes up to four face to face visits.)**	
	Home Care Training to Home Care Client

	Respite Care (limited to 600 hours per contract year- October 1 through September 30)
	Emergency and Non-Emergency Transportation
	Behavioral Health Nursing Services
	Behavioral Health Case Management Services
	Emergency Behavioral Health Care
	Psychosocial Rehabilitation (living skills training; health promotion; supportive employment services)
	Behavioral Health Substance Abuse Transitional Facilities
	Behavior Management (member care, family support/home care training, peer support)

Medicare Part D Prescription Drug Coverage

Members eligible for Medicare Part D must access the Medicare Part D prescription drug coverage by enrolling with a Medicare Prescription Drug Plan (PDP) or Medicare Advantage Prescription Drug plan (MA-PD). Members eligible for both Medicare Part D and Title XIX/XXI (AHCCCS) will continue to have coverage of the following excluded Part D drugs through Title XIX/XXI, if not included in the PDP or MA plans' formulary:

- Benzodiazepines;
- Barbiturates; and
- Certain over the counter drugs

Medicaid Only Behavioral Health Benefits- Not covered by Medicare

- Behavior Management (personal care, family support/home care training, peer support)
- Behavioral Health Case Management Services
- Behavioral Health Nursing Services
- Emergency Behavioral Health Care
- Emergency and Non-Emergency Transportation
- Non-Hospital Inpatient Psychiatric Facilities Services (Level I residential treatment centers and sub-acute facilities)
- Behavioral Health Residential Facility

- Partial Care (supervised day program, therapeutic day program and medical day program)
- Respite Care (limited to 600 hours per contract year- October 1 through September 30)
- Behavioral Health Substance Abuse Transitional Facilities
- Home Care Training to Home Care Client

2.2 Third Party Liability and Coordination of Benefits

Third party liability refers to situations in which members enrolled in the public health care system also have health care service coverage through another health insurance plan, or "third party". The third party can be liable or responsible for covering some or all the services a member receives, including medications. Providers are responsible for determining and verifying if a member has third party health insurance before using other sources of payment such as Medicaid (Title XIX), KidsCare (Title XXI) or State appropriated health care funds. All of UAHP GMH/SA dual eligible members will be eligible for Medicaid and Medicare. Their Medicare benefit will either be with UAHP as the University Care Advantage Plan or another Medicare Advantage Plan/ Medicare Fee For Service Plan that is not affiliated with the UAHP. Regardless, it is still the provider's responsibility to confirm the member's Medicaid and Medicare benefits.

There are two methods used in the coordination of benefits; cost avoidance and post-payment recovery:

- UAHP will initiate cost avoidance procedures when claims or services are subject to third-party payment and may deny a service to a member if it is known that a third party (i.e., other insurer) is responsible for the payment of the service. UAHP may deny payment to a provider if a provider is aware of third party liability and submits a claim or encounter to UAHP. UAHP will coordinate benefits and reimburse providers a portion of the member's liability up to the AHCCCS or primary payer allowed amount, whichever is less. The provider's must submit a copy of the primary payer's EOB or Remittance advice with the claim. In emergencies, providers must provide the necessary services and then coordinate payment with the third party payer
- Post-payment recovery is necessary in cases when either UAHP or the provider are unaware of third party coverage at the time services were rendered or paid for, or when UAHP was unable to cost avoid.

The intent of this section is to describe the requirements for providers to:

- Determine if a member has third party health insurance coverage before using Federal or State funds;
- Coordinate services and assign benefit coverage to third party payers when information regarding the existence of third party coverage is available; and
- Submit billing information that includes documentation that third party payers were assigned coverage for any covered services that were rendered to the enrolled member.
- Coordinate benefits for members enrolled with Medicare Part A, Part B, and/or Part D.
- Coordinate benefits for members enrolled in a qualified health plan through the federal health insurance exchange.

Additional Information

- If third party information becomes available to the provider at any time for Title XIX or Title XXI eligible members, that information must be reported to the AHCCCS Administration within 10 days from the date of discovery;
- An online Medical Insurance Referral should be completed and submitted to AHCCCS through the Health Management Systems (HMS) website whenever an AHCCCS member is discovered to have other medical insurance, or whenever other medical insurance has terminated or changed. HMS has launched a new Third Party Liability ("TPL") Referral Web Portal. The site to gain this access is http://www.azahcccs.gov/commercial/ContractorResources/TPL.aspxf;
- Third parties include, but are not limited to, private health insurance, Medicare, employment related health insurance, medical support from non-custodial parents, court judgments or settlements from a liability insurer, State worker's compensation, first party probate-estate recoveries, long term care insurance and other Federal programs;
- For those Medicare Part A and Part B services that are also covered under Title XIX/XXI, there is no cost sharing obligation if UAHP has a contract with the Medicare provider and the provider's subcontracted rate includes Medicare cost sharing as specified in the contract;
- As of January 1, 2006, Medicare Part D Prescription Drug coverage became available to all Medicare eligible members. Medicare is considered third party liability and must be billed prior to use of Title XIX/XXI or state funds.

Identifying Other Health Insurance

Providers are responsible for determining and verifying if a member has third party health insurance before using other sources of payment such as Medicaid (Title XIX) or Title XXI.

- Providers must identify the existence of potentially liable parties.
- If third party information becomes available to the provider at any time for Title XIX or Title XXI eligible members, that information must be reported to the AHCCCS Administration within 10 days from the date of discovery.
- Providers must report Commercial third party information via the following website: http://www.azahcccs.gov/commercial/ContractorResources/TPL.aspx. From this link, you will be directed to Health Management Systems (HMS), where you can enter members TPL information.

UAHP will receive notification of updated information on the TPL files. UAHP is responsible for making third party payer information available to all providers involved with the member receiving services.

Providers must inquire about a member's other health insurance coverage during the initial appointment or intake process. When providers attempt to verify a member's Title XIX or Title

XXI eligibility, information regarding the existence of any third party coverage is provided through AHCCCS' automated eligibility verification systems. If a member is not eligible for Title XIX or Title XXI benefits, he/she will not have any information to verify through the automated systems. Therefore, the existence of third party payers must be explored with the member during the screening and application process for AHCCCS health insurance.

Services Covered by Other Health Insurance Party

Third party health insurance coverage may cover all or a portion of the behavioral health services rendered to a member. Providers must contact the third party directly to determine what coverage is available to the member. However, payments by another state agency are not considered third party and in this circumstance, UAHP is not the payer of last resort.

- In an emergency situation, the provider must first provide any medically necessary covered services, and then coordinate payment with any potential third party payers.
- When coverage from a third party payer has been verified, there are two methods used in the coordination of benefits:
    - **Cost avoidance** - Providers must cost avoid all claims or services that are subject to third-party payment. UAHP may deny payment to a provider if a provider is aware of third party liability and submits a claim or encounter to UAHP. In emergencies, providers must provide the necessary services and then coordinate payment with the third party payer; or
    - Post-payment recovery is necessary in cases where a behavioral health provider was not aware of third party coverage at the time services were rendered or paid for, or was unable to cost avoid.

If a third-party insurer requires a member to pay a copayment, coinsurance or deductible, UAHP is responsible for covering those costs for Title XIX/XXI eligible members if the third party payer is not another state agency. UAHP must be the payer of last resort for Title XIX/XXI covered services. Payment by another state agency is not considered third party and, in this circumstance, and UAHP is not the payer of last resort

Billing requirements

Upon determination that a member has third party coverage, a provider must submit proper documentation to demonstrate that the third party has been assigned responsibility for the covered services provided to the member. The following guidelines must be adhered to by behavioral health providers regarding third party payers:

- Providers must bill claims for any covered services to any third party payer when information on that third party payer is available. Documentation that such billing has occurred must accompany the claim when submitted for payment. Such documentation includes a copy of the Remittance Advice or Explanation of Benefits from the third party payer. The only exceptions to this billing requirement are:
    - When a response from the third party payer has not been received within the

timeframe established by UAHP for claims submission or, in the absence of a subcontract, within 90 days of submission;
    - When it is determined that the member had relevant third party coverage after services were rendered or reimbursed;
    - When a member eligible for both Medicaid and Medicare (dual eligible) receives services in a Behavioral Health Inpatient facility that is not Medicare certified. Non-Medicare certified facilities may be utilized for dual eligible members when a Medicare certified facility is not available; or
    - When a member is receiving covered services from a preferred provider (i.e., the provider is close to member's home) and the provider is unable to bill the member's third party payer.
- UAHP may deny payment to a provider if a provider is aware of third party liability and submits a claim to UAHP. If the provider does not know whether a particular medically necessary covered service is covered by the third party payer, the provider must contact the third party payer rather than requiring the member receiving services to do so. This policy permits the denial of *claims payment* based upon third party payment sources, but must not be interpreted to permit the denial of *services or service coverage* based upon third party payment sources. UAHP and providers may not employ cost avoidance strategies that limit or deny a member eligible for services from receiving timely, clinically appropriate, accessible, medically necessary covered services.
- A provider has 90 days from the date the provider becomes aware that payment will not be made by a third party to submit a new claim and documentation from the primary insurer that payment will not be made. Documentation includes but is not limited to any of the following items establishing that the primary insurer has or would deny payment based on timely filing limits or lack of prior authorization: an Explanation of Benefits (EOB); policy or procedure; or a Provider Manual excerpt.

Discovery of Third Party Liability After Services Were Rendered or Reimbursed
If it is determined that a member has third party liability after services were rendered or reimbursed, providers must identify all potentially liable third party payers and pursue reimbursement from them. In instances of post-payment recovery, the provider must submit an adjustment to the original claim, including a copy of the Remittance Advice or the Explanation of benefits. Providers shall not pursue recovery in the following circumstances, unless the case has been referred to UAHP and the provider by AHCCCS or AHCCCS's authorized representative:

- Uninsured/underinsured motorist insurance;
- Restitution Recovery;
- First- and third-party liability insurance;
- Worker's Compensation;
- Tortfeasors, including casualty;
- Estate Recovery; or
- Special Treatment Trust Recovery.

The provider must report any cases involving the above circumstances to UAHP, which will then report such cases to AHCCCS's authorized representative for determination of a "total plan" case. Providers may be asked to cooperate with AHCCCS in third party collection efforts.

Copayments, premiums, coinsurance and deductibles
Providers are responsible for identifying whether members are enrolled in Medicare Part A or Medicare Part B and covering services accordingly.

Members are responsible for third party copayments for services that are not services that UAHP covers and third party premiums, coinsurance and deductibles, if applicable.

Transportation
Providers shall maintain all records in compliance with the noted specifications for record keeping related to transportation services. It is the responsibility of the provider 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.

UAHP will cover medically necessary non-emergency ground and air transportation to and from a required medical service for most recipients. Non-emergency transportation providers must bill the number of trips and the number of loaded miles as units of service on the CMS 1500 claim form. Loaded mileage is defined as the distance traveled, measured in statute miles, with a recipient on board the vehicle and being transported to receive medically necessary covered services.

Transportation billing guidelines related to Third Party Liability and Coordination of Benefits are the same. Providers must identify all potentially liable third party payers and pursue reimbursement from them.

Medicare does not typically cover transportation HCPCS codes; however providers should periodically check CMS.gov for updates related to these codes to ensure there have not been any updates regarding billing guidelines.

Providers must provide and retain fiscal responsibility for transportation for Title XIX and Title XXI members in order for the member to receive a covered behavioral health service reimbursed by a third party, including Medicare.

Medicaid eligible members with Medicare Part A and Part B
Providers are responsible for identifying whether members are enrolled in Medicare Part A or Medicare Part B and covering services accordingly. For Medicaid eligible members with Medicare Part A, Part B, and/or Part D:

- A Title XIX eligible member may receive coverage under both Medicaid (AHCCCS) and

Medicare. These members are sometimes referred to as "dual eligible".

- Some dual eligible AHCCCS members may have Medicare Part B only. As these members do not have Medicare Part A, Medicaid is the primary payer for services which generally would be covered under Part A including hospitalizations. A claim should not be denied for a lack of EOB when the member is not enrolled in Medicare Part A;
- In the same way, if members have Medicare Part A only, Medicaid is the primary payer for services which are generally covered under Part B including physician visits
- In the event that a Title XIX eligible member also has coverage through Medicare, behavioral health providers must ensure adherence with the requirements described in this subsection.

Qualified Medicare Beneficiary (QMB) Duals are entitled to all AHCCCS and Medicare Part A and B covered services. UAHP is responsible for payment of Medicare cost sharing for all Medicare covered services regardless of whether the services are covered by AHCCCS. UAHP only has responsibility to make payments to providers registered with AHCCCS to provide services to AHCCCS eligible members. The payment of Medicare cost sharing must be provided regardless of whether the provider is in UAHP's network or prior authorization has been obtained.

QMB Dual Cost Sharing Matrix

Covered Services	UAHP Responsibility	In Network	Out of Network
Medicare Only—not covered by AHCCCS	Cost sharing responsibility only	YES	YES
AHCCCS Only—not covered by Medicare, including pharmacy and other prescribed services	Reimbursement for all medically necessary services	YES	NO*
AHCCCS and Medicare covered Service (except for emergent)	Cost sharing responsibility only	YES	YES
Emergency Services	Cost sharing responsibility only	YES	YES

*Subject to UAHP Policy

UAHP is responsible for the payment of the Medicare cost sharing for AHCCCS covered services for Non-QMB Duals that are rendered by a Medicare provider within UAHP's network.

Non-QMB Dual Cost Sharing Matrix

Covered Services	UAHP Responsibility	In Network	Out of Network
Medicare Only—not covered by AHCCCS	No cost sharing responsibility	NO	NO
AHCCCS Only—not covered by Medicare, including pharmacy and other prescribed services	Reimbursement for all medically necessary services	YES*	NO*
AHCCCS and Medicare covered Service (except for emergent)	Cost sharing responsibility only	YES	NO*
Emergency Services	Cost sharing responsibility only	YES	YES

Limits on cost sharing:
UAHP shall have no cost sharing obligation if the Medicare payment exceeds UAHP's contracted rate for the services. UAHP's liability for cost sharing plus the amount of Medicare's payment shall not exceed UAHP's contracted rate for the service. There is no cost sharing obligation if UAHP has a contract with the provider, and the provider's contracted rate includes Medicare cost sharing.

UAHP can require prior authorization, but if the Medicare provider determines that a service is medically necessary, UAHP is responsible for Medicare cost sharing, even if UAHP determines otherwise. If Medicare denies a service for lack of medical necessity, UAHP must apply its own criteria to determine medical necessity. If criteria support medical necessity, then UAHP shall cover the cost of the service.

For QMB Dual members, UAHP has cost sharing responsibility regardless of whether the services were provided by an in or out of network provider. For AHCCCS covered services rendered by an out of network provider to a non-QMB Dual, UAHP is not liable for any Medicare cost sharing unless UAHP has authorized the member to obtain services out of network. If a member has been advised of UAHP's network, and the member's responsibility is delineated in the member handbook, and the member elects to go out of network, UAHP is not responsible for paying the Medicare cost sharing amount.

2.3 Crisis Intervention Services

Crisis intervention services are provided to a member 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, such as hospital emergency departments, face-to-face at a member's home, over the telephone or in the community. These intensive and time limited services may include screening, (e.g., triage and arranging for the provision of additional crisis services) assessing, evaluating or 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 Regional Behavioral Health Authorities (RBHAs) are responsible for managing the crisis service delivery system for all AHCCCS members. UAHP has members located throughout the state. Depending on where the member resides, the RBHA Crisis Provider will provide all crisis services. Each RBHA is required to notify UAHP when a GMH/SA Dual member has engaged with any crisis services in order to coordinate care with the member's Adult Recovery Team (ART) or to refer the member for behavioral health services if appropriate.

Providers are required to coordinate care with any RBHA crisis provider/facility including inpatient facilities, UAHP and other providers to ensure the member receives the most appropriate level of care; appropriate discharge planning and follow up services are scheduled as needed.

General Requirements
To meet the needs of individuals in communities throughout Arizona, the RBHA's ensure that the following crisis services are available:

- Telephone crisis intervention services, including a toll-free number, available 24 hours per day, seven days a week;
- Mobile crisis intervention services, available 24 hours per day, seven days a week;
    - If one crisis team member responds, this person shall be a Behavioral Health Professional or a Behavioral Health Technician; and
    - If a two-member crisis team responds, one may be a Behavioral Health Paraprofessional, including a peer or family member, provided he/she has supervision and training as currently required for all mobile team members.
- 23-hour crisis observation/stabilization services, including detoxification services.
- Up to 72 hours of additional crisis stabilization as funding is available for mental health and substance abuse related services.

UAHP's Responsibility for Crisis Services

- UAHP is responsible for GMH/SA Dual members who are hospitalized as a result of their crisis episode. At that time, the standard utilization management functions occur between the admitting facility and the UAHP Behavioral Health Department and Medical Management Department

- UAHP will be notified by the RBHA Crisis Provider when a GMH/SA Dual member has engaged with the crisis service delivery system. The member will receive case management services until the member is psychiatrically stabilized. Providers are required to coordinate care for all GMH/SA Dual members that require follow up services after receiving crisis services.

Management of Crisis Services

While the RBHA's provide a standard set of crisis services to ensure the availability of these services throughout the state, they must also be able to meet the specific needs of communities located within their service area. RBHA's utilize the following in managing crisis services:

- RBHAs allocate and manage funding to maintain the availability of required crisis services for the entire fiscal year;
- RBHAs and UAHP work collaboratively with local hospital-based emergency departments to determine whether a crisis provider should be deployed to such locations for crisis intervention services;
- RBHAs and UAHP work collaboratively with local Behavioral Health Inpatient Facilities to determine whether and for how many hours such locations are used for crisis observation/stabilization services.

UAHP seeks to ensure members receive crisis services on a timely basis and, when appropriate, in their homes and communities. Crisis mobile teams are available to help members obtain the appropriate crisis services. UAHP discourages providers from sending members to emergency rooms for non-medical reasons. Arizona's two major metropolitan areas have facilities especially designed for assessment of members in crisis and to refer for additional services if needed. The facilities are the Crisis Response Center (CRC) in Tucson, the Urgent Psychiatric Care Center (UPC) in Phoenix and Recovery Innovation's Recovery Response Center in Peoria.

RBHA Crisis Contact Information

County Location	CALL THIS NUMBER FOR BEHAVIORAL HEALTH.
Yavapai and Gila County	HealthChoice Integrated Care Customer Service 1-800-640-2123 For Hearing Impaired, use Arizona Relay Service at 711 or call: 1-800-367-8939 Crisis: 1-877-756-4090
Maricopa County	Mercy Maricopa Integrated Care (MMIC) Member Services (602) 586-1841 1-800-564-5465 (toll free) Hearing Impaired TTY: 711 The Maricopa Crisis Line: (602) 222-9444 1-800-631-1314 (toll free) Hearing Impaired TTY: 1-800-327-9254
Pima, Cochise, Gila, Graham, Greenlee, Pinal, Yuma, La Paz or Santa Cruz County	Cenpatico Integrated Care Customer Services: 1-866-495-6738 TTY: 1-877-613-2076 Cenpatico Crisis 1-866-495-6735

Section 3 – Behavioral Health Network Provider Service Delivery Requirements

3.1 Appointment Standards and Timeliness of Service

It is vital that the UAHP health care delivery system be responsive and accessible to all enrolled members. It is the expectation of UAHP that provider response to a member's identified behavioral health service need is timely and based on clinical need, resulting in the best possible behavioral health outcomes for that member.

Response time is always determined by the acuity of a member's assessed behavioral health condition at the moment he/she is in contact with the provider. UAHP has organized responses into three categories: immediate, and routine responses.

Type of response by a behavioral health provider for non- hospitalized members

1) **Immediate Need Appointments**: within 24 hours of the referral or request. Services can be telephonic or face-to-face; the response may include any medically necessary covered behavioral health service.

2) **Routine Care Appointments:**
   - Initial assessment within 7 days of referral
   - The first behavioral health service following the initial assessment within the timeframe indicated by the behavioral health condition, but no later than 23 days after the initial assessment
   - All subsequent behavioral health services within the timeframe indicated by the behavioral health condition, but no later than 45 days from identification of need

3) **Appointments/ Referrals for psychotropic medications**
   GMH/SA Dual members will access their medication benefit through their Medicare benefit. Although Medicaid/AHCCCS is not paying or authorizing psychotropic medications for the GMH/SA Dual member, it is required that the member's need for medication be assessed immediately and, if clinically indicated, that the member be scheduled for an appointment within a timeframe that ensures:

   - The member does not run out of any needed psychotropic medications; or
   - The member is evaluated for the need to start medications to ensure that the member does not experience a decline in his/her behavioral health condition but no later than 30 days from the identification of the need.

Referrals for hospitalized members
Providers contracted to conduct discharge planning must quickly respond to referrals pertaining to eligible members who have not been receiving services prior to being hospitalized for psychiatric reasons. Upon receipt of such a referral, the provider must conduct an initial face to face contact, an assessment and disposition must occur within 24 hours of the referral/request for services.

Wait Times
UAHP has established standards so that members presenting for scheduled appointments do not have to wait unreasonable amounts of time. Unless a provider is unavailable due to an emergency, a member appearing for an established appointment must not wait for more than 45 minutes.

Providers arranging for, or providing non-emergency transportation services for members must adhere to the following standards:

- A member must not arrive sooner than one hour before his/her scheduled appointment; and
- A member must not have to wait for more than one hour after the conclusion of his/her appointment for transportation home or to another pre-arranged destination.

Other Requirements
All referrals from a member's primary care provider (PCP) requesting a psychiatric evaluation and/or psychotropic medications must be accepted and acted upon in a timely manner according to the needs of the member, and the response time must help ensure that the member does not experience a lapse in necessary psychotropic medications.

GMH/SA Dual members must never be placed on a "wait list" for any Medicaid covered behavioral health service. If the UAHP network is unable to provide medically necessary covered services for GMH/SA Dual members, UAHP will ensure timely and adequate coverage of needed services through an alternative provider until a network provider is subcontracted. In this circumstance, UAHP will ensure coordination with respect to authorization and payment issues. In the event that a covered behavioral health service is temporarily unavailable to a GMH/SA Dual member, the behavioral health provider must adhere to the following procedure.

UAHP requires that the provider:

1. Maintain the current level of services being provided to the member;
2. Identify and provide any supportive services needed by the member while securing the needed service;
3. Ensure the creation of a service plan and a crisis plan for the GMH/SA Dual member and

ensure that the member understands how to access crisis services during this time; and

4. Contact UAHP's Behavioral Health Case Management Department at **UAHPCaseManagementBHMailbox@bannerhealth.com** to coordinate and track care while securing the service, and to discuss needs for any non-contracted services, including for members who are in an inpatient or residential facility and are awaiting a referral for outpatient services.

3.2 Referral and Intake Process

The referral process serves as the principal pathway by which members are able to gain prompt access to publicly supported services. The intake process serves to collect basic demographic information from members and determine the need for any copayments. It is critical that both the referral process and intake process are culturally sensitive, efficient, engaging and welcoming to the member and/or family member seeking services, and leads to the provision of timely and appropriate services based on the urgency of the situation.

If the UAHP network is unable to provide medically necessary services to Medicaid and Medicare eligible GMH/SA members, UAHP will ensure timely and adequate coverage of needed services through an out-of-network provider until a network provider is subcontracted.

A referral is any oral, written, faxed or electronic request for behavioral health services made by a member, or member's legal guardian, a family member, primary care provider, hospital, jail, court, probation and parole officer, tribal government, Indian Health Services, school or other governmental or community agency.

To facilitate a member's access to services in a timely manner, UAHP subcontracted providers will maintain an effective process for the referral and intake for services which includes:

- Engaging with the member and/or member's legal guardian/family member.
- Communicating to potential referral sources the process for making referrals (e.g., centralized intake, identification of providers accepting referrals);
- After obtaining appropriate consents, informing the referral source as appropriate about the final disposition of the referral.
- Collecting enough basic information about the member to determine the urgency of the situation and subsequently scheduling the initial assessment within the required timeframes (See Section 3.1 Appointment Standards in this manual) and with an appropriate provider;
- Adopting a welcoming and engaging manner with the member and/or member's legal guardian/family member;
- Ensuring that intake interviews are culturally appropriate and delivered by providers that are respectful and responsive to the member's cultural needs
- Conducting intakes that ensure the accurate collection of all the required information and ensure that members who have difficulty communicating because of a disability or who require language services are afforded appropriate accommodations to assist them in fully expressing their needs.
- Conducting intake interviews that ensure the accurate collection of all the required information necessary for the receipt of services.

Where to send referrals

UAHP will accept referrals in written format or provided orally. All referrals are documented. UAHP maintains provider directories which can be accessed at http://uahealthplans.com. These directories indicate which providers are accepting referrals. Providers are required to promptly notify **UAHP's Network Provider Department**, at **UAHPProviderNotifications@bannerhealth.com**, of any changes that would impact the accuracy of the provider directory (e.g., change in telephone or fax number, no longer accepting referrals). Providers are required to notify UAHP of any changes that would alter or change information provided through the directory. Notice is required for changes in telephone number, fax number, email address, service changes, staff changes, service capacity changes or ability to accept new referrals. Changes in telephone number, email address, fax number or ability to accept new referrals are required to be submitted three working days prior to the change.

Members may access services by directly contacting a UAHP contracted behavioral health provider. UAHP contracted behavioral health providers are identified on the UAHP website at http://uahealthplans.com. Members may also call **UAHP Customer Care department** at **1-800-582-8686,** 24 hours a day/7 days a week, and receive a referral to a contracted behavioral health provider.

Choice of Providers
UAHP offers members a choice in selecting providers, and providers are required to provide each member a choice in selecting a provider of services, provider agency, and direct care staff. Providers are required to allow members to exercise their right to services from an alternative In-Network provider, and offer each member access to the most convenient In Network service location for the service requested by the member

Referral to a provider for a second opinion
GMH/SA Dual members are entitled to a second opinion and providers are required to provide proof that each member is informed of the right to a second opinion. Upon a GMH/SA dual member's request or at the request of the provider's treating physician, the provider must make available a second opinion from a health care professional within the network, or arrange for the member to obtain one outside the network, at no cost to the member. Out-of-Network providers must have an active AHCCCS Provider Registration number to be approved.

Submit requests for out-of-network services via fax to **UAHP Prior Authorization** department at **520-694-0599** for review and processing, or the behavioral health provider can arrange for a second opinion in-network or can contact **UAHP Customer Care** at **1-800-582-8686** 8:00 a.m. – 5:00 p.m. Monday – Friday, for assistance.

Accepting referrals
UAHP subcontracted providers are required to accept referrals for services 24 hours a day, seven days a week. The following information shall be collected from referral sources:

- Date and time of referral;
- Information about the referral source including name, telephone number, fax number, affiliated agency, and relationship to the member being referred;
- Name of member being referred, address, telephone number, gender, age, date of birth and, when applicable, name and telephone number of parent or legal guardian;
- Whether or not the member, parent or legal guardian is aware of the referral;
- Special needs for assistance due to impaired mobility, visual/hearing impairments or developmental or cognitive impairment;
- Accommodations due to cultural uniqueness and/or the need for interpreter services;
- Information regarding payment source i.e., University Family Care, University Care Advantage, other Medicare Advantage Plan, private insurance, or self-pay.
- Name, telephone number and fax number of primary care provider (PCP) ;
- Reason for referral including identification of any potential risk factors such as recent hospitalization, evidence of suicidal or homicidal thoughts, pregnancy, and current supply of prescribed psychotropic medications; and
- The names and telephone numbers of individuals the member, parent or guardian may wish to invite to the initial appointment with the referred member.

Providers should act on a referral regardless of how much information you have. While the information listed above will facilitate evaluating the urgency and type of practitioner the member may need to see, timely triage and processing of referrals must not be delayed because of missing or incomplete information.

When psychotropic medications are a part of an enrolled member's treatment or have been identified as a need by the referral source, providers must respond as outlined in the Appointment Standards and Timeliness of Service section of this manual.

In situations in which the member seeking services or his/her family member, legal guardian or significant other contacts a provider directly about accessing services, UAHP subcontracted provider shall ensure that the protocol used to obtain the necessary information about the member seeking services is engaging and welcoming.

When a SMI eligibility determination is being requested as part of the referral or by the member directly, UAHP subcontracted providers must conduct an eligibility evaluation for SMI and submit the evaluation to the Crisis Response Network (See Section 3.5 Determining Serious Mental Illness).

Responding to referrals

Follow-Up

When a request for services is initiated but the member does not appear for the initial appointment, the UAHP subcontracted provider must attempt to contact the member and

implement engagement activities consistent with **Section 3.3 Outreach, Engagement, Re-engagement and Closure** of this manual**.**

Documenting and tracking referrals

Providers must ensure referrals for behavioral health services tracking and include at a minimum the following information:

- Member's name and, if available, AHCCCS identification number;
- Name and affiliation of referral source;
- Date of birth;
- Type of referral (immediate, urgent, routine) as defined in Appointment Standards and Timeliness of Service;
- Date and time the referral was received;
- If applicable, date and location of first available appointment and, if different, date and location of actual scheduled appointment; and
- Final disposition of the referral

Within 30 days of receiving the referrals and/or the intake evaluation, or if the member declines behavioral health services, the UAHP subcontracted provider shall document and ensure notification regarding the final disposition to the referring entity or individual, with appropriate release of information signed by the member , as applicable including but not limited to ,

a. UAHP Behavioral Health Case Management Department
b. Primary Care Provider
c. Arizona Department of Economic Security/ Division of Developmental Disabilities
d. Arizona Department of Corrections
e. Administrative Offices of the Court
f. Arizona Department of Economic Security/Rehabilitation Services
g. Arizona Department of Education and affiliated school, college or university entities.

The final disposition must include:

a. The date the member was seen for the intake evaluation and the name and contact information of the provider who will assume primary responsibility for the member's behavioral health care, or
b. If no services will be provided, the reason why. Authorization to release the information will be obtained prior to communicating the final disposition to the referral sources referenced above.

Intake
An intake is the collection by appropriately trained staff of basic demographic information and preliminary determination of the member's needs. Providers must conduct intake interviews in an efficient and effective manner that is both "member friendly" and ensures the accurate collection of all the required information necessary for enrollment into services.

Providers are required to respond to referrals regarding members admitted to a hospital for psychiatric reasons or when requested by UAHP staff. Providers must attempt to conduct a face to face intake evaluation with the member prior to discharge from the hospital.

The intake process must:

- Be flexible in terms of when and how the intake occurs. For example, in order to best meet the needs of the member seeking services, the intake might be conducted over the telephone prior to the visit, at the initial appointment prior to the assessment and/or as part of the assessment; and
- Make use of readily available information (e.g., referral form, AHCCCS eligibility screens) in order to minimize any duplication in the information solicited from the member and his/her family.

During the intake, the provider will collect, review and disseminate certain information to members seeking services. Examples can include:

- The collection of contact information, insurance information,
- The reason why the member is seeking services and information on any accommodations the member may require to effectively participate in treatment services (i.e., need for oral interpretation or sign language services, consent forms in large font, etc.);
- The collection of required demographic information and completion of client demographic information sheet, including the member's primary/preferred language.
- The completion of any applicable authorizations for the release of information to other parties
- The review and completion of a general consent to treatment
- The collection of financial information, including the identification of third party payers
- The review and dissemination of UAHP Notice of Privacy Practices (NPP) and the AHCCCS HIPAA Notice of Privacy Practices (NPP) located at https://www.azahcccs.gov/Members/Downloads/privacy/PrivacyLetter-Eng.pdfin compliance with 45 CFR 164.520 (c)(1)(B); and
- The review of the member's rights and responsibilities, including an explanation of the TXIX/TXXI member grievance and appeal process, if applicable.
- The review of services, including an explanation of the appeal process.

The member, member's legal guardian, advocate and/or family members may complete some of the paperwork associated with the intake, if acceptable to the member and/or family members.

Coordination of care with Medicare providers

Medicare Advantage plans

Medicare health plans, also known as Medicare Advantage (MA) plans, are managed care entities that have a Medicare contract with the Centers for Medicare and Medicaid Services (CMS) to provide services to Medicare beneficiaries. MA plans provide the full array of Medicare benefits, including Medicare Part A, hospital insurance, and Medicare Part B, medical insurance. As of January 1, 2006, MA plans also included Medicare Part D, prescription drug coverage.

AHCCCS Contracted Health Plans are MA plans. These plans provide Medicare Part A, Part B and Part D benefits in addition to Medicaid services for dual eligible members and are referred to as MA-PD SNPs (Medicare Advantage- Prescription Drug/Special Needs Plans).

Coordination with MA plans **must** be attempted by when the Medicare services are provided by the MA plan.

Medicare Fee-for-Service Program

Instead of enrolling in a Medicare Advantage plan, Medicare eligible members may elect to receive all Medicare services (Parts A, B and/or D) through any provider authorized to deliver Medicare services.

Inpatient Psychiatric Services

Medicare has a lifetime benefit maximum of 190 days for inpatient psychiatric services. For GMH/SA dual members, once the maximum Medicare benefit has been met, Medicaid may become the payer.

Outpatient Behavioral Health Services

Medicare provides some outpatient services that are also UAHP covered services. Please refer to the UAHP Behavioral Health Covered Services Guide on our website at www.UAHealth.com.

UAHP **requires** all contracted providers to bill all Third Parties , including Medicare, Veteran's Association, private insurance, worker's compensation, etc. prior to billing UAHP for Medicaid covered services. UAHP Medicaid covered services is payer of last resort.

Prescription Medication Services
Medicare eligible members must enroll in a Medicare Part D Prescription Drug Plan (PDP) or a Medicare Advantage Prescription Drug Plan (MA-PD) to receive the Part D benefit. PDPs only provide the Part D benefit and any Medicare registered provider may prescribe medications to members enrolled in PDPs.

While PDPs and MA-PDs are responsible for ensuring prescription drug coverage to members enrolled in their plans, there are some prescription medications that are not included on plan formularies (non-covered) or are excluded Part D drugs.

3.3 Outreach, Engagement, Re-Engagement, and Closure

The activities described within this section are an essential element of clinical practice. Outreach to vulnerable populations, establishing an inviting and non-threatening clinical environment, and re-establishing contact with members who have become temporarily disconnected from services are critical to the success of any therapeutic relationship.

This section addresses critical activities that providers must incorporate when delivering services:

1. Expectations for the engagement of members seeking or receiving services;
2. Procedures to re-engage members in care who have withdrawn from participation in the treatment process;
3. Conditions necessary to end care for a member receiving behavioral health services and
4. Expectations for serving members who are attempting to re-engage with behavioral health services.

<u>Overview of Outreach Activities</u>
Outreach activities conducted by UAHP and UAHP subcontracted providers may include, but are not limited to:

- Participation in community events, local health fairs or health promotion activities;
- Involvement with local schools;
- Involvement with outreach activities for military veterans, such as Arizona Veterans Stand Down Coalition Events,
- Outreach programs and activities for first responders (i.e. police, fire, EMT)
- Routine contact with UAHP's behavioral health case management and/or primary care providers;
- Development of homeless outreach programs;
- Development of outreach programs to members who are at risk, are identified as a group with high incidence or prevalence of behavioral health issues or are underserved;
- Publication and distribution of informational materials;
- Liaison activities with local, county and tribal jails, county detention facilities, and local and county Department of Child Safety Offices and programs, including participating in effective release planning;
- Routine interaction with agencies that have contact with substance abusing pregnant women/teenagers;
- Conduct home visits;
- Development and implementation of outreach programs that identify members with co-morbid medical and behavioral health disorders, including those who could be determined or have been determined to have a Serious Mental Illness within UAHP's geographic service area, including members who reside in jails, homeless shelters,

county detention facilities or other settings;
- Provision of information to mental health advocacy organizations; and
- Development of information of outreach programs to American Indian tribes in Arizona to provide services for tribal members.

Engagement
UAHP providers are required to actively engage the following in the treatment planning process:

- The member and/or member's legal guardian;
- For any GMH/SA Dual that is determined SMI but has not yet been transitioned to the Integrated RBHA, and is receiving Special Assistance, the person (guardian, family member, advocate or other) designated to provide Special Assistance.
- The member's family/significant others, if applicable and amenable to the member;
- Other agencies/providers as applicable; and
- Providers are required to provide services in a culturally competent manner.

Behavioral health providers are required to:
- Provide a courteous, welcoming environment that provides members with the opportunity to explore, identify and achieve their personal goals;
- Engage members in an empathic, hopeful and welcoming manner during all contacts;
- Provide culturally relevant care that addresses and respects language, customs, and values and is responsive to the member's unique family, culture, traditions, strengths, age and gender;
- Provide an environment that in which members from diverse cultural backgrounds feel comfortable discussing their cultural health beliefs and practices in the context of negotiating treatment options;
- Provide care by communicating to members in their preferred language and ensuring that they understand all clinical and administrative information
- Be aware of and seek to gain an understanding of members with varying disabilities and characteristics;
- Display sensitivity to, and respect for, various cultural influences and backgrounds (e.g. ethnic, racial, gender, sexual orientation and socio-economic class);
- Establish an empathic service relationship in which the member experiences the hope of recovery and is considered to have the potential to achieve recovery while developing hopeful and realistic expectations;
- Demonstrate the ability to welcome the member, and/or the member's legal guardian, the member's family members, others involved in the member's treatment and other service providers as collaborators in the treatment planning and implementation process;
- Demonstrate the desire and ability to include the member's and/or legal guardian's viewpoint and to regularly validate the daily courage needed to recover from persistent

and relapsing disorders;
- Assist in establishing and maintaining the member's motivation for recovery; and
- Provide information on available services and assist the member and/or the member's legal guardian, the member's family, and the entire Adult Recovery Team in identifying services that help meet the member's goals.

Re-engagement
UAHP providers are required to attempt to re-engage members in care who have withdrawn from participation in the treatment process prior to the successful completion of treatment, refused services or failed to appear for a scheduled service. All attempts to re-engage members who have withdrawn from treatment, refused services or failed to appear for a scheduled service must be documented in the medical record. The provider must attempt to re-engage the member by:

- Communicating in the member's preferred language;
- Contacting the member or the member's legal guardian by telephone, at times when the member may reasonably be expected to be available (e.g., after work or school);
- Whenever possible, contacting the member or the member's legal guardian face-to-face, if telephone contact is insufficient to locate the member or determine acuity and risk;
- Sending a letter to the current or most recent address requesting contact, if all attempts at member contact are unsuccessful, except when a letter is contraindicated due to safety concerns (e.g., domestic violence) or confidentiality issues. The provider is expected to note safety or confidentiality concerns in the progress notes section of the medical record and include a copy of the letter sent in the medical record.

