# Behavioral Health Comprehensive Provider Manual Supplement

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Section 1 – Introduction

Banner University Health Plans (BUHP) 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. BUHP is committed to bringing the best care possible to vulnerable populations through a focus on innovative programs and services. BUHP serves ten Arizona counties—Pima, La Paz, Yuma, Santa Cruz, Cochise, Greenlee, Graham, Pinal, Maricopa and Gila Counties—and recognizes that the needs of each county are uniquely based on the county’s resources and challenges. BUHP tailors services to meet the needs of each community and supports local community-based efforts to effectively coordinate care. BUHP developed this Behavioral Health 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). BUHP’s Behavioral Health Provider Manual is applicable to those members who have both Medicare and Medicaid funded health care and are enrolled in the BUHP Arizona Long Term Care Services (ALTCS) and the AHCCCS Complete Care (ACC) plan. Providers are obligated to adhere to and comply with all terms and conditions of the BUHP Behavioral Health Provider Manual, the provider’s agreement with BUHP, and all applicable federal and State laws and regulations. For requirements for Primary Care Providers, please refer to the Provider Manual. In addition, providers are obligated to understand and comply with all AHCCCS requirements. Please refer to: AHCCCS ACOM and AMPM located at www.ahcccs.gov for additional information regarding State requirements.

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

1. **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 are 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 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.

BUHP endorses and requires for all contracted providers to comply with the Arizona Vision- 12 Principles for Children’s Behavioral Health Service Delivery.

Background the Arizona Vision states, “In collaboration with the child and family and others, Arizona will provide accessible behavioral health services designed to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults. Services will be tailored to the child and family and provided in the most appropriate setting, in a timely fashion and in accordance with best practices, while respecting the child’s and family’s cultural heritage.”

**The 12 Arizona Principles are:**

1. Collaboration with the child and family
2. Functional outcomes
3. Collaboration with others
4. Accessible services
5. Best practices
6. Most appropriate setting
7. Timeliness
8. Services tailored to the child and family
9. Stability
10. Respect for the child and family’s unique cultural heritage
11. Independence
12. Connection to natural supports
Section 2 – Covered Services and Related Program Requirements

Behavioral Health Medicaid and Medicare Covered Services

Arizona Health Care Cost Containment System (AHCCCS) has developed a comprehensive array of covered behavioral health services to meet the individual needs of eligible persons. Covered services assist and encourage each person to achieve and maintain the highest possible level of health and self-sufficiency. The type of service covered is contingent on each person’s current eligibility status and, for some persons, is based on available funding. All behavioral health services are required to be medically necessary, based upon the needs of the person. The Health Plan contracted providers are required to operate within their scope of practice.

The AHCCCS Covered Behavioral Health Services Guide contains information regarding each of the covered services that are available through the publicly funded health care system including: a definition of each service; the requirements of individuals or agencies providing the service; and any limitations to using or billing for the service. The Health Plan contracted providers must deliver covered services in accordance with the AHCCCS Covered Behavioral Health Services Guide, the AHCCCS Policy and Procedures Manual, the AHCCCS Medical Policy Manual, the AHCCCS Contractor Operations Manual, and the requirements of any other funding source (i.e., Medicare Advantage requirements for dual eligible Members).

The Health Plan contracted behavioral health providers are required to assist adult or the guardian on the behalf the child with applying for Arizona Public Programs (Title XIX/XXI, Medicare Savings Programs, Nutrition Assistance, and Cash Assistance), and Medicare Prescription Drug Program (Medicare Part D), including the Medicare Part D “Extra Help with Medicare Prescription Drug Plan Costs” low income subsidy program, as well as verification of U.S. citizenship/lawful presence prior to receiving Non-Title XIX/XXI covered behavioral health services, at the time of intake for behavioral health services.

Eligibility status is essential for identification of the types of behavioral health services a member may be able to access. For individuals who are not currently Title XIX/XXI eligible, a financial and eligibility screening and application must be completed to determine eligibility. Verification of an individual’s identification and citizenship/lawful presence in the United States is completed through the AHCCCS Health-e-Arizona PLUS (HEAPlus) application process. The Health Plan contracted behavioral health providers are required to assist individuals in completing this screening and verification processes.

If the individual is in need of emergency services, the individual may begin to receive these services immediately provided that within five days from the date of service a financial screening is initiated. Individuals presenting for and receiving crisis services are not required to provide documentation of Title XIX/XXI eligibility nor are they required to verify U.S. citizenship/lawful presence prior to or in order to receive crisis services.

Decisions made with respect to the coverage and provision of services are subject to Notice and Appeal requirements (SMI). Services must be provided in collaboration with other agencies to coordinate the culturally appropriate delivery of covered behavioral health services with other services provided to the person and the person’s family.
Covered Behavioral Health Services Table

The Covered Behavioral Health Services Table below lists the available covered services for the Health Plan enrolled Members and persons determined to have a Serious Mental Illness. These services must be provided by AHCCCS registered providers, AHCCCS only providers or Medicare registered providers. The Covered Services Table is a condensed summary of available services and related funding sources. Health Plan contracted providers may reference the AHCCCS Covered Behavioral Health Services Guide for more detailed information.

Available Behavioral Health Services*

<table>
<thead>
<tr>
<th>BEHAVIORAL HEALTH SERVICES</th>
<th>TITLE XIX/XXI CHILDREN AND ADULTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TREATMENT SERVICES</strong></td>
<td></td>
</tr>
<tr>
<td>Behavioral Health Counseling and Therapy</td>
<td>Individual</td>
</tr>
<tr>
<td></td>
<td>Available</td>
</tr>
<tr>
<td></td>
<td>Group</td>
</tr>
<tr>
<td></td>
<td>Available</td>
</tr>
<tr>
<td></td>
<td>Family</td>
</tr>
<tr>
<td></td>
<td>Available</td>
</tr>
<tr>
<td>Behavioral Health Screening, Mental Health Assessment and Specialized Testing</td>
<td>Behavioral Health Screening</td>
</tr>
<tr>
<td></td>
<td>Available</td>
</tr>
<tr>
<td></td>
<td>Mental Health Assessment</td>
</tr>
<tr>
<td></td>
<td>Available</td>
</tr>
<tr>
<td></td>
<td>Specialized Testing</td>
</tr>
<tr>
<td></td>
<td>Available</td>
</tr>
<tr>
<td>Other Professional</td>
<td>Traditional Healing</td>
</tr>
<tr>
<td></td>
<td>Provided based on available funds*</td>
</tr>
<tr>
<td></td>
<td>Auricular Acupuncture</td>
</tr>
<tr>
<td></td>
<td>Provided based on available funds*</td>
</tr>
<tr>
<td><strong>REHABILITATION SERVICES</strong></td>
<td></td>
</tr>
<tr>
<td>Skills Training and Development</td>
<td>Individual</td>
</tr>
<tr>
<td></td>
<td>Available</td>
</tr>
<tr>
<td></td>
<td>Group</td>
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<tr>
<td></td>
<td>Available</td>
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<tr>
<td></td>
<td>Extended</td>
</tr>
<tr>
<td></td>
<td>Available</td>
</tr>
<tr>
<td>Cognitive Rehabilitation</td>
<td>Available</td>
</tr>