If the above activities are unsuccessful, the provider must make further attempts to re-engage members under court ordered treatment, pregnant substance abusing women, or any member determined to be at risk of relapse, deterioration or a potential harm to self or others, and members that have been identified by UAHP as needing re-engagement. Further attempts shall include contacting the member or member's legal guardian, face to face visits, or contacting natural supports who the member has given permission to the provider to contact. If the member appears to meet clinical standards as a danger to self, danger to others, persistently and acutely disabled or gravely disabled, the provider must make attempts as appropriate to engage the member to voluntarily seek inpatient care. If this is not a viable option for the member and the clinical standard is met, the provider must initiate the pre-petition screening or petition for treatment process described in **Section 3.8 Pre-Petition Screening, Court Ordered Evaluation and Court Ordered Treatment** of this manual.

All attempts to re-engage pregnant substance abusing women/teenagers, or any member determined to be at risk of relapse, deterioration or a potential harm to self or others must be clearly documented in the medical record.

Re-Engagement for Members on Court Ordered Treatment
For members who are on Court Ordered Treatment, it is the expectation that providers will re-engage the member within 24 hours of a missed appointment and continue frequent re-engagement efforts until such a time as the member is re-engaged and adherent with treatment, the court order is amended/suspended with the member placed in a psychiatric facility, or it has been confirmed that the member is now living in a different geographical area and is re-assigned to another health plan, or that the member has permanently moved out of state.

If a member misses a Behavioral Health Medical Prescriber (BHMP) appointment, whether it is because the member canceled, no-showed, or the provider canceled the appointment, the provider should reschedule the member to see the BHMP within two business days. BHMP emergency appointment slots should be utilized to accommodate this appointment. Missed appointments and non-adherence to the treatment plan should prompt the treatment team to re-evaluate the treatment plan to ensure that it is meeting the member's needs and goals. A member's input into the plan, with attention to achieving *their* goals as much as possible, will help with engagement. Any barriers to attending appointments should be assertively and creatively addressed, for example a member's difficulty with communication, transportation, competing commitments, childcare, managing schedules, etc. The treatment plan should be as flexible and member centric as possible to facilitate each member's adherence.

If maximal effort to re-engage a member into outpatient treatment fails, the treatment team should file a suspension so that the member may be assessed in a crisis setting. This is especially important if the member has missed a medication injection as a result of missing their outpatient appointment. Whether or not the member is hospitalized as a result of the suspension, suspensions are another opportunity to re-engage the member and amend the treatment plan with the member's input.

If a provider does not reschedule the missed appointment within two business days, the provider should **not** suspend the member for this reason alone. Instead, the provider must make arrangements to reschedule the member as soon as possible. **Providers should not suspend a member due to a provider administrative or coordination issue.**

Follow-Up After Missed Appointments
Providers are required to contact all members who miss scheduled appointments without rescheduling. Providers must contact the member following a missed appointment or as soon as possible but no later than two work days after the missed appointment. Documentation of all attempts to reach the member shall be documented in the member's medical record. At least three attempts shall be made to reschedule a missed appointment and shall include contacts made by certified mail and telephone. Face-to-face outreach shall be required for all members receiving medication services, all individuals identified to be at risk, or members who have

reported danger to self/danger to others in the last year. All outreach attempts shall be completed within thirty days of a missed appointment.

Follow-up after significant and/or critical events
Providers must document engagement activities in the medical record and conduct follow-up activities to maintain engagement within the following timeframes:

- Discharged from inpatient services in accordance with the discharge plan and within 7 days of the person's discharge to ensure stabilization , medication adherence, and to avoid re-hospitalization
- Involved in a behavioral health crisis within timeframes based upon the member's clinical needs, but no later than 7 days;
- Refusing prescribed psychotropic medications within timeframes based upon the member's clinical needs and individual history; and
- Released from local and county jails and detention facilities within 72 hours.

Additionally, for members to be released from jail or hospital settings, providers must help establish priority prescribing clinician appointments within 3 days of the member's release to ensure client stabilization, medication adherence, and to avoid re-hospitalization.

Notification of the Crisis Call Center for At-Risk Situations
Providers are required to notify the Crisis Call Center by telephone call within 2 hours of any member determined to be a danger to self or others and supply an updated crisis plan. Providers are also required to notify the Crisis Call Center by telephone call and report a member who has withdrawn from treatment and presents a potential risk to self, others, or the community; including, all pregnant substance abusing women and any member determined to be at risk of relapse. The Crisis Call Center will assist with telephonic engagement activities, assist providers in developing appropriate intervention strategies, and coordinate with the provider to bring additional resources to assist effective engagement in treatment. See **Section 2.2 Crisis Intervention Services** for specific Crisis Call Center contact information.

Clinical Factors: Treatment Completed
Prior to terminating the behavioral health services for a member or dis-enrolling a member following the completion of treatment, the provider and the member or the member's legal guardian must mutually agree that services are no longer needed.

Clinical Factors: Further Treatment Declined
A member's care must be terminated if the member or the member's legal guardian decides to refuse ongoing services. Prior to ending the services or dis-enrolling a member for declining further treatment, the provider must ensure the following:

- All applicable and required re-engagement activities have taken place. Re-engagement

have been conducted and clearly documented in the member's medical record; and
- The member does not meet clinical standards for initiating the pre-petition screening or petition for treatment process.

Clinical Factors: Lack of Contact

A member's care may be ended if the provider is unable to locate or make contact with the member after ensuring that all applicable and required re- engagement activities described in re-engagement have been conducted.

Administrative Factors

A member's behavioral health services may be ended based on eligibility/entitlement information changes including:

- Loss of Title XIX/XXI eligibility, if other funding is not available to continue services; and
- Members who become or are enrolled as elderly or physically disabled (EPD) under the Arizona Long Term Care System (ALTCS) must be disenrolled from UAHP after ensuring appropriate coordination and continuity of care with the ALTCS program contractor.

Out-of-State Relocations

A member's behavioral health services must be terminated for a member who relocates out-of-state after appropriate transition of care. This does not apply to members placed out-of-state for purposes of providing behavioral health treatment.

Arizona Department of Corrections Confinements

A member must be disenrolled upon acknowledgement that the member has been placed in the long-term control and custody of a correctional facility.

Inmates of public institutions

AHCCCS has implemented an electronic inmate of public institution notification system developed by the AHCCCS Division of Member Services (DMS). If a member is eligible for AHCCCS covered services during the service delivery period, UAHP is obligated to cover the services regardless of the perception of the members' legal status.

Provider's Responsibility to Notify UAHP

In order for AHCCCS to monitor any change in a members' legal status, and to determine eligibility, providers are required to notify UAHP and AHCCCS via e-mail if they become aware that a GMH/SA Dual member is incarcerated in a county detention facility. Please note that providers do **not** need to report members incarcerated with the Arizona Department of Corrections.

Notification of incarceration is sent to UAHP at **UAHPCaseManagementBHMailbox@bannerhealth.com** and AHCCCS at **DMSADULTIncarceration@azahcccs.gov**. Notifications must include the following member information:

- AHCCCS ID;
- Name;
- Date of Birth;
- Incarceration date; and
- Name of public institution where incarcerated.

Deceased Members

A member's behavioral health services must be terminated following acknowledgement that the member is deceased, effective on the date of the death. Notify UAHP by contacting the UAHP Member Services at: **memberservicesinquir@bannerhealth.com**

Crisis Episodes

For members who are enrolled as a result of a crisis episode, the member's services would end if the following conditions have been met:

- The provider conducts all applicable and required re-engagement activities and such re-engagement attempts are unsuccessful; or
- The provider and the member or the member's legal guardian mutually agree that ongoing services are not needed.

One-Time Consultations

For members who receive a service for the purpose of a one-time consultation as described in Section 4.2 - Coordination of Care, Primary Care Providers and Medicare Providers of this manual, the member's services may be ended if the provider and the member or the member's legal guardian mutually agree that ongoing services are not needed.

Engagement and Re-engagement Activity Verification

Providers are required to complete the **Provider Manual Form 3.3.1** Engagement and Re-engagement Review upon completion of treatment for all members. The Adult Recovery Team is required to coordinate with the Clinical Director (or an independently licensed BHP designated by the Clinical Director) to determine if all attempts to engage/re-engage a member in services have been exhausted. If there is agreement that all attempts have been exhausted the provider must complete **Provider Manual Form 3.3.1** Engagement and Re-engagement Review. The Clinical Director or independently licensed BHP designee is required to verify by signature that all engagement and re-engagement activities have been exhausted. If a member has moved out of state, there must be documentation that the provider attempted to assist the member in obtaining services in their new state when possible (i.e. helped to schedule an intake with a

receiving provider; provided the member with a list of mental health resources in their new state); and ensured adequate supply of medications to allow time to complete the transition. A copy of the completed form, **Provider Manual Form 3.3.1** Engagement and Re-engagement Review is required to be entered into the member's electronic health record.

Serving a member previously enrolled in the behavioral health system
Some members who have terminated their care or were terminated may need to re-enter behavioral health services. The process used is based on the length of time that a member has been dis-engaged from behavioral health services.

For members not receiving services for less than six months	**For members not receiving services for six months or longer**
If the member has not received a behavioral health assessment in the past six months, conduct a new behavioral health assessment consistent with Assessment and Service Planning, and revise the member's service plan as needed. If the member has received a behavioral health assessment in the last six months and there has not been a significant change in the member's behavioral health condition, providers may utilize the most current assessment. Review the most recent service plan (developed within the last six months) with the member, and if needed, coordinate the development of a revised service plan with the member's ART (Section 3.4, Assessment and Service Planning).	Conduct a new intake, behavioral health assessment and service plan consistent with Section. 3.4 Assessment and Service Planning.
If the member presents at a different UAHP provider, obtain new general and informed consent to treatment.	Obtain new general and informed consent to treatment.
If the member presents at a different UAHP provider, obtain new authorizations to disclose confidential information	Obtain new authorizations to disclose confidential information

3.4 Assessment and Service Planning

UAHP supports a model for assessment, service planning, and service delivery that is strength-based, member-centered, family friendly, culturally and linguistically appropriate, and clinically sound and supervised. The model is based on four equally important components:

- Input from the member regarding his/her individual needs, strengths, and preferences;
- Input from other members involved in the member's care who have integral relationship with the member;
- Development of a therapeutic alliance between the member and provider that fosters an ongoing partnership built on mutual respect and equality; and
- Clinical expertise.

The model incorporates the concept of a "team", established for each member receiving services. For adults this team is the Adult Recovery Team (ART). At a minimum, the functions of the ART include:

- Ongoing engagement of the member, family and others who are significant in meeting the behavioral health needs of the member, including their active participation in the decision-making process and involvement in treatment;
- An assessment process is conducted to:
    - Elicit information on the strengths, needs and goals of the individual member and his/her family;
    - Identify the need for further or specialty evaluations; and
    - Support the development and updating of a service plan which effectively meets the member's/family's needs and results in improved health outcomes.
- Continuous evaluation of the effectiveness of treatment through the ART process, the ongoing assessment of the member, and input from the member and his/her team resulting in modification to the service plan, if necessary;
- Provision of all covered services as identified on the service plan, including assistance in accessing community resources which are provided consistent with the Arizona Adult Service System's Nine Guiding Principles.
- Ongoing collaboration, including the communication of appropriate clinical information, with other individuals and/or entities with whom delivery and

coordination of services is important to achieving positive outcomes (e.g., primary care providers, or adult probation, other involved service or other healthcare providers.);

- Oversight to ensure continuity of care by taking the necessary steps (e.g., clinical oversight, development of facility discharge plans, or after-care plans, transfer of relevant documents) to assist members who are transitioning to a different treatment program, (e.g., inpatient to outpatient setting), changing providers and/or: Transferring to another service delivery system (e.g., out-of-area, out-of-state or to an Arizona Long Term Care System (ALTCS) Contractor); and

- Development and implementation of transition plans prior to discontinuation or modification of services.

Assessments
All members being served in the public behavioral health system must have a behavioral health assessment upon an initial request for services. For members who continue to receive services, updates to the assessment must occur at least ***annually.***

Behavioral health assessments must be utilized to collect necessary information that will inform providers of how to plan for effective care and treatment of the individual.

UAHP does not mandate that a specific assessment tool or format be used but requires certain minimum elements.

The initial and annual assessment must be completed by a behavioral health professional (BHP) or behavioral health technician (BHT) under the clinical oversight of a BHP, who are trained on the minimum elements of a behavioral health assessment.

Minimum elements of the behavioral health assessment
AHCCCS has established the following minimum elements that must be included in a comprehensive behavioral health assessment and documented in the comprehensive medical record, in accordance with **Section 8.1 Behavioral Health Medical Record Standards** of this manual:

- Presenting issues/concerns; s (including trauma-related symptoms and behaviors);
- History of present illness, including review of major psychiatric symptoms (i.e., mood, depression, anxiety, psychosis, suicidal ideation, homicidal ideation, and other behavioral health symptoms) and frequency/duration of symptoms;
- Psychiatric history, including history of previous psychiatric hospitalization(s) and psychotropic medication trial(s);
- Medical history;

- Current medications, including over the counter (OTC) medications;
- Allergies and other adverse reactions;
- Developmental history if clinically relevant;
- Family history;
- Trauma history (i.e. cultural factors impacting experienced trauma, adverse childhood events, combat experiences, forms of violence, etc.)
- Educational history/status;
- Employment history/status;
- Housing status/living environment;
- Social history;
- Legal history, including custody/guardianship status, pending litigation, Court Ordered Evaluation/Court Ordered Treatment (COE/COT) history, criminal justice history, and any history of sex offender adjudication;
- Substance abuse history including type of substance, duration, frequency, route of administration, longest period of sobriety, and previous treatment history;
- Substance use screen using the American Society of Addiction Medicine (ASAM) Second Edition – Revised of Patient Placement Criteria (ASAM PPC-2R);
- Labs/diagnostics, if applicable;
- Mental status examination;
- Risk assessment: the potential risk of harm to self or others based on self-reports, clinical symptoms, personality factors, past history, substance abuse, criminogenic factors, etc.;
- Brief summary/Bio-psycho-social formulation;
- Axial diagnoses I-V; V (which considers presence of trauma-related symptoms and behaviors);
- Cultural needs (i.e. age, ethnicity, race, national origin, sex (gender), gender identity, sexual orientation, tribal affiliation, disability);
- Date, begin, and end time of the assessment and printed name, signature, and professional credential of the provider completing the behavioral health assessment. If a BHT completes the assessment, the assessment must also include a printed name,

signature, professional credential, date and time of the BHP who reviewed the assessment information;

- REQUIRED FOR ALL MEMBERS: Primary Care Provider (PCP) name and contact information;
- REQUIRED FOR ALL TITLE XIX/XXI MEMBERS: Involvement with other agencies [e.g.,), Probation, Adult Probation/ Parole;
- REQUIRED FOR LIMITED ENGLISH PROFICIENCY (LEP) MEMBERS: linguistic needs (i.e. primary language, preferred language, language spoken at home, alternative language);

For members referred for or identified as needing ongoing psychotropic medications for a behavioral health condition, the assessor must establish an appointment with a licensed medical practitioner with prescribing privileges, in accordance with **Section 3.1 Provider Standards and Responsibilities- Appointment Standards and Timeliness of Service** of this manual. If the assessor is unsure regarding a member's need for psychotropic medications, then the assessor must review the initial assessment and treatment recommendations with his/her clinical supervisor or a licensed medical practitioner with prescribing privileges.

Service Planning

All members being served in the public behavioral health system must have a written plan for services upon an initial request for services and periodic updates to the plan to meet the changing behavioral health needs for members who continue to receive services. Service plans must be utilized to document services and supports that will be provided to the individual, based on behavioral health service needs identified through the member's behavioral health assessment.

If a member is in immediate or urgent need of services an interim service plan may need to be developed to document services until a complete service plan is developed. A complete service plan, however, must be completed no later than 90 days after the initial appointment.

At a minimum, the member, his/her guardian (if applicable), advocates (if assigned), and a qualified behavioral health representative must be included in the development of the service plan. In addition, family members, designated representatives, agency representatives and other involved parties, as applicable, may be invited to participate in the development of the service plan. Providers **must** coordinate with UAHP PCP or others involved in the care or treatment of the individual, as applicable, regarding service planning. Service plans must be completed by BHPs and BHTs who are trained on the behavioral health service plans and meet requirements in **Section 10.1 Training Requirements**. In the event that a BHT completes the service plan, a BHP must review and sign the service plan. The service plan must be documented in the comprehensive medical record in accordance with **Section 8.1 Behavioral**

Health Medical Record Standards, be based on the current assessment, and contain the following elements:

- The member/family vision that reflects the needs and goals of the member/family;
- Identification of the member's/family's strengths;
- Measurable objectives and timeframes to address the identified needs of the member/family, including the date when the service plan will be reviewed;
- Identification of the specific services to be provided and the frequency with which the services will be provided;
- Include services that comprehensively address the triggers, behaviors and symptoms related to the member's trauma (if applicable);
- The signature of the member/guardian and the date it was signed;
- Documentation of whether or not the member/guardian is in agreement with the plan;
- The signature of an Adult Recovery Team member and the date it was signed;
- The Service Plan Rights Acknowledgement, dated and signed by the member or guardian, the member who filled out the service plan, a designated representative or advocate (if any), and a behavioral health professional if a behavioral health technician fills out the service plan.

The member must be provided with a copy of his/her plan.

These services should be incorporated into the peer-driven, self-developed proposed service plan as appropriate. It is recommended that a standardized process be used to develop peer-driven, self-developed proposed service plans.

Additionally, the peer-driven, self-developed proposed service plan must be reviewed with and approved by the behavioral health medical practitioner and maintained in the medical record. Progress and outcomes related to the approved peer-driven, self-developed service plan must be tracked and documented by the behavioral health medical practitioner.

Appeals or Service Plan Disagreements

Every effort should be taken to ensure that the service planning process is collaborative, solicits and considers input from each team member and results in consensus regarding the type, mix and intensity of services to be offered. In the event that a member and/or legal or designated representative disagree with any aspect of the service plan, including the inclusion or omission of services, the team should take reasonable attempts to resolve the differences and actively address the member's and/or legal or designated representative's concerns.

Updates to the Assessment and Service Plan

Providers must complete an annual assessment update with input from the member and family, if applicable, that records a historical description of the significant events in the member's life and how the member/family responded to the services/treatment provided during the past year. Following this updated assessment, the service plan should then be updated as necessary. While the assessment and service plan must be updated at least annually, the assessment and service plan may require more frequent updates to meet the needs and goals of the member and his/her family.

3.5 Determining Serious Mental Illness (SMI)

A critical component of the service delivery system is the effective and efficient identification of members who have special behavioral health needs due to the severity of their behavioral health disorder. One such group is members with Serious Mental Illness (SMI). Without receipt of the appropriate care, these members are at high risk for further deterioration of their physical and mental condition, increased hospitalizations, potential homelessness and incarceration.

In order to ensure that GMH/SA Dual members who are eligible for SMI services are promptly identified and enrolled for services, AHCCCS requires that all SMI determinations to be determined by a statewide contractor, referred to as the Determining Entity. The Determining Entity for the service areas covered by UAHP is Crisis Response Network (CRN). CRN has adopted the process that Regional Behavioral Health Authorities (RBHAs) use for referral, evaluation and determination for SMI eligibility.

UAHP Behavioral Health Contracted Provider Responsibilities
The process to determine a member to be eligible for SMI services starts with the member's behavioral health provider, or an assessment completed by a behavioral health provider (for example, if a member is hospitalized and is not engaged in outpatient services.)

All SMI evaluations must be completed by a qualified assessor. If the qualified assessor is a Behavioral Health Technician then the evaluation must be reviewed, approved, and signed by a Behavioral Health Professional.

All members must be evaluated for SMI eligibility by a qualified assessor, and have a SMI determination made by Crisis Response Network: if the member:

- Requests a SMI determination; or
- Has a score of 50 or lower on the Global Assessment of Functioning Scale (GAF) and has a qualifying SMI diagnosis as indicated by the following (Also see AMPM Exhibit 320-P-4):

Anxiety Disorders: (300.00, 300.01, 300.02, 300.14, 300.21, 300.22, 309.81)
Bipolar Disorders: (296.00, 296.01, 296.02, 296.03, 296.04, 296.05, 296.06, 296.40, 296.41, 296.42, 296.43, 296.44, 296.45, 296.46, 296.50, 296.51, 296.52, 296.53, 296.54, 296.55, 296.56, 296.60, 296.61, 296.62, 296.63, 296.64, 296.65, 296.66, 296.7, 296.80, 296.89)
Major Depression: (296.20, 296.21, 296.22, 296.23, 296.24, 296.25, 296.26, 296.30, 296.31, 296.32, 296.33, 296.34, 296.35, 296.36)
Obsessive-compulsive Disorder: (300.3)
Other Mood Disorders: (296.90, 301.13, 311, 300.4)
Personality Disorders: (301.0, 301.20, 301.22, 301.4, 301.50, 301.6, 301.81, 301.82, 301.83, 301.9)
Psychotic Disorders: (295.10, 295.20, 295.30, 295.60, 295.70, 297.1, 295.90, 298.9)

Behavioral health providers must use the GAF score as a screening mechanism for identifying members. The GAF score shall not be used as a criterion for determining or denying SMI eligibility. The GAF is completed as part of the assessment process.

Process for completion of the initial SMI evaluation

Upon receipt of a referral for, a request, or identification of the need for an SMI determination, a provider designee, or designated Department of Corrections (DOC) staff member will schedule an appointment for an initial meeting with the member and a qualified assessor. This shall occur no later than 7 days after receiving the request or referral. For referrals seeking an SMI eligibility determination for individuals admitted to a hospital for psychiatric reasons, the entity scheduling the evaluation shall ensure that documented efforts are made to schedule a face to face SMI assessment with the member while hospitalized.

During the initial meeting with the member by a qualified assessor, the assessor must:

- Make a clinical assessment whether the member is competent enough to participate in an assessment;
- Obtain general consent from the member or, if applicable, the member's guardian to conduct an assessment;
- Provide to the member and, if applicable, the member's guardian, the information required in R9-21-301(D)(2), a client rights brochure, and the appeal notice required by R9-21-401(B); and
- Obtain authorization for the release of information, if applicable, for any documentation that would assist in the determination of the person's eligibility for SMI services.
- Conduct an assessment if one has not been completed within the last six months
- Complete the SMI Determination form AMPM Exhibit 320-P-1
- Upon completion of the initial evaluation, submit all information to the Determining Entity within one business day.
- If, during the initial meeting with the member, the assessor is unable to obtain sufficient information to determine whether the applicant is SMI, the assessor must:
    - Request the additional information in order to make a determination of whether the member is SMI and obtain an authorization for the release of information.

Criteria for SMI eligibility

The final determination of SMI requires both a qualifying SMI diagnosis and functional impairment as a result of the qualifying diagnosis (see above for a list of qualifying diagnoses).

Functional Criteria for SMI eligibility

- To meet the functional criteria for SMI status, a member must have, as a result of a qualifying SMI diagnosis, dysfunction in at least one of the following four domains, as described below, for most of the past twelve (12) months or for

most of the past six(6) months with an expected continued duration of at least six (6) months:

- Inability to live in an independent or family setting without supervision – Neglect or disruption of ability to attend to basic needs. Needs assistance in caring for self. Unable to care for self in safe or sanitary manner. Housing, food and clothing must be provided or arranged for by others. Unable to attend to the majority of basic needs of hygiene, grooming, nutrition, medical and dental care. Unwilling to seek prenatal care or necessary medical/dental care for serious medical or dental conditions. Refuses treatment for life threatening illnesses because of behavioral health disorder.
- A risk of serious harm to self or others – Seriously disruptive to family and/or community. Pervasively or imminently dangerous to self or others' bodily safety. Regularly engages in assaultive behavior. Has been arrested, incarcerated, hospitalized or at risk of confinement because of dangerous behavior. Persistently neglectful or abusive towards others in the member's care. Severe disruption of daily life due to frequent thoughts of death, suicide, or self-harm, often with behavioral intent and/or plan. Affective disruption causes significant damage to the member's education, livelihood, career, or member relationships.
- Dysfunction in role performance – Frequently disruptive or in trouble at work or at school. Frequently terminated from work or suspended/expelled from school. Major disruption of role functioning. Requires structured or supervised work or school setting. Performance significantly below expectation for cognitive/ developmental level. Unable to work, attend school, or meet other developmentally appropriate responsibilities; or
- Risk of Deterioration – A qualifying diagnosis with probable chronic, relapsing and remitting course. Co-morbidities (like mental retardation, substance dependence, personality disorders, etc.). Persistent or chronic factors such as social isolation, poverty, extreme chronic stressors (life-threatening or debilitating medical illnesses, victimization, etc.). Other (past psychiatric history; gains in functioning have not solidified or are a result of current compliance only; court-committed; care is complicated and requires multiple providers; etc.).

The following reasons shall not be sufficient in and of themselves for denial of SMI eligibility:

- An inability to obtain existing records or information; or
- Lack of a face-to-face psychiatric or psychological evaluation.

For members who have a qualifying SMI diagnosis and co-occurring substance abuse, for

purposes of SMI determination, presumption of functional impairment is as follows:

For psychotic diagnoses (bipolar I disorder with psychotic features, delusional disorder, major depression, recurrent, severe, with psychotic features, schizophrenia, schizoaffective disorder and psychotic disorder NOS) functional impairment is presumed to be due to the qualifying psychiatric diagnosis;

For other major mental disorders (bipolar disorders, major depression and obsessive compulsive disorder), functional impairment is presumed to be due to the psychiatric diagnosis, unless:

- The severity, frequency, duration or characteristics of symptoms contributing to the functional impairment cannot be attributed to the qualifying mental health diagnosis; or
- The assessor can demonstrate, based on a historical or prospective period of treatment, that the functional impairment is present only when the member is abusing substances or experiencing symptoms of withdrawal from substances.

For all other mental disorders not covered above, functional impairment is presumed to be due to the co-occurring substance use unless*:*

- The symptoms contributing to the functional impairment cannot be attributed to the substance abuse disorder
- The functional impairment is present during a period of cessation of the co-occurring substance use of at least thirty (30) days; or
- The functional impairment is present during a period of at least ninety (90) days of reduced use and is unlikely to cause the symptoms or level of dysfunction.

Once the SMI Evaluation has been completed, the behavioral health provider must submit the SMI evaluation and accompanying documents to the Crisis Response Network via the Provider Submission Portal (PSP) located at http://www.crisisnetwork.org/smi/. **CRN can be contacted** at **1-800-631-1314 or (TTY) 1-800-327-9254**.

Crisis Response Network Responsibilities

The SMI eligibility determination record must include all of the documentation that was considered during the review including, but not limited to current and/or historical treatment records. The record may be maintained in either hardcopy or electronic format.

Computation of time is as follows:

- Evaluation date with a qualified clinician = day zero (0), regardless of time of the evaluation
- Determination due date = Three (3) business days from day zero (0), excluding weekends and holidays

- The final determination is required three (3) business days from day 0, not 3 business days from the date of submission to the Crisis Response Network (CRN).

Contractors with UAHP must submit the SMI evaluation to CRN as soon as practicable, but no later than 11:59 p.m. on the next business day following the evaluation. CRN will have at least two (2) business days to complete the SMI determination.

Process for completion of final SMI determination
A licensed psychiatrist, psychologist, or psychiatric nurse practitioner designated by the CRN must make a final determination as to whether the member meets the eligibility requirements for SMI status based on:

- A face-to-face assessment or reviewing a face-to-face assessment by a qualified assessor: and
- A review of current and historical information, if any, obtained orally or in writing by the assessor from collateral sources, and/or present or previous treating clinicians.

The following must occur if the designated reviewing psychiatrist, psychologist, or psychiatric nurse practitioner has not conducted a face-to-face assessment and has a disagreement with the qualified assessor and/or the treating Behavioral Health Professional that cannot be resolved by oral or written communication:

- Disagreement regarding diagnosis: Determination that the member does not meet eligibility requirements for SMI status must be based on a face to face diagnostic evaluation conducted by a designated psychiatrist, psychologist, or nurse practitioner. The resolution of (specific reasons for) the disagreement shall be documented in the member's comprehensive medical record.
- Disagreement regarding functional impairment: Determination that the member does not meet eligibility requirements must be based upon a face-to-face functional evaluation conducted by a designated psychiatrist, psychologist, or nurse practitioner. The psychiatrist, psychologist, or nurse practitioner shall document the specific reason(s) for the disagreement in the member's medical record.

If there is sufficient information to determine SMI eligibility, the member shall be mailed written notice of the SMI eligibility determination within three (3) business days of the initial meeting with the qualified assessor in accordance with the next section of this policy.

<u>Issues preventing timely completion of SMI eligibility determination</u>

The time to initiate or complete the SMI eligibility determination may be extended no more than 20 days if the member agrees to the extension and:

- There is substantial difficulty in scheduling a meeting at which all necessary participants can attend;
- The member fails to keep an appointment for assessment, evaluation or any

other necessary meeting
- The member is capable of, but temporarily refuses to cooperate in the preparation of the completion of an assessment or evaluation;
- The member or the member's guardian and/or designated representative requests an extension of time;
- Additional documentation has been requested, but has not yet been received; or
- There is insufficient functional or diagnostic information[1] to determine SMI eligibility within the required time periods.

The Crisis Response Network must:

- Document the reasons for the delay in the member's eligibility determination record when there is an administrative or other emergency that will delay the determination of SMI status; and
- Not use the delay as a waiting period before determining SMI status or as a reason for determining that the member does not meet the criteria for SMI eligibility (because the determination was not made within the time standards).

In situations in which the extension is due to insufficient information:

- CRN shall request and obtain the additional documentation needed (e.g., current and/or past medical records) and/or perform or obtain any necessary psychiatric or psychological evaluations;
- The designated reviewing psychiatrist, psychologist, or nurse practitioner for CRN must communicate with the member's current treating clinician, if any, prior to the determination of SMI, if there is insufficient information to determine the member's level of functioning; and
- SMI eligibility must be determined within three (3) days of obtaining sufficient information, but no later than the end date of the extension.

If the member refuses to grant an extension, SMI eligibility must be determined based on the available information. If SMI eligibility is denied, the member will be notified of his/her appeal rights and the option to reapply.

If the evaluation or information cannot be obtained within the required time period because of the need for a period of observation or abstinence from substance use in order to establish a qualifying mental health diagnosis, the member shall be notified that the determination may, with the agreement of the member, be extended for up to 90 (calendar) days.[2]

[1] Insufficient diagnostic information shall be understood to mean that the information available to the reviewer is suggestive of two or more equally likely working diagnoses, only one of which qualifies as SMI, and an additional piece of existing historical information or a face-to-face psychiatric evaluation is likely to support one diagnosis more than the other(s).

Notification of SMI eligibility determination
If the eligibility determination results in approval of SMI status, CRN must report to the member in writing, including notice of his/her right to appeal the decision.

If the eligibility determination results in a denial of SMI status, CRN shall include in the notice above:

- The reason for denial of SMI eligibility
- The right to appeal
- The statement that Title XIX/XXI eligible members will continue to receive needed Title XIX/XXI covered services.

Review of SMI Eligibility
Behavioral health providers may seek a review of a person's SMI eligibility from the Determining Entity:

- As part of an instituted, periodic review of all persons determined to have a SMI,
- When there has been a clinical assessment that supports that the person no longer meets the functional and/or diagnostic criteria, or
- As requested by a member who has been determined to meet SMI eligibility criteria, or their legally authorized representative.

SMI Decertification
There are two established methods for removing a SMI designation, one clinical and the other an administrative option, as follows:

- SMI Clinical Decertification: A member who has a SMI designation or an individual from the member's clinical team may request a SMI Clinical Decertification. A SMI Clinical Decertification is a determination that a member who has a SMI designation no longer meets SMI criteria. If, as a result of a review, the person is determined to no longer meet the diagnostic and/or functional requirements for SMI status:
    - The Determining Entity shall ensure that the written notice of determination and the right to appeal is provided to the affected person with an effective date of 30 days after the date the written notice is issued,
    - The provider must ensure that services are continued in the event an appeal is timely filed, and that services are appropriately transitioned as part of the discharge planning process.
- SMI Administrative Decertification: A member who has a SMI designation may request a SMI Administrative Decertification if the member has not received behavioral health services for a period of two or more years.
    - Upon receipt of a request for Administrative Decertification, the Contractor shall

[2] This extension may be considered a technical re-application to ensure compliance with the intent of Rule. However, the member does not need to actually reapply. Alternatively, the determination process may be suspended and a new application initiated upon receipt of necessary information. Just make sure when this is formatted, that this foot note is related to the SMI process in section 3.5.

direct the member to contact AHCCCS DHCM Customer Service,

- AHCCCS will evaluate the member's request and review the data sources to determine the last date the member received a behavioral health service. AHCCCS will inform the member of changes that may result with the removal of the member's SMI designation. Based upon review, the following will occur:
    - In the event the member has not received a behavioral health service within the previous two years, the member will be provided with the Administrative Serious Mental Illness Decertification Form AMPM 320-P-3. This form must be completed by the member and returned to AHCCCS.
    - In the event the review finds that the member has received behavioral health services within the prior two year period, the members will be notified that they may seek decertification of their SMI status through the Clinical Decertification process.

3.6 General and Informed Consent to Treatment

Each member has the right to participate in decisions regarding his or her behavioral health care, including the right to refuse treatment. It is important for members seeking services to agree to those services and be made aware of the service options and alternatives available to them as well as specific risks and benefits associated with these services.

General consent is a one-time agreement to receive services that is usually obtained from a member during the intake process at the initial appointment, and is always obtained prior to the provision of any services. General consent must be verified by a member's or legal guardian's signature.

Informed consent must be obtained before the provision of a specific treatment that has associated risks and benefits. Informed consent is required prior to the provision of the following services and procedures:

- Complementary and Alternative Medicine (CAM);
- Psychotropic medications;
- Electro-convulsive therapy (ECT);
- Use of telemedicine;
- Application for a voluntary evaluation;
- Research;
- Procedures or services with known substantial risks or side effects.

Prior to obtaining informed consent, an appropriate behavioral health representative, as identified in R9-21-206.01(c), must present the facts necessary for a member to make an informed decision regarding whether to agree to the specific treatment and/or procedures. Documentation that the required information was given and that the member agrees or does not agree to the specific treatment must be included in the medical record, as well as the member's/guardian's signature when required.

The intent of this section is to describe the requirements for reviewing and obtaining general and informed consent, for members receiving services within the public behavioral health system

General Requirements
Members must give voluntary general consent to treatment, demonstrated by the member's or legal guardian's signature on a general consent form, before receiving services.

The member or the member's legal guardian, after being fully informed of the consequences, benefits and risks of treatment, has the right not to consent to receive services.

The member or the member's legal guardian, or a lawfully authorized custodial agency has the right to refuse medications unless specifically required by a court order or in an emergency situation.

Providers treating members in an emergency situation are not required to obtain general consent prior to the provision of emergency services. Providers treating members pursuant to court order must obtain consent, as applicable, in accordance with A.R.S. Title 36, Chapter 5.

Prior to obtaining informed consent, an appropriate behavioral health professional as identified I R9-21-206.01 (c) , must present the facts necessary for a member to make an informed decision regarding whether to agree to the specific treatment and/or procedures.

Documentation that the required information was given and that the member agrees or does not agree to the specific treatment must be included in the comprehensive medical record, as well as the member's /guardian's signature.

General Consent
Administrative functions associated with a Member's enrollment do not require consent, but before any services are provided, general consent must be obtained. General consent is usually obtained during the intake process and represents a person's, or legal guardian or lawfully authorized custodial agency representative's, written agreement to participate in and to receive non-specified (general) services.

Informed Consent
In all cases where informed consent is required by this policy, informed consent must include at a minimum:

- Members right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions;
- Information about the member's diagnosis and the proposed treatment, including the intended outcome, nature and all available procedures involved in the proposed treatment;
- The risks, including any side effects, of the proposed treatment, as well as the risks of not proceeding;
- The alternatives to the proposed treatment, particularly alternatives offering less risk or other adverse effects;
- That any consent given may be withheld or withdrawn in writing or orally at any time.
- When this occurs the provider must document the member's choice in the medical record;
- The potential consequences of revoking the informed consent to treatment; and
- A description of any clinical indications that might require suspension or termination of the proposed treatment.

Documented Informed Consent

a. Members, or if applicable the member's guardian or representative shall give informed consent for treatment by signing and dating an acknowledgment that he or she has received the information and gives informed consent to the proposed treatment.

b. When informed consent is given by a third party, the identity of the third party and the legal capability to provide consent on behalf of the member, must be established. If the informed consent is for psychotropic medication or telemedicine and the member, or if applicable, the member's guardian refuses to sign an acknowledgment and gives verbal informed consent, the medical practitioner shall document in the member's record that the information was given, the client refused to sign an acknowledgment and that the client gives informed consent to use psychotropic medication or telemedicine.

c. When providing information that forms the basis of an informed consent decision for the circumstances identified above, the information must be:

- Presented in a manner that is understandable and culturally appropriate to the member, parent, legal guardian or an appropriate court; and
- Presented by a credentialed behavioral health medical practitioner or a registered nurse with at least one year of behavioral health experience. It is preferred that the prescribing clinician provide information forming the basis of an informed consent decision. In a specific situation in which that is not possible or practicable, information may be provided by another credentialed behavioral health medical practitioner or registered nurse with at least one year of behavioral health experience.

d. Psychotropic Medications, Complementary and Alternative Treatment and Telemedicine

- Unless treatments and procedures are court ordered, providers must obtain written informed consent, and if written consent is not obtainable, providers must obtain oral informed consent. If oral informed consent is obtained instead of written consent from the member, or legal guardian, it must be documented in written fashion. Informed consent is required in the following circumstances:

    - Prior to the initiation of any psychotropic medication or initiation of Complementary and Alternative Treatment
    - Prior to the delivery of services through telemedicine.

UAHP requires contracted providers to use the AHCCCS AMPM Policy 310- V, Exhibit 310-V-1 "Informed Consent/Assent for Psychotropic Medication Treatment".

e. Electro-Convulsive Therapy (ECT), research activities, voluntary evaluation and procedures or services with known substantial risks or side effects.

- Written informed consent must be obtained from the member, or legal guardian, unless treatments and procedures are under court order, in the following circumstances:

  Before the provision of (ECT);
  Prior to the involvement of the member in research activities;
  Prior to the provision of a voluntary evaluation for a member.
  Prior to the delivery of any other procedure or service with known substantial risks or side effects.

Additional Provisions
Written informed consent must be obtained from the member, legal guardian or an appropriate court prior to the member's admission to any medical detoxification, inpatient facility or residential program operated by a behavioral health provider.

Revocation of Informed Consent
If informed consent is revoked, treatment must be promptly discontinued, except in cases in which abrupt discontinuation of treatment may pose an imminent risk to the member. In such cases, treatment may be phased out to avoid any harmful effects.

Informed Consent for Telemedicine:

a. Before a health care provider delivers health care via telemedicine, verbal or written informed consent from the member or their health care decision maker must be obtained.
b. Informed consent may be provided by the behavioral health medical practitioner or registered nurse with at least one year of behavioral health experience. When providing informed consent it must be communicated in a manner that the member or legal guardian can understand and comprehend.
c. Exceptions to this consent requirement include:
    - If the telemedicine interaction does not take place in the physical presence of the member,
    - In an emergency situation in which the member or the member's health care decision maker is unable to give informed consent, or
    - To the transmission of diagnostic images to a health care provider serving as a consultant or the reporting of diagnostic test results by that consultant.

Informed Consent during Involuntary Treatment
At times, involuntary treatment can be necessary to protect safety and meet needs when a member, due to mental disorder, is unwilling or unable to consent to necessary treatment. In

this case, a court order may serve as the legal basis to proceed with treatment. However, capacity to give informed consent is situational, not global, a member may be willing and able to give informed consent for aspects of treatment even when not able to give general consent. Members should be assessed for capacity to give informed consent for specific treatment and such consent obtained if the individual is willing and able, even though the individual remains under court order.

3.7 Psychotropic Medication: Prescribing and Monitoring

Medications for the GMH/SA dual population are covered under Medicare Part D. Regulation does not allow AHCCCS/UAHP to cover a Medicare Part D eligible drug.

Psychotropic medication will be prescribed by a licensed psychiatrist, psychiatric nurse practitioner, physician assistant, or other physician trained or experienced in the use of psychotropic medication. The prescribing clinician must have seen the member and is familiar with the member's medical history or, in an emergency, the prescribing clinician is at least familiar with the member's medical history.

When a member on psychotropic medication receives a yearly physical examination, the results of the examination will be reviewed by the physician prescribing the medication. The physician will note any adverse effects of the continued use of the prescribed psychotropic medication in the member's record. Whenever a prescription for medication is written or changed, a notation of the medication, dosage, frequency or administration, and the reason why the medication was ordered or changed will be entered in the member's record.

3.8 Pre-Petition Screening, Court-Ordered Evaluation, and Court-Ordered Treatment

At times, it may be necessary to initiate civil commitment proceedings to ensure the safety of a member, or the safety of other members, due to a member's mental disorder when that member is unable or unwilling to participate in treatment. In Arizona, state law permits any responsible member to submit an application for pre-petition screening when another member may be, as a result of a mental disorder:

A danger to self (DTS);
A danger to others (DTO);
Persistently or acutely disabled (PAD); or
Gravely disabled (GD).

If the member who is the subject of a court ordered commitment proceeding is subject to the jurisdiction of an Indian tribe rather than the state, the laws of that tribe, rather than state law, will govern the commitment process.

Pre-petition screening includes an examination of the member's mental status and/or other relevant circumstances by a designated screening agency. Upon review of the application, examination of the member and review of other pertinent information, a licensed screening agency's medical director or designee will determine if the member meets criteria for DTS, DTO, PAD, or GD as a result of a mental disorder.

Providers who are licensed by the Arizona Department of Health Services/Division of Licensing Services as a court-ordered evaluation or court-ordered treatment agency must adhere to ADHS Licensing requirements.

If the pre-petition screening indicates that the member may be DTS, DTO, PAD, or GD, the screening agency will file an application for a court-ordered evaluation. Based on the immediate safety of the member or others, an emergency admission for evaluation may be necessary. Otherwise, an evaluation will be arranged for the member by a designated evaluation agency within timeframes specified by state law.

Based on the court-ordered evaluation, the evaluating agency may petition for court- ordered treatment on behalf of the member. A hearing, with the member and his/her legal representative and the physician(s) treating the member, will be conducted to determine whether the member will be released and/or whether the agency will petition the court for court-ordered treatment. For the court to order ongoing treatment, the member must be determined, as a result of the evaluation, to be DTS, DTO, PAD, or GD. Court-ordered treatment may include a combination of inpatient and outpatient treatment. Inpatient treatment days are limited contingent on the member's designation as DTS, DTO, PAD, or GD. Members identified as:

- DTS may be ordered up to 90 inpatient days per year;
- DTO and PAD may be ordered up to 180 inpatient days per year; and
- GD may be ordered up to 365 inpatient days per year.

If the court orders a combination of inpatient and outpatient treatment, a mental health agency may be identified by the court to supervise the member's outpatient treatment. In some cases, the mental health agency may be referred to as the health plan or UAHP; however, before the court can order a mental health agency to supervise the member's outpatient treatment, the agency medical director must agree and accept responsibility by submitting a written treatment plan to the court.

At every stage of the pre-petition screening, court-ordered evaluation, and court-ordered treatment process, a member will be provided an opportunity to change his/her status to voluntary. Under voluntary status, the member is no longer considered to be at risk for DTS/DTO and agrees in writing to receive a voluntary evaluation.

County agencies are responsible for pre-petition screening and court-ordered evaluations must use the following forms prescribed in 9 A.A.C. 21, Article 5 for members determined to have a Serious Mental Illness:

- AMPM Exhibit 320-U-1, Application for Involuntary Evaluation
- AMPM Exhibit 320-U-2, Application for Emergency Admission for Evaluation
- AMPM Exhibit 320-U-3, Petition for Court-Ordered Evaluation
- AMPM Exhibit 320-U-4, Petition for Court-Ordered Treatment Gravely Disabled Person
- AMPM Exhibit 320-U-5, Affidavit
- AMPM Exhibit 320-U-7, Application for Voluntary Evaluation.

Pre-Petition Screening
Arizona counties are responsible for managing, providing, and paying for pre-petition screening and court-ordered evaluations and are required to coordinate provision of services with UAHP. UAHP's Behavioral Health Department is available to answer any questions the caller may have about the process and direct to the appropriate county contracted pre-petition screening agency.

The pre-petition screening agency must follow these procedures:

- Provide pre-petition screening within forty-eight hours excluding weekends and holidays;
- Prepare a report of opinions and conclusions. If pre-petition screening was not possible, the screening agency must report reasons why the screening was not possible, including opinions and conclusions of staff members who attempted to conduct the pre-petition

screening;

- Have the Medical Director or designee review the report if it indicates that there is no reasonable cause to believe the allegations of the applicant for the court-ordered evaluation;
- Prepare a petition for court-ordered evaluation and file the petition if the Medical Director or designee determines that the member, due to a mental disorder, including a primary diagnosis of dementia and other cognitive disorders, is DTS, DTO, PAD, or GD. AMPM Exhibit 320-U-3, Petition for Court-Ordered Evaluation documents pertinent information for court-ordered evaluation;
- If the screening agency determines that there is reasonable cause to believe that the member, without immediate hospitalization, is likely to harm himself/herself or others, the screening agency must ensure completion of AMPM Exhibit 320-U-2, Application for Emergency Admission for Evaluation, and take all reasonable steps to procure hospitalization on an emergency basis;
- Contact the county attorney prior to filing a petition if it alleges that a member is DTO;

Emergency Admission for Evaluation

- An application for emergency admission may be made only when a member, as a result of a mental disorder, is determined to be DTS or DTO and there is imminent danger that precludes the use of the pre-petition screening process.
- Application must be completed by an individual with direct or first-hand knowledge of the facts requiring the emergency admission and must be made using AMPM Exhibit 320-U-2, Application for Emergency Admission for Evaluation. An application by a doctor or nurse does not require an original signature, may be a facsimile and does not have to be notarized.
- A telephonic application for emergency admission may be made in the presence of a peace officer or by a health care provider directly involved with the care of the member no more than 24 hours prior to a written application. Upon receipt of a telephonic application, the admitting officer of the evaluation agency may advise the peace officer to take the member into custody and transport him/her to the evaluation agency.
- The individual can be held in an inpatient setting up to 24 hours (excluding weekends and holidays) following a written application for emergency evaluation pending the filing of a petition for court ordered evaluation. If no petition for court ordered evaluation is filed within the 24 hours, the individual must be released. If a petition is submitted, the hospital may hold the patient for an additional seventy-two (72) hours to complete examinations by two (2) physicians.

Court-Ordered Evaluation

If the pre-petition screening indicates that the member may be DTS, DTO, PAD, or GD, the screening agency will file an application for a court-ordered evaluation. The procedures for

court-ordered evaluations are outlined below:

- If, upon review of a petition for court ordered evaluation, the court agrees that there is significant evidence to warrant an involuntary evaluation, it will issue an Order for Evaluation.
- Evaluations may be conducted inpatient or outpatient.
- *If outpatient, an evaluation must be completed by the fourth day following the first appointment.
- If a member is inpatient, the evaluation must be completed within seventy-two hours.
- At the conclusion of the 72 hour evaluation period, the inpatient team will determine whether the patient requires court ordered treatment for a mental disorder. If the medical director of the inpatient facility does not believe the patient requires court ordered treatment, the patient must be discharged from the hospital unless he/she completes an application for further care and treatment on a voluntary basis.
- If the medical director of the inpatient facility believes the patient requires court ordered treatment, a Petition for Court Ordered Treatment is signed and filed by the Evaluation Agency's medical director or physician designee and a hearing is scheduled. (see AMPM Exhibit 320-U-4, Petition for Court-ordered Treatment - Gravely Disabled Person);
- Any behavioral health provider filing a petition for court-ordered treatment must do so in consultation with the member's clinical outpatient team prior to filing the petition;
- The petition must be accompanied by the affidavits of the two physicians who conducted the examinations during the evaluation period and by the affidavit of the applicant for the evaluation (AMPM Exhibit 320-U-5, Affidavit, and attached addenda);
- A copy of the petition, in cases of grave disability, must be mailed to the public fiduciary in the county of the patient's residence, or in which the patient was found before evaluation, and to any individual nominated as guardian or conservator; and
- A copy of all petitions must be mailed to the superintendent of the Arizona State Hospital.
- During the evaluation process, a patient may not be treated psychiatrically unless he/she consents. However, seclusion and mechanical or pharmacological restraints may be employed when the member's safety or the safety of others may be jeopardized.
- UAHP is not responsible for the costs associated with court-ordered evaluation.

Voluntary Evaluation
Any UAHP subcontracted provider that receives an application for voluntary evaluation must immediately refer the member to the facility responsible for voluntary evaluations.

The UAHP subcontracted provider must follow these procedures:

- The evaluation agency must obtain the individual's informed consent prior to the evaluation (see AMPM Exhibit 320-U-7, Application for Voluntary Evaluation) and provide evaluation at a scheduled time and place within five days of the notice that the member will voluntarily receive an evaluation; and
- For inpatient evaluations, the evaluation agency must complete evaluations in less than seventy-two hours of receiving notice that the member will voluntarily receive an evaluation.

If a provider conducts a voluntary evaluation service as described in this section, the comprehensive clinical record must include:

- A copy of the application for voluntary evaluation, AMPM Exhibit 320-U-7, Application for Voluntary Evaluation;
- A completed informed consent form and;

A written statement of the member's present medical condition.

Background
Per Arizona Revised Statutes 36-545.06-County Services: "Each County shall provide directly, or by contract the services of a screening Provider and an evaluation Provider."
Each County must have a process in place for:

- Involuntary mental health treatment requests and evaluations
- Court proceedings to satisfy the statutory requirements under Title 36 for individuals under court-ordered evaluation and court-ordered treatment

Every County in Arizona manages this responsibility differently based on their interpretation of the state statutes and the resources in that County. The outpatient behavioral health agency COT/COE Coordinator is required to work with the County Attorney's Office to ensure proper execution of its procedures.

In serving as regional authority, UAHP is responsible for treatment of an eligible member* once placed under a Title36 civil commitment or court-ordered treatment (COT). Per Arizona Administrative Code (R9-21-504) the regional authority "shall perform, either directly or by contract all treatment required by A.R.S. Title 36, Chapter 5, Article 5."

Responsibilities
Each behavioral health agency per UAHP contract scope of service is required to designate a staff member to serve as Title 36 Liaison for Court-Ordered services.

A contracted provider coordinates the provision of clinically appropriate covered services to members requiring court-ordered treatment and serves as the Supervising Agency for court-ordered outpatient treatment plans of UAHP enrolled members.

In all cases, the contracted provider's Medical Director or his/her physician designee has primary responsibility for oversight of a member's court-ordered treatment and is responsible for reviewing and signing all documents filed with the court

** *Per ARS 36-501 (24) Definitions - Medical Director of a mental health treatment Provider" means a psychiatrist, or other licensed physician experienced in psychiatric matters, who is designated in writing by the governing body of the Provider as the member in charge of the medical services of the Provider for the purposes of this chapter and includes the chief medical officer of the state hospital."*

Individuals on COT must be seen every 30 days by the Medical Director or designee (must be a Prescriber). In conducting the review, the medical director shall consider all reports and information received and may require the patient to report for further evaluation. If a COT member misses an appointment, the agency must demonstrate attempts to see the Member within two (2) business days. UAHP requires providers to consistently track all members on court-ordered treatment to facilitate continued adherence to the court order.

- Outreach and engagement with these individuals should be assertive and follow the reengagement processes within the UAHP Provider Manual. The goal is to avoid re-hospitalization and improve the quality of life for the individual.
- A solid crisis plan must be developed that includes what works and does not work for this individual, supports that can help, and types of outreach that should be attempted if the individual has an increase in symptoms or disengages from treatment.
- Providers must closely monitor COT expiration dates. Pursuant to A.R.S 36-540 (D), a court order cannot exceed 365 days, but some counties may order fewer days. Providers must ensure they understand the County's interpretation of the COT Expiration date. Providers must monitor expiration dates to schedule annual reviews to determine if the individual's COT should continue for another year. Additionally, it gives Providers enough time to file a Petition for Continued Treatment with Court for individuals who were found Persistently or Acutely Disable or Gravely Disabled.
- UAHP will monitor and audit COT requirements and will issue Corrective Action Letters and/or Sanctions for failure to follow the requirements.

Requirements

Title 36 Liaisons
UAHP contracted providers that serve as Supervising Agencies for court orders will appoint a Title 36 Liaison to serve as a central point of contact for all County Mental Health Defenders Office, assigned County Attorney/Office Attorney General, local hospitals and UAHP. The contracted provider Title 36 Liaison is also responsible for developing and implementing a process for ensuring that contracted provider clinical staff is aware of expectations and changes in procedures as communicated by UAHP.
Contracted Provider T36 Liaison responsibilities will include:

Coordinate policies and procedures with UAHP for enrolled members who have been and/or in the process of a civil commitment. Reconcile, on a monthly basis with UAHP, the roster of members receiving court ordered treatment. Due date of roster will be submitted no later than the 15th of each month to UAHPCaseManagementBHMailbox@bannerhealth.com. If an agency developed roster is not available, the **Provider Manual Form 3.8.1 -** UAHP Provider COT Roster template can be utilized. This list will include, but may not be limited to, the following:

- Member's name
- Date of birth
- UAHP identification number
- Mental Health number
- Date of court order
- Standard(s) under which the individual was court ordered
- Due dates of Judicial Review, date Judicial Review was completed, indication if Judicial Review was requested by member
- Dates of suspensions, type of suspension, date admitted under suspension
- Due date of annual examination, date annual examination completed, recommendation of examination
- List of deputized psychiatrists/licensed physician by medical director to do or perform in his/her stead.

Provide oversight and technical assistance to contracted provider staff on the T36 process, e.g. testifying, filing of court documents, development of treatment plans, ensure compliance with statutory requirements, e.g. Judicial Reviews, Suspensions, Annual Examination, etc.

Development of current list of members under a T36 order to contracted provider team leaders, supervisors, on call staff to ensure communication of current treatment plan recommendations, active suspensions, and other related information.

Compliance with any additional requests by UAHP which will assist in tracking and monitoring of census data, the implementation of the T36 statutes, and delivery of clinical care to members under a T36 court order.

Participation in Hearings
The individual's assigned case manager must attend all Title 36 hearings, including the original hearing for court-ordered treatment, judicial reviews, annual reviews and petitions for continued treatment of GD or PAD orders. The case manager should be prepared to provide information/clarification to the court regarding facts relevant to the topic of the hearing and the proposed outpatient treatment plan. The case manager must be present to receive orders set forth by the Judge/Commissioner including the dates that T-36 status reports are to be submitted to contracted legal counsel, specific orders regarding submission of the outpatient treatment plan, and the standard of the order (i.e. DTO, DTS, etc.).

The case manager should arrive 15 minutes prior to the hearing. Cell phones and electronic devices must be turned off or silenced. Chewing gum, eating food, or wearing sunglasses are not permitted in the court room. Attire must be professional: no halter tops, tee shirts, sagging pants, spaghetti straps, flip-flops or tennis shoes.

Contracted provider staff must not discuss the case in the presence of the Judge/Commissioner. Such conversations must be held outside the courtroom. The Judge/Commissioner is not to be privy to information regarding the case prior to the hearing. If this occurs the hearing may need to be rescheduled.

During testimony, the County Attorney will obtain information through a series of questions. The attorneys should be addressed as "Mr.", "Ms.", or other appropriate title and the Judge as "Your Honor". Answers must be made verbally in a clear, direct, non-argumentative and audible manner to facilitate recording of the procedures. Head shakes or nods are not permissible.

If the member is court-ordered to treatment, the Judge/Commissioner will request the name of the proposed supervising agency and whether a T-36 outpatient treatment plan has been prepared. The case manager is to be prepared to submit the original T-36 outpatient treatment plan to the Judge/Commissioner, with copies to the County Attorney, the Defense Attorney, the hospital T-36 Liaison, and the member.

If a T-36 Outpatient Treatment Plan has not been completed, the case manager is to inform the Court why the plan has not been completed and the projected date of completion.

PIMA COUNTY:
Providers are responsible for establishing a group generic email box to receive minute entries from the Court. An example is **MinuteEntries@[provider name].com**. UAHP has identified a law firm to provide legal representation in filing post-hearing documents and coordinating with the Pima County Superior Court on behalf of Providers serving as Supervising Providers.

Treatment Plan Development and Filing
Prior to the date of the hearing, the case manager is responsible for coordinating an Adult Recovery Team (ART) meeting for enrolled members to develop discharge plans and ensure that those plans are included in the member's Individual Service Plan (ISP). The ISP must be discussed/reviewed with the Medical Director of the contracted agency, or physician designee. The member's inpatient team must be involved in and agree to discharge decisions.

The case manager then develops **Provider Manual Form 3.8.2** - UAHP Court Ordered Treatment Plan - Individual, which incorporates the terms of the ISP.

The case manager must submit a Court-Ordered Treatment Plan to the Court at the Title 36 hearing. The plan must be signed by staff member that reviewed the plan with the member and the outpatient team. The member is not required to sign the plan and member signature is optional. If the member does not sign the plan, the member signature line is to be left blank. Information regarding why the member did not sign the plan is not to be written on the plan.

The Court-Ordered Treatment Plan must have the member's correct address/zip code and phone number. If the member is to reside with family, friends, etc., provider staff must confirm this arrangement with family, friends, etc.

The original Court-Ordered Treatment Plan is signed by the Judge/Commissioner at the hearing. Pima County: Total of 6 treatment plans are to be taken to hearing:

1. Original for Judge/Commissioner,

2 .County Attorney,

3. Defense Attorney,

4. Hospital T-36 Liaison,

5. Individual

6. UAHP T-36 Lead

Subsequent changes to treatment plans are to be followed per ARS 36-540 depending on the County process.

Pima County
Subsequent revisions regarding change in provider site, residence, psychiatrist, payee, services, etc. are developed by the member's Adult Recovery Team and included in the ISP. The ISP must be signed by the BHMP, case manager and member. If the member does not agree with

the ISP, he/she may file an appeal with UAHP. The case manager must explain the appeal process to the member. Since all revisions to the ISP are incorporated into and enforced by the original Court-Ordered Treatment Plan, a revised Court Ordered Treatment Plan does not need to be submitted to the Court.

Upon re-hospitalization following a suspension of an outpatient treatment plan, the case manager coordinates an ART meeting to develop discharge plans and to ensure that those plans are included in a revised ISP. This plan must be reviewed with the outpatient psychiatrist. The outpatient psychiatrist must discuss the proposed plan and any additional concerns with the inpatient psychiatrist. The member's inpatient team must be involved in and agree to discharge decisions. If the member does not agree with the ISP, he/she may file an appeal with UAHP. The case manager must explain the appeal process to the member. If there are changes in the ISP such as residence or covered services, the revised ISP must be signed by the member, case manager and outpatient psychiatrist. The original ISP is filed in the outpatient chart and a copy of the ISP is filed in the inpatient chart. A member may leave the hospital once this process is complete. Since all revisions to the ISP are incorporated into and enforced by the original Court-Ordered Treatment Plan, a revised Court Ordered Treatment Plan does not need to be submitted to the Court.

Amendments/Suspensions

If a member fails to comply with the outpatient treatment plan or needs to be hospitalized, the Medical Director of the contracted agency, or physician designee can rescind the Outpatient Treatment Plan.

- It is important the provider track the numbers of days a member has spent in an inpatient setting, because there are a limited amount of inpatient days the court may order pursuant to A.R.S. 36-540:
  * DTS up to 90 days
  * DTO & PAD up to 180 days
  *GD up to 365 days
  - If there are no more inpatient days available, the Medical Director must determine if the individual requires continued court-ordered treatment. If the individual is DTO/DTS the provider can follow the process for an Emergency Application for Evaluation for Admission. If the individual is PAD/GD the provider can initiate the Annual Review process or follow the Pre-Petition Screening process.
  - Amended outpatient treatment orders do not increase the total period of commitment originally ordered by Court.

Emergent Amendments/Suspension/A.R. S. 36-540 (E) (5)

When the member is presenting with DTO/DTS behavior and requires immediate acute hospitalization, the request to suspend the outpatient treatment plan can be telephonic (emergent). The medical director or physician designee must contact an inpatient psychiatrist,

discuss and agree that the member requires immediate acute inpatient treatment. The medical director or physician designee may authorize a peace officer to transport the member to the inpatient treatment facility.

Following the admission to a hospital based upon a telephonic suspension of an outpatient treatment plan, the contracted provider must file a motion for an amended court order requesting inpatient treatment no later than the next working day following the admission. If this paperwork is not filed, the member may be detained and treated for no more than 48 hours, excluding weekends and holidays. The suspension form cannot be submitted to the inpatient treatment facility in an attempt to admit the member. Admission requires coordination/contact by the medical director or physician designee.

When an individual is hospitalized pursuant to an amended order, the provider must inform the individual of the right to judicial review and the right to consult with counsel pursuant to A.R. S. 36-546.

Non-Emergent Amendment/Suspension A.R. S. 36-540€ (4)

If the provider determines that the individual is not complying with the terms of the order or that the outpatient treatment plan is no longer appropriate, the Medical Director or physician designee can petition the court to amend/revoke the outpatient treatment plan to inpatient treatment. Court, without a hearing and based on the court record, the patient's medical record, the affidavits and recommendations of the Medical Director (must be notarized), and the advice of staff and physicians or the psychiatric and mental health nurse practitioner familiar with the treatment of the patient, may enter an order amending its original order.
If the individual refuses to comply with an amended order for inpatient treatment, the court may authorize and direct a peace officer, on the request of the Medical Director, to take the individual into protective custody and transport the individual for inpatient treatment.
When an individual is hospitalized pursuant to an amended order, the provider must inform the individual of the right to judicial review and the right to consult with counsel pursuant to A.R.S.36-546.

If the request is written (non-emergent), **UAHP Provider Manual forms 3.8.3** --Law Enforcement Committal Information, and **3.8.4** - Request for Suspension of Outpatient Treatment Plan are required. The Request for Suspension of Outpatient Treatment Plan must be signed by the outpatient psychiatrist and notarized. The Court requires specific information/facts regarding the member's lack of compliance with the outpatient treatment plan. The preparer of the suspension request should avoid using conclusions such as "delusional," "non-compliant," "AWOL," "disruptive," and "inappropriate". The request should contain information regarding outreach attempts, attempts to engage the member in treatment, or to offer hospitalization on a voluntary basis. If the member agrees to voluntary hospitalization, suspension paperwork is not submitted.

Pima County:

The original is submitted to UAHP contracted law firm and copy to UAHP Behavioral Health Department at **UAHPCaseManagementBHMailbox@bannerhealth.com**. If the documents are submitted by 10:00 a.m., they will be filed with court that day. If submitted after 10:00 a.m., documents will be filed the following day.

If contracted staff obtains updated information as to the member's location after suspension paperwork has been filed with the Court, they should contact law enforcement directly to provide updated information. When providing updated location information, staff should inform the law enforcement officer that a suspension of the outpatient treatment plan has been filed with the Court.

Upon admission to the hospital, the contracted provider is required to inform the patient of the right to judicial review and right to consult with counsel, see **Judicial Reviews** below.

Quashing an Order to Transport/Suspension

If the individual returns to treatment, the order to transport/suspension shall be quashed (terminated). The outpatient psychiatrist submits a written statement providing the date when the individual returned and engaged in treatment.

PIMA COUNTY**:**
If 90 days has expired since the last amendment, the Provider is required to submit a written statement to UAHP contracted law firm requesting to quash the previous amended and transport order and file a new amendment. If an individual becomes incarcerated at Pima County Adult Detention Center (PCADC) during the timeframe of the amended outpatient treatment plan, a court order to quash the transport is not required if the current amendment does not indicate the address of PCADC. The Provider is responsible for notifying Pima County's Mental Health Support Team (MHST) of the change in location of the individual. The Provider must email the amended pleading to MHST and PCADC records.

Judicial Reviews A.R.S. 36-546

Every 60 days and upon suspension, the individual is to be informed of his/her right to Judicial Review. In cases where the individual's outpatient treatment plan has been suspended to an inpatient facility, he/she must be offered a Judicial Review within seventy-two (72) hours of admission. The case manager must inform the individual of this right to Judicial Review and explain the process. It is the responsibility of the Provider to track the Judicial Review dates and ensure a Judicial Review is offered to an individual under Court-Ordered Treatment (COT) every 60 days.

If the individual requests Judicial Review, the case manager must schedule an appointment to be evaluated by the contracted BHMP. The evaluation must be completed and submitted to UAHP within 72 hours of the request and by the filing deadline of 10:00 a.m. It is best to schedule the BHMP appointment no later than 48 hours from request, so the Judicial Review form is received by UAHP the next day, to meet the 72 hour timeframe.

If the individual requests a Judicial Review, the case manager completes **Provider Manual Form 3.8.5** - Notification of Individual's Right to Request Judicial Review and Right to Speak to Legal Counsel. The individual completes his/her current address and signs the form. Additionally, the treating contracted BHMP completes a psychiatric evaluation. **The Provider Manual Form 3.8.6** - Release from COT Worksheet contains the format for and additional instructions for completing the evaluation. The Court requires the psychiatric evaluation contains sufficient clinical information to render a decision regarding whether the individual needs continued court-ordered treatment. This can be in the form of a progress note.

Pima County:
The completed Judicial Review Form and psychiatric report is submitted to UAHP contracted law firm within 72 hours of the request and by the filing deadline. Copy of the Judicial Review form is to be submitted to UAHP at **UAHPCaseManagementBHMailbox@bannerhealth.com**

For GREENLEE, GRAHAM, LA PAZ, PINAL, SANTA CRUZ AND YUMA Counties:
Designated process directed by County Attorney office should be followed. The following documents are to be submitted to designated County Attorney Office:

- Letter from Medical Director
- The Right to Notification of Judicial Review form
- The last progress note from the BHMP proving the Judicial review was discussed with member and reporting recommendations
- ***Pinal County also requires the most current Psychiatric Evaluation.***

For COCHISE County:
The following documents are to be filed with the clerk of the court:

- The Psychiatric Report RE: Request for Judicial Review (The medical director's letter)
- The Right to Notification and Legal Counsel of Judicial Review form
- The last psychiatric evaluation that was completed

All other Counties:
Original Judicial Review Form is to be submitted to the designated county attorney office/law firm. Copy of Judicial Review form is to be submitted to UAHP at **UAHPCaseManagementBHMailbox@bannerhealth.com**. If the individual declines a Judicial Review, the case manager completes the same **Provider Manual form 3.8.5** -Notification of Individual's Right to Request Judicial Review and Right to Speak to Legal Counsel, and the

individual signs this form. The individual provides his/her current address and location. The contracted provider maintains this form in the clinical record.

If the individual is unavailable at the time the Judicial Review is due, the case manager completes the same **Form 3.8.5**- Notification of Individual's Right to Request Judicial Review and Right to Speak to Legal Counsel. The case manager must provide reasons why the individual was not available for the Judicial Review and include a minimum of two outreach attempts made. The contracted provider maintains this form in the clinical record. It should match the progress notes regarding outreach.

A hearing can be set by the Judge/Commissioner on his/her own or if requested by the defense attorney.

Status Reports

At the original hearing for court order, the Judge/Commissioner may direct the contracted provider to submit two status reports to the UAHP. The Judge/Commissioner will set the dates when the reports are to be submitted.

- Pinal County court requires status reports due to the court at 30, 90, 180, 270 days. If the Provider fails to complete the status report to the court, the judge can order the member to appear and provide an in member status report regarding the treatment and process of the consumer.
- Yuma County requires status reports to be completed the first is 30 days, 90 days, 180 days, and lastly at 270 days.
- Maricopa County requires status reports to be completed the first 30 days and 180 days.
- At this time, the following counties do not require a status report: Cochise, Graham, Greenlee, La Paz and Pima.

The status report is completed using the **Provider Manual Form 3.8.7** - Court Ordered Treatment Status form. The status report is completed by the case manager and reviewed and signed by the team supervisor and attending BHMP.

Copy of the report is submitted to UAHP 7 days prior to due date ordered by the court. Report is to be submitted to UAHP at **UAHPCaseManagementBHMailbox@bannerhealth.com.**

Annual Review and Examination A.R. S. 36-543

The contracted agency shall assure the BHMP has completed an examination and review of a court-ordered individual in an effective and timely manner. This must take place within 90 days but not less than 30 days prior to expiration of any court-ordered treatment (see A.R.S. 36-543 and 9 A.A.C. 21-506). To ensure this review has taken place UAHP requires the contracted agency to provide UAHP with the progress note from the contracted BHMP showing the BHMP

met with the individual 30-90 days prior to expiration of the court order. This progress note will be collected by UAHP on a monthly basis.

The progress note is due on the 1st day of each month. Submit the Progress Report to UAHPCaseManagementBHMailbox@bannerhealth.com.

Additionally, the individual's Adult Recovery Team shall hold a service planning meeting, not less than 30 days prior to the expiration of the court-ordered treatment to determine if the court-order should continue (see A.A.C.9S21-506).

Contracted providers can request court orders for individuals determined to be PAD and GD be continued for another year based on an annual review and examination conducted by the member's BHMP and a petition to the court. For individuals determined DTS and/or DTO the contracted provider must request a new court-ordered evaluation.

If the Medical Director believes that continuation of the court-ordered treatment is appropriate, the Medical Director appoints one or more psychiatrists (depending on the County) to carry out a psychiatric examination of the individual. Each psychiatrist participating in the psychiatric examination must submit a report to the Medical Director that includes the following:

- The psychiatrist's opinions as to whether the individual continues to have a grave disability or persistent or acute disability as a result of a mental disorder and is in need of continued COT
- A statement as to whether suitable alternatives to COT are available
- A statement as to whether voluntary treatment would be appropriate
- Review of the individual's need for a guardian or conservator or both
- Whether the individual has a guardian with mental health powers that would not require continued COT
- The result of any physical examination that is relevant to the psychiatric condition of the individual/

The annual exam must have current contact information for the member. This includes full address, zip code, and telephone number. If the member's location and/or other contact information changes, contracted staff must contact UAHP with the new contact information.

A hearing is conducted if requested by the member's attorney or otherwise ordered by the court.

If set for hearing, the contracted BHMP who completed the Annual Exam must testify at the hearing. The contracted agency T-36 Liaison is responsible for informing the assigned staff and the BHMP of the hearing and ensures coordination for the hearing. The contracted case manager must inform the member of the hearing and arrange for his/her transport to the hearing.

PIMA County:

For continued treatment examinations for individuals found to be GD, utilize **UAHP Provider Manual Form 3.8.8**, Psychiatric Examination for Annual Review of Gravely Disabled Members. For continued treatment examinations for individuals found to be PAD, utilize **Form 3.8.9** Psychiatric Examination for Annual Review of a Persistently or Acutely Disabled. UAHP contracted law firm will forward to the contracted provider conformed copies of the petition and order that was filed in court. The contracted provider is required to provide the paperwork to the member and obtain a signed **UAHP Form 3.8.10**-Notice of Filing Confirmation of Receipt. This form provides evidence to the court and defense counsel the member is aware of the petition and his/her right to speak to his/her attorney. This original signed form must be returned to UAHP within five (5) business days of receipt at **UAHPCaseManagementBHmailbox@bannerhealth.com**. UAHP will submit this form to court.

Termination/Release from Court Order Treatment A.R. S. 36-541.01

The Court can order a member to be released from court-ordered treatment prior to the expiration of the period originally ordered by the Court upon the written request of the member's BHMP.

Before the release or discharge of an individual ordered to undergo COT, the Medical Director must notify any relative or victim of the individual who has filed a demand for notice with the treatment Provider or any individual found by Court to have a legitimate reason for receiving notice the Medical Director's intention to release or discharge the individual.

A request for release can be based upon the following conditions:

- The member has become voluntarily engaged in treatment
- Has developed insight regarding the need for treatment
- Has moved out of state, been appointed a guardian,
- Has been sentenced to Department of Corrections,
- Has died.

A written evaluation signed by the contracted BHMP must be submitted to Court for the Judge/Commissioner to review and render a decision. Criteria required by the court to render a decision are contained in the **Provider Manual Form 3.8.6**-Release from COT Worksheet.

PIMA County:
The original psychiatric evaluation is submitted to UAHP contracted law firm to be filed with court.

All Counties:
Copy of the psychiatric evaluation is to be submitted to UAHP at **UAHPCaseManagementBHMailbox@bannerhealth.com.**

If sufficient criteria are not provided to the court or the evaluation is illegible, the judge may deny the request or may set a hearing to hear testimony from the contracted outpatient BHMP as to why the individual should be released from court-ordered treatment. The contracted case manager is responsible for informing the member of the hearing and to arrange transport to the hearing, if needed. The case manager must be familiar with specifics of the case as he/she may be called to testify at the hearing.

If the individual is released from court order, the case manager must notify the individual and the Title36 Liaison must update its systems and UAHP at **UAHPCaseManagementBHMailbox@bannerhealth.com** to indicate the court order is terminated.

Termination/Release for Lack of Contact – All Counties
For those members who have been absent and the supervising agency has been unable to administer the member's outpatient treatment plan; the T36 Liaison must notify UAHP T-36 lead at **UAHPCaseManagementBHMailbox@bannerhealth.com** to review documentation of re-engagement attempts before the release or discharge of an individual ordered to undergo COT (per **Section 3.3 Outreach, Engagement, Re-engagement and Closure** of this Provider Manual).

Change of Venue Counties other than Pima

When a client transfers from one County to another, the receiving provider must agree to accept the individual on COT through a Letter of Intent (LOI) and, once transferred, must request the change of venue from the County in which the COT originated. Although Change of Venue is a Court jurisdiction process, the receiving provider must follow-up with Court to ensure the change of venue is completed to ensure there is an accurate record of COT. Until venue has been changed, filing of court documents must be submitted to court that initially issued court order.

If the court order was made in a county in which the member does not reside or receive treatment, the court order will need to be changed (moved) to the county where the member resides. The request should be presented at the time of the initial COT hearing. The provider should appear in court with an outpatient treatment plan and request the judge to change the venue to the receiving County. If a change of venue needs to occur following the initial COT hearing, the outpatient provider is to follow process set forth by designated County Attorney or law firm.

PIMA COUNTY:
To change venue from Pima County to another County. The following must be submitted by the outpatient provider:

- Motion for approval of court ordered outpatient treatment plan, accompanied by a Court Ordered Treatment Plan
- Motion to Change Venue, Order to Change Venue, accompanied by a Letter of Intent
- The documents must be submitted to UAHP contracted law firm to file with Court.
- If the individual is transferring from UAHP to a RBHA, the contracted provider must contact UAHP Behavioral Health Case Management Program for assistance and coordination at **UAHPCaseManagementBHMailbox@bannerhealth.com**.

Change in Supervising Agencies (Transfers)

NOTE: The following are general guidelines-each County has the right to request additional or different documentation.

*Before an individual under COT can be transferred from one treating Provider to another, the sending Provider must have verification that the Medical Director of the receiving Provider has accepted the member and accepted the responsibility for overseeing treatment under the court order. This must happen before the transfer is completed.

*Standard of practice is to request a Letter of Intent to Treat (LOI). The LOI is a letter from the Medical director, or designee, of the receiving agency that includes:

- Name and DOB of the individual on COT
- COT start and end date
- The standard under which the member is court ordered (DTO, DTS, PAD, GD)
- Printed name and signature of the receiving Provider's Medical Director
- Effective transfer date (date of intake)
- The letter can read simply: "*This letter is to verify that Dr. X and Provider Y has agreed to provide court ordered treatment to member Z"*
- The contracted provider must keep a copy of the letter in the clinical record. Proposed outpatient treatment plan, signed by the contracted psychiatrist, case manager, and the member
- The Medical Director of the receiving provider notifies the court in writing that there has been a change in oversight of the individual's COT. *It is recommended that an official document from the court be requested that reflects the current treatment Provider/Medical Director as the responsible party overseeing the court ordered treatment.*
- The transferring contracted case manager must notify UAHP Behavioral Health Case Management Program of all transfers at **UAHPCaseManagementBHMailbox@bannerhealth.com**.

Court-Ordered Treatment for American Indian Tribal Members in Arizona

Arizona Tribes are sovereign nations, and tribal courts have jurisdiction over their members residing on reservation. Tribal court jurisdiction, however, does not extend to tribal members residing off the reservation or to State court-ordered evaluation or treatment ordered because of a behavioral health crisis occurring off reservation. Although some Arizona Tribes have adopted procedures in their tribal codes that are similar to Arizona law for court-ordered evaluation and treatment, each Tribe has its own laws which must be followed for the tribal court process. Tribal court ordered treatment for American Indian tribal members in Arizona is initiated by tribal behavioral health staff, the tribal prosecutor, or other member authorized under tribal laws. In accordance with tribal codes, tribal members who may be a danger to themselves or others and in need of treatment due to a mental health disorder are evaluated and recommendations are provided to the tribal judge for a determination of whether court ordered treatment is necessary. Tribal court orders specify the type of treatment needed. Additional information on the history of the tribal court process, legal documents, and forms as well as contact information for the tribes, and tribal court representatives can be found on the AHCCCS web page titled, Tribal Court Procedures for Involuntary Commitment - Information Center. Since many Tribes do not have treatment facilities on reservation to provide the treatment ordered by the tribal court, tribes may need to secure treatment off reservation for tribal members. To secure court ordered treatment off reservation, the court order must be "recognized" or transferred to the jurisdiction of the State. The process for establishing a tribal court order for treatment under the jurisdiction of the State is a process of recognition, or "domestication" of the tribal court order (see A.R.S. § 12-136).

Once this process occurs, the State recognized tribal court order is enforceable off reservation. The State recognition process is not a rehearing of the facts or findings of the tribal court. Treatment facilities, including the Arizona State Hospital, must provide treatment, as identified by the tribe and recognized by the State.

UAHP and UAHP contracted providers must comply with State recognized tribal court orders for Title XIX/XXI members. When tribal providers are also involved in the care and treatment of court-ordered tribal members, UAHP and UAHP contracted providers must involve tribal providers to verify the coordination and continuity of care of the members for the duration of court ordered treatment and when members are transitioned to services on the reservation, as applicable. This process must run concurrently with the tribal staff's initiation of the tribal court ordered process in an effort to communicate and ensure clinical coordination with the appropriate RBHA/Health plan. This clinical communication and coordination with the RBHA/health plan is necessary to assure continuity of care and to avoid delays in admission to an appropriate facility for treatment upon State/county court recognition of the tribal court order. The Arizona State Hospital should be the last placement alternative considered and used in this process A.R.S. § 36-540 (B) states, "The Court shall consider all available and appropriate alternatives for the treatment and care of the patient. The Court shall order the least restrictive

treatment alternative available." UAHP is expected to partner with American Indian Tribes and tribal courts in their geographic service areas to collaborate in finding appropriate treatment settings for American Indians in need of services.

Due to the options American Indians have regarding their health care, including services, payment of services for AHCCCS eligible American Indians may be covered through a TRBHA, RBHA or IHS/638 provider (see Behavioral Health Services Payment Responsibilities on the AHCCCS Tribal Court Procedures for Involuntary Commitment web page for a diagram of these different payment structures).

Arizona State Hospital (AzSH)

When a need for a referral to the Arizona State Hospital has been identified, the contracted provider contacts UAHP Behavioral Health Case Management Program to initiate and coordinate the process.

Pima County:
A transfer hearing must be set if the member objects to the transfer to AzSH.

AzSH Psychiatric Security Review Board (PSRB) GEI-If a member is being released from AzSH after serving a sentence under the guilty except insane (GEI) standard, the release of this member is generally reviewed by the PSRB. The PSRB will make recommendations for the individuals release into the community. This will often include a referral to the UAHP where the individual plans to reside upon release and often consideration for court ordered treatment. In these situations, the local County Attorney's office is notified by AzSH to initiate the court ordered evaluation process.

Court-Ordered Treatment For Persons Charged with or Convicted of a Crime
UAHP or providers may be responsible for providing evaluation and/or treatment services when an individual has been ordered by a court due to: conviction of a domestic violence offense; or upon being charged with a crime when it is determined that the individual is court ordered to treatment, or programs, as a result of being charged with a crime and appears to be an "alcoholic."

Domestic Violence Offender Treatment
Domestic violence offender treatment may be ordered by a court when an individual is convicted of a misdemeanor domestic violence offense. Although the order may indicate that the domestic violence (DV) offender treatment is the financial responsibility of the offender under A.R.S. § 13-3601.01, UAHP will cover DV services with Title XIX/XXI funds when the member is Title XIX/XXI eligible, the service is medically necessary, required prior authorization is obtained if necessary, and/or the service is provided by an in-network provider.

Court ordered substance abuse evaluation and treatment

Substance abuse evaluation and/or treatment (i.e., DUI services) ordered by a court under A.R.S. § 36-2027 is the financial responsibility of the county, city, town or charter city whose court issued the order for evaluation and/or treatment. If UAHP receives a claim for such services, the claim will be denied with instructions to the provider to bill the responsible county, city or town.

3.9 Out of State Placements for GMH/SA Duals Ages 18-20

At times, it may be necessary to consider an out-of-state placement for a young adult to meet the member's unique circumstances or clinical needs. The following factors may lead a member's Adult Recovery Team to consider the temporary out-of-state placement of a young adult:

- A young adult needs specialized programming not currently available in Arizona to effectively treat a specified behavioral health condition;
- An out-of-state placement's approach to treatment incorporates and supports the young adult's unique cultural heritage;
- A lack of current in-state bed capacity; and/or
- Geographical proximity encourages support and facilitates family involvement in the member's treatment.

AHCCCS requires that decisions to place young adults in out-of-state placements for behavioral health care and treatment are examined closely and made after the Adult Recovery Team and UAHP Behavioral Health Department have reviewed all other in-state options. Other options may include single case agreements with in-state providers that would allow enhanced programming or staffing to meet the specific needs of the member or the development of an Individual Service Plan (ISP) that incorporates a combination of support services and clinical interventions and takes advantage of the full extent of all available covered services to meet the clinically identified needs of the young adult. In the event that an out-of-state placement is necessary and is supported by UAHP and the Adult Recovery Team, the steps and procedures outlined in this section must be followed. Services provided out-of-state must meet the same requirements as those rendered in-state. Out-of-state providers must follow all AHCCCS reporting requirements and policies and procedure, including appointment standards and timelines as specified in **Section 3.1 Appointment Standards and Timeliness of Services**.

When UAHP is considering an out-of-state placement for a young adult, the following conditions apply:

- The Adult Recovery Team will consider all applicable and available in-state services and determine that the services do not adequately meet the specific needs of the member;
- The member's guardian is in agreement with the out-of-state placement for young adults between 18 and 20 years of age under guardianship;
- The out-of-state placement is registered as an AHCCCS provider;
- A plan for the provision of non-emergency medical care must be established.

Conditions before a referral for out-of-state placement is made
Documentation in the medical record must indicate the following conditions have been met before a referral for an out-of-state placement is made:

- All less restrictive, clinically appropriate approaches have either been provided or considered by the Adult Recovery Team and found not to meet the member's needs;
- All applicable in-state facilities have declined to accept the member;
- The Adult Recovery Team has been involved in the service planning process and is in agreement with the out-of-state placement;
- The Adult Recovery Team has determined how they will remain active and involved in service planning once the out-of-state placement has occurred;
- A proposed ISP that includes a discharge plan has been developed that addresses the needs and strengths of the member
- All applicable prior authorization requirements have been met
- The Arizona Department of Education has been consulted to ensure that the educational program in the out-of-state placement meets the Arizona Department of Education Academic Standards and the specific educational needs of the member;
- The member's primary health care provider and UAHP have been contacted and a plan for the provision of any necessary non-emergency medical care has been established and is included in the medical record by the assigned case manager;

The Individual Service Plan (ISP)
For a member placed out-of-state, the ISP developed by the Adult Recovery Team must require that:

- Discharge planning is initiated at the time of referral or notification of admission, including:
    - The measurable treatment goals being addressed by the out-of-state placement and the criteria necessary for discharge back to in-state services;
    - The possible or proposed in-state residence where the member will be returning;
    - The recommended services and supports required once the member returns from the out- of-state placement;
    - What needs to be changed or arranged to accept the member for subsequent in-state placement that will meet the member's needs;
    - How effective strategies implemented in the out-of-state placement will be transferred to the members' subsequent in-state placement; and
    - The actions necessary to integrate the member into family and community life upon discharge.
- The Adult Recovery Team actively reviews the member's progress with clinical staffing's occurring at least every 30 days. Clinical staffing's must include the staff of the out-of-state facility;
- The member's family/guardian is involved throughout the duration of the placement. This may include family counseling in person or by teleconference or video- conference;
- The Adult Recovery Team must ensure that essential and necessary health care services are provided;

- Home passes are allowed as clinically appropriate and in accordance with the UAHP Medicaid Behavioral Health Covered Services Guide; and
- The member's needs, strengths and cultural considerations have been addressed.

Initial notification to UAHP Behavioral Health Case Management Department

Providers are required to notify UAHPs Behavioral Health Case Management Department prior to initiating a referral for an out-of-state placement and assisting UAHP in gathering the required information to notify AHCCCS's Medical Management, if requested, prior to a referral for out-of-state placement and upon discovering that a UAHP member is in an out-of-state placement using **Provider Manual Form 3.9.1 -** Out-of-State Placement, Initial Notice. Prior authorization must be obtained prior to making a referral for out-of-state placement, in accordance with UAHP criteria.

Process for Providing Initial Notification to UAHP
For providers subcontracted with UAHP, the provider notifies UAHP Behavioral Health Case Management Department of the intent to make a referral for out-of-state placement on Provider Manual Form Out-of-State placement.

Prior to placing the young adult or upon discovering that a UAHP member has been admitted to an out-of-state placement, provider must complete Provider Manual Form, Out-of-State Placement, and Initial Notice and submit it to UAHP Behavioral Health Case Management Department. UAHP will review the documentation and forward it to AHCCCS's Office of Medical Management, if required, for approval of the out-of-state placement request.

Periodic updates to AHCCCS Office of Medical Management
In addition to providing initial notification, the provider is required to submit updates to UAHP Behavioral Health Case Management for review. The updates will be forwarded to the AHCCCS Office of Medical Management regarding the member's progress in meeting the identified criteria for discharge from the out-of-state placement every 30 days. To adhere to this requirement, providers must use **Provider Manual Form 3.9.2** - Out-of-State Placement, 30-Day Update.

Once completed, the provider must submit the form to the UAHP Behavioral Health Case Management Department every 30 days the member continues to remain in out-of-state placement. The 30 day update timelines will be based upon the date of admission to the out-of-state placement.

Required Reporting of an Out-of-State Provider

All out-of-state providers are required to meet the reporting requirements of all incidences of injury/accidents, abuse, neglect, exploitation, healthcare acquired conditions, and/or injuries from seclusion/restraint implementations.

3.10 Discharge Planning

Discharge planning refers to the assessment of and preparation for members' needs after discharge from an inpatient setting or out-of-home placement. Inpatient and out-of-home facilities must begin discharge planning upon admission of a member to the facility so that the member is able to be discharged as soon as is clinically appropriate. Examples of member needs at discharge include outpatient appointments, prescriptions, medical equipment, housing, home health care, residential treatment, family interventions and support, and connection to outpatient organizations and programs. Facilities must work with outpatient providers to develop and implement a discharge planning process to address the post-discharge clinical and social needs of members upon discharge.

Inpatient and out-of-home residential facilities must provide sufficient staff to discharge the member when the member is clinically ready, *including weekends and holidays*, and the facility must ensure medication records are faxed at discharge to the assigned outpatient provider to allow coordination of care upon transition to the community. Requests for prior authorization for residential placements after inpatient hospitalization may be initiated by outpatient provider or by the inpatient facility as part of the concurrent review and discharge planning process with UAHP. The process shall be initiated by a qualified health care professional and the provider's discharge planner, who works with the facility to ensure that continuing care needs have been accurately determined. The provider's discharge planner must appropriately document discharge plans in the member's medical record prior to discharge. The provider's discharge planner/hospital liaison must include as part of this process:

- Proactive discharge assessment by qualified healthcare professionals identifying and assessing the specific post discharge bio-psychosocial and medical needs of the member prior to discharge. This process shall include the involvement and participation of the member and representative(s), as applicable. The member and representative(s) must be provided with the written discharge plan instructions and recommendations identifying resources, referrals, and possible interventions to meet the member's assessed and anticipated needs after discharge.
- The coordination and management of the care that the member receives following discharge from an acute setting. This may include:
    - Providing appropriate post discharge community referrals and resources or scheduling follow up appointments with the member's primary care provider and/or other outpatient healthcare providers within 7 days or sooner of discharge;
    - Coordination of care involving effective communication of the member's treatment plan and medical history across the various outpatient providers to

ensure that the member receives medically-necessary services that are both timely and safe after discharge. This includes access to nursing services and therapies;

- Coordination with the member's outpatient Adult Recovery Team to explore interventions to address the member's needs such as case management, disease management, placement options, and community support services.
- Access to prescribed discharge medications;

and

- Post discharge follow up contact to assess the progress of the discharge plan according to the member's assessed clinical (physical health care) and social needs.

Individuals who are discharged from the Arizona State Hospital (AzSH) must be provided with the same brand and model glucometer and supplies the individual was trained on while in the hospital.

Avoidable Days

At times, there are delays in discharging members because necessary outpatient services are not yet available. As long as the inpatient or out-of-home facility has carried out discharge planning activities in a timely and thorough manner, UAHP will continue to authorize inpatient care for members who cannot be discharged due to the lack of necessary outpatient services. However, if delays in discharge are deemed to be the direct result of the failure of discharge planning on the part of the inpatient or out-of-home facility, UAHP may cease to authorize further inpatient or residential bed days. If there are delays in discharge deemed to be the direct result of the outpatient provider's failure to engage in appropriate discharge planning, UAHP will continue to authorize inpatient or out-of-home care but may sanction the outpatient provider for the cost of the avoidable bed days.

3.11 Cultural Competence

UAHP and its providers must have the ability to be responsive to the unique cultural, ethnic, or linguistic characteristics of the population it serves to ensure that services are culturally competent for diverse, underserved, and underrepresented populations.

In 1997, the U.S. Department of Health and Human Services - Office of Minority Health (OMH), developed the **National Standards on Culturally and Linguistically Appropriate Services (CLAS),** to support a more consistent and comprehensive approach to cultural and linguistic competence in health care. UAHP has adopted CLAS standards as its cultural competence framework.

Culturally and Linguistically Appropriate Services (CLAS) Standards
The CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for individuals as well as health and health care organizations to implement culturally and linguistically appropriate services. The CLAS Standards are a comprehensive series of guidelines that inform, guide, and facilitate practices related to culturally and linguistically appropriate health services. Providers are required to adhere to all areas of the CLAS standards:

- **Principal Standard (Standard 1)**: Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs;
- **Governance, Leadership, and Workforce (Standards 2-4)**: Provide greater clarity on the specific locus of action for each of these Standards and emphasizes the importance of the implementation of CLAS as a systemic responsibility, requiring the investment, support, and training of all individuals within an organization;
- **Communication and Language Assistance (Standards 5-8)**: Provides a broader understanding and application of appropriate services to include all communication needs and services, including sign language, braille, oral interpretation, and written translation; and
- **Engagement, Continuous Improvement, and Accountability (Standards 9-15)**: Underscores the importance of establishing individual responsibility in verifying that CLAS is supported, while retaining the understanding that effective delivery of CLAS demands actions across an organization. These Standards focus on the supports necessary for adoption, implementation, and maintenance of culturally and linguistically appropriate policies and services regardless of one's role within an organization or practice. All individuals are accountable for upholding the values and intent of the CLAS Standards.

Culturally Competent Care

To comply with the Culturally Competent Care requirements, UAHP and its providers must:

- Recruit, promote, and support culturally and linguistically diverse representation within governance, leadership, and the workforce that is responsive to the population in the service area(s);
- Educate and train representatives within governance, leadership, and the workforce in culturally and linguistically appropriate policies and practices on an ongoing basis. Providers with direct care responsibilities must complete mandated Cultural Competency training and verify that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery;
- Guarantee a member's right to be treated fairly without regard to age, ethnicity, race, sex (gender), religion, national origin, creed, tribal affiliation, ancestry, gender identity, sexual orientation, marital status, genetic information, socio-economic status, physical or intellectual disability, ability to pay, mental illness, and/or cultural and linguistic need; and
- Provide culturally relevant and appropriate services for members of various populations including but not limited to: age groups, gender and sexual minorities, members with disabilities, racial and ethnic groups, religious affiliations, socio-economic statuses, tribal nations, etc.

Organizational Supports for Cultural and Linguistic Need

To comply with the Organizational Supports for Cultural Competence, UAHP and providers must:

- Establish culturally and linguistically appropriate goals, policies, and management accountability and infuse them throughout the organization's planning and operations;
- Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities;
- Partner with the community to design, implement, and evaluate policies, practices, and services to verify cultural and linguistic appropriateness;
- Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area;
- Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints;
- Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public;
- Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public;
- Verify the use of multi-faceted approaches to assess satisfaction of diverse

individuals, families, and communities, including the identification of minority responses in the analysis of client satisfaction surveys, the monitoring of service outcomes, Member complaints, grievances, provider feedback and/or employee surveys;
- Include prevention strategies by analyzing data to evaluate the impact on the network and service delivery system, with the goal of minimizing disparities in access to services and improving quality; and
- Consult with diverse groups to develop relevant communications, outreach and marketing strategies that review, evaluate, and improve service delivery to diverse individuals, families, and communities, and address disparities in access and utilization of services.

Workforce Development and Training

UAHP and its Providers must:

- Ensure all staff receive training in cultural competence and culturally and linguistically appropriate services during new employee orientation;
- Provide ongoing and annual training on Cultural Competence, to include at least the following: the Cultural Competence requirements in this Provider Manual, the CLAS standards, use of oral interpretation and translation services, and alternative formats and services for Limited English Proficiency (LEP) clients. Providers must ensure that all staff members have completed the annual training and achieved a passing score of at least 80% on post-test score;
- Provide annual training to all staff in diversity awareness and culturally relevant topics customized to meet the needs of their service area;
- Ensure all staff have access to resources for members with diverse cultural needs;
- Recruit, retain, and promote, at all levels of the organization, a culturally competent, diverse staff and leadership that reflects the cultural background of Members served;
- Maintain full compliance with all mandatory trainings (see **Section 10.1 Training Requirements**);
- Develop and implement cultural-related trainings/curriculums as determined by AHCCCS, UAHP, Cultural Competence Committees, policies, and contract requirements.

Documenting Clinical Cultural and Linguistic Need

To advance health literacy, reduce health disparities, and identify the individual's unique needs, UAHP and providers are required to do the following:

- Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery;
- Verify documentation of the cultural (for example: age, ethnicity, race, national origin, sex (gender), gender identity, sexual orientation, tribal affiliation, disability)

and linguistic (for example, primary language, preferred language, language spoken at home,) needs within the medical records;

- Maintain documentation within the medical record of oral interpretation services provided in a language other than English- by certified bilingual staff or an interpretation vendor. Documentation must include the date of service, interpreter name, type of language provided, interpretation duration, and type of interpretation services provided;
- Ensure that the cultural preferences of members and their families are assessed and included in the development of treatment plans; and
- Assess the unique needs of the Geographical Service Area (GSA), as communities' cultural preferences are critical in the development of goals and strategies of prevention within documentation of cultural and linguistic need.

Communication and Language Assistance

To comply with the communication and language access service requirements in the CLAS Standards, UAHP and its providers must do the following:

Identify Prevalent Non-English Language Needs. Providers must identify the prevalent non-English language(s) within the provider service areas to ensure service capacity meets those needs.

- **Provide Services in a Culturally Competent Manner**. Provider must give consideration for members with limited English proficiency or reading skills, and those with diverse cultural and ethnic backgrounds, including those who identify with deaf culture, as well as members with visual or auditory limitations. Options include providing access to a language interpreter, a member proficient in sign language for the hearing impaired, and written materials available in Braille for the blind or in different formats, as appropriate. Providers must also provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the provider's service area. Members have the right to know which providers speak languages other than English.
- **Offer Language Assistance Services**. Providers must clearly inform members of the availability of language assistance services in their preferred language, verbally and in writing. A provider must offer language assistance to individuals who have limited English proficiency and/or other communication needs such as sign language interpreters and American Sign Language-fluent staff, at no cost to them, to facilitate timely access to all health care services. Language assistance services must be available during all hours of operation.
- **Document Language Assistance Needs**. Providers must document in a member's medical record if the member has a preferred language other than English. If the member care requires the presence of a legal parent or guardian who does not speak English (*e.g.*, when the member is severely disabled), UAHP and providers must document the language not only of the member but also of the guardian or

legal appointed representative.

- **Ensure Competence and Proficiency of those Providing Language Assistance**. Provider must ensure that qualified oral interpreters and bilingual staff as well as certified sign language interpreters provide access to oral interpretation, translation, sign language and disability-related services, and provide auxiliary aids and alternative formats on request. The use of untrained individuals and/or minors as interpreters should be avoided. An interpreter must be certified at the appropriate level of proficiency to be qualified to provide these interpretation services or to provide direct services in a language other than English.
- **Develop Policies for Staff to Provide Interpreting Services**. Each agency must develop and have available at the time of any UAHP audit or upon request, a policy outlining in detail the steps an employee should take to:
    - Provide American Sign Language (ASL) interpretation services for the deaf and hard of hearing;
    - Provide oral interpretation services for anyone whose preferred language is one other than English; and
    - Obtain certification that the employee meets the required level of proficiency to provide services in either ASL or a language other than English.
- **Bill Appropriately for Language Assistance Services**. Oral interpretation and sign language services are provided at no charge to all Arizona Health Care Cost Containment System (AHCCCS) eligible members. Interpretation services are an administrative cost included in the billing of the services provided with the interpretation. Interpretation services must be billed in conjunction with another service, never a standalone code.

Accessing Oral Interpretation Services

In accordance with **Title VI of the Civil Rights Act**, Prohibition against National Origin Discrimination, and **President's Executive Order 13166**, UAHP and its providers must make oral interpretation services available to members with Limited English Proficiency (LEP) at all points of contact. Oral interpretation services are provided at no charge to AHCCCS eligible members. Members must be provided with information instructing them how to access these services.

All providers must have their own interpretation services available. UAHP provides customer care representatives who are available to speak to members/family members in their preferred language, or will conference in an interpreter. Anyone can call **Customer Care** at **1-800-582-8686** for assistance and information.

Accessing Interpretation Services for the Deaf and the Hard of Hearing

UAHP and its providers must adhere to the rules established by the Arizona Commission for the Deaf and Hard of Hearing, in accordance with A.R.S. § 36-1946, which cover the following:

- Classification of interpreters for the deaf and the hard of hearing based on the level

of interpreting skills acquired by that member;
- Establishment of standards and procedures for the qualification and licensure of each classification of interpreters;
- Utilizing licensed interpreters for the deaf and the hard of hearing; and
- Providing auxiliary aids or licensed sign language interpreters that meet the needs of the individual upon request. Auxiliary aids include computer-aided transcriptions, written materials, assistive listening devices or systems, closed and open captioning, and other effective methods of making aurally delivered materials available to members with hearing loss.
    - The Arizona Commission for the Deaf and the Hard of Hearing provides a listing of licensed interpreters, information on auxiliary aids and the complete rules and regulations regarding the profession of interpreters in the State of Arizona. (Arizona Commission for the Deaf and the Hard of Hearing www.acdhh.org or **602-542-3323** (V/TTY)).
    - UAHP can be contacted via TDD/TTY line, 24 hours a day, and 7 days a week at-**1-800-367-8939**.

Translation of Written Materials

UAHP and its providers must ensure that written materials disseminated to members meet cultural competence and LEP requirements. UAHP and providers must translate ***all member informational materials*** when a language other than English is spoken by 3,000 people or 10%, whichever is less, of UAHP's members who also have LEP.

UAHP and providers must translate ***all vital materials*** when a language other than English is spoken by 1,000 people or 5%, whichever is less, of UAHP's members who also have LEP (42 CFR 438.10(3)). ***Vital materials*** include the following:

- notices for denials, reductions, suspensions or terminations of services;
- Individual Service Plans (ISPs);
- consent forms;
- communications requiring a response from the member;
- all grievance, appeal and request for State fair hearing documentation;
- the Member Handbook; and
- a detailed description of Early Periodic Screening, Diagnostic and Treatment (EPSDT) services.

In addition, all written notices informing members of their right to interpretation and translation services must be translated when 1000 people or 5%, whichever is less, of UAHP's members speak that language and have LEP.

Members with LEP, whose languages are not considered commonly encountered, must be provided written notice in their primary or preferred language of the right to receive competent translation of written material and provide instructions for obtaining culturally competent

materials.

Assessment
If the member requests a copy of the assessment, those documents must be provided to the member in his/her primary/preferred language. Documentation in the assessment also must be made in English; both versions must be maintained in the member's record. This will verify that if any members, who must review the member's record for purposes such as coordination of care, emergency services, auditing and data validation, have an English version available.

Individual Service Plan (ISP) and Inpatient Treatment and Discharge Plan (ITDP)
In general, any document that requires the signature of the member, and that contains vital information such as the treatment, medications or notices, or service plans, must be translated into their preferred/primary language if requested by the member or his/her guardian.

The Individual Service Plan (ISP) is intended to fulfill several functions, which include identification of necessary behavioral health services (as evaluated during the assessment and through participation from the member and his/her team), documentation of the member's agreement or disagreement with the plan, and notification of the member's right to a Notice of Action or Notice of Decision and Right to Appeal, if the member does not agree with the plan.

If the member's primary/preferred language is other than English and any of the service plans have been completed in English, the provider must ensure the service plans are translated into the member's primary/preferred language for his/her signature. Providers must also maintain documentation of the ISP in both the preferred/primary language as well as in English. Service plans specifically incorporate a member's rights to disagree with services identified on the plan. If the plan is not in the member's preferred language, the member has not been appropriately informed of services he/she will be provided and afforded the opportunity to exercise his/her rights when there is a disagreement.

Cultural Competency Reporting and Accountability

Reporting and Accountability Measures
Reporting and accountability measures are intended to track, monitor, and verify access to quality and effective care. Equity in the access, delivery, and utilization of services is accomplished by UAHP and providers:

- Conducting annually and ongoing strategic planning in Cultural Competency with the inclusion of national level priorities, contractual requirements, stakeholder input, community involvement and initiative development in areas, including but not limited to: Continuing Education, Training, Community Involvement, Health Integration, Outreach, Prevention, Data Analysis/Reporting, Health Literacy, and Policies/Procedures Development;
- Capturing and reporting on language access services which include: linguistic

needs (primary language, preferred language, language spoken at home, alternative language); interpretive services (which includes submitting the appropriate codes with each service provided either by an interpreter or in a language other than English); written translation services; and maintaining documentation on how to access qualified/licensed interpreters and translators; and

- Assessing and developing reports quarterly and annually within the areas of cultural competency and workforce development to review the initiatives, activities, and requirements impacting diverse communities, and the individuals accessing and receiving services.
    - Continuous and ongoing reporting provides insight to strengths, gaps, and needs within communities served by UAHP and UAHP providers with a goal of health and wellness for all.

Cultural Competency Plan

On an annual basis, UAHP will develop and implement a written **Cultural Competency Plan**.

Providers, implement and maintain a Cultural Competency Plan (CCP) to monitor the effective delivery of culturally competent covered services in accordance with the requirements of the UAHP CCP and this Provider Manual. The provider CCPs must meet the following requirements:

- Be based on the Federal CLAS Standards and address language, ethnicity, gender, sexual orientation, religion and the culture of poverty.
- Be an outcome-based format including expected results, measurable outcomes and outputs with a focus on the priorities and initiatives identified in UAHP's CCP;
- Include an effectiveness assessment of current services provided by the agency in the GSA that focuses on culturally competent care delivered in the network, as part of outreach services and other programs, which includes an assessment of timely access, hours of operation and twenty-four (24) hour, seven (7) days a week availability for all provider and staff types delivering covered services (42 CFR 438.206(c));
- Be data-driven and the data sources utilized to determine goals and objectives;
- Include strategies to deliver services that are culturally competent and linguistically appropriate including methods for evaluating the cultural diversity of members and to assess needs and priorities in order to continually improve provision of culturally competent care; and
- Include methods to deliver linguistic and disability-related services by qualified member.

Providers must monitor the CCP at least quarterly and update the CCP annually and submit a copy of the update to UAHP as requested. The annual update must include an evaluation of the prior year's efforts. Providers must seek out and obtain feedback from peer support and family support staff in completing the annual update. The update must include the provider's level of

success in matching the cultural needs of each community and future plans to address the outstanding cultural needs of the communities served.

Laws Addressing Discrimination and Diversity
UAHP and provider agencies must abide by the following referenced federal and state applicable rules, regulations and guidance documents:

- Title VI of the Civil Rights Act prohibits discrimination on the basis of race, color, and national origin in programs and activities receiving federal financial assistance;
- Department of Health and Human Services - Guidance to Federal Financial Assistance Members Regarding Title VI Prohibition Against National Origin Discrimination affecting Limited English Proficient members;
- Title VII of the Civil Rights Act of 1964 prohibits employment discrimination based on race, color, religion, sex, or national origin by any employer with 15 or more employees. (The Civil Rights Act of 1991 reverses in whole or in part several Supreme Court decisions interpreting Title VII, strengthening and improving the law and providing for damages in cases of intentional employment discrimination);
- President's Executive Order 13166 improves access to services for members with Limited English Proficiency. The Executive Order requires each Federal agency to examine the services it provides and develop and implement a system by which LEP members can meaningfully access those services consistent with, and without unduly burdening, the fundamental mission of the agency;
- State Executive Order 99-4 and President's Executive Order 11246 mandates that all members regardless of race, color, sex, age, national origin or political affiliation shall have equal access to employment opportunities;
- The Age Discrimination in Employment Act (ADEA) prohibits employment discrimination against employees and job applicants 40 years of age or older. The ADEA applies to employers with 20 or more employees, including state and local governments. The Older Workers Benefit Protection Act (Pub. L. 101-433) amends the ADEA to prohibit employers from denying benefits to older employees;
- The Equal Pay Act (EPA) and A.R.S. § 23-341 prohibit sex-based wage discrimination between men and women in the same establishment who are performing under similar working conditions;
- Section 503 of the Rehabilitation Act prohibits discrimination in the employment or advancement of qualified members because of physical or mental disability for employers with federal contracts or subcontracts that exceed $10,000. All covered contractors and subcontractors must also include a specific equal opportunity clause in each of their nonexempt contracts and subcontracts;
- Section 504 of the Rehabilitation Act prohibits discrimination on the basis of disability in delivering contract services; and
- The Americans with Disabilities Act prohibits discrimination against members who have a disability. Providers must deliver services so that they are readily accessible

to members with a disability. UAHP and its providers who employ less than fifteen members and who cannot comply with the accessibility requirements without making significant changes to existing facilities may refer the member with a disability to other providers where the services are accessible. UAHP or its provider who employs fifteen or more members must designate at least one member to coordinate its efforts to comply with federal regulations that govern anti-discrimination laws.

In addition to providing services that are culturally competent, UAHP requires providers to serve behavioral health members with the following guiding principles:

Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems

1. Respect

Respect is the cornerstone. Meet the member where they are without judgment, with great patience and compassion.

2. Members in recovery choose services and are included in program decisions and program development efforts

A member in recovery has choice and a voice. Their self-determination in driving services, program decisions and program development is made possible, in part, by the ongoing dynamics of education, discussion, and evaluation, thus creating the "informed consumer" and the broadest possible palette from which choice is made. Members in recovery should be involved at every level of the system, from administration to service delivery.

3. Focus on individual as a whole member, while including and/or developing natural supports

A member in recovery is held as nothing less than a whole being: capable, competent, and respected for their opinions and choices. As such, focus is given to empowering the greatest possible autonomy and the most natural and well-rounded lifestyle. This includes access to and involvement in the natural supports and social systems customary to an individual's social community.

4. Empower individuals taking steps towards independence and allowing risk taking without fear of failure

A member in recovery finds independence through exploration, experimentation, evaluation, contemplation and action. An atmosphere is maintained whereby steps toward independence are encouraged and reinforced in a setting where both security and risk are valued as ingredients promoting growth.

5. Integration, collaboration, and participation with the community of one's choice

A member in recovery is a valued, contributing member of society and, as such, is deserving of and beneficial to the community. Such integration and participation underscores one's role as a vital part of the community, the community dynamic being inextricable from the human experience. Community service and volunteerism is valued.

6. Partnership between individuals, staff, and family members/natural supports for shared decision making with a foundation of trust

A member in recovery, as with any member of a society, finds strength and support through partnerships.

Compassion-based alliances with a focus on recovery optimization bolster self-confidence, expand understanding in all participants, and lead to the creation of optimum protocols and outcomes.

7. Members in recovery define their own success

A member in recovery -- by their own declaration -- discovers success, in part, by quality of life outcomes, which may include an improved sense of well-being, advanced integration into the community, and greater self-determination. Members in recovery are the experts on themselves, defining their own goals and desired outcomes.

8. Strengths-based, flexible, responsive services reflective of an individual's cultural preferences

A member in recovery can expect and deserves flexible, timely, and responsive services that are accessible, available, reliable, accountable, and sensitive to cultural values and mores. A member in recovery is the source of his/her own strength and resiliency. Those who serve as supports and facilitators identify, explore, and serve to optimize demonstrated strengths in the individual as tools for generating greater autonomy and effectiveness in life.

9. Hope is the foundation for the journey towards recovery

A member in recovery has the capacity for hope and thrives best in associations that foster hope. Through hope, a future of possibility enriches the life experience and creates the environment for uncommon and unexpected positive outcomes to be made real. A member in recovery is held as boundless in potential and possibility.

Section 4 – Behavioral Health Provider Coordination of Care Requirements

4.1 Transition of Members

Members receiving services may experience transitions during the course of their care and treatment. Examples of transitions of care include changing service providers, establishing eligibility under Arizona Long Term Care Services (ALTCS), and being determined Seriously Mentally Ill (SMI). During transitions of care, providers must ensure that services are not interrupted and that the person continues to receive needed services. Coordination and continuity of care during transitions are essential in maintaining a person's stability and avoiding relapse or decompensation in functioning.

Transition due to a change of the Behavioral Health Provider or the behavioral health category assignment.

Upon changes of a member's provider or behavioral health category assignment, the provider must:

- Review the current individual service plan and, if needed, coordinate the development of a revised individual service plan with the member, Adult Recovery Team and the receiving behavioral health provider;
- Ensure that the member's medical record is transitioned to the receiving behavioral health provider;
- Ensure the transfer of responsibility for court ordered treatment, if applicable; and
- Coordinate the transfer of any other relevant information between the provider and other provider agencies, if needed.

Transition to ALTCS Program contractors

Once a member is determined eligible and becomes enrolled with the Arizona Long Term Care Services/Elderly or Physically Disabled (ALTCS/EPD) Program, providers must not submit claims or encounters for Title XIX covered services to UAHP. To determine if a member is ALTCS/EPD eligible, providers shall contact **UAHP Customer Care** for assistance at **1-800-582-8686.**

Providers who contract as an ALTCS provider must not submit encounters for an ALTCS/EPD enrolled member to UAHP after a member transfers to ALTCS, but must submit bills/claims for payment to the ALTCS Program Contractor who in turn submits the encounters to AHCCCS. Providers must facilitate effective transitions for members who became eligible for ALTCS services. Providers must complete the following coordination efforts for ALTCS-eligible

members:

- Provide continuity of care between inpatient and outpatient settings, services, and supports;
- Develop and implement transition, discharge, and aftercare plans prior to discontinuation of services in accordance with this Provider Manual;
- Include the member in transition planning and provide any available information about changes in physician, services, etc.
- Ensure that the clinical and fiscal responsibility for Title XIX/XXI services shifts to the ALTCS Program Contractor;
- Complete a transfer packet and letter of transition that providers clinical information to the ALTCS Program Contractor regarding the member's on-going needs for services to assist them in effectively meeting the ongoing health and cultural needs of the member and ensure continuity of care during the transition period;
- Review the current treatment plan and, if needed, coordinate the development of a revised treatment plan with the Adult Recovery Team and the receiving ALTCS provider and/or case manager;
- Transfer responsibility for any court ordered treatment;
- Coordinate the transfer of records to the ALTCS program contractor; and
- Provide information as follows:
    - o For Title XIX/XXI eligible 21-64 year olds, the number of days the member has received services in an Institution for Mental Disease (IMD) in the contract year (October 1 – September 30);
    - o For all members, the number of hours of respite received in the contract year (October 1 - September 30); and
    - o Whether there is a signed authorization for the release of information contained in the medical record according to –Provider Manual Section Disclosure of Behavioral Health Information

Transition of members receiving Court Ordered Services

This section pertains to court ordered treatment under A.R.S. § 36, Chapter 5 (Pre-petition Screening, Court Ordered Evaluation and Treatment).

A member ordered by the court to undergo treatment and who is without a guardian may be transferred from one provider to another provider, as long as the medical director of the provider initiating the transfer has established that:

- There is no reason to believe that the member will suffer more serious physical harm or serious illness as a result of the transfer;
- The member is being transitioned to a level and kind of treatment that is more appropriate to the member's treatment needs; and
- The medical director of the receiving provider has accepted the member for transition.

The medical director of the provider requesting the transition must have been the provider that the court committed the member to for treatment or have obtained the court's consent to transition the member to another provider as necessary.

The medical director of the provider requesting the transition must provide notification to the receiving provider allowing sufficient time (but no less than 3 days) for the transition to be coordinated between the providers. Notification of the request to transition must include:

- A summary of the member's needs;
- A statement that, in the medical director's judgment, the receiving provider can adequately meet the member's treatment needs;
- A modification to the individual service plan, if applicable;
- Documentation of the court's consent, if applicable;
- A written compilation of the member's treatment needs and suggestions for future treatment by the medical director of the transitioning provider to the medical director of the receiving provider. The medical director of the receiving provider must accept this compilation before the transition can occur; and
- Transportation from the initiating provider to the receiving provider is the responsibility of the initiating behavioral health provider.

Transition of members being discharged from inpatient settings
Discharge Planning and communication with the Adult Recovery Team must begin at admission to ensure a smooth transition for members being discharged from inpatient settings. Furthermore, re-engagement activities must occur for members who are discharged from inpatient settings in accordance with **Section 3.3 Outreach, Engagement, Re- engagement and Closure**.

4.2 Coordination of Care with Primary Care Providers (PCP's) and All Healthcare Providers

GMH/SA Dual members enrolled with UAHP may be enrolled with a UAHP Medicare Advantage Plan such as University Care Advantage or; they may be enrolled in another Medicare Advantage Plan. Because of this separation in responsibilities, communication and coordination between providers, the Arizona Health Care Cost Containment System (AHCCCS), UAHP Primary and Specialty Care Providers and UAHP Behavioral Health Case Management Department is essential to ensure the well-being of members receiving services from both systems. Medicare covers limited inpatient services, outpatient services and prescription medications. Medicare covered services are provided on either a fee-for-service basis or a managed care basis (through Medicare Advantage Plans). The term Medicare provider refers to both the fee-for-service Medicare providers and the Medicare Advantage Plans. Coordination of care must occur with Medicare providers to achieve positive health outcomes for Medicare eligible members.

Holistic treatment requires integration of physical health with behavioral health to improve the overall health of an individual. Members may be receiving care from multiple health care entities. Duplicative medication prescribing, contraindicated combinations of prescriptions and/or incompatible treatment approaches could be detrimental to a member. For this reason, communication and coordination of care between providers, and Medicare providers must occur on a regular basis to ensure safety and positive clinical outcomes for members receiving care.

AHCCCS does not provide prescription drug coverage for dual eligible members, except for certain excluded Medicare Part D drugs, in accordance with the Medicare Prescription Drug Modernization and Improvement Act of 2003. Medicare eligible members must enroll in a Medicare Part D plan to receive prescription drug coverage through Medicare.

Coordination of Care
The following procedures will assist providers in coordinating care:

- If the identity of the member's primary care provider (PCP) is unknown, a provider must contact **UAHP's Customer Care Department** at **1-800-582-8686** to determine the name of the member's assigned PCP.
- UAHP enrolled members who have never contacted their PCP prior to entry into the behavioral health system should be encouraged to seek a baseline medical evaluation. UAHP enrolled members should also be prompted to visit their PCP for routine medical examinations annually or more frequently if necessary;
- Providers should request medical information from the member's assigned PCP. Examples include current diagnosis, medications, pertinent laboratory results, last PCP visit, Early Periodic Screening, Diagnosis and Treatment (EPSDT) screening results and

last hospitalization. If the PCP does not respond to the request, contact **UAHP's Customer Care** for assistance at **1-800-582-8686**; and

- Providers must address and attempt to resolve coordination of care issues with PCP's at the lowest possible level. If problems persist contact **UAHP's Customer Care** at **1-800-582-8686**.

UAHP Behavioral Health Case Management Department
UAHP has designated behavioral health and medical case managers who gather, review and communicate clinical information requested by providers.

Sharing information with other treating professionals, and involved stakeholders
To support quality medical management and prevent duplication of services, providers are required to disclose relevant behavioral health information pertaining to GMH/SA dual eligible members to the assigned PCP, UAHP, other treating professionals and other involved stakeholders within the following required timeframes:

- "Urgent" – requests for intervention, information, or response within 24 hours; and
- "Routine" – Requests for intervention, information, or response within 10 days.

Behavioral Health providers are required to pro-actively coordinate behavioral health and medical care for members. This includes helping members identify their health and wellness goals, include those goals in the members' Individualized Service Plans, and coordinating with medical professionals to help members achieve those goals.

Upon request by the PCP or member, information for any enrolled member must be provided to the PCP.

When contacting or sending any of the above referenced information to the member's PCP, providers must provide the PCP with an agency contact name and telephone number in the event the PCP needs further information.

An official form will not have to be used if there is a properly documented progress note. To be considered properly documented the progress note must:

- Include a header that states "Coordination of Care";
- Be legible; and
- Include all of the following required elements:
  - PCP's name and address
  - Reason for the communication
  - Clinical Summary including:
    - Diagnoses
    - Dose, frequency and target symptoms of current behavioral health

medications
        - Summary of critical labs
        - Other information as requested by the PCP
    - Response to PCP's referral questions
    - Additional Behavioral Health Provider Contact Information
    - Indicate the date and if the information was either mailed or faxed to the PCP

Responsibility for members enrolled in UAHP
Services are covered by UAHP for Prior Period Coverage.

Emergency Behavioral Health Services
When a GMH/SA Dual member presents in an emergency room setting, UAHP is the payer of last resort, after Medicare and any county fiscal responsibilities, for all emergency medical services including triage, physician assessment, and diagnostic tests. Additionally, UAHP is responsible for psychiatric and/or psychological evaluations in emergency room settings provided to all GMH/SA dual eligible members enrolled with UAHP.

UAHP is responsible for providing all inpatient emergency services to members with psychiatric or substance abuse diagnoses for all GMH/SA dual eligible members.

Emergency transportation of a GMH/SA dual eligible to the emergency room (ER) is the responsibility of UAHP. Emergency transportation of GMH/SA dual eligible member required to manage an acute medical condition, which includes transportation to the same or higher level of care for immediate medically necessary treatment, is the responsibility of UAHP. If a GMH/SA dual eligible member is assessed as needing inpatient psychiatric services by UAHP or its subcontracted provider prior to admission to an inpatient psychiatric setting, the entity responsible for primary coverage (Medicare coverage) is responsible for authorization and payment for the full inpatient stay, as per **Section 9.1- Securing Services and Prior Authorization** of this manual.

When a medical team or health plan requests a behavioral health or psychiatric evaluation prior to the implementation of a surgery, medical procedure or medical therapy to determine if there are any behavioral health contraindications, the entity responsible for primary coverage (Medicare coverage) is responsible for the provision of this service. Surgeries, procedures or therapies can include gastric bypass, interferon therapy or other procedures for which behavioral health support for a patient is indicated.

Non-emergency Transportation
Transportation of a GMH/SA eligible member to an initial behavioral health intake appointment is the responsibility of UAHP.

Medical Treatment for Members in Behavioral Health Treatment Facilities
When a GMH/SA Dual member is in a behavioral health residential treatment center and requires medical treatment, the entity responsible for primary coverage (Medicare coverage) is responsible for the provision of covered medical services.

If a GMH/SA Dual member is in a Level I psychiatric facility and requires medical treatment, those services are included in the per diem rate for the treatment facility. If the member requires inpatient medical services that are not available at the Level I psychiatric facility, the member must be discharged from the psychiatric facility and admitted to a medical facility. UAHP is responsible for Medicaid medically necessary services received at the medical facility.

PCPs prescribing psychotropic medications

Within their scope of practice and comfort level, a UAHP PCP may elect to treat select behavioral health disorders. The select behavioral health disorders that UAHP PCP's can treat are:

- Attention-Deficit/Hyperactivity Disorder;
- Uncomplicated depressive disorders; and
- Anxiety disorders.

Certain requirements and guiding principles regarding medications for psychiatric disorders have been established for members under the care of both a health plan PCP and behavioral health provider simultaneously. The following conditions apply:

- GMH/SA dual eligible members must not receive medications for psychiatric disorders from the health plan PCP and behavioral health provider simultaneously. If a member is identified to be simultaneously receiving medications from the health plan PCP and behavioral health provider, the provider must immediately contact the PCP to coordinate care and agree on who will continue to medically manage the member's behavioral health condition.

Transitions of members with ADHD, depression, and/or anxiety to the care of their Primary Care Physician

Members who have a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD), depression, and/or anxiety and who are stable on their medications may transition back to the care of their PCP for the management of these diagnoses, as long as the member, their guardian, and the PCP agree to this treatment transition. UAHP is required to facilitate this process and to ensure that the following steps are taken:

- The behavioral health provider must contact the member's PCP to discuss the

member's current medication regime and to confirm that the PCP is willing and able to provide treatment for the member's ADHD, depression, and/or anxiety;

- If the PCP agrees to transition treatment for the member's diagnosis of ADHD, depression and/or anxiety, The behavioral health provider must provide the PCP with the following information:
  - A written statement indicating that the member is stable on a medication regime;
  - A medication sheet or list of medications currently prescribed by a UAHP Behavioral Health Medical Practitioner (BHMP);
  - A psychiatric evaluation;
  - Any relevant psychiatric progress notes that may assist in the ongoing treatment of the member; and
  - A discharge summary outlining the member's care and any adverse responses the member has had to treatment or medication.
- A copy of the packet must be sent to the **UAHPCaseManagementBHmailbox@bannerhealth.com**.

UAHP will ensure that the member's transition to the PCP is seamless, and that the member does not go without medications during this transition period.

UAHPs contracted behavioral health providers must ensure the member is eligible for transition to the care of their PCP by completing the following steps:

- The member's behavioral health provider must confirm that the member has a diagnosis of ADHD, depression, and/or anxiety;
- The member's behavioral health provider must confirm that the member has been stable for at least six months. Indicators for stability are as follows:
  - No medication changes or dosage changes;
  - No inpatient admissions; and
  - No crisis episodes.
- The behavioral health prescriber who is actively prescribing psychiatric medications for the GMH/SA dual member must contact the member's assigned PCP telephonically to discuss the member's current prescription regimen. The behavioral health prescriber must confirm that the PCP is willing and able to provide medication management services to the member.

If these requirements are met, then the member is eligible to transition back to the care of their PCP. When a member is determined eligible to have their PCP prescribe their psychotropic medications, the member's behavioral health provider must confirm with the member at the time of the transition that he or she is willing to transition back to the care of their PCP.

UAHP's behavioral health providers are responsible for submitting the clinical information to the PCP and the UAHP Behavioral Health Case Management Department at UAHPCaseManagementBHmailbox@bannerhealth.com.

UAHP behavioral health providers must ensure that the member has sufficient medications to cover the transition period.

General Psychiatric Consultations
Behavioral health medical practitioners must be available to UAHP's primary providers to answer diagnostic and treatment questions of a general nature.

General psychiatric consultations are not member specific and are usually conducted over the telephone between the PCP and the behavioral health medical practitioner.

One-Time Face-to-Face Psychiatric Evaluations
Providers must be available to conduct a face-to-face evaluation with a GMH/SA dual eligible member upon his/her primary provider request in accordance with **Section 3.1 Appointment Standards and Timeliness of Service** of this manual.

A one-time face-to-face evaluation is used to answer primary provider specific questions and provide clarification and evaluation regarding a member's diagnosis, recommendations for treatment, need for behavioral health care, and/or ongoing behavioral health care or medication management provided by the PCP.

The PCP must have seen the member prior to requesting a one-time face-to-face psychiatric evaluation with the behavioral health provider.

UAHP's behavioral health providers must supply information to UAHP and/or UAHP primary care providers' current information about how to access psychiatric evaluation services.

4.3 Coordination of Care with Other Governmental Entities

Effective communication and coordination of services are fundamental objectives for providers when serving members involved with other government entities. When providers coordinate care efficiently, the following positive outcomes can occur:

- Duplicative and redundant activities, such as assessments, service plans, and agency meetings are minimized;
- Continuity and consistency of care are achieved;
- Clear lines of responsibility, communication and accountability across service providers in meeting the needs of the member and family are established and communicated; and
- Limited resources are effectively utilized.

UAHP recognizes the importance of a responsive behavioral health system, especially when the needs of vulnerable members have been identified by other government entities. The intent of this section is to communicate UAHP's expectations for providers who must cooperate and actively work with other agencies serving members.

Courts and Corrections
UAHP and its providers are expected to collaborate and coordinate care for members involved with the justice system including:

- The Arizona Department of Corrections (ADOC);
  - Administrative Offices of the Court (AOC).
  - County Jails
  - Sheriff's Offices
  - Correctional Health Services
  - Community Supervision and Probation Departments
  - Parole Offices

When a member receiving services is also involved with a court or correctional agency or UAHP has identified an incarcerated member that will require services upon release, providers work towards effective coordination of services by:

- Working in collaboration with the appropriate staff involved with the member;
- Inviting probation or parole to participate in the development of the service plan and all subsequent planning meetings as approved by the member;
- Actively considering information and recommendations contained in probation or parole case plans when developing the service plan; and
- Ensuring that the provider evaluates and participates in transition planning prior to the release of eligible members and arranges and coordinates care upon the member's release.

Arizona County Jails

When someone detained in jail is believed to have a behavioral health diagnosis and the member does not have alternative means to obtain services, jail member may request the assistance of UAHP's contracted providers to coordinate care as outlined below. UAHP's contracted providers are required to accept all requests for Coordination of Care assistance from county jails and perform the following duties:

- Timely and proactively collaborate with the appropriate jail and court staff involved with the member;
- Proactively ensure that screening and assessment services, and coordination of care services are provided;
- Provide consultation services to advise jail staff related to diagnosis, medications and the provision of other behavioral health services to jailed members upon request;
- Ensure that the member has a viable release plan, that includes access to medications, peer support services, counseling, transportation and housing;
- Facilitate continuity of care if the member is discharged or incarcerated in another correctional institution;
- Share pertinent information with all staff involved with the member's care or incarceration with member approval.
- Provide assistance in the determination of whether the member is eligible for Mental Health Court or a Jail Diversion Program.
- Collaborate with UAHP's Case Management Department to ensure the member has a scheduled assessment or intake appointment, as per instructed by the UAHP Case Manager transitioning the member from incarceration back into the community.
- Immediately assess recently released members for service needs such as substance abuse treatment, psychiatric services, medication management, anger management, etc. and enroll members into these programs to support their transition back into their community.
- Collaborate with UAHP's Case Management Department regarding coordination of care for at risk members that have been identified by UAHP as having complicated/complex health care conditions that require high touch case management and care coordination to ensure improved health outcomes and reduction in recidivism.

Arizona Department of Economic Security/Rehabilitation Services Administration (ADES/RSA)

The purpose of RSA is to work with members with disabilities to achieve increased independence or gainful employment through the provision of comprehensive rehabilitative and employment support services.

Supportive employment services available through the AHCCCS system are distinct from

vocational services available through RSA. Please refer to the UAHP Medicaid Behavioral Health Covered Services Guide for more details at www. UAHealth.com

Arizona Department of Health Services/Office of Assisted Living Licensing
When a member receiving services is residing in an assisted living facility, providers must coordinate with the Office of Assisted Living Licensing to ensure that the facility is licensed and that there are no existing violations or legal orders. Providers must also determine and ensure that the member living in an assisted living facility is at the appropriate level of care. The provider can coordinate with the Office of Assisted Living Licensing to determine the level of care that a particular assisted living facility is licensed to provide.

First Responders and Community Agencies
UAHP expects its providers to proactively collaborate with municipal first responders: police, fire, EMS, RBHA contracted crisis providers and hospital emergency departments and develop strong, effective relationships in the communities they serve.

Veterans Administration
The Veteran's Administration (VA) is a federally funded health system that provides benefits to members who served in the active military, naval, or air service, and who were discharged or released under conditions other than dishonorable (Congressional Research Center, 2012). UAHP members with Veteran benefits can receive services from UAHP contracted providers. Veterans have a choice from whom they prefer to receive services. Veterans can receive mental health benefits through UAHP's network and physical health services through the VA, or medication only from one or the other, or any combination thereof. UAHP and its contracted providers are responsible to work collaboratively with the VA to share information and coordinate care.

UAHP endorses the Arizona Coalition for Military Families, a public/private partnership to care for and support all service members, veterans and their families. Contact them at www.ArizonaCoalition.org.

When working with service members keep in mind the following considerations:

1. The interests of the service member, veteran and family should come first.
2. Potential conflicts of interests should be disclosed.
3. Respect the service member, veteran and/or family member providing accurate information.
4. Individuals and organizations should only offer programs, services and resources they are equipped or trained to deliver.
5. Organizations that outreach to the military/veteran population have an obligation to equip their personnel and organizations.
6. Outreach and messaging to the military and veteran population should be truthful.

7. Organizations should be cautious about promising outcomes.
8. Coordination of care and follow up is essential.

Indian Health Services

Indian Health Services (IHS) is an agency within the Department of Health and Human Services and is responsible for providing federal health services to American Indians and Alaskan Natives. Individuals who are eligible for IHS benefits through an IHS provider or 638 licensed facility and are eligible to received services from UAHP's contracted providers have a choice in whom they prefer to receive services. American Indian and Alaskan Natives can receive mental health benefits through UAHP's network and physical health services through the IHS, or medication only from one or the other, or any combination thereof. UAHP and its contracted providers are responsible to work collaboratively with IHS to share information and coordinate care.

Section 5 – Specific Behavioral Health Program Requirements

5.1 Requirements for Providers of Intravenous Drug and Opioid Treatment Services

Intravenous Drug and Opioid Treatment Providers must comply with all Opioid Treatment Regulations at 42 CFR Part 8, AHCCCS Licensing regulations, and UAHP Provider Manual requirements. IV Drug and Opioid Treatment Providers must provide an Opioid Treatment Program that includes, at a minimum, treatment for opiate dependence, dosing as appropriate, and all services necessary to facilitate effective treatment. IV Drug and Opioid Treatment Providers must verify services are delivered as outlined on the member's Service Plan.

Promotion of Recovery
Treatment must promote recovery, minimizing the impact of substances on the member's life and assisting the member in reaching the maximum level of functioning in life appropriate for the member.

Adult Recovery Team Meetings
IV Drug and Opioid Treatment Providers must attend ART meetings by phone or in person, coordinate effectively with all providers engaged in the provision of services to the member, and provide monthly updates to the Adult Recovery Team facilitator.

Provider Access
IV Drug and Opioid Treatment Providers must verify members have access to adequate medical, counseling, vocational, educational and other assessment and treatment services to members through the UAHP provider network. Services may be available at the provider's facility or may be provided by a UAHP provider or a private or public agency, organization, practitioner, or institution for which a formal agreement has been obtained with UAHP. IV Drug and Opioid Treatment Providers must verify the member's medical record includes documentation that these services are fully and reasonably available to the member through the UAHP provider network, and provided in accordance with the member's Individual Service Plan. Not all assessments, screenings, diagnostic evaluations and supportive services need to be done within the program itself, and it may be more appropriate to facilitate access to the array of evaluations and services needed through qualified and cooperating agencies affiliated as part of the UAHP provider Network. IV Drug and Opioid Treatment Providers must verify members are given access to services near their homes to facilitate better care for patients and to avoid additional travel and inconvenience.

Maintenance Treatment
IV Drug and Opioid Treatment Providers must maintain current procedures designed to verify that members are admitted to maintenance treatment by qualified member staff who have determined, using the Diagnostic and Statistical manual for Mental Disorders (DSM), that the

member is currently addicted to an opioid drug, and that the member became addicted at least 1 year before admission for treatment. If clinically appropriate, the program physician may waive the requirement of a 1-year history of addiction for patients released from penal institutions (within 6 months after release), for pregnant patients (program physician must certify pregnancy), and for previously treated patients (up to 2 years after discharge).

IV Drug and Opioid Treatment Providers must verify the program physician verifies that each member voluntarily chooses maintenance treatment and that all relevant facts concerning the use of the opioid drug are clearly and adequately explained to the member, and that each member provides informed written consent to treatment. IV Drug and Opioid Treatment Providers must fully educate the member about all treatment options and strategies to promote recovery from opiate abuse; including, health risks, relapse risks, and alternative treatments. Each member must undergo a complete, fully documented physical evaluation by a program physician or a primary care physician before admission to the program. The full medical examination, including the results of serology and other tests, must be completed within 14 days following admission.

Screening

IV Drug and Opioid Treatment Providers must verify members are screened and evaluated for the possibility of infectious disease, liver or pulmonary conditions, cardiac abnormalities, psychiatric problems, dermatologic sequelae of addiction, and possible concurrent surgical and other problems by conducting testing or referring patients for consultation and testing. Methadone has well documented impacts on several organ systems, including the respiratory, nervous, liver, and cardiac systems. Therefore, medical exams must determine whether the treatment drug will be Methadone, Buprenorphine, or another medication, or whether the treatment indicated is induction, detoxification, or maintenance. This assessment must occur upon entry into the program and includes documenting a list of medications the patient is currently taking with the actual (rather than prescribed) doses, any diverted or illicit substances the patient is taking, potential adulterants sometimes contained within illicit substances that are in themselves medically active (e.g. quinine), and medically active over-the-counter (OTC) or natural remedies. The physician should check on and consider interactions between these medications and the medication ordered to treat opioid addiction prior to initiating treatment.

Many medications can act to increase the QT interval seen on an electrocardiogram (EKG) and potentially lead to torsade's de pointes, a potentially life-threatening cardiac arrhythmia. Physicians must monitor for the potential QT-prolonging effects of methadone, especially with high doses. In addition, physicians must monitor for interactions between Methadone and other medications that also have QT-prolonging properties, or with medications that slow the elimination of methadone. The medical assessment must specifically cover the symptoms and risk factors for torsade's de pointes, and any indicated follow-up tests that may include an EKG or a more comprehensive electrophysiological assessment. IV Drug and Opioid Treatment Providers must verify the member reads and signs documentation outlining the discovery or

risk of torsade's de pointes. IV Drug and Opioid Treatment Providers must verify a thorough assessment has been completed including, medical and family history, including sex and age of children, whether children are living with parents, and family medical and drug use histories. In addition, providers must verify a complete medical history has been completed; including current information to determine chronic or acute medical conditions, such as diabetes; renal diseases; hepatitis A, B, C, and D; HIV exposure; tuberculosis (TB); sexually transmitted diseases (STDs); other infectious diseases; sickle-cell trait or anemia; pregnancy (including past history of pregnancy and current involvement in prenatal care); and chronic cardiopulmonary diseases. Provider must verify a full medical evaluation is completed within 14 days of treatment initiation.

Tests and Assessments

Members must receive all appropriate tests and assessments, as medically appropriate, including the following:

- Vital signs, including blood pressure, pulse, respirations, and temperature
- TB skin test and chest x-ray, if skin test is positive (including consideration for
- energy)
- Screening test for syphilis
- Complete blood count (CBC) and lipid panel
- Electrocardiogram (EKG), chest x-ray, Pap smear, and screening for sickle cell
- disease
- Liver function tests and viral hepatitis marker tests
- HIV testing and counseling
- Tests appropriate for the screening or confirmation of illnesses or conditions, as
- recommended by U.S. Preventive Services Task Force or based on concerns specific to the patient regarding renal function, electrolyte imbalance, metabolic syndromes, pain, etc.
- Pregnancy test when indicated
- Appropriate neurological or psychological testing and assessment, as indicated
- Based on baseline screening tests, providers must coordinate with the member's Adult Recovery Team to make appropriate referrals for more diagnostic testing, especially when those results have potential to significantly change treatment decisions (such as when a screening EKG suggests a prolonged QT interval in a symptomatic patient). An initial toxicology test must be completed as part of the admission process. IV Drug and Opioid Treatment Providers must test admission samples for opiates, methadone, amphetamines, cocaine, marijuana, and benzodiazepines, at the minimum. Additional testing is required based on the individual member's need and local drug-using conditions and trends.

Dosing Procedures
IV Drug and Opioid Treatment Providers must develop and maintain procedures to verify that the correct dose of medication(s) is administered and that appropriate actions are taken if a medication error is made. Procedures should include a mechanism for reporting untoward incidents to appropriate program staff and UAHP. Dosing supplies must be available in the event of an emergency.

Diversion Control Plan
IV Drug and Opioid Treatment Providers must maintain a current Diversion Control Plan as part of its quality assurance program that contains specific measures to reduce the possibility of diversion of controlled substances from legitimate treatment use to illicit use and that assigns specific responsibility to the medical and administrative staff for carrying out the diversion control measures and functions described in the Diversion Control Plan. The goal of this program is to reduce the scope and significance of diversion and its impact on communities.

The Diversion Control Plan must contain a mechanism for periodic monitoring of clinical and administrative activities to reduce the risk of medication diversion.

Alternative Treatments
Member requests for alternative treatment such as acupuncture must be honored and providers must coordinate with the member's Adult Recovery Team to make appropriate referrals. Please contact UAHP's Behavioral Health Department regarding services for acupuncture to treat opiate addiction.

Detoxification
IV Drug and Opioid Treatment Providers must facilitate appropriate detoxification, tapering or medically supervised withdrawal when medically indicated or requested by the member (either with or against medical advice). Providers must verify members withdrawing from Opioid Treatment Program receive access to community supports, relapse prevention services, self-help groups and professional counseling.

Information Regarding Dangers of Street Drugs
IV Drug and Opioid Treatment Providers must post in all clinic lobbies posters that warn members of the potential life-threatening dangers of using street drugs, other opioids, or benzodiazepines while being prescribed opioids. IV Drug and Opioid Treatment Providers must ask members to read and sign a statement that indicates the life threatening dangers of using street drugs, other opioids, or benzodiazepines while being enrolled in an Opioid Treatment Program at the time of entry into the Opioid Treatment Program and at least annually thereafter. In addition, providers must ask the member to read and sign a statement that indicates the life-threatening dangers of using street drugs, other opioids, or benzodiazepines while being enrolled in an Opioid Treatment Program at any time the provider learns the member is using street drugs, other opioids, or benzodiazepines.

Section 6- Credentialing and Re-Credentialing Requirements

6.1 Credentialing and Re-Credentialing

Credentialing and re-credentialing is an ongoing review process to assure the current competence of practitioners by validating the training and competence of individual practitioners in particular specialty areas. This level of review is intended to provide verification that the appropriate training, experience, qualifications, and ongoing competence has been demonstrated by individual practitioners for the services they provide.

The credentialing and re-credentialing requirements differ depending on the type of provider. Physicians, nurse practitioners, physician assistants, psychologists and all other behavioral health professionals who are registered to bill independently (Licensed Professional Counselor, Licensed Marriage and Family Therapist or Licensed Certified Social Worker) or provide services for which they are licensed to perform must be credentialed prior to providing services

This section applies to providers providing services to GMH/SA Dual members enrolled with the UAHP. The following provider types are subject to credentialing and re- credentialing requirements outlined below in the Initial and Re-credentialing Review:

- Physicians (MD and DO);
- Licensed Psychologists;
- Nurse Practitioners (Nurse Practitioners must have certifications that denote they have certifications that align with their Scope of Practice);
- Physician Assistants;
- Licensed Clinical Social Workers (only required if they will be billing independently);
- Licensed Professional Counselors (only required if they will be billing independently);
- Licensed Marriage and Family Therapists (only required if they will be billing independently);
- Licensed Independent Substance Abuse Counselors (only required if they will be
- billing independently);
- Board Certified Behavior Analysts
- Behavioral Health Residential Facilities;
- Behavioral Health Outpatient Clinics;
- Free standing psychiatric hospitals;
- Psychiatric and addiction disorder units;
- Hospitals and units in general hospitals;
- Psychiatric and addiction disorder residential treatment centers; and
- Community mental health centers.

Credentialing Process

As a quality measure, UAHP requires providers to complete the credentialing process prior to rendering care to our members. The initial credentialing process includes extensive review and verification of education, training, previous work history, licensure, professional liability coverage, and malpractice claims history, as well as all other information relevant to the qualifications and ability of any provider to render quality medical care to members in accordance with our policies and procedures. The credentialing process is based on the standards of the National Committee for Quality Assurance (NCQA) as well as the standards set forth by AHCCCS. Procedures are also in compliance with all applicable State and Federal legal requirements.

UAHP providers are re-credentialed every three years, at a minimum. The re-credentialing process consists of updating all of the applicable exportable information, review of licensure, board certification, screening for sanctions, review of medical malpractice history, and site reviews if necessary. In addition, the re-credentialing process includes thorough review of performance information to include grievance and appeals date, quality of care indicators, Medicaid performance measures and utilization management.

UAHP is participating in the AzAHP credentialing alliance in order to streamline the credentialing and re-credentialing process, reduce the administrative burden and eliminate duplication for our providers.

As part of the streamlined process, UAHP has agreed to utilize the Council for Affordable Quality Healthcare (CAQH) Universal Provider Data source for all practitioner credentialing applications and a common paper application for all facility credentialing applications. A common practitioner data form and organizational data form has been developed to collect information necessary for the contract review process and system loading requirements.

On behalf of the participating plans, AzAHP has contracted with Aperture™ Credentialing (Aperture™) for primary source verification (PSV) services for the alliance. Aperture™ will perform the PSV once and share the results with each participating plan that you have authorized to receive it.

<u>Following are additional details related to the AzAHP credentialing alliance and some of the benefits that you can expect to see from it.</u>

Practitioners and Facilities <u>CURRENTLY</u> Contracted with more than one of the Participating Plans

1. A single date will be established that allows one re-credentialing process to satisfy the re-credentialing requirement for each of the participating plans with which you are contracted. That date will be the earliest date that you were set to be re-credentialed by

any of the participating plans. Following the initial alliance re-credentialing event, your next re-credentialing date will be set 3 years out.

2. For practitioner groups that are adding a new practitioner, you will simply complete the common Practitioner Data Form (found on our websites) once and send to each of the participating plans you are contracted with. Practitioners must also make sure CAQH is updated and each of the participating plans that you are contracted with are approved to access your CAQH application.

Practitioners and Facilities REQUESTING Contracts with one or more of the participating plans

1. Complete the appropriate common data form (Practitioner or Organizational forms, found on our websites) once and send to the participating plan(s) you wish to contract with.
2. Practitioners who are registered with CAQH are encouraged to make sure CAQH is updated and each of the participating plans that you wish to contract with is approved to access your CAQH application. Practitioners who are not currently registered with CAQH and Facilities will be contacted by the plan or Aperture™ regarding the need for a credentialing application.
3. If you are a practitioner that requires a site visit as part of the initial credentialing event or a facility that requires a site visit as part of the initial credentialing event (facilities that are not accredited or surveyed), the participating plan(s) that you are requesting to contract with will have access to any site visit already performed under the alliance. If a site visit has already been performed by another participating plan in the AzAHP credentialing alliance, another site visit will not be necessary. If no site visit has been performed by a participating plan in the AzAHP credentialing alliance, a single site visit will be performed as part of the initial credentialing event and made available to all participating plans.

NOTE: Each participating plan retains the right to make their own contracting decisions (whether or not to add practitioners and facilities to their network) and will make their own credentialing committee decisions (review of the primary source verification information obtained by Aperture™ resulting in approval/denial by the plan's committee).

Information About the AzAHP Credentialing Alliance Partners

Aperture Credentialing is the nation's largest Credentials Verification Organization (CVO) performing approximately 550,000 credentialing events each year. They are certified by NCQA, accredited by URAC, and compliant with JCAHO standards. Aperture™ has experience as the

CVO of other credentialing alliances similar to the AzAHP credentialing alliance, and works closely with CAQH.

You will receive correspondence from Aperture™ on behalf of the plans participating in the AzAHP credentialing alliance requesting that you complete or update a credentialing application and/or provide additional documentation in order to complete your application process. Likewise, if your application process includes CAQH, it will be imperative that you continue to update and re-attest to your information on a regular and timely basis.

Any requests from Aperture™ are legitimate and vital to the timely completion of your initial credentialing or re-credentialing event.

Launched in 2002, CAQH's data-collection initiative, the Universal Provider Data Source® (UPD) allows registered physicians and other health professionals in all 50 states and the District of Columbia to enter their credentialing information free of charge into a single, uniform online system that meets the credentialing needs of most health plans, hospitals and other healthcare organizations. In April 2012, CAQH surpassed 1 million registered healthcare providers. More than 550 health plans/organizations currently participate in UPD, and approximately 10,000 new providers register in the service each month.

All data submitted by providers through UAHP is maintained by CAQH in a secure, state-of-the-art data center. Providers authorize health plans and other organizations access to the information. Providers needing more information about registering with the service or completing the UPD application should visit https://proview.caqh.org/.

Temporary/Provisional Credentialing Process
Occasionally, it is in the interest of members to allow practitioners availability in the network prior to completion of the entire initial credentialing process.

Provisional credentialing can only be conducted on the following provider types:

- Physicians (MD's and DOs);
- Licensed Psychologists (PhDs);
- Licensed Psychiatrists;
- Nurse Practitioners;
- Physician Assistants;
- Licensed Clinical Social Workers (LCSWs);
- Licensed Marriage and Family Therapists (LMFTs);
- Licensed Independent Substance Abuse Counselors (LISACs);

- Licensed Professional Counselor (LPCs).

Per the AHCCCS Medical Policy Manual, Policy 950, UAHP has 14 days from receipt of a complete application accompanied by the designated documents to render a decision regarding temporary or provisional credentialing. Practitioners applying to the network for the first time are eligible for provisional credentialing. A practitioner may only be provisionally credentialed once and practitioners may not be held in a provisional credentialing status for more than 60 calendar days. Providers that are in a provisional status, that do not clear the Initial Credentialing Requirements will be terminated.

If you have any questions, please contact your Provider Relations Representative.
The University Arizona Health Plans (520) 874-5290 or (800) 582-8686
www.uahealthplans.com
www.ufcaz.com.

Section 7 – Finance/Billing

7.1 Copayments

The purpose of this policy is to describe copayment requirements for health care services provided by UAHP. A copayment is a monetary amount that a member pays directly to a provider at the time covered services are rendered. This policy covers Arizona Health Care Cost Containment System (AHCCCS) copayments for the Title XIX (Medicaid)/XXI (KidsCare) population. Although members may be exempt from AHCCCS copayments, these individuals may still be subject to Medicare copayments.

AHCCCS Copayments for Title XIX/XXI members
Members who are Title XIX/XXI eligible will be assessed a copayment in accordance with A.A.C. R9-22-711. Certain populations and certain services are exempt from copayments. This means that copayments will not be charged to anyone if they are in a population or category listed in section 3 (C) - or if the service is listed in section 3.(C). AHCCCS copayments are not charged to the following members for any service:

1. Members under age 19;
2. Members who are eligible for Medicare Cost Sharing in 9 A.A.C. 29;

AHCCCS copayments are not charged for the following services for anyone:

1. Inpatient hospital services and services in the Emergency Department;
2. Emergency services;

Nominal (optional) copayments for certain AHCCCS members
Individuals eligible for AHCCCS through any of the populations listed below may have nominal (optional) copayments for certain services. Nominal copayments are also referred to as optional copayments. Providers are prohibited from refusing services to members who have nominal (optional) copayments if the member states he or she is unable to pay the copayment.

Members with nominal (optional) copayments are:

1. Individuals eligible under the Young Adult Transitional Insurance (YATI) for young adults who were in foster care;
2. Individuals receiving Supplemental Security Income (SSI) through Social Security Administration for people who are age 65 or older, blind or disabled;
3. Individuals in the Freedom to Work (FTW) program.
4. Caretaker relatives eligible under AAC R9-22-1427(A) (also known as AHCCCS for Families with Children under section 1931 of the Social Security Act);

5. Individuals receiving SSI Medical Assistance Only (SSI MAO) who are age 65 or older, blind or disabled

Nominal (optional) copayments are listed in Table 1:

Table 1

Nominal (Optional) Copayments

Service	Copayment
Prescriptions	$2.30
Out-patient services for physical, occupational and speech therapy	$2.30
Doctor or other provider outpatient office visits for evaluation and management of your care. This excludes emergency room/emergency department visits	$3.40

Five Percent Aggregate limit for nominal (optional) and mandatory copayments
The total aggregate amount of copayments for members who have nominal (optional) and/or mandatory copayments cannot exceed 5% of the family's income on a quarterly basis. The AHCCCS Administration will review claims and encounters information to establish when a member's copayment obligation has reached 5% of the family's income and will communicate this information to providers. The member may also establish that the aggregate limit has been met on a quarterly basis by providing the AHCCCS Administration with records of copayments incurred during the quarter.

Section 8 – Quality Management Requirements

8.1 Medical Records Standards

The purpose of this section is to ensure that providers maintain medical records that document medical needs, changes, and the delivery of necessary services. Medical records must be complete, accurate, accessible, and permit systematic retrieval of information while maintaining confidentiality. Documentation in the medical record facilitates diagnosis and treatment, coordination of care, supports billing reimbursement information, provides evidence of compliance during periodic medical record reviews and can protect practitioners against potential litigation.

The medical record contains clinical information pertaining to a member's physical, if applicable, and behavioral health. Maintaining current, accurate, and comprehensive medical records assists providers in successfully treating and supporting recipient care.

Providers must maintain legible, signed, and dated medical records in paper or electronic format that are written in a detailed and comprehensive manner; conform to good professional practices; permit effective professional review and audit processes; and facilitate an adequate system for follow up treatment.

Adequacy and Availability of Documentation
All providers must maintain and store records and data that document and support the services provided to Members and the associated encounters/billing for those services. In addition to any records required to comply with providers' contracts with UAHP, there must be adequate documentation to support that all billings or reimbursements are accurate, justified and appropriate.

All providers must prepare, maintain and make available to UAHP or AHCCCS, adequate documentation related to services provided and the associated encounters/billings. Adequate documentation is electronic records and "hard-copy" documentation that can be readily discerned and verified with reasonable certainty. Adequate documentation must establish medical necessity and support all medically necessary services rendered and the amount of reimbursement received (encounter value/billed amount) by a provider; this includes all related clinical, financial, operational and business supporting documentation and electronic records. It also includes medical records that support and verify that the member's assessment, diagnosis and Individual Service Plan (ISP) are accurate and appropriate and that all services (including those not directly related to clinical care) are supported by the assessment, diagnosis and ISP.

For monitoring, reviewing and auditing purposes, all documentation and electronic records must be made available at the same site at which the service is rendered. If requested documents and electronic records are not available for review at the time requested, they are considered missing. All missing records are considered inadequate. If documentation is not available due to off-site storage, the provider must submit their applicable policy for off-site storage, demonstrate where the requested documentation is stored and arrange to supply the documentation at the site within 24 hours of the original request.

A provider's failure to prepare, retain and provide to UAHP or AHCCCS adequate documentation and electronic records for services encountered or billed may result in the recovery and/or voiding (not to be resubmitted) of the associated encounter values or payments for those services not adequately documented and/or result in financial sanctions to the provider and UAHP.

Inadequate documentation may be determined to be evidence of suspected fraud or program abuse that may result in notification or reporting to the appropriate law enforcement or oversight agency. These requirements continue to be applicable in the event the provider discontinues as an active participating and/or provider as the result of a change of ownership or any other circumstance.

Paper or electronic format
Records may be documented in paper or electronic format. For paper medical records the documentation must include:

- Date and time
- Signature and credentials
- Legible text written in blue or black ink or typewritten;
- Corrections with a line drawn through the incorrect information, a notation that the incorrect information was an error, the date when the correction was made, and the initials of the member altering the record. Correction fluid or tape is not allowed; and
- If a rubber-stamp signature is used to authenticate the document or entry, the individual whose signature the stamp represents is accountable for the use of the stamp.

A progress note is documented on the date that an event occurs. Any additional information added to the progress note is identified as a late entry (see **A.A.C. R9-20-211(C), Client Records**).

Providers that use electronic medical records and documentation must require that:

- Safeguards are in use to prevent unauthorized access;
- The date and time of an entry in a medical record is recorded as noted by the computer's internal clock;

- The record is recorded only by persons authorized to make entries using UAHP's or its subcontracted providers established policies and procedures;
- The record indicates the identity of the member making an entry; and
- Electronic signatures used to authenticate a document are properly safeguarded and the individual whose signature is represented is accountable for the use of the electronic signature.

Electronic medical records and systems must also:

- Ensure that the information is not altered inadvertently;
- Track when, and by whom, revisions to information are made; and
- Maintain a backup system including initial and revised information.

Providers must meet all federal electronic health record requirements. The federal government may impose penalties on the provider of service in the form of rate reductions for noncompliance.

Medical Record

The provider of care must verify the development and maintenance of a comprehensive medical record for each member. The medical record, whether electronic or hard copy, may contain information contributed by several service providers involved with the care and treatment of a member. This section describes categories of information to be included in a member's medical record: (a) the minimum information; (b) physical health information; (c) the behavioral health record; and (d) information from Community Service Agencies (CSAs), Home Care Training to Home Care Client (HCTC) providers and Habilitation providers.

Minimum Information

The comprehensive medical record must include the following to the fullest extent possible:

- Member identification information on each page of the record (i.e., member's name and AHCCCS /CIS identification number);
- Documentation of identifying demographics including a member's name, address, telephone number, AHCCCS identification number, gender, age, date of birth, marital status, next of kin, and, if applicable, guardian or authorized representative;
- Initial history for the member that includes family medical/behavioral health history, social history and laboratory screenings (the initial history of a member under age 21 should also include prenatal care and birth history of the member's mother while pregnant with the member);
- Past medical/behavioral health history for all members that includes disabilities and any previous illnesses or injuries, smoking, alcohol/substance abuse, allergies and adverse reactions to medications, hospitalizations, surgeries and emergent/urgent care received;
- Current presenting concerns;

- Documentation of any review of behavioral health record information by any member or entity (other than members of the Adult Recovery Team) that includes the name and credentials of the member reviewing the record, the date of the review, and the purpose of the review; and
- Identification of other Stakeholder involvement (DES/DDD, Adult Probation Officer/ Department of Corrections (DOC), Department of Child Safety (DCS), DES Adult Protective Services (APS), etc.).

Physical Health Information

In addition to the minimum information requirements above, the medical record must include the following physical health information:

- Immunization records (if available);
- Current medical and behavioral health problem list;
- Current physical and behavioral health medications;
- Current and complete Early and Periodic Screening, Diagnostic and Treatment (EPSDT) forms (required for all members age 18 through 20 years);
- Documentation in the comprehensive medical record must be initialed and dated by the member's UAHP-contracted PCP, to signify review of diagnostic information including:
    - o Laboratory tests and screenings,
    - o Radiology reports,
    - o Physical examination notes,
    - o Behavioral health information received from the behavioral health provider; and
    - o Other pertinent data.
- Reports from referrals, consultations and specialists;
- Emergency and urgent care reports;
- Hospital discharge summaries;
- Behavioral health referrals and services provided, if applicable, including notification of behavioral health providers, if known, when a member's health status changes or new medications are prescribed;
- Behavioral health history;
- Documentation as to whether or not the member has completed advance directives and location of the document;
- Documentation related to requests for release of information and subsequent releases, including retaining consent and authorization for medical records as prescribed in A.R.S. § 12-2297. HIPAA related documents must be retained for a period of six years per 45 CFR 164.530(j) (2); and
- Documentation that reflects that diagnostic, treatment and disposition information related to a specific member was transmitted to the PCP and other providers, including behavioral health providers, as appropriate to promote continuity of care and quality management of the member's health care.

Behavioral Health Records

Any information maintained in a behavioral health provider's record must also be maintained in the medical record. For General Mental Health/ Substance Abuse (GMH/SA) and Integrated Health where the provision of behavioral health services is separate from the provision of physical health services, in addition to the minimum information listed above, the following information must be maintained and forwarded for inclusion in the medical record:

Intake Documentation:

- For members receiving state only services, documentation that notice was provided regarding the member's right to receive services from a provider to whose religious character the member does not object
- Documentation of the member's receipt of the Notice of Privacy Practice; and
- Contact information for the member's primary care provider (PCP), if applicable.

Assessment Documentation:

- Documentation of all information collected in the behavioral health assessment, any applicable addenda and required demographic information
- Documentation of all information collected in the annual update to the behavioral health assessment including any applicable addenda and updated demographic information;
- Diagnostic information including psychiatric, psychological and medical evaluations;
- An English version of the assessment and/or service plan if the documents are completed in any language other than English; and
- For members receiving services via telemedicine, copies of electronically recorded information of direct, consultative or collateral clinical interviews.

Treatment and Service Plan Documentation:

- The member's treatment and service plan;
- Adult Recovery Team (ART) documentation; and
- Progress reports or Service Plans from all other additional service providers
- Progress Notes Documentation:
    - Documentation of the type of services provided;
    - The diagnosis, including an indicator that clearly identifies whether the progress note is for a new diagnosis or the continuation of a previous diagnosis. After a primary diagnosis is identified, the member may be determined to have co-occurring diagnoses. Each provider that the member is referred to for treatment may be addressing a different or new diagnosis. The service providing clinician will place the diagnosis code in the progress note to indicate which diagnosis is being addressed during the provider session. The addition of the progress note diagnosis code (**accurate to all digits of the specific ICD-10/DSM-V code that applies**) should be included;

- The date the service was delivered;
- Duration of the service (time increments) including the code used for billing the service;
- A description of what occurred during the provision of the service related to the member's treatment plan;
- In the event that more than one provider simultaneously provides the same service to a member, documentation of the need for the involvement of multiple providers including the name and roles of each provider involved in the delivery of services;
- The member's response to service; and
- For members receiving services via telemedicine, electronically recorded information of direct, consultative or collateral clinical interviews.

Medical Services Documentation:

- Laboratory, x-ray, and other findings related to the member's physical and behavioral health care;
- The member's treatment plan related to medical services
- Physician's orders;
- Requests for service authorizations
- Documentation of facility-based or inpatient care;
- Documentation of preventative care services;
- Medication record, when applicable; and
- Documentation of Certification of Need (CON) and Re-Certification of Need (RON), when applicable.

Reports from Other Agencies:

- Reports from providers of services, consultations, and specialists;
- Emergency/urgent care reports; and
- Hospital discharge summaries.

Paper or Electronic Correspondence:

- Documentation of the provision of diagnostic, treatment, and disposition information to the PCP and other providers to promote continuity of care and quality management of the member's health care;
- Letters;
- E-mails, printed out; and
- Documentation of any requests for and forwarding of behavioral health record information.

Legal Documentation:

- Documentation related to requests for release of information and subsequent releases;

- Copies of any advance directives or mental health care power of attorney, if applicable including:
    - Documentation that the adult member was provided the information on advance directives and whether an advance directive was executed;
    - Documentation of authorization of any health care power of attorney that appoints a designated member to make health care decisions (not including mental health) on behalf of the member if they are found to be incapable of making these decisions; and
    - Documentation of authorization of any mental health care power of attorney that appoints a designated member to make behavioral health care decisions on behalf of the member if they are found to be incapable of making these decisions.
- Documentation of general and informed consent to treatment
- Authorization to disclose information
- Any extension granted for the processing of an appeal must be documented in the case file, including the Notice regarding the extension sent to the member and his/her legal guardian or authorized representative if applicable
- For members undergoing a voluntary evaluation, as described in **Section 3.8 Pre-Petition Screening, Court Ordered Evaluation and Court Ordered Treatment**, a copy of the application for voluntary treatment; and
- Copies of any order for guardianship and letters of acceptance.

Requirements for Community Service Agencies (CSA), Home Care Training to Home Care Client (HCTC) Providers and Habilitation Providers

CSAs, HCTC Providers and Habilitation Providers must maintain a record of the services delivered to each member. Every thirty (30) days, a summary of the information required in this section must be transmitted from the CSA, HCTC Provider or Habilitation Provider to the member's Adult Recovery Team for inclusion in the medical record.
The minimum written requirement for each member's record must include:

- The service provided (including the code used for billing the service) and the time increment;
- Signature and the date the service was provided;
- The name title and credentials of the member providing the service;
- The member's AHCCCS identification number;
- UAHP ensures that services provided by the agency/provider are reflected in the member's service plan.
- CSAs, HCTC Providers and Habilitation Providers must keep a copy of each Member's service plan in the member's record; and
- Daily documentation of the service(s) provided and monthly summary of progress toward treatment goals.

CSA, HCTC Provider and Habilitation Provider medical records must be: dated and signed with credentials noted; legible; typed or written in blue or black ink; and factual and correct. If required records are kept in more than one location, the agency/provider shall maintain a list indicating the location of the records.

Transportation Services

For providers that supply transportation services for members using provider employees (i.e. facility vans, drivers, etc.) and providers that use subcontracted transportation services, for non-emergency transport of members, that are not direct employees of the provider (i.e. cab companies, shuttle services, etc.) the original signature and credentials portion of these requirements is waived. Instead, documentation for the member record must include a summary log of the transportation event received from the transportation provider that includes all other elements listed as follows:

- Complete service provider's name and address;
- Name signature and credentials of the driver who provided the service;
- Vehicle identification (car, van, wheelchair van, etc.);
- Member's' AHCCCS ID number;
- Complete date of service, including month day and year;
- Complete address of pick up site;
- Complete address of drop off destination;
- Odometer reading at pick up;
- Odometer reading at drop off;
- Type of trip – round trip or one way;
- Escort (if any) must be identified by name and relationship to the member being transported; and
- Signature of the member, parent and/or guardian/caregiver, verifying services were rendered. If the member refuses to sign the trip validation form, then then driver should document his/her refusal to sign and this document is to be placed into the comprehensive medical record
- 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.

Transition of Medical Records

Transfer of a member's medical records due to transitioning of the member to a new T/RBHA and/or provider or due to UAHP terminating the provider contract, is important to ensure that there is minimal disruption to the member's care and provision of services. The medical record must be transferred in a timely manner that ensures continuity of care.
When a member changes his or her PCP, the member's medical record or copies of it must be forwarded to the new PCP within ten business days from receipt of the request for transfer of

the medical record.

Written Authorization Requirements
Federal and State law allow the transfer of medical records from one provider to another, without obtaining the Member's written authorization if it is for treatment purposes (45 C.F.R. §164.502(b), 164.514(d) and A.R.S. 12-2294(C)). Generally, the only instance in which a provider must obtain written authorization is for the transfer of alcohol/drug and/or communicable disease treatment information.

Information that Must be Sent to the New Provider
The original provider must send that portion of the medical record that is necessary to the continuing treatment of the member. In most cases, this includes all communication that is recorded in any form or medium and that relates to patient examination, evaluation or behavioral or mental health treatment. Records include medical records that are prepared by a health care provider or other providers. Records do not include materials that are prepared in connection with utilization review, peer review or quality assurance activities, including records that a health care provider prepares pursuant to section A.R.S. § 36-441, 36-445, 36-2402 or 36-2917.

Retention of the Original Medical Record
Federal privacy law indicates that the Designated Record Set (DRS) is the property of the provider who generates the DRS. Therefore originals of the medical record are retained by the terminating or transitioning provider. The cost of copying and transmitting the medical record to the new provider shall be the responsibility of the transitioning provider. (see the **AHCCCS Contractors Operation Manual, Policy 402, Section C**).

Medical Record Audits
UAHP will conduct periodic medical record audits to assess the completeness of medical records maintained by provider agencies contracted by UAHP and compliance with established standards. Medical records may be requested when UAHP or AHCCCS are conducting audits or investigating quality of care issues. Providers must respond to these requests within seven days. Medical records must be made available to AHCCCS for quality review upon request.

Behavioral health providers must send copies of any information maintained in their own behavioral health record that must also be maintained in the medical record.

Availability of Documentation
The behavioral health record is the property of the provider that generates the record, not UAHP. Health records must be maintained as confidential and must only be disclosed

When requested by a member's primary care provider or the members' ALTCS case manager, the behavioral health record or copies of behavioral health record information must be forwarded within ten (10) days of the request.

Providers must obtain consent and authorization to disclose protected health information in accordance with 42 CFR 431, 42 CFR part 2, 45 CFR parts 160 and 164, and A.R.S. § 36-509. Unless otherwise prescribed in federal regulations or statute, it is not necessary to obtain a signed release in order to share behavioral health related information with the member's parent/legal guardian, primary care provider (PCP), UAHP staff acting on behalf of the PCP or authorized State social service agencies. Notwithstanding the foregoing, all medical records, data and information obtained, created, or collected by the provider related to the member, including confidential information, must be made available electronically to AHCCCS upon request.

AHCCCS or its designee may inspect Title XIX/XXI medical records at any time during regular business hours at the offices of UAHP or its providers.

UAHP has the discretion to obtain a copy of a member's medical records without written approval by the member if the reason for such request is directly related to the administration of service delivery. Furthermore, UAHP has the discretion to release information related to fraud and abuse so long as protected HIV-related information is not disclosed (see A.R.S. § 36-664) and substance abuse information is only disclosed consistent with federal and State law, including but not limited to 42 CFR 2.1, et seq.

Additionally, providers must provide each member who makes a request one copy of his or her medical record free of charge annually. Upon request, Providers must allow members to view and amend their medical record as specified in 45 C.F.R. § 164.524, 164.526 and A.R.S. § 12-2293.

Retention of records
All providers must retain the original or copies of a member's medical records for at least six years after the last date the adult member received medical or health care services from UAHP or a provider.

The requirements for maintenance of and access to the member's medical record shall survive the termination of a provider's contract with UAHP, regardless of the cause of the termination.

8.2 Medical Institution Reporting of Medicare Part D

GMH/SA Duals are Medicare eligible members that receive Medicare Part D prescription drug benefits through Medicare Prescription Drug Plans (PDPs) or Medicare Advantage Prescription Drug Plans (MA- PDs). Medicare Part D coverage includes copayment and co-insurance requirements. However, Medicare Part D copayments are waived when a GMH/SA dual eligible member enters a Medicaid funded medical institution for at least a full calendar month. Medical institutions must notify the Arizona Health Care Cost Containment System (AHCCCS) when a dual eligible member is expected to be in the medical institution for at least a full calendar month to ensure copayments for Part D are waived. The waiver of copayments applies for the remainder of the calendar year, regardless of whether the member continues to reside in a medical institution. Given the limited resources of many dual eligible members and to prevent the unnecessary burden of additional copay costs, it is imperative that these individuals are identified as soon as possible.

The objective of this policy is to inform providers designated as medical institutions of reporting and tracking requirements for dual eligible members to ensure Medicare Part D copays are waived.

Reporting Requirements
To ensure that GMH/SA dual eligible members' Medicare Part D copayments are waived when it is expected that dual eligible members will be in a medical institution, funded by Medicaid, for at least a full calendar month, AHCCCS must be notified immediately upon admittance.

Reporting must be done using AHCCCS Notification to Waive Medicare Part D Copayment. Providers must not wait until the member has been discharged from the medical institution to submit the form. Reporting must be done on behalf of the following:

- Members who have Medicare Part "D" only:
- Members who have Medicare Part "B" only;
- Members who have used their Medicare Part "A" lifetime inpatient benefit; and
- Members who are in continuous placement in a single medical institution or any combination of continuous placements that are identified below.

Medical Institutions
Medical institutions include the following providers:

- Acute Hospital (PT 02)
- Psychiatric Hospital – Non-IMD
- Psychiatric Hospital – IMD (PT 71)
- Behavioral Health Inpatient Facility – IMD (PT B1, B3)
- Behavioral Health Inpatient Facility – Non IMD (PT 78, B2)

- Nursing Homes – (PT 22)
- Residential Treatment Center – IMD
- Residential Treatment Center – Non-IMD
- Skilled Nursing Facility

Additional information regarding Medicare cost sharing for members covered by Medicare and Medicaid can be found in **AHCCCS Contractor Operations Manual, Policy 201**.

Section 9 – Medical Management/Utilization Management Requirements

9.1 Securing Services and Prior Authorization/Retrospective Authorization For GMH/SA Dual Eligibles

It is important that members receiving services have timely access to the most appropriate services. It is also important that limited resources are allocated in the most efficient and effective ways possible. UAHP will approve AHCCCS Behavioral Health Covered Services as the payer of last resort. Medicare is the primary payer for many behavioral health services.

Most behavioral health services do not require prior authorization. Based upon the recommendations and decisions of the Adult Recovery Teams or sometimes referred to as the Adult Recovery Team (ART), any and all covered services that address the needs of the member and family will be secured. During the treatment planning process, the Adult Recovery Team may use established tools to guide clinical practice and to help determine the types of services and supports that will result in positive outcomes for the member. Adult Recovery Teams should make decisions based on a member's identified needs and should not use these tools as criteria to deny or limit services.

Prior authorization processes are used to promote appropriate utilization of behavioral health services while effectively managing associated costs. Except during an emergency situation, AHCCCS requires prior authorization before accessing inpatient services in a licensed inpatient facility and for accessing medications reflected as requiring prior authorization on the AHCCCS Minimum Required Prescription Drug List. In addition to the prior authorization of inpatient services, University of Arizona Health plans also requires prior authorization for certain other covered behavioral health services.

The purpose of the prior authorization function is to monitor the use of designated services before services are delivered in order to confirm they are:

- Provided in an appropriate level of care and place of service;
- Included in the defined benefits,
- Appropriate, timely and cost effective;
- Coordinated as necessary with additional departments, such as Quality Management;
- Accurately documented in order to facilitate accurate and timely reimbursement; and,
- Meet AHCCCS requirements.

When it is determined that a member is in need of a behavioral health service requiring prior authorization, a behavioral health professional applies the designated authorization and continued stay criteria to approve the provision of the covered service. When appropriate,

UAHP will provide a consultation with the requesting provider to gather additional information to make a determination. A decision to deny a prior authorization request must be made by UAHP's Medical Director or physician designee.

Prior authorization procedures for providers contracted by UAHP

What services must be prior authorized?

Services requiring prior authorization are:

- Non-emergency admission to and continued stay in hospital
- Non-emergency admission to and continued stay in BHIF (sub-acute services ;)
- Admission to and continued stay in BHIF (Residential Treatment Services, members 18-20 years old);
- Admission to and continued stay in a BHRF (group home);
- Admission to and continued stay in a BHTH (adult);
- Admission to and continued stay in HCTC services; and
- Initiation and continuation of Out Of Network outpatient services.
- Non emergency medical transportation to and from covered behavioral health services when the trip exceeds 100 miles one way or round trip. Prior authorization is required regardless of the diagnosis on the code billed on the claim.

Who makes prior authorization decisions?

A UAHP behavioral health professional is required to prior authorize services unless it is a decision to deny. A decision to deny must be made by a UAHP physician.

OBHL Terminology	10/01/13 DLS Terms*	07/01/14 DLS Terms	Requires PA Yes/No
Level I Acute Psychiatric Hospital	Licensed Hospital	Hospital	Yes
Level I Sub-Acute Facility	BH Hospital Facility (BHHF)	BH Inpatient Facility (BHIF)	Yes
Level I Residential Treatment Center (RTC)	BH Inpatient Facility (BHIF)	BH Inpatient Facility (BHIF)	Yes
Level II (TGH) & III Group Homes (L3GH)	BH Residential Facility (BHRF)	BH Residential Facility (BHRF)	Yes
Adult TFC	BH Supportive Home (BHSH)	Behavioral Health Therapeutic Home	Yes

		Adult (BHTH)	
HCTC	HCTC	HCTC	Yes
Level IV Rural Substance Use Transitional Unit	Substance Abuse Transitional Facility (SATF)	Substance Abuse Transitional Facility	Yes
Behavioral Health Outpatient Clinic	Outpatient Treatment Center	Outpatient Treatment Center	No

*OBHL: Office of Behavioral Health Licensure; DLS: Division of Licensure Services

Securing services that do not require prior authorization
Who can secure behavioral health services that do not require prior authorization?
The Adult Recovery Team is responsible for identifying and securing the service needs of each member through the assessment and service planning processes. Rather than identifying pre-determined services, the Adult Recovery Team should focus on identifying the underlying needs of the member, including the type, intensity and frequency of supports needed.

As part of the service planning process, it is the Adult Recovery Team's responsibility to identify available resources and the most appropriate provider(s) for services. This is done in conjunction with the Adult Recovery Team, the member, family, and natural supports. If the service is available through a contracted provider the member can access the service directly. If the requested service is only available through a non-contracted provider or if the Adult Recovery Team requests services from a non-contracted provider, the Adult Recovery Team is responsible for coordinating with UAHP Behavioral Health Case Management Department and obtaining the requested service as outlined below.

Securing Out Of Network Services

Sometimes it may be necessary to secure services through a non-contracted provider in order to provide a needed covered behavioral health service or to fulfill an Adult Recovery Team's request. The process for securing services through a non-contracted provider is as follows:

- If a needed covered outpatient service is unavailable within UAHP's contracted provider network, the provider submits an Out of Network Request to UAHP's Prior Authorization Department via fax at **520-694-0599** on the **Provider Manual Form 9.1.1** - Behavioral Health Prior Authorization Form;
- A completed request contains pertinent information on the member, the requested out-of-network service(s) and the requested out-of-network provider. The request must be accompanied by the current service plan and any relevant medical records;

- All requested providers must be licensed by the ADHS Division of Licensing and/or the applicable Arizona licensing board. All providers must have an AHCCCS Provider ID Number and a National Provider ID (NPI) Number. All out-of-network providers must agree to provide the requested services, possess appropriate insurance, and agree to an UAHP-approved reimbursement rates. If for any reason UAHP's Contracts Department is unable to establish a single case agreement with the requested non-contracted provider, the Medical Management Department will notify the requesting Clinical Director and/or Adult Recovery Team.
- The Adult Recovery Team then meets to consider alternative services. The Adult Recovery Team is responsible for ensuring that a similar level of equivalent services is in place for the member; and
- UAHP secures services through and provides payment to non-contracted providers through single case agreements.

In the event that a request to secure covered services through a non-contracted provider is denied, notice of the decision will be provided by UAHP within the AHCCCS required timelines for Notices of Action.

Accessing services that require prior authorization

What does prior authorization do?

Prior authorization seeks to ensure that members are treated in the most appropriate, least restrictive and most cost effective setting, with sufficient intensity of service and supervision to safely and adequately treat the member's behavioral health condition. When an Adult Recovery Team initiates a request for a service requiring prior authorization, the request must immediately be forwarded to the person responsible for making prior authorization decisions. Authorizations are not a guarantee of payment. Refer to the **UAHP Behavioral Health Covered Services Guide** for specific codes and services that require a prior authorization at www.ufcaz.com.

When is prior authorization available?

University of Arizona Health Plan has staff available 24 hours a day, seven days a week to receive requests for any service that requires prior authorization.

UAHP has Arizona-licensed prior authorization staff that may include nurses, nurse practitioners, physicians, physician assistants, pharmacists, pharmacy technicians, or licensed behavioral health professionals with appropriate training to apply the UAHP prior authorization criteria and make prior authorization decisions.

What about emergencies?

Prior authorization for inpatient services must never be applied in an emergency situation. If upon review of the circumstances, the behavioral health service did not meet admission authorization criteria, payment for the service may be denied. The test for appropriateness of

the request for emergency services must be whether a prudent lay member, similarly situated, would have requested such services.

Retrospective Reviews

All facilities will receive a technical denial for an inpatient psychiatric claim if the authorization is not received by the plan within the first 72 hours of the inpatient admission. UAHP will not be granting a retrospective authorization. The inpatient authorization requirement for UAHP is a contractual term/condition. The denial is not based on medical necessity but is based on contractual provisions that require providers to notify UAHP within 72 hours following the admission.

What criteria are used to determine whether to approve or deny a service that requires prior authorization?

Criteria for **Hospital and BHIF hospital** (sub-acute services), UAHP uses Milliman Care Guidelines. Milliman Care Guidelines can be found at www.mcg.com. When submitting clinical documentation to support the admission, concurrent and discharge criteria please refer to the following guidelines.

Admission Criteria

Admission criteria: Admission to any level of care requires an objective professional evaluation of the member's current condition indicating a level of severity appropriate to the requested care as evidenced by features of one or more of the following:

1. Acute dangerousness: Member presents with a level of risk related to harm towards themselves through suicide, self-injury, irritability or mania; or to others through aggression, assaultive, or homicidal behavior. This dimension identifies elements of dangerousness that represent or describe a member's behavior. To evaluate dangerousness, the mental health practitioner is to assess suicidal intent and homicidal intent; including psychosocial stressors.
2. Functional impairment: Member presents a temporary and reversible reduction in ability to function such as performing personal hygiene and bodily care activities, obtaining adequate nutrition, sleep, functioning in the work place or at school, or becoming socially isolated. This dimension addresses the degree to which psychological problems affect the member's functioning, vary from the member's own typical baseline, and contribute to the ability to survive or maintain him/herself in the environment. The assessment of functional impairment must be made each time the member is assessed, to determine whether the member's level of functioning may have changed from the previous baseline level of functioning.
3. Mental status changes or co-occurring conditions: Member presents with disrupted mood, disordered thinking, disorientation, or other mental status changes that need care

at the level requested; or there are medical or substance related issues that require care at the level requested.

4. Additional modifiers: The member's history of response to prior treatment, their personal resources such as intellect, characterological issues, and past history of violence or self-harm. It is preferred treatment is provided in the least restrictive setting. However, the member's history of response to prior treatment, their personal resources such as intellect, or underlying characterological issues, and past history of violence or self-harm may influence the decision about which level of care is medically necessary.
5. Primary diagnosis: A valid diagnosis causing the symptoms, and that requires professional intervention and the intensity of services needed. At least one valid DSM-5 diagnosis and the member's condition must be directly attributable to the designated mental disorder and not to an antisocial personality or be a part of a pervasive pattern of antisocial conduct, and professional intervention is considered likely to be effective and is essential to contain risks presented and provide for improvement.

Concurrent Review:

In order to justify remaining in an inpatient/sub-acute level of care, progress must be evident to show that the condition or its symptoms are treatment responsive, the member must continue to manifest symptoms justifying the principal DSM-5 diagnosis, and one or more of the following:

1. The intensity of service being delivered should be appropriate to the risk level that justified the admission
2. Complications arising from initiation of, or change in, medications or other treatment modalities.
3. Need for continued observation
4. Persistence of symptoms such that continued observation or treatment is required
5. Increased risk of complications as a result of intervention or as a product of newly discovered conditions
6. Effective planning for transition to a less restrictive level of care has begun and additional time in treatment days will reduce the probability of a readmission to a more restrictive level of care.

UAHP bases concurrent review determinations solely on the medical information obtained by the reviewer at the time of the review determination. Frequency of the reviews is based on the severity or complexity of the member's condition or on necessary treatment and discharge planning activity but will also meet the prescribed review timelines according to Milliman criteria. Authorization for hospital stay will have a specified date and time by which requested clinical documents will be submitted for review. This information will be provided to the requesting provider to ensure coordination and understanding of when additional member condition updates are required.

Discharge Criteria:

The member is ready for discharge when they satisfy any of the following criteria:

1. They complete the planned course of treatment
2. Their symptom intensity or impairment in functioning no longer requires the level of observation or intensity of service at the requested level of care.
3. Further professional intervention is not expected to result in significant improvement in the patient's condition
4. The member leaves against medical advice (AMA).
   *Please refer to **Section 3.10 Discharge Planning** in this manual

Notification of Inpatient Admission:

Inpatient notification is required for all inpatient Mental Health admissions within 72 hours of admission. It is the admitting facility's responsibility to submit notification of a member's admissions:

- By fax: For admission occurring with University Care Advantage/University Family Care: 520-874-3420.
- Notifications can be faxed 24 hours a day, 7 days a week.
- Precertification department requires the following information for all inpatient notification requests:
  - Member's name
  - Member's identification number
  - Member's date of birth
  - Admission date
  - Attending physician name and phone number
  - Admitting hospital name
  - Diagnosis
  - Contact name and phone number/e mail of in-patient Utilization Reviewer

Failure to submit notification within 72 hours may result in denial at which point an appeal can be submitted. To request appeal:

*Submit request for payment to UAHP Claims department

*Upon receipt of denial of payment; submit request for appeal through UAHP Grievance and Appeal department.

What is Certification Of Need (CON)?

When a member has exhausted their Medicare inpatient lifetime limit of 190 days in a psychiatric facility a CON must be submitted to initiate the member's Medicaid benefit. A CON is a certification made by a physician that inpatient services are or were needed at the time of the member's admission. Although a CON must be submitted prior to a member's admission (except in an emergency), a CON is not an authorization tool designed to approve or deny an inpatient service, rather it is a federally required attestation by a physician that inpatient services are or were needed at the time of the member's admission. The decision to authorize a

service that requires prior authorization is determined through the application of admission and continued stay authorization criteria (See **Provider Manual Form 9.1.2** - Certificate of Need.)

In the event of an emergency, the CON must be submitted:

- For members age 21 or older, within 72 hours of admission; and
- For members age 18-20, within 14 days of admission.

What is Re-certification Of Need (RON)?
A RON is a re-certification made by a physician, if made by a nurse practitioner or physician assistant. The RON must recertify for each applicant or beneficiary that inpatient services in a behavioral health hospital are needed. A RON must be completed at least every 60 days for a member who is receiving services in a Behavioral Health Inpatient Facility. An exception to the 60-day timeframe exists for inpatient services provided to members age 18-20. The treatment plan (individual plan of care) for members age 18-20 in a behavioral health inpatient services must be completed and reviewed every 30 days. The completion and review of the treatment plan in this circumstance meets the requirement for the re-certification of need. For a sample RON form see **Provider Manual Form 9.1.3** - Recertificate of Need.

What must be documented on a CON or RON?
The following documentation is needed on a CON and RON:

- Proper treatment of the member's behavioral health condition requires services on an inpatient basis under the direction of a physician;
- The service can reasonably be expected to improve the member's condition or prevent further regression so that the service will no longer be needed;
- Outpatient resources available in the community do not meet the treatment needs of the member;
- CONs must have a dated physician's signature; and
- RONs must have a dated signature by a physician, nurse practitioner or physician assistant.

Additional CON requirements:

- If a member becomes eligible for Title XIX or Title XXI services while receiving inpatient services, upon request the CON must be completed and submitted to UAHP's Prior Authorization Department prior to the authorization of payment; and
- Federal rules set forth additional requirements for completing CONs when members age 18-20 are admitted to, or are receiving services in a Behavioral Health Inpatient Facility. These requirements include the following:

- For an individual who is Title XIX/XXI eligible when admitted, the CON must be completed by the Adult Recovery Team that is independent of the facility and must include a physician who has knowledge of the member's situation and who is competent in the diagnosis and treatment of mental illness,
- For emergency admissions, the CON must be completed by the team responsible for the treatment plan within 14 days of admission. This team is defined in 42 CFR §441.156 as "an interdisciplinary team of physicians and other personnel who are employed by, or provide services to patients in the facility"; and
- For members who are admitted and then become Title XIX or Title XXI eligible while at the facility, the team responsible for the treatment plan must complete the CON. The CON must cover any period of time for which claims for payment are made.

Prior to denials for such placement, UAHP's Medical Director or physician designee is expected to talk with the treating psychiatrist/psychiatric nurse practitioner most familiar with the member in order to gather any additional information that could be helpful in making the determination. If a psychiatrist or psychiatric nurse practitioner has not yet been involved, an evaluation should be arranged in order for the UAHP physician to obtain the professional opinion of a behavioral health clinician.

In addition, if a denial is issued for admission to a BHIF residential placement, UAHP will work with the requesting provider to develop a clearly outlined alternative plan at the time of the denial. This may require development of a Recovery Team if one has not already been established, or consultation with the Recovery Team. It is expected that the alternative treatment plan will adequately address the behavioral health treatment needs of the individual and will provide specific information detailing what services will be provided, where these services will be provided, and when these services will be available and what specific behaviors will be addressed by these services. It is also expected that the alternative treatment plan will include what crisis situations can be anticipated and how the crises will be addressed.

Criteria for **Behavioral Health Residential Facility (BHRF), Behavioral Health Therapeutic Home (BHTH)/ Home Care Training for Home Care Client (HCTC)** setting, UAHP has developed the following criteria to be used by all contracted providers:

- *University of Arizona Health Plan's Prior Authorization Criteria for Admission and Continued Stay for Behavioral Health Residential Facilities*
- *University of Arizona Health Plan's Prior Authorization Criteria for Admission and Continued Stay for Behavioral Health Therapeutic Homes/ Home Care Training to Home Care Client (HCTC)*

What happens if a member is ready to leave a hospital or sub-acute facility but an alternative placement is not available? How does this effect medical necessity? Will authorization

continue?

If a member receiving hospital or sub-acute services no longer requires such services under the direction of a physician, but services suitable to meet the member's behavioral health needs are not available or the member cannot return to the member's residence because of a risk of harm to self or others, services may continue to be authorized as long as there is an ongoing, active attempt to secure a suitable discharge placement or residence in collaboration with the community or other state agencies as applicable.

What are the considerations for denials?
A denial of a request for admission to or continued stay in a hospital facility can only be made by a UAHP's Chief Medical Officer or physician designee after verbal or written collaboration with the requesting clinician.

For outpatient authorizations and planned admissions - After UAHP notifies a provider of the decision to deny a requested authorization the requesting provider has several options.

- The provider can resubmit another authorization request with additional information
- The provider can request a peer to peer with the UAHP physician who issued the denial
- The provider can appeal the denial.

For Title XIX/XXI covered services requested by members who are Title XIX/XXI eligible or who have been determined to have a serious mental illness, UAHP must provide the individual for whom the request is made) with a Notice of Action following:

- The denial or limited authorization of a requested service, including the type or level of service;
- The reduction, suspension, or termination of a previously authorized service; and
- The denial in whole or in part, of payment for a service (this is UAHP's responsibility).

A copy of the Notice of Action will also be sent to the provider submitting the request.

Before a final decision to deny is made, the member's attending psychiatrist can ask for reconsideration and present additional information.

UAHP will ensure 24-hour access to a delegated psychiatrist or other physician designee for any denials of hospital admission.

What documentation must be submitted to obtain a prior authorization and what are the timeframes for making a decision?
For admission requests:

- To non-emergent hospital or sub-acute services**:**

During normal business hours (Monday through Friday from 8:00 am to 5:00 pm), providers submit a completed Certificate of Need (CON) via fax to UAHP's Medical Management Department.

- **University Family Care Members fax to UFC UM at 520-874-3420.**

Providers must include relevant supporting clinical documentation with the CON submission.

Once the CON is sent, providers contact a UAHP Behavioral Health Care Manager telephonically at **1-800-582-8686** or **UAHPCaseManagementBHMailbox@bannerhealth.com** to discuss the authorization.

After hours, providers may contact UAHP at **1-800-582-8686** 24 hours per day, 365 days per year to request assistance.

- To BHIF Residential and other out-of-home services**:**
  Providers submit a completed Prior Authorization Request, **Provider Manual Form 9.1.4** - Request for Out-of-Home Admission and supporting clinical documentation via fax to **UAHP Behavioral Health Prior Authorization** at **520-694-0599**. Documentation required includes:
  - The most current behavioral health service plan;
  - Most recent psychiatric evaluation;
  - Psychiatric progress notes from the previous ninety days;
  - Case management and Recovery Team progress notes from the previous ninety days;
  - Previous psychological or psycho-educational evaluations;
  - Hospital or residential discharge summaries; and
  - Any other relevant clinical information.

If the request is approved and the member admits to an inpatient hospital, sub-acute or residential facility, the requesting provider submits a completed CON via secure email to UAHP. **University Family Care Members** fax to **520-874-3420.** Providers must include relevant supporting clinical documentation with the CON submission. Once the CON is sent, providers contact a **UAHP Behavioral Health Care Manager telephonically at 1-800-582-8686** or **UAHPCaseManagementBHMailbox@bannerhealth.com** to discuss the authorization**.**

UAHP is required to make decisions regarding the prior authorization according to these guidelines:

- For standard requests for prior authorized services, a decision must be made as expeditiously as the member's health condition requires, but not later than fourteen calendar days following the receipt of the authorization request, with a possible

extension of up to fourteen calendar days if the member or provider requests an extension, or if UAHP justifies a need for additional information and the delay is in the member's best interest;

- An expedited authorization decision for prior authorized services can be requested if UAHP or the provider determines that using the standard timeframe could seriously jeopardize the member's life and/or health or the ability to attain, maintain or regain maximum function. UAHP will make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires but no later than three working days following the receipt of the authorization request, with a possible extension of up to fourteen calendar days if the member or provider requests an extension, or if UAHP justifies a need for additional information and the delay is in the member's best interest;
- When UAHP receives an expedited request for a service authorization and the requested service is not of an urgent medical nature, UAHP may downgrade the expedited authorization request to a standard request. A UAHP Behavioral Health Case Manager notifies the requesting provider of such downgrades and gives the provider an opportunity to disagree with the decision.

For all requests for continued stay, regardless of setting, submit clinical documentation (RONs, etc.) via secure e mail directly to **UAHPCaseManagementBHMailbox@bannerhealth.com.**

Requests for continued stay must be submitted within the following timelines**:**

- For Hospital or sub-acute requests: prior to noon on the last day of the current authorization;
- For BHIF-RTC (18-20 year olds) requests: prior to noon on the last business day prior to the end of the current authorization; and
- For BHRF, BHTH and HCTC services: prior to noon on the last business day prior to the end of the current authorization.

Prior Authorizing Medications

UAHP has developed drug lists for use for by all providers. These lists denote all drugs which require prior authorization. These prior authorization criteria have been developed by the AHCCCS pharmacy and therapeutics committee, and must be used by UAHP's providers. Medications or other prior authorization criteria cannot be added to UAHP's medication list. For specific information on medications requiring prior authorization, see **UAHP's drug formulary available on the health plan website under the provider section**.

The approved prior authorization criteria are posted on the UAHP website. The prior authorization requirements for availability, decision timelines and provision of Notice are the same as that outlined for prior authorized services. UAHP and providers must assure that

a member will not experience a gap in access to prescribed medications due to a change in prior authorization requirements. UAHP and providers are required to ensure continuity of care in cases in which a medication that previously did not require prior authorization is now required to be prior authorized.

Notification of prior authorization changes
UAHP gives providers at least thirty days' notice of changes in authorization processes or criteria through provider forums, blast faxes and on our website. Updated materials are posted to the University of Arizona Health Plan website for provider and member access.

Coverage and payment of emergency behavioral health services
The following conditions apply with respect to coverage and payment of emergency behavioral health services for members who are Title XIX or Title XXI eligible:

- Emergency behavioral health services must be covered and reimbursement made to providers who furnish the services regardless of whether the provider has a contract with UAHP;
- Payment must not be denied when:
    - UAHP or a provider instructs a member to seek emergency services;
    - A member has had an emergency behavioral health condition, including cases in which the absence of medical attention would have resulted in:
        - Placing the health of the member (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
        - Serious impairment to bodily functions; or
        - Serious dysfunction of any bodily organ or part.
        - Emergency behavioral health conditions must not be limited to a list of diagnoses or symptoms;
        - UAHP may not refuse to cover emergency behavioral health services based on the failure of a provider to notify UAHP of a member's screening and treatment within ten calendar days of presentation for emergency services;
        - A member who has an emergency behavioral health condition must not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the member; and
        - The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and such a determination is binding UAHP for coverage and payment.

The following conditions apply with respect to coverage and payment of post-stabilization care services for members who are GMH/SA dual eligible:

- UAHP is responsible for ensuring adherence to the following requirements, even in

situations when the function has been delegated to a subcontracted provider;

- Post-stabilization care services must be covered without authorization and reimbursement made to providers that furnish the services regardless of whether the provider has a contract with UAHP for the following situations:
    - Post-stabilization care services that were pre-authorized by UAHP ;
    - Post-stabilization care services that were not pre-authorized by UAHP or because UAHP did not respond to the treating provider's request for pre-approval within one hour after being requested to approve such care or could not be contacted for pre-approval; or
    - UAHP and the treating physician cannot reach agreement concerning the member's care and a UAHP physician is not available for consultation. In this situation, UAHP must give the treating physician the opportunity to consult with a contracted physician and the treating physician may continue with care of the member until a contracted physician is reached or one of the following criteria is met:
        - A UAHP physician with privileges at the treating hospital assumes responsibility for the member's care;
        - A UAHP physician assumes responsibility for the member's care through transfer;
        - UAHP and the treating physician reach an agreement concerning the member's care; or
        - The member is discharged.

State Only Services

There are limited state only funds available for GMH/SA Dual members. These funds cover certain support services which include:

- Supported housing (H0043)
- Mental Health Services (Room and Board- H0046-E)
  (Pregnant females who use drugs by injection, pregnant females who use substances, other persons who use drugs by injection, substance abusing females with dependent children and families, including women who are attempting to regain custody, all other GMH/SA Duals with substance abuse disorders, regardless of gender or route of use *as funding is available.*
- Mental Health Services Not Otherwise Specified (Formerly Traditional Healing Services-H0046)
- Auricular Acupuncture (97810, 97811,97813, 97814)

Please contact UAHP's Behavioral Health Department for information on how to access these services at **UAHPCaseManagementBHMailbox@bannerhealth.com**.

Section 10 – Training and Peer Support Supervision Requirements

10.1 Training Requirements

In order to effectively meet the requirements of AHCCCS, UAHP must participate in development, implementation and support of trainings for behavioral health contractors and subcontractors to ensure appropriate training, education, and technical assistance and workforce development opportunities. Specifically to:

- Promote a consistent practice philosophy; provide voice and empowerment to staff and members;
- Ensure a qualified, knowledgeable and culturally competent workforce;
- Provide timely information regarding initiatives and best practices; and
- Ensure that services are delivered in a manner that results in achievement of the Arizona System Principles, which include the 9 Guiding Principles for Recovery Oriented Adult Behavioral Health Services and Systems
- To ensure UAHP and its subcontracted providers have the necessary knowledge, education and skills to increase and successfully provide high quality services for all individuals accessing and receiving services in the public behavioral health system.
- Annually evaluate the impact of the training requirements and activities in order to develop a qualified, knowledgeable and culturally competent workforce.

Required training for providers
UAHP and its providers must ensure the following within 90 days of the staff member's hire date, as relevant to each staff member's job duties and responsibilities and annually as applicable (see subsection for training requirements applicable to Home Care Training to Home Care Client (HCTC) providers and subsection for training requirements applicable to Community Service Agencies):

Basic Core Training

- Annual Fraud, Waste and program abuse recognition and reporting requirements and protocols;
- Managed care concepts, including information on UAHP's GMH/SA Dual Members and their special needs
- Cultural competency;
- Interpretation and translation services;
- UAHP's Covered services (including information on how to assist members in accessing all medically necessary covered services regardless of a member's behavioral health category assignment or involvement with any one type of service provider);
- Rights and responsibilities of eligible and enrolled GMH/SA Dual members, including rights for members determined to have Serious Mental Illness (SMI);

- Appeals, grievances and requests for investigations;
- Complaint process
- Customer service;
- Third party liability and coordination of benefits
- Other involved agencies and government entities
- Claims/encounters submission process;
- Confidentiality/Health Information Portability and Accountability Act (HIPAA);
- Sharing of treatment/medical information;
- Overview of Arizona's behavioral health system policies and procedures in the 9 Guiding Principles for Recovery Oriented Adult Behavioral Health Services and Systems in the adult system;

<u>Clinical Staff (BHPP, BHT and BHP Must complete the Basic Core trainings as well)</u>

- Use of assessment and other screening tools (e.g., substance-related, crisis/risk, developmental, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program etc.).
- Use of effective interview and observational techniques that support engagement and are strengths-based, recovery-oriented, and culturally sensitive;
- Application of diagnostic classification systems and methods depending upon population(s) served;
- Best practices in the treatment and prevention of behavioral health disorders;
- Behavioral health service planning and implementation which includes family vision and voice, developed in collaborations with the individual/family needs as identified through initial and ongoing assessment practices;
- Providers should receive training on National Practice Guidelines and Clinical Guidance Documents with required elements before providing services, but must receive training within six months of the staff member's hire date. (Protocol training is only required if pertinent to populations served);
- Clinical training as it relates to specialty populations including but limited to conditions based on identified need;
- Understanding behavioral and environmental risk factors, nonphysical interventions, the safe use of seclusion or restraint and responding to emergency situations
- Behavioral health record documentation requirements
- Coordination of service delivery for members with complex needs (e.g. members at risk of harm to self and others, court ordered to receive treatment);
- Advance Directives
- Providers delivering services through distinct programs (e.g., Dialectical Behavioral Therapy, developmental disabilities, trauma, substance abuse, and Behavioral Health Inpatient Facilities); and
- Member benefit options trainings: such as Medicare Modernization Act (MMA), Department of Economic Security/Rehabilitation Services Administration (DES/RSA)

- **Additional UAHP required trainings:**
    - Arizona State Hospital (ASH);
    - Out of Home Placement;
    - Psychopharmacology;
    - Re-engagement;
    - Relapse Prevention for Therapists: Helping Your Client Develop a Prevention and Recovery Plan;
    - Community Resources;
    - Trauma Informed Care Training; and
    - Coordination of Services for Members Involved with the Courts and Jail/Detention/Prison Facilities.

Specific situations may necessitate the need for additional trainings. For example, quality improvement initiatives that may require focused training efforts and/or new regulations that impact the public behavioral health system (e.g., the Balanced Budget Act (BBA), Medicaid Modernization Act (MMA), the Affordable Care Act (ACA) and Deficit Reduction Act (DRA)). Additional trainings may be required, as determined by geographic service area identified needs.

Annual and Ongoing Training Requirements
In addition to training required within the first 90 days of hire, all UAHP subcontracted providers are required to undergo and provide ongoing training for the following content areas:

- Monthly trainings concerning procedures for submissions of encounters as determined by AHCCCS;
- Annual cultural competency and linguistically appropriate training updates for staff at all levels and across all disciplines respective to underrepresented/underserved;
- Inter-rater reliability:
    - American Society of Addition Medicine Patient Placement Criteria (ASAM PPC-2R); and
- Ticket to Work/Disability Benefits 101;
- Peer, family member, peer-run, family-run and parent-support training and coaching;
- Workforce Development trainings specific to hiring, support, continuing education and professional development.

<u>Adults</u>
Medicaid reimbursable HCTC services for adults are provided in Adult Behavioral Therapeutic Homes licensed by ADHS/DLS, and must comply with training requirements as listed in R9-20-1502:

- Protecting the member's rights;

- Providing services that the Adult Behavioral Therapeutic Home is authorized to provide and the provider delivering HCTC services is qualified to provide;
- Protecting and maintaining the confidentiality of medical records;
- Recognizing and respecting cultural differences;
- Recognizing, preventing or responding to a situation in which a member:
    - May be a danger to self or a danger to others;
    - Behaves in an aggressive or destructive manner;
    - May be experiencing a crisis situation; or
    - May be experiencing a medical emergency.
- Reading and implementing a member's treatment plan; and
- Recognizing and responding to a fire, disaster, hazard or medical emergency.

In addition, providers delivering HCTC services to adults must complete and credibly document annual training as required by R9-20-1502.

Required training specific to Community Service Agencies
Community Service Agencies (CSAs) must submit documentation as part of the initial and annual CSA application indicating that all direct service staff and volunteers have completed training specific to CSAs prior to providing services to members. For a complete description of all required training specific to CSAs:

- Client rights;
- Providing services in a manner that promotes client dignity, independence, individuality, strengths, privacy and choice;
- Recognizing common symptoms of and differences between a mental disorder, personality disorder, and/or substance abuse;
- Protecting and maintaining confidentiality of client records and information;
- Record keeping and documentation;
- Ethical behavior such as staff and client boundaries and the inappropriateness of receiving gratuities from a client; and
- Recognizing, preventing or responding to a client who may be a danger to self or a danger to others; behave in an aggressive or destructive manner; need crisis services or be experiencing a medical emergency;
- **Additional UAHP required trainings:**
    - Community Service Agency Training;
    - Customer Relations;
    - Confidentiality Duty to Report-Warn Med Info PO-C;
    - Crisis System;
    - Cultural Competency (*Annual Requirement);
    - Fraud and Abuse (*Annual Requirement);
    - Limited English Proficiency; and

Training Requests
For additional training requests and/or technical assistance specific to the trainings listed above and /or identified area of need, contact UAHP.

AHCCCS Ownership of any intellectual property
This policy will serve as disclosure of ownership of any intellectual property created or disclosed during the course of the service contract such as educational materials created for classroom training and/or learning programs. Exceptions:

- Those cases in which the production of such materials is part of sponsored programs;
- Those cases in which substantial university resources were used in creating educational materials; and
- Those cases which are specifically commissioned by contacted vendors or done as part of an explicitly designated assignment other than normal contactor educational pursuits.

10.2 Peer Support/Recovery Support Training, Certification and Supervision Requirements

AHCCCS has developed training requirements and certification standards for Peer Support Specialists/Recovery Support Specialists providing Peer Support Services, as described in the AHCCCS Covered Behavioral Health Services Guide. Peers serve an important role as providers, and AHCCCS expects consistency and quality in peer-delivered services and support for peer-delivered services statewide.

This applies to all providers delivering training services for certification[3] of individuals as Peer Support Specialists/Recovery Support Specialists within the AHCCCS public behavioral health system.

Additional Information
People who have achieved and sustained recovery can be a powerful influence for individuals seeking their own path to recovery (see Center for Mental Health Services (MHBG) Consumer Affairs E-News October 2, 2007, Vol. 07-158). By sharing personal experiences, peers help build a sense of self-worth, community connectedness, and an improved quality of life.

Peer services are supported on a statewide and national level. The Centers for Medicare and Medicaid Services (CMS) issued a letter to states, recognizing the importance of peer support services as a viable component in the treatment of mental health and substance abuse issues. In the letter, CMS provides guidance to states for establishing criteria for peer support services, including supervision, care-coordination and training/credentialing.

Peer Support Specialist/Recovery Support Specialist Qualifications
Individuals seeking to be certified and employed as Peer Support Specialists/Recovery Support Specialists must:

- Self-identify as a peer; and
- Meet the requirements to function as a behavioral health paraprofessional, behavioral health technician, or behavioral health professional.

Individuals meeting the above criteria may be certified as a Peer Support Specialist/Recovery Support Specialist by completing training and passing a competency test through an AHCCCS approved Peer Support Employment Training Program. AHCCCS will oversee the approval of all certification materials including curriculum and testing tools.

[3] Peer Support Services are also billed by family members who provide services in the public behavioral health system (Training and certification requirements described in this policy, however, are specific to peers, as defined in this policy.

Certification through AHCCCS approved Peer Support Employment Training Program is applicable statewide.

Some agencies may wish to employ individuals prior to the completion of certification through a Peer Support Employment Training Program. However, certain trainings must be completed prior to delivering services. An individual must be certified as a Peer Support Specialist/Recovery Support Specialist or currently enrolled in an AHCCCS -approved Peer Support training program under the supervision of a qualified individual prior to billing Peer Support Services.

Peer Support Employment Training Program Approval Process
A Peer Support Employment Training Program must submit their program curriculum, competency exam, and exam scoring methodology (including an explanation of accommodations or alternative formats of program materials available to individuals who have special needs) to AHCCCS, and AHCCCS will issue feedback or approval of the curriculum, competency exam and exam scoring methodology.

Approval of curriculum is binding for no longer than three years. Three years after initial approval and thereafter, the program must resubmit their curriculum for review and re-approval. If a program makes substantial changes (meaning change to content, classroom time, etc.) to their curriculum or if there is an addition to required elements during this three year period, the program must submit the updated curriculum to AHCCCS for review and approval.

AHCCCS will base approval of the curriculum, competency exam and exam scoring methodology only on the elements included in this policy. If a Peer Support Employment Training Program requires regional or culturally specific training exclusive to a GSA or tribal community, the specific training cannot prevent employment or transfer of Peer Support Specialist/Recovery Support Specialist certification based on the additional elements or standards.

Competency Exam
Members must complete and pass a competency exam with a minimum score of 80% upon completion of required training. Each Peer Support Employment Training Program has the authority to develop a unique competency exam. However, all exams must include at least one question related to each of the curriculum core elements. Individuals certified in another state may obtain certification after passing a competency exam. If an individual does not pass the competency exam, the Peer Support Employment Training Program may require the individual to repeat or complete additional training prior to taking the competency exam again.

Peer Support Employment Training Curriculum Standards
A Peer Support Employment Training Program curriculum must include, at a minimum, the following core elements:

- **Concepts of Hope and Recovery:**
    - Instilling the belief that recovery is real and possible;
    - The history of recovery and the varied ways that behavioral health issues have been viewed and treated over time and in the present;
    - Knowing and sharing one's story of a recovery journey; how one's story can assist others in many ways;
    - Mind- Body-Spirit connection and holistic approach to recovery; and
    - Overview of the individual service plan and its purpose.
- **Advocacy and Systems Perspective:**
    - Overview of state and national behavioral health system infrastructure and the history of Arizona's behavioral health system;
    - Stigma and effective stigma reduction strategies: countering self-stigma; role modeling recovery and valuing the lived experience;
    - Introduction to organizational change- how to utilize member-first language and energize one's agency around recovery, hope, and the value of peer support;
    - Creating a sense of community; the role of culture in recovery;
    - Forms of advocacy and effective strategies – consumer rights and navigating behavioral health system; and
    - Introduction to the Americans with Disabilities Act (ADA).
- **Psychiatric Rehabilitation Skills and Service Delivery:**
    - Strengths based approach; identifying one's own strengths and helping others identify theirs; building resilience;
    - Distinguishing between sympathy and empathy; emotional intelligence;
    - Understanding learned helplessness; what it is, how it is taught and how to assist others in overcoming its effects;
    - Introduction to motivational interviewing; communication skills and active listening;
    - Healing relationships – building trust and creating mutual responsibility;
    - Combating negative self-talk; noticing patterns and replacing negative statements about one's self, using mindfulness to gain self-confidence and relieve stress;
    - Group facilitation skills; and
    - Introduction to Culturally & Linguistically Appropriate Services (CLAS) Standards; creating a safe and supportive environment
- **Professional Responsibilities of the Peer Support Employee and Self-Care in the Workplace:**
    - Qualified peers must receive training on the following elements prior to delivering any covered services:
        - Professional boundaries & ethics- the varied roles of the helping professional; Collaborative supervision and the unique features of the Peer/Recovery Support Specialist;

- Confidentiality laws and information sharing – understanding the Health Insurance Portability and Accountability Act (HIPAA)
- Mandatory reporting requirements;
- Understanding common signs and experiences of mental illness, substance abuse, addiction and trauma; orientation to commonly used medications and potential side effects;
- Guidance on proper service documentation/billing and using recovery language throughout documentation; and
- Self-care skills and coping practices for helping professionals; the importance of ongoing supports for overcoming stress in the workplace; resources to promote personal resilience; and, understanding burnout and using self-awareness to prevent compassion fatigue, vicarious trauma and secondary traumatic stress.

Peer support employment training programs must not duplicate training required of peers for employment with a licensed agency or Community Service Agency (CSA). Training elements in this section must be specific to the peer role in the public behavioral health system and instructional for peer interactions.

Supervision of the Certified Peer Support Specialist / Recovery Support Specialist
Supervision is intended to provide support to Peer Support Specialists/Recovery Support Specialists in meeting treatment needs of members receiving care from Peer Support Specialists/Recovery Support Specialists. Supervision provides an opportunity for growth within the agency and encouragement of recovery efforts.

Agencies employing Peer/Recovery Support Specialists must provide supervision by individuals qualified as Behavioral Health Technicians or Behavioral Health Professionals. Supervision must be appropriate to the services being delivered and the Peer/Recovery Support Specialist's qualifications as a Behavioral Health Technician, Behavioral Health Professional or Behavioral Health Paraprofessional. Supervision must be documented and inclusive of both clinical and administrative supervision.

The individual providing supervision must receive training and guidance to ensure current knowledge of best practices in providing supervision to Peer/Recovery Support Specialists.

Process for Submitting Evidence of Certification
Agencies employing Peer Support Specialists/Recovery Support Specialists who are providing peer support services are responsible for keeping records of required qualifications and certification. UAHP must ensure that Peer Support Specialists/Recovery Support Specialists meet qualifications and have certification, as described in this policy.

Section 11 – Compliance

11.1 Duty to Report Abuse, Neglect or Exploitation

Any employee of the UAHP and/or its subcontracted providers who has been informed of or has a reasonable basis to believe that abuse, neglect or exploitation of an incapacitated or vulnerable adult or minor child has occurred shall immediately report the incident to a peace officer, the Department of Economic Security/ Adult Protective Services (DES/APS) or the Department of Economic Security/Division of Youth and Families/Department of Child Safety (DES/DCYF/DCS) worker as appropriate.

Duty to report healthcare acquired conditions, abuse, neglect, injuries, high profile cases, unexpected death and exploitation of incapacitated or vulnerable adults

Providers responsible for the care of an incapacitated or vulnerable adult and who have a reasonable basis to believe that abuse or neglect of the adult has occurred or that exploitation of the adult's property has occurred shall report this information immediately either in member or by telephone. This report shall be made to a peace officer or to a protective services worker within APS. Information on how to contact APS to make a report is located by going to the webpage for the APS Central Intake Unit . A written report must also be mailed or delivered within forty-eight hours or on the next working day if the forty-eight hours expire on a weekend or holiday. The report shall contain:

- The names and addresses of the adult and any members who have control or custody of the adult, if known;
- The adult's age and the nature and extent of his/her incapacity or vulnerability;
- The nature and extent of the adult's injuries or physical neglect or of the exploitation of the adult's property; and
- Any other information that the member reporting believes might be helpful in establishing the cause of the adult's injuries or physical neglect or of the exploitation of the adult's property.

Upon written and signed request for records from the investigating peace officer or APS worker, the member who has custody or control of medical or financial records of the incapacitated or vulnerable adult for whom a report is required shall make such records or a copy of such records available. Records disclosed are confidential and may be used only in a judicial or administrative proceeding or investigation resulting from the report. If psychiatric records are requested, the custodian of the records shall notify the attending psychiatrist, who may remove the following information from the records before they are made available:

- Personal information about individuals other than the patient; and
- Information regarding specific diagnoses or treatment of a psychiatric condition, if the attending psychiatrist certifies in writing that release of the information would be detrimental to the patient's health or treatment.

If any portion of a psychiatric record is removed, a court, upon request of a peace officer or APS worker, may order that the entire record or any portion of such record containing information relevant to the reported abuse or neglect be made available to the peace officer or APS worker investigating the abuse or neglect.

11.2 Duty to Warn

Any mental health provider employed or subcontracted by UAHP or a subcontracted provider of a mental health provider, having determined that a patient poses a serious danger of violence to others, shall take reasonable actions to protect the potential victim(s) of that danger.

Duty to Protect Potential Victims of Physical Harm
All mental health providers employed or contracted by UAHP, or subcontracted providers of mental health providers have a duty to protect others against the violent conduct of a patient. When a mental health provider employed or contracted by UAHP or a subcontracted provider of a mental health provider determines, or under applicable professional standards, reasonably should have determined that a patient poses a serious danger to others, he/she bears a duty to exercise care to protect the foreseeable victim of that danger. The foreseeable victim need not be specifically identified by the patient, but may be someone who would be the most likely victim of the patient's violent conduct.

While the discharge of this duty may take various forms, mental health providers employed or contracted by UAHP or a subcontracted provider of a mental health provider need only exercise that reasonable degree of skill, knowledge and care ordinarily possessed and exercised by members of that professional specialty under similar circumstances. Any duty owed by a mental health provider employed or contracted by UAHP or a subcontracted provider of a mental health provider to take reasonable precautions to prevent harm threatened by a patient can be discharged by any of the following, depending upon the circumstances:

- Communicating, when possible, the threat to all identifiable victims;
- Notifying a law enforcement agency in the vicinity where the patient or any potential victim resides;
- Taking reasonable steps to initiate proceedings for voluntary or involuntary hospitalization, if appropriate, and in accordance with Pre-petition Screening, Court Ordered Evaluation and Court Ordered Treatment; or
- Taking any other precautions that a reasonable and prudent mental health provider would take under the circumstances.

UAHP contracted providers are required to immediately notify by telephone the UAHP crisis line providers when a patient is identified to be a potential danger to self or others, and update the crisis line provider as appropriate based on the level of risk to the member and the community. Providers are required to report to the crisis line all relevant information; including, information about the member's access to weapons, names and addresses of potential victims, attempts to protect victims, police involvement, relevant clinical information and support system information.

For Yavapai and Maricopa County call the Crisis Response Network at **1-800-631-1314**.
For Pima, Graham, Greenlee, Santa Cruz, Yuma, Pinal, Cochise, Gila, La Paz call **Nursewise** at **1-866-495-6735**.

11.3 Confidentiality

This section is intended to provide guidance to protect the privacy of members who receive behavioral health services, guidance as to whom information can be disclosed to and when authorization[4] is required prior to that disclosure, and guidance on the notification of those members in the event their unsecured Protected Health Information (PHI) is breached. It is not all-inclusive of the HIPAA and State Laws; the references throughout are available for providers to access and examine the applicable laws for more detail.

Information and records obtained in the course of providing or paying for behavioral health services to a member are confidential and are only disclosed according to the provisions of applicable federal and state law. In the event of an unauthorized use/disclosure of unsecured PHI, UAHP's subcontracted providers must notify all affected members.

Overview of confidentiality information
UAHP and its subcontracted providers must keep medical records, payment records, and behavioral health records and all information contained in those records confidential and cannot disclose such information unless permitted or required by federal or state law. The law regulates two major categories of confidential information:

- Information obtained when providing services not related to alcohol or drug abuse referral, diagnosis and treatment; and
- Information obtained in the referral, diagnosis and treatment of alcohol or drug abuse.

Behavioral Health Information Not Related to Alcohol and Drug Treatment
Information obtained when providing services not related to alcohol and drug abuse treatment is governed by state law and the HIPAA Privacy Rule, 45 C.F.R., Part 164, Subparts A and E, Part 160 Subparts A and B ("the HIPAA Rule"). The HIPAA Rule permits a covered entity (health plan, health care provider, or health care clearinghouse) to use or disclose protected health information with or without patient authorization in a variety of circumstances, some of which are required and others that are permissive. Many of the categories of disclosures contain specific words and phrases that are defined in the HIPAA Rule. Careful attention must be paid to the definitions of words and phrases in order to determine whether disclosure is allowed. In addition, the HIPAA Rule may contain exceptions or special rules that apply to a particular disclosure. State law may affect a disclosure. For example, the HIPAA Rule may preempt a state law or a state law may preempt the HIPAA Rule. HIPAA when read together with state law may impose additional requirements for disclosure. In addition, a covered entity must, with certain exceptions, make reasonable efforts to limit protected health information to the

[4] For purposes of uniformity and clarity, the term "authorization" is used throughout this policy to reference a member's permission to disclose medical records and protected health information and has the same meaning as "consent" which is used in 42 C.F.R. Part 2.

minimum necessary to accomplish the intended purpose of the disclosure.

Before disclosing protected health information, it is good practice to consult the specific citation to the HIPAA Rule, state law and consult with legal counsel before disclosing an individual's protected health information. See below for more detail regarding the disclosure of behavioral health information not related to alcohol or drug referral, diagnosis or treatment.

Drug and Alcohol Abuse Information

Information regarding treatment for alcohol or drug abuse is afforded special confidentiality by federal statute and regulation (42 USCA 290 dd-3, 290 ee-3, 42 C.F.R. Part 2). This includes any information concerning a member's diagnosis or treatment from a federally assisted alcohol or drug abuse program or referral to a federally assisted alcohol or drug abuse program.

General procedures for all disclosures

Unless otherwise accepted by state or federal law, all information obtained about a member related to the provision of services to the member is confidential whether the information is in oral, written, or electronic format.

All records generated as a part of the UAHP grievance and appeal processes are legal records, not medical or payment records, although they may contain copies of portions of a member's medical record. To the extent these legal records contain personal medical information, UAHP will redact or de-identify the information to the extent allowed or required by law.

List of Members Accessing Records

UAHP's subcontracted providers must ensure that a list is kept of every member or organization that inspects a currently or previously enrolled member's records other than the member's Adult Recovery Team, the uses to be made of that information and the staff member authorizing access. The access list must be placed in the enrolled member's record and must be made available to the enrolled member, their guardian or other designated representative.

Disclosure to Adult Recovery Teams

Disclosure of information to members of an Adult Recovery Team may or may not require an authorization depending upon the type of information to be disclosed and the status of the receiving party. Information concerning diagnosis, treatment or referral for drug or alcohol treatment may only be disclosed to members of an Adult Recovery Team with authorization from the enrolled member. Information not related to drug and alcohol treatment may be disclosed without patient authorization to members of an Adult Recovery Team who are providers of health, mental health or social services, provided the information is for treatment purposes as defined in the HIPAA Rule. Disclosure to members of an Adult Recovery Team who are not providers of health, mental health or social services requires the authorization of the member or the member's legal guardian or parent.

Disclosure to members involved in court proceedings

Disclosure of information to members involved in court proceedings including attorneys, probation or parole officers, guardians' ad litem and court appointed special advocates may or may not require an authorization depending upon the type of information to be disclosed and whether the court has entered orders permitting the disclosure.

Disclosure of information not related to alcohol and drug treatment

The HIPAA Rule and state law allow a covered entity to disclose protected health information under a variety of conditions. This is a general overview and does not include an entire description of legal requirements for each disclosure. Below is a general description of all required or permissible disclosures:

- To the individual and the individual's health care decision maker;
- To health, mental health and social service providers for treatment, payment or health care operations;
- Incidental to a use or disclosure otherwise permitted or required by 45 C.F.R. Part 160 and Part 164, Subpart E;
- To a member or entity with a valid authorization;
- Provided the individual is informed in advance and has the opportunity to agree or prohibit the disclosure:
    - For use in facility directories;
    - To members involved in the individual's care and for notification purposes.
- When required by state or federal law;
- For public health activities;
- About victims of child abuse, neglect or domestic violence;
- For health oversight activities;
- For judicial and administrative proceedings;
- For law enforcement purposes;
- About deceased members;
- For cadaveric organ, eye or tissue donation purposes;
- For research purposes, if the activity is conducted pursuant to applicable federal or state laws and regulations governing research;
- To avert a serious threat to health or safety or to prevent harm threatened by patients;
- To a human rights committee;
- For purposes related to the Sexually Violent Members program;
- With communicable disease information;
- To personal representatives including agents under a health care directive;
- For evaluation or treatment;
- To business associates;
- To the Secretary of Health and Human Services or designee to investigate or determine compliance with the HIPAA Rule;

- For specialized government functions;
- For worker's compensation;
- Under a data use agreement for limited data;
- For fundraising;
- For underwriting and related purposes;
- To the Arizona Center For Disability Law in its capacity as the State Protection and Advocacy Agency;
- To a third party payer the payer's contractor to obtain reimbursement;
- To a private entity that accredits a health care provider;
- To the legal representative of a health care entity in possession of the record for the purpose of securing legal advice;
- To a member or entity as otherwise required by state or federal law;
- To a member or entity permitted by the federal regulations on alcohol and drug abuse treatment (42 C.F.R. Part 2);
- To a member or entity to conduct utilization review, peer review and quality assurance pursuant to Section 36-441, 36-445, 36-2402 or 36-2917;
- To a member maintaining health statistics for public health purposes as authorized by law; and
- To a grand jury as directed by subpoena.

Disclosure to an individual

Below is a description of the circumstances in which behavioral health information is likely to be required or permitted to be disclosed.

A covered entity is required to disclose information in a designated record set to an individual when requested unless contraindicated. Contraindicated means that access is reasonably likely to endanger the life or physical safety of the patient or another member (See A.R.S. § 36-507(3); 45 C.F.R. § 164.524; A covered entity should read and carefully apply the provisions in 45 C.F.R. §164.524 before disclosing protected health information in a designated record set to an individual.

An individual has a right of access to his or her designated record set, except for psychotherapy notes and information compiled for pending litigation. See 45 C.F.R. § 164.524(a) (1) and Section 13405(e) of the HITECH Act. Under certain conditions a covered entity may deny an individual access to the medical record without providing the individual an opportunity for review. See 45 C.F.R. § 164.524(a) (2); ARS. § 12-2293. Under other conditions, a covered entity may deny an individual access to the medical record and must provide the individual with an opportunity for review. See 45 C.F.R. § 164.524(a) (3). A covered entity must follow certain requirements for a review when access to the medical record is denied. See 45 C.F.R. § 164.524(a) (4).

An individual must be permitted to request access or inspect or obtain a copy of his or her medical record. See 45 C.F.R. § 164.524(b) (1). A covered entity is required to act upon an

individual's request in a timely manner. See 45 C.F.R. § 164.524(b) (2).
An individual may inspect and be provided with one free copy per year of his or her own medical record, unless access has been denied.

A covered entity must follow certain requirements for providing access, the form of access and the time and manner of access. See 45 C.F.R. § 164.524(c).

A covered entity is required to make other information available in the record when access is denied, must follow other requirements when making a denial of access, must inform an individual of where medical records are maintained and must follow certain procedures when an individual requests a review when access is denied. See 45 C.F.R. § 164.524(d).

A covered entity is required to maintain documentation related to an individual's access to the medical record. See 45 C.F.R. § 164.524(e).

Disclosure with an individual's authorization or the individual's health care decision maker
The HIPAA Rule allows information to be disclosed with an individual's written authorization.

For all uses and disclosures that are not permitted by the HIPAA Rule, patient authorization is required. See 45 C.F.R. §§ 164.502(a) (1) (iv); and 164.508. An authorization must contain all of the elements in 45 C.F.R. § 164.508.

A copy of the authorization must be provided to the individual. The authorization must be written in plain language and must contain the following elements:

- A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion;
- The name or other specific identification of the member(s), or class of members, authorized to make the requested use or disclosure;
- The name or other specific identification of the member(s), or class of members, to whom the covered entity may make the requested use or disclosure;
- A description of each purpose of the requested use or disclosure. The statement "at the request of the individual" is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose;
- An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure. The statement "end of the research study," "none," or similar language is sufficient if the authorization is for a use or disclosure of protected health information for research, including for the creation and maintenance of a research database or research repository; and
- Signature of the individual and date. If the authorization is signed by a personal representative of the individual, a description of the representative's authority to act for

the individual must also be provided.

In addition to the core elements, the authorization must contain statements adequate to place the individual on notice of all of the following:

- The individual's right to revoke the authorization in writing, and either:
  - The exceptions to the right to revoke and a description of how the individual may revoke the authorization; or
  - A reference to the covered entity's notice of privacy practices if the notice of privacy practices tells the individual how to revoke the authorization.
- The ability or inability to condition treatment, payment, enrollment or eligibility for benefits on the authorization, by stating either:
  - The covered entity may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs the authorization when the prohibition on conditioning of authorizations in 45 C.F.R. § 164.508 (b)(4) applies; or
  - The consequences to the individual of a refusal to sign the authorization when, in accordance with 45 C.F.R. § 164.508 (b) (4), the covered entity can condition treatment, enrollment in the health plan or eligibility for benefits on failure to obtain such authorization.
- The potential for information disclosed pursuant to the authorization to be subject to re-disclosure by the member.

Disclosure to health, mental health and social service providers for treatment, payment or health care operations; reports of abuse and neglect

Disclosure is permitted without patient authorization to health, mental health and social service providers involved in caring for or providing services to the member for treatment, payment or health care operations as defined in the HIPAA Rule. These disclosures are typically made to primary care physicians, psychiatrists, psychologists, social workers (including DES and DDD) or other behavioral health professionals. Particular attention must be paid to 45 C.F.R. §164.506(c) and the definitions of treatment, payment and health care operations to determine the scope of disclosure. For example, a covered entity is allowed to disclose protected health information for its own treatment, payment or health care operations. See 45 C.F.R. §164.506(c) (1). A covered entity may disclose for treatment activities of a health care provider including providers not covered under the HIPAA Rule. See 45 C.F.R. § 164.506(c) (2). A covered entity may disclose to both covered and non-covered health care providers for payment activities. See 45 C.F.R. § 164.506(c) (3). A covered entity may disclose to another covered entity for the health care operations activities of the receiving entity if each entity has or had a direct treatment relationship with the individual and the disclosure is for certain specified purposes in the definition of health care operations. See 45 C.F.R. § 164.506(c) (4).

If the disclosure is not for treatment, payment, or health care operations or required by law,

patient authorization is required unless otherwise allowed by law.

The HIPAA Rule does not modify a covered entity's obligation under A.R.S. § 13-3620 to report child abuse and neglect to Department of Child Safety or disclose a child's medical records to the Department of Child Safety for investigation of child abuse cases.

Similarly, a covered entity may have an obligation to report adult abuse and neglect to Adult Protective Services. See A.R.S. § 46-454. The HIPAA Rule imposes other requirements in addition to those contained in A.R.S. § 46-454, primarily that the individual be notified of the making of the report or a determination by the reporting member that it is not in the individual's best interest to be notified. See 45 C.F.R. § 164.512(c).

Disclosure to other members including family members who are actively participating in the patient's care, treatment, or supervision

A covered entity may disclose protected health information without authorization to other members including family members actively participating in the patient's care, treatment or supervision. Prior to releasing information, an agency or non-agency treating professional or that member's designee must have a verbal discussion with the member to determine whether the member objects to the disclosure. If the member objects, the information cannot be disclosed. If the member does not object, or the member lacks capacity to object, or in an emergency circumstance, the treating professional must perform an evaluation to determine whether disclosure is in that member's best interests. A decision to disclose or withhold information is subject to review pursuant to A.R.S. § 36-517.01.

An agency or non-agency treating professional may only release information relating to the member's diagnosis, prognosis, need for hospitalization, anticipated length of stay, discharge plan, medication, medication side effects and short-term and long-term treatment goals. See A.R.S. § 36-509(7).

The HIPAA Rule imposes additional requirements when disclosing protected health information to other members including family members. A covered entity may disclose to a family member or other relative the protected health information directly relevant to the member's involvement with the individual's care or payment related to the individual's health care. If the individual is present for a use or disclosure and has the capacity to make health care decisions, the covered entity may use or disclose the protected health information if it obtains the individual's agreement, provides the individual with the opportunity to object to the disclosure and the individual does not express an objection. If the individual is not present, or the opportunity to agree or object to the use or disclosure cannot practicably be provided because of the individual's incapacity or an emergency circumstance, the covered entity may, in the exercise of professional judgment, determine whether the disclosure is in the best interests of the individual and, if so, disclose only the protected health information that is directly relevant to the member's involvement with the individual's health care. See 45 C.F.R. §

164.510(b).

Disclosure to an agent under a health care directive

A covered entity may treat an agent appointed under a health care directive as a personal representative of the individual. See 45 C.F.R. § 164.502(g). Examples of agents appointed to act on an individual's behalf include an agent under a health care power of attorney, see A.R.S. § 36-3221 *et seq.*; surrogate decision makers, see A.R.S. § 36-3231; and an agent under a mental health care power of attorney, see A.R.S. § 36-3281.

Disclosure to a personal representative

A covered entity may disclose protected health information to a personal representative, including the personal representative of an un-emancipated minor, unless one or more of the exceptions described in 45 C.F.R. §§ 164.502(g)(3)(i) or 164.502(g)(5) applies. See 45 C.F.R. § 164.502(g) (1).

The general rule is that if state law, including case law, requires or permits a parent, guardian or other member acting *in loco parentis* to obtain protected health information, then a covered entity may disclose the protected health information. See 45 C.F.R. § 164.502(g) (3) (ii) (A).

Similarly, if state law, including case law, prohibits a parent, guardian or other member acting *in loco parentis* from obtaining protected health information, then a covered entity may not disclose the protected health information. See 45 C.F.R. § 164.502(g) (3) (ii) (B).

When state law, including case law, is silent on whether protected health information can be disclosed to a parent, guardian or other member acting *in loco parentis*, a covered entity may provide or deny access under 45 C.F.R. § 164.524 to a parent, guardian or other member acting *in loco parentis* if the action is consistent with State or other applicable law, provided that such decision must be made by a licensed health care professional, in the exercise of professional judgment. See 45 C.F.R. § 164.502(g) (3) (ii) (C).

Disclosure to a member representative, Adults and Emancipated Minors

If under applicable law, a member has authority to act on behalf of an individual who is an adult or an emancipated minor in making decisions related to health care, a covered entity must treat such members as a member representative with respect to protected health information relevant to such member representation. See 45 C.F.R. § 164.502(g) (2). Simply stated, if there is a state law that permits the member representative to obtain the adult or emancipated minor's protected health information, the covered entity may disclose it. A covered entity may withhold protected health information if one or more of the exceptions in 45 C.F.R. § 164.502(g) (5) applies.

Deceased members

If under applicable law, an executor, administrator or other member has authority to act on

behalf of a deceased individual or of the individual's estate, a covered entity must treat such members as a personal representative with respect to protected health information relevant to the personal representation. See 45 C.F.R. § 164.502(g) (4). A covered entity may withhold protected health information if one or more of the exceptions in 45 C.F.R. § 164.502(g) (5) applies. A.R.S. §§ 12-2294 (D) provides certain members with authority to act on behalf of a deceased member.

Disclosure for court ordered evaluation or treatment

An agency in which a member is receiving court ordered evaluation or treatment is required to immediately notify the member's guardian or agent or, if none, a member of the member's family that the member is being treated in the agency. See A.R.S. § 36-504(B). The agency shall disclose any further information only after the treating professional or that member's designee interviews the member undergoing treatment or evaluation to determine whether the member objects to the disclosure and whether the disclosure is in the member's best interests. A decision to disclose or withhold information is subject to review pursuant to section A.R.S. § 36-517.01.

If the individual or the individual's guardian makes the request for review, the reviewing official must apply the standard in 45 C.F.R. § 164.524(a) (3). If a family member makes the request for review, the reviewing official must apply the "best interest" standard in A.R.S. § 36-517.01.

The reviewer's decision may be appealed to the superior court. See A.R.S. § 36-517.01(B). The agency or non-agency treating professional must not disclose any treatment information during the period an appeal may be filed or is pending.

Disclosure for health oversight activities

A covered entity may disclose protected health information without patient authorization to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions or other activities necessary for appropriate oversight of entities subject to government regulatory programs for which health information is necessary for determining compliance with program standards. See 45 C.F.R. § 164.512(d).

Disclosure for judicial and administrative proceedings including court ordered disclosures

A covered entity may disclose protected health information without patient authorization in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal, provided that the covered entity discloses only the protected health information expressly authorized by the order. See 45 C.F.R. § 164.512(e). In addition, a covered entity may disclose information in response to a subpoena, discovery request or other lawful process without a court order if the covered entity receives satisfactory assurances that the requesting party has made reasonable efforts to provide notice to the individual or has made reasonable efforts to secure a qualified protective order. See 45 C.F.R. §§ 164.512(e) (1)(iii),(iv)

and (v) for what constitutes satisfactory assurances.

Disclosure to members doing research

A covered entity may disclose protected health information to members doing research without patient authorization provided it meets the de-identification standards of 45 C.F.R. § 164.514(b). If the covered entity wants to disclose protected health information that is not de-identified, patient authorization is required or an Institutional Review Board or a privacy board in accordance with the provisions of 45 C.F.R. § 164.512(i) (1) (i) can waive it.

Disclosure to prevent harm threatened by patients

Mental health providers have a duty to protect others against the harmful conduct of a patient. See A.R.S. § 36-517.02. When a patient poses a serious danger of violence to another member, the provider has a duty to exercise reasonable care to protect the foreseeable victim of the danger. *Little v. All Phoenix South Community Mental Health Center, Inc.*, 186 Ariz. 97, 919 P.2d 1368 (1996). A covered entity may, consistent with applicable law and standards of ethical conduct, use or disclose protected health information without patient authorization if the covered entity, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a member or the public and is to a member or members reasonably able to prevent or lessen the threat, including the target of the threat, or is necessary for law enforcement authorities to identify or apprehend an individual. See 45 C.F.R. § 164.512(j) (1) (ii); 164.512(f) (2) and (3) for rules that apply for disclosures made to law enforcement. See 45 C.F.R. § 164.512(j) (4) for what constitutes a good faith belief.

Disclosures to human rights committees

Protected health information may be disclosed to a human rights committee without patient authorization provided personal identifiable information is redacted or de-identified from the record. See A.R.S. §§ 36-509(10) and 41-3804. In redacting personal identifiable information, a covered entity must comply with the HIPAA Rule de-identification standards in 45 C.F.R. §164.514(b) and not state law. If a human rights committee wants non-redacted identifiable health information for official purposes, it must first demonstrate to AHCCCS that the information is necessary to perform a function that is related to the oversight of the behavioral health system, and in that case, a covered entity may disclose protected health information to the human rights committee in its capacity as a health oversight agency. See 45 C.F.R. §164.512(d) (1).

Disclosure to the Arizona Department of Corrections

Protected health information may be disclosed without patient authorization to the state department of corrections in cases where prisoners confined to the state prison are patients in the state hospital on authorized transfers either by voluntary admission or by order of the court. See A.R.S. § 36-509(5) The HIPAA Rule limits disclosure to correctional institutions to certain categories of information that are contained in 45 C.F.R. § 164.512(k) (5).

Disclosure to a governmental agency or law enforcement to secure return of a patient
Protected health information may be disclosed to governmental or law enforcement agencies if necessary to secure the return of a patient who is on unauthorized absence from any agency where the patient was undergoing court ordered evaluation or treatment. See A.R.S. § 36-509 (6) A covered entity may disclose limited information without patient authorization to law enforcement to secure the return of a missing member. See 45 C.F.R. § 164.512(f) (2)(i). In addition, a covered entity is permitted limited disclosure to governmental agencies to prevent or lessen a serious and imminent threat to the health or safety of a member or the public. See 45 C.F.R. § 164.512(j).

Disclosure to a Sexually Violent Members (SVP) Program
Protected health information may be disclosed to a governmental agency or a competent professional, as defined in A.R.S. § 36-3701, in order to comply with the SVP Program (Arizona Revised Statutes, Title 36, Chapter 37). See A.R.S. § 36-509(9).

A "competent professional" is a member who may be a psychologist or psychiatrist, is approved by the Superior Court and is familiar with the state's sexually violent member's statutes and sexual offender treatment programs. A competent professional is either statutorily required or may be ordered by the court to perform an examination of a member involved in the sexually violent members program and must be given reasonable access to the member in order to conduct the examination and must share access to all relevant medical and psychological records, test data, test results and reports. See A.R.S. § 36-3701(2).

In most cases, the disclosure of protected health information to a competent professional or made in connection with the sexually violent members program is required by law or ordered by the court. In either case, disclosure under the HIPAA Rule without patient authorization is permitted. See 45 C.F.R. § 164.512(a) (disclosure permitted when required by law) and 45 C.F.R. § 164.512(e) (disclosure permitted when ordered by the court). If the disclosure is not required by law or ordered by the court or is to a governmental agency other than the sexually violent members program, the covered entity may have the authority to disclose if the protected health information is for treatment, payment or health care operations. See 45 C.F.R. § 164.506(c) to determine rules for disclosure for treatment, payment or health care operations.

Disclosure to third party payers
Disclosure is permitted to a third party payer to obtain reimbursement for health care, mental health care or behavioral health care provided to a patient. See A.R.S. § 36-509(13).

Disclosure to Accreditation Organization
Disclosure is permissible to a private entity that accredits a health care provider and with whom the health care provider has an agreement that requires the agency to protect the confidentiality of patient information. See A.R.S. § 36-509(14).

Disclosure of communicable disease information

A.R.S. § 36-661 et seq., includes a number of provisions that address the disclosure of communicable disease information. The general rule is that a member who obtains communicable disease related information in the course of providing a health service or pursuant to a release of communicable disease related information must not disclose or be compelled to disclose that information. See A.R.S. § 36-664(A). Certain exceptions for disclosure are permitted to:

- The individual or the individual's health care decision maker;
- ADHS or a local health department for the purpose of notifying a Good Samaritan;
- An agent or employee of a health facility or a health care provider;
- A health facility or a health care provider;
- A federal, state or local health officer;
- Government agencies authorized by law to receive communicable disease information;
- Members authorized pursuant to a court order;
- The Department of Economic Security for adoption purposes;
- The Industrial Commission;
- The Department of Health Services to conduct inspections;
- Insurance entities;
- A private entity that accredits a health care facility or a health care provider; and
- A member or entity for research only if the research is conducted pursuant to applicable federal or state laws governing research.

A.R.S. § 36-664 also addresses issues with respect to Disclosures to the Department of Health Services or local health departments. These disclosures are also permissible under certain circumstances:

- Authorizations;
- Redisclosures;
- Disclosures for supervision, monitoring and accreditation;
- Listing information in death reports;
- Reports to the Department; and
- Applicability to insurance entities.

An authorization for the release of communicable disease related information must be signed by the protected member or, if the protected member lacks capacity to consent, the member's health care decision maker (see A.R.S. § 36-664(F)). If an authorization for the release of communicable disease information is not signed, the information cannot be disclosed. An authorization must be dated and must specify to whom disclosure is authorized, the purpose for disclosure and the time period during which the authorization is effective. A general authorization for the release of medical or other information, including communicable disease

related information, is not an authorization for the release of HIV-related information unless the authorization specifically indicates its purpose as authorization for the release of HIV-related information and complies with the requirements of A.R.S. § 36-664(F).

The HIPAA Rule does not preempt state law with respect to disclosures of communicable disease information; however, it may impose additional requirements depending upon the type, nature and scope of disclosure. It is advisable to consult with the HIPAA Compliance Officer and/ or legal counsel prior to disclosure of communicable disease information.

For example, if a disclosure of communicable disease information is made pursuant to an authorization, the disclosure must be accompanied by a statement in writing which warns that the information is from confidential records which are protected by state law that prohibits further disclosure of the information without the specific written consent of the member to whom it pertains or as otherwise permitted by law. A.R.S. § 36-664(H) affords greater privacy protection than 45 C.F.R. § 164.508(c) (2) (ii), which requires the authorization to contain a statement to place the individual on notice of the potential for re-disclosure by the member and thus, is no longer protected. Therefore, any authorization for protected health information that includes communicable disease information must contain the statement that re-disclosure of that information is prohibited.

Disclosure to business associates

The HIPAA Rule allows a covered entity to disclose protected health information to a business associate if the covered entity obtains satisfactory assurances that the business associate will safeguard the information in accordance with 45 C.F.R. § 164.502(e) and the HITECH Act. See the definition of "business associate" in 45 C.F.R. § 160.103. Also see 45 C.F.R. § 164.504(e) and Section 13404 of the HITECH Act for requirements related to the documentation of satisfactory assurances through a written contract or other written agreement or arrangement.

Disclosure to the Arizona Center for Disability Law, acting in its capacity as the State Protection and Advocacy Agency pursuant to 42 U.S.C. § 10805

- Allowed when an enrolled member is mentally or physically unable to consent to a release of confidential information, and the member has no legal guardian or other legal representative authorized to provide consent; and
- Allowed when a complaint has been received by the Center or the Center asserts that the Center has probable cause to believe that the enrolled member has been abused or neglected.

Disclosures of alcohol and drug information

UAHP's subcontracted providers that provide drug and alcohol screening, diagnosis or treatment services are federally assisted alcohol and drug programs and must ensure compliance with all provisions contained in the Federal statutes and regulations referenced in this section.

UAHP's subcontracted providers must notify members seeking and/or receiving alcohol or drug abuse services of the existence of the federal confidentiality law and regulations and provide each member with a written summary of the confidentiality provisions. The notice and summary must be provided at admission or as soon as deemed clinically appropriate by the member responsible for clinical oversight of the member.

UAHP's subcontracted providers may require enrolled members to carry identification cards while the member is on the premises of an agency. UAHP's providers may not require enrolled members to carry cards or any other form of identification when off the provider's premises that will identify the member as a member of drug or alcohol services.
UAHP's subcontracted providers may not acknowledge that a currently or previously enrolled member is receiving or has received alcohol or drug abuse services without the enrolled member's authorization.

UAHP's subcontracted providers must respond to any request for a disclosure of the records of a currently or previously enrolled member that is not permissible under this policy or federal regulations in a way that will not reveal that an identified individual has been, or is being diagnosed or treated for alcohol or drug abuse.

UAHP's subcontracted provider must advise the member or guardian of the special protection given to such information by federal law.

Release of information concerning diagnosis, treatment or referral from an alcohol or drug abuse program must be made only as follows:

- The currently or previously enrolled member or their guardian authorizes the release of information. In this case, authorization must be documented on an authorization form which has not expired or been revoked by the patient. The proper authorization form must be in writing and must contain each of the following specified items:
    - The name or general designation of the program making the disclosure;
    - The name of the individual or organization that will receive the disclosure;
    - The name of the member who is the subject of the disclosure;
    - The purpose or need for the disclosure;
    - How much and what kind of information will be disclosed;
    - A statement that the member may revoke the authorization at any time, except to the extent that the program has already acted in reliance on it;
    - The date, event or condition upon which the authorization expires, if not revoked before;
    - The signature of the member or guardian; and
    - The date on which the authorization is signed.

Re-disclosure

Authorization, written or oral, as provided above must be accompanied by the following written statement: "This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the member to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient."

If the member is a minor, authorization must be given by both the minor and his or her parent or legal guardian.

If the member is deceased, authorization may be given by:

- A court appointed executor, administrator or other personal representative;
- If no such appointments have been made, by the member's spouse; or
- If there is no spouse, by any responsible member of the member's family.

Authorization is not required under the following circumstances:

- Medical Emergencies – information may be disclosed to medical personnel who need the information to treat a condition which poses an immediate threat to the health of any individual, not necessarily the currently or previously enrolled member, and which requires immediate medical intervention. The disclosure must be documented in the member's medical record and must include the name of the medical member to whom disclosure is made and his or her affiliation with any health care facility, name of the member making the disclosure, date and time of the disclosure and the nature of the emergency. After emergency treatment is provided, written confirmation of the emergency must be secured from the requesting entity;
- Research Activities – information may be disclosed for the purpose of conducting scientific research according to the provisions of 42 C.F.R. § 2.52;
- Audit and Evaluation Activities – information may be disclosed for the purposes of audit and evaluation activities according to the provisions of 42 C.F.R. § 2.53;
- Qualified Service Organizations – information may be provided to a qualified service organization when needed by the qualified service organization to provide services to a currently or previously enrolled member;
- Internal Agency Communications - the staff of an agency providing alcohol and drug abuse services may disclose information regarding an enrolled member to other staff within the agency, or to the part of the organization having direct administrative control over the agency, when needed to perform duties related to the provision of alcohol or

drug abuse diagnosis, treatment, or referral for treatment to a member. For example, an organization that provides several types of services might have an administrative office that has direct administrative control over each unit or agency that provides direct services; and

- Information concerning an enrolled member that does not include any information about the enrolled member's receipt of alcohol or drug abuse diagnosis, treatment or referral for treatment is not restricted under this section. For example, information concerning an enrolled member's receipt of medication for a psychiatric condition, unrelated to the member's substance abuse, could be released. Court-ordered disclosures-A state or federal court may issue an order that authorizes an agency to make a disclosure of identifying information that would otherwise be prohibited. A subpoena, search warrant or arrest warrant is not sufficient standing alone, to require or permit an agency to make a disclosure.
- Crimes committed by a member on an agency's premises or against program personnel. Agencies may disclose information to a law enforcement agency when a member who is receiving treatment in a substance abuse program has committed or threatened to commit a crime on agency premises or against agency personnel. In such instances, the agency must limit the information disclosed to the circumstances of the incident. It may only disclose the member's name, address, last known whereabouts and status as a member receiving services at the agency.
- Child abuse and neglect reporting. Federal law does not prohibit compliance with the child abuse reporting requirements contained in A.R.S. § 13-3620.

Telemedicine

See Section 11.4 on Telemedicine.

Security Breach Notification

UAHP and its subcontracted providers, in the event of an impermissible use/disclosure of unsecured PHI, must provide notification to any and all members affected by the breach in accordance with Section 13402 of the HITECH Act.

11.4 Telehealth and Telemedicine

Telemedicine shall not replace provider choice and/or member preference for in person/physical delivery. UAHP covers medically necessary behavioral health services that can be provided via telemedicine with the exception of the following:

- Home Care Training Family Services (Family Support)
- Self-Help/Peer Support Services (Peer Support)
- Skills Training and Development
- Psychosocial Rehabilitation Services (Living Skills Training)
- Case Management

Telemedicine is the practice of health care delivery, diagnosis, consultation and treatment, and the transfer of medical/behavioral health data through interactive audio, video or data communications that occur in the physical presence of the member, including audio or video communications sent to a health care provider for diagnostic or treatment consultation.

Telehealth (or telemonitoring) is the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance.

a. Telehealth includes such technologies as telephones, facsimile machines, electronic mail systems, and remote member monitoring devices, which are used to collect and transmit member data for monitoring and interpretation. While they do not meet the Medicaid definition of telemedicine they are often considered under the broad umbrella of telehealth services. Even though such technologies are not considered "telemedicine" they may nevertheless be covered and reimbursed as part of the UAHP Medicaid covered behavioral health benefit.

Asynchronous or "Store and Forward" is the transfer of data from one site to another through the use of a camera or similar device that records (stores) an image that is sent (forwarded) via telecommunication to another site for consultation. Asynchronous or "store and forward" applications would not be considered telemedicine but may be utilized to deliver services.**Consulting Provider** is any AHCCCS registered provider who is not located at the originating site who provides an expert opinion to assist in the diagnosis or treatment of a member.

Distant or Hub Site is the site at which physician or other licensed practitioner delivering the service is located at the time the service is provided via telecommunications system.

Originating or Spoke site is the location of the member at the time the service is being furnished via a telecommunications system occurs. Telepresenters may be needed to facilitate the delivery of this service.

Telepresenter is the designated individual who is familiar with the member's case and has been asked to present the member's case at the time of the telehealth service delivery if the member's originating site provider is not present. The telepresenter must be familiar, but not necessarily a behavioral/medical expert, with the member's condition in order to present the case accurately.

Telecommunications Technology is the transfer of medical/behavioral data from one site to another through the use of a camera, electronic data collection system or other similar device that records (stores) an image which is then sent (forwarded) via telecommunication to another site for consultation which includes store and forward. Services delivered using telecommunications technology but not requiring the member to be present during their implementation are not considered telemedicine**.**

Informed Consent

If a recording of the interactive video service is to be made, a separate consent to record shall be obtained. The responsibility of ensuring the informed consent is completed lies with the provider delivering the service. The informed consent must include:

a. Identifying information
b. A state of understanding that the participation in telemedicine is voluntary
c. A statement of understanding that a recording of the information and images from the interactive video service will be made, and likely viewed by other persons for specific clinical or educational purpose
d. A description of the purpose(s) for the recording
e. A statement of the person's right to rescind the use of the recording at any time
f. A date upon which permission to use the recording will be void unless otherwise renewed by signature off the person receiving the recorded service
g. A statement of understanding that the person has the right to inspect all information obtained and recorded in the course of telemedicine interaction, and may receive copies of the information for a reasonable fee
h. A statement of understanding that providers will have access to any relevant medical/behavioral information about the person, including psychiatric and/or psychological information, alcohol and/or drug use and mental health records. However if the person is receiving services related to alcohol and other drugs or HIV status, no material , including video recordings may be re-disclosed unless further disclosure is expressly permitted by the person under 42 CFR Part 2 or A.R.S 36-664 and:

A statement of understanding that the informed consent document witll become a part of the member's medical record. If a telemedicine session is recorded, the recording must be maintained as a component on the member's record in accordance with 45 CFR Part 164.152. To ensure confidentiality of telemedicine sessions, providers must do the following when providing services via telemedicine:

- The videoconferencing room door must remain closed at all times;
- If the room is used for other purposes, a sign must be posted on the door, stating that a clinical session is in progress;
- If a recording of the session is made, an authorization, signed by the member, shall be obtained;
- All videoconferencing equipment shall be set to automatically mute its microphone(s) when answering any incoming calls;
- All videoconferencing equipment shall be set not to automatically answer multipoint calls;
- All videoconferencing equipment with Internet access that is used for telemedicine shall be set to not allow remote monitoring; and
- All videoconferencing equipment in rooms used for telemedicine or member services shall have the camera lens covered and the microphone muted or must be turned off whenever the equipment is not in use.

Section 12 – Disputes, Grievances and Member Rights

12.1 Notice Requirements and Appeal Process for Title XIX/XXI Eligible Members

The Health Plan Appeals Department is available to members or providers, acting on behalf of a member, and with the member's written consent, to file an appeal. After the resubmission process, the Appeals Department handles unresolved claim disputes for providers. The State of Arizona and the AHCCCS Administration have established laws, rules, policies and procedures that determine processes and adjudicate Appeals and Requests for Fair Hearings.

What is a Grievance?
A grievance (complaint) is an expression by a member or a provider of dissatisfaction about any aspect of care. Examples of grievances are: service issues, transportation issues, quality of care issues and provider office issues. These issues are filed with Grievance and Appeals, the Customer Care Center or Network Development departments.

A grievance can be filed in writing by mailing, faxing or emailing to the address listed below. An oral grievance may be filed by calling our Customer Care Center number below.

YOU CAN MAIL GRIEVANCES TO:
The University of Arizona Health Plan
ATTENTION: Grievance & Appeals Department
2701 E. Elvira Road
Tucson, AZ 85756
(Fax) 866-465-8340
grievance@uahealth.com

A grievance will be reviewed and a response will be provided within 90 days. You can also file a complaint regarding the adequacy of the Notice of Action (a denial of service by the Health Plan). If we cannot take care of your concern with the adequacy of the Notice of Action, you can also call AHCCCS.

What is an Action?
An action is a denial, reduction, suspension, or termination of a service/benefit or payment, or a failure to act in a timely manner.

What is an Appeal?
An appeal is a request to reconsider or change a decision, also known as an action. An appeal must be filed in writing within 60 days from the Notice of Action. A request for a standard or expedited appeal can be made orally or in writing.

The enrollee, their representative, or a legal representative of a deceased enrollee's estate may file an appeal. A provider acting on behalf of an enrollee may file an appeal. If the provider is filing on behalf of the member, a written consent from the member must accompany the request. If filed orally by the member, a written request must follow. Access to medical records is critical for UAHP to meet the timeframe for a decision. The reasons you may file an appeal are:

- Denial or limited authorization of a requested service, including the type or level of service;
- Reduction, suspension, or termination of a previously authorized service;
- Denial, in whole or in part, of payment for a service;
- Failure to provide services in a timely manner;
- Failure to act within the timeframe required for standard and expedited resolution of appeals and standard disposition of grievances;
- The denial of a rural enrollee's request to obtain services outside the contractor's network under 42CFR 438.52 (b) (2) (ii), when the contractor is the only contractor in the rural area.

YOU CAN MAIL AN APPEAL TO:
The University of Arizona Health Plan
ATTENTION: Grievance & Appeals Department
2701 E. Elvira Road
Tucson, AZ 85756
(Fax) 866-465-8340
grievance@uahealth.com

You may also call the Customer Care Center at 800-582-8686 and ask to speak to an Appeals Department representative to file an oral appeal. You may also fax in your request to the fax number above. UAHP will request additional medical information and the appeal will be reviewed by healthcare professionals who have the appropriate clinical expertise and who were not involved in the previous level of review. The member or provider will be given the opportunity to present information or fact of law to the reviewer either in person or in writing during the appeal process. The case file is available for review by the member or provider during the appeal process. A decision will be rendered by UAHP within 30 days of receipt of the appeal request, unless a request for an extension of 14 days is requested.

Standard Appeal
Standard appeals can take up to 30 days to resolve. A 14 day extension may be taken if it is needed for a standard appeal if you request it or if it is in your best interest to extend the time to resolve.

Expedited Appeal
An expedited appeal may be filed by the enrollee or on the enrollee's behalf by the provider. It will be approved if UAHP determines that the time to process a standard appeal would seriously jeopardize the health, life or ability to attain, maintain or regain maximum function. If an expedited appeal request is not approved, UAHP will notify the member and the provider within two (2) days and transition the appeal to the standard appeal timelines.

Continuation of Benefits
Benefits may be continued during the appeal or hearing process if the member or provider requests in writing that the services be continued. The member may be required to pay the cost of services while the appeal or hearing is processed if the final decision is adverse to the member.

Assistance with filing an Appeal or the State Fair Hearing Process
If you need help with the Appeals or State Fair Hearing process or need translator services, please contact Customer Care or the Grievance & Appeals Department at 1-800-582-8686.

Also, there are legal services programs in your area that may be able to help you with the hearing process. General information about your rights can also be found on the internet at the following web site: www.azlawhelp.org. Specific information about your rights as it relates to the Arizona Administrative Codes can be found at the following web site: www.azsos.gov/public_services/Title_09/09_table.htm (Chapter 22). Specific information about the grievance and appeals (including hearing) process are found in the Arizona Revised Statutes and the web address is: http://www.azleg.gov/ArizonaRevisedStatutes.asp

Claims Issues/Disputes
If the provider has a dispute with the resolution of a claim after resubmitting the claim for review, the provider may challenge the claim denial or adjudication by filing a formal appeal (claim dispute), in writing, with the Grievance and Appeals Department. The claim dispute request should include the following for faster processing:

- Member information: name, date of birth, AHCCCS ID;
- Claim Number;
- Date of Service;
- Denial Reason (this should match the denial reason provided on the Health Plan
- Copy of the Health Plan's Remittance Advice in which the claim was denied or incorrectly paid;
- Any additional documentation required and/or that supports your request;
- Any and all denied claims must be appealed separately with all required information And/or documentation.
- *Note* All dispute requests received that are deemed to be incomplete will be dismissed. If a claim dispute is dismissed, a written notification will be mailed to the provider. In addition, the written notice will state the reason for the dismissal.

An appeal for a claims payment issue must be received within twelve (12) months from the date of service, or for a hospital claim within twelve (12) months from the date of discharge, 12 months after the date of eligibility posting or within sixty (60) days after the date of a timely claim submission, whichever is later. UAHP ensures that no punitive action will be taken against a provider who requests a claim dispute or supports a member's appeal.

CLAIM DISPUTES SHOULD BE ADDRESSED TO:
The University of Arizona Health Plan
ATTENTION: Grievance & Appeals Department
2701 E. Elvira Road
Tucson, AZ 85756

How do I request a State Fair Hearing?
If you are not satisfied with the appeal/claim dispute decision, you may file a Request for State Fair Hearing with UAHP. This request must be made in writing to UAHP within thirty (30) days of the date of receipt of the Notice of Appeal Resolution. UAHP will send the appeal file to AHCCCS and a hearing date will be scheduled for attendance.

REQUESTS FOR HEARING SHOULD BE SUBMITTED TO:
The University of Arizona Health Plan
ATTENTION: Grievance & Appeals Department
2701 E. Elvira Road
Tucson, AZ 85756
Requests may also be faxed.

Medicare Grievance and Appeals
The UAHP Appeals Department is available to members or providers, acting on behalf of a member, to file an appeal. After the resubmission process, the Appeals Department handles unresolved claim disputes for providers. The Centers for Medicare & Medicaid have established

laws, rules, policies and procedures that determine processes and adjudicate Appeals and external reviews.

What is a Grievance?
A grievance (complaint) is an expression by a member or a provider of dissatisfaction about any aspect of care, other than dissatisfaction with an organization or coverage determination. Examples of grievances are: service issues, quality of care issues and provider office issues. These issues are filed with Grievance and Appeals, the Customer Care Center or any department within UAHP.

A grievance can be filed in writing by mailing, faxing or emailing to the address listed below. An oral grievance may be filed by calling our Customer Care Center number below. A grievance will be reviewed and a response will be provided within 30 days.

The University of Arizona Health Plan
ATTENTION: Manager, Grievance & Appeals
2701 E. Elvira Road
Tucson, AZ 85756
(Phone) 1-877-874-3930
(Fax) 866-465-8340

If your grievance involves a quality of care issue or a member would like to file an appeal regarding their disapproval of notification of discharge from an inpatient facility, you have a right to file a grievance with a Medicare Quality Improvement Organization (QIO).

In the state of Arizona, the agency contracted for this service is:
Livanta, LLC
BFCC-QIO Program, Area 5
9090 Junction Drive, Suite 10
Annapolis Junction, MD 20701
Telephone: 1-877-588-1123, TTY: 1-855-887-6668
Fax for Appeals: 1-855-694-2929
Fax for all other reviews: 1-844-420-6672
www.BFCCQIOAREA5.com

What is an Organization Determination?
Any determination made by the Health Plan with respect to any of the following:

- Payment for temporarily out of the area emergency services, post-stabilization care, or urgently needed services;
- Payment for any other health services furnished by a provider other than UAHP that the member believes are covered under Medicare, or if not covered under Medicare, should have been furnished arranged for, or reimbursed by UAHP:

- UAHP's refusal to provide or pay for services, in whole or in part, including the type or level of services that the enrollee believes should be furnished or arranged for UAHP;
- Reduction, or premature discontinuation of a previously authorized ongoing course of treatment;
- Failure of UAHP to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the member.

What is a Coverage Determination?
Any decision made by or on behalf of UAHP regarding payments or benefits to which an enrollee believes he or she is entitled.

What is an Appeal (Reconsideration/Redetermination)?
An appeal is a request to reconsider or change an adverse organization or coverage determination. An appeal must be filed in writing within 60 calendar days from the date of the notice of the organization or coverage determination. A request for a standard or expedited appeal can be made orally or in writing.

A reconsideration is an enrollee's first step in the appeal process after an adverse organization determination (Part C).

A redetermination is an enrollee's first step in the appeal process after an adverse coverage determination (Part D).

All appeal requests should include the following for faster processing:

- Member information: name, date of birth, ID;
- Claim number or pre-service authorization request number;
- Date of Service;
- Denial reason;
- Reason for appeal;
- A copy of UAHP's Remittance Advice or Pre-Service Denial notice;
- Any additional documentation required and/or that supports your appeal;
- Any and all denied claims must be appealed separately with all required information and/or documentation.

Appeals for Part C (Reconsideration)

The member, their representative, non-contract physician or provider, or physician, with the member's consent may file an appeal. Access to medical records is critical for UAHP to

meet the timeframe for a decision.

YOU CAN MAIL, EMAIL OR FAX AN APPEAL TO:
The University of Arizona Health Plan
ATTENTION: Manager, Grievance & Appeals
2701 E. Elvira Road
Tucson, AZ 85756
(Fax) 866-465-8340

You may also call the Customer Care Center at 1-877-874-3930 and ask to speak to an Appeals Department representative to file an oral appeal. The Health Plan will request additional medical information and the appeal will be reviewed by healthcare professionals who have the appropriate clinical expertise and who were not involved in the previous level of review. The enrollee, their representative or provider will be given the opportunity to present information or fact of law to the reviewer, either in person or in writing, during the appeal process. The case file is available for review by the enrollee, their representative, or provider during the appeal process.

Standard Appeal
Standard appeals for a pre-service request will be resolved no later than 30 calendar days from the date the request is received by UAHP. The time frame may be extended by up to 14 calendar days if the member requests the extension or if UAHP requires additional information and the delay is in the interest of the member. Standard appeals for a payment request will be resolved no later than 60 calendar days from the date the request is received by UAHP.

Expedited Appeal
Expedited appeals for pre-service requests will be approved by UAHP if the request is submitted or supported by a physician. An expedited request not supported by the physician will be reviewed to determine if the life or health of the member, or the member's ability to regain maximum function could be seriously jeopardized by applying the standard time frame. If the request is approved, UAHP will resolve the request no later than 72 hours after receiving the request. If the request is not approved, UAHP will promptly notify the member of the denial, their rights and automatic transfer to the standard processing timeframes of their appeal. A written notification to the member is provided within 3 calendar days of the oral notification.

The expedited appeal process is not available for payment requests.

Appeals for Part D (Redetermination)
The member, their representative, or their prescribing physician or other prescriber may file an appeal. Access to medical records is critical for UAHP to meet the timeframe for a

decision.

YOU CAN MAIL, EMAIL OR FAX AN APPEAL TO:
The University of Arizona Health Plan
ATTENTION: Manager, Grievance & Appeals
2701 E. Elvira Road
Tucson, AZ 85756
(Fax) 866-465-8340

You may also call the Customer Care Center at 1-877-874-3930 and ask to speak to an Appeals Department representative to file an oral appeal. UAHP will request additional medical information and the appeal will be reviewed by healthcare professionals who have the appropriate clinical expertise and who were not involved in the previous level of review. The member, their representative, or prescriber will be given the opportunity to present information or fact of law to the reviewer, either in person or in writing, during the appeal process. The case file is available for review by the enrollee, their representative, or prescriber during the appeal process.

Standard Appeal
Standard appeals can take up to 7 days to resolve.

Expedited Appeal
An expedited appeal will be approved by UAHP if the request is submitted by a physician or other prescriber, or supported by a physician's or other prescriber's oral or written statement. An expedited appeal request will be reviewed when submitted by the member or the member's representative to determine whether the request indicates that the member's life, health, or ability to regain maximum function could be jeopardized by applying the standard time frame for processing the request. If the request is not approved, UAHP will promptly notify the member and the provider and transition the appeal to the standard appeal timelines. In addition, the member will be informed of their rights. A written notice to the member will be provided within 3 calendar days of the oral notification.

Continuation of Benefits

Benefits may be continued during the appeals process if the member or provider requests in writing that the services be continued. The member may be required to pay the cost of services while the appeal is processed if the final decision is adverse to the member.

Assistance with filing an Appeal
If you need help with the Appeals process or need translator services, please contact Customer Care or the Grievance & Appeals Department at 1-877-874-3930.

Resources
There are legal services programs in your area that may be able to help you with the appeals process. General information about your rights is also available by calling 1-800-MEDICARE. Specific information about your rights as it relates to Medicare can be found at the following web site: www.cms.gov.

Reopenings
Contracted providers have reopening rights not appeal rights. A reopening is a review of a final determination or decision of a payment (claim) decision. Reasons available for reopenings are:

- Mathematical or computational mistakes;
- Inaccurate data entry;
- Denials of claims as duplicates; or
- Additional evidence for consideration which was not available at the time of the decision.

If the provider has a payment dispute with the resolution of a claim after resubmitting the claim for review, the provider may challenge the claim denial or adjudication by filing a request for a reopening, in writing, with the Grievance and Appeals Department. The reopening request should include the following for faster processing:

- Member information: name, date of birth, ID;
- Claim Number;
- Date of Service;
- The request for a reopening must be clearly stated;
- The specific reason for requesting the reopening
- Any additional documentation required and/or that supports your request;
- Any and all requests must be submitted separately with all required information and/or documentation.
- *Note* All dispute requests received that are deemed to be incomplete or past the filing deadline will be dismissed. If a claim dispute is dismissed, a written notification will be mailed to the provider. In addition, the written notice will state the reason for the dismissal.

A reopening must be submitted to UAHP within one (1) year from the date of the determination or reconsideration, within four (4) years from the date of the determination or reconsideration for good cause; at any time if there exists reliable evidence that the determination was procured by fraud or similar fault; at any time if the determination is unfavorable, in whole or in part, but only for the purpose of correcting a clerical error on which the determination was based; or at any time to effectuate a decision issued under the coverage (National Coverage Determination) appeals process. UAHP ensures that no punitive action will be taken against a provider who requests a reopening or supports a member's appeal.

REOPENINGS SHOULD BE ADDRESSED TO:
The University of Arizona Health Plan
ATTENTION: Manager, Grievance & Appeals
2701 E. Elvira Road
Tucson, AZ 85756

Independent Review for Appeals
If UAHP decides to uphold the original adverse decision, either in whole or in part, UAHP will automatically forward the entire file to the Independent Review Entity (MAXIMUS) for a new and impartial review. MAXIMUS is CMS's independent contractor for appeal reviews involving Medicare Advantage plans. UAHP must send MAXIMUS the file within thirty (30) days of the request for services and sixty (60) days of a request for payment.

UAHP will notify the interested parties that the file has been forwarded for review.
For cases submitted for review, MAXIMUS will make a reconsideration decision and notify the appellant in writing of their decision and the reasons for the decision. If MAXIMUS decides in favor of the appellant, UAHP must pay for, provide or authorize the service as expeditiously as the member's health condition requires, but no later than sixty (60) days from the date notice UAHP's decision is received. If MAXIMUS upholds UAHP's, their notice will inform the member of rights to a hearing before an Administrative Law Judge (ALJ).

If MAXIMUS does not rule fully in the appellant's favor, there are further levels of appeal:
If the amount in controversy meets a certain threshhold (the amount is calculated annually and published in the Federal Register prior to the end of each calendar year), the member may request a hearing before an ALJ by submitting a written request to UAHP, MAXIMUS, or the Social Security Administration within sixty (60) days of the date of MAXIMUS's notice that the reconsideration decision was not in the member's favor. This sixty (60) day notice may be extended for good cause. All hearing requests will be forwarded to MAXIMUS. MAXIMUS will then forward the request and the reconsideration file to the hearing office. UAHP will also be made a party to the appeal at the ALJ level. Either the member or UAHP may request a review of an ALJ decision by the Medicare Advisory Council (MAC), which may either review the decision or decline review.

If the amount involved meets the threshhold or more, either the member or UAHP may request that a decision made by the MAC, or the ALJ if the MAC has declined review, be reviewed by a Federal district court. Any initial reconsideration decision made by UAHP, MAXIMUS, the ALJ or the MAC can be reopened by any party (a) within twelve (12) months, (b) within four (4) years.

Section 13 – Integrated Behavioral Health Providers

Behavioral health providers that are licensed by ADHS/DLS as an Integrated Clinic (Provider Type IC), may provide primary care/prevention services as well as pharmacy, laboratory and diagnostics in one or more of their clinical sites.

UAHP requires that all primary care and other acute care providers are credentialed and contracted with UAHP as a provider. Please refer to the UAHP Provider Manual at www.ufcaz.com for specific instructions regarding the contractual requirements to serve UAHP members, including University Care Advantage.

Section 14 – Resources and Deliverables

Guides and Forms

All Guides and Forms can be found at www.ufcaz.com/ProviderResourcePage.aspx under "Behavioral Health Guides and Forms."

AHCCCS Notification to waive Medicare Pt. D Copayments
AMPM 310-V Informed Consent – Assent for Psychotropic Medication Treatment
AMPM Exhibit 320-U-1
AMPM Exhibit 320-U-2
AMPM Exhibit 320-U-3
AMPM Exhibit 320-U-4
AMPM Exhibit 320-U-5
AMPM Exhibit 320-U-7
AMPM Exhibit 320-P-1
AMPM Exhibit 320-P-2
AMPM Exhibit 320-P-3
BHRF Prior Authorization Criteria
BHTH Prior Authorization Criteria
Form 3.3.1 Engagement and Re-engagement Review
Form 3.8.1 Provider COT Roster Template
Form 3.8.2 Court Ordered Treatment Plan
Form 3.8.3 Law Enforcement Committal Information Form
Form 3.8.4 Request for Suspension
Form 3.8.5 Judicial Review
Form 3.8.6 Release from COT
Form 3.8.7 Network Status Report to the Court – Mandatory
Form 3.8.8 Annual Review – GD
Form 3.8.9 Annual Review – PAD
Form 3.8.10 Confirmation of Receipt
Form 3.9.1 Out of State Placement – Initial Notice
Form 3.9.2 Out of State Placement – 30 Day Update
Form 9.1.1 Behavioral Health Prior Authorization
Form 9.1.2 Certification of Need (CON)
Form 9.1.3 Recertification of Need (RON)
Form 9.1.4 Request for OOH Admission
Medicaid-Medicare Behavioral Health Covered Services Matrix
UAHP Covered Services Guide

Fax Numbers

Department/Organization	Fax Number
UAHP Prior Authorization	520-694-0599
UAHP Inpatient Notification	520-874-3420
UFC Utilization Management	520-874-3420
UAHP Grievance and Appeals	866-465-8340
Livanta, LLC Appeals	855-694-2929
Livanta, LLC All Other Reviews	844-420-6672

Phone Numbers

Department/Organization	Phone Number
UAHP Customer Care	800-582-8686
UAHP TDD/TTY	800-367-8939
UAHP Grievance and Appeals	877-874-3930
Crisis Response Network (CRN)	800-631-1314
Nursewise	866-495-6735
Livanta, LLC	877-588-1123

Emails

Department	Email Address
UAHP Behavioral Health	UAHPCaseManagementBHMailbox@bannerhealth.com
UAHP Network Development	UAHPProviderNotifications@bannerhealth.com
UAHP Member Services	memberservicesinquir@bannerhealth.com
UAHP Grievance and Appeals	grievance@uahealth.com

Websites

www.uahealthplans.com
www.ufcaz.com
www.crisisnetwork.org/smi/
www.mcg.com

Deliverables

Due Date	Deliverable
15th of each month (even if you have a count of nil)	Monthly COT Roster submitted to UAHPCaseManagementBHMailbox@bannerhealth.com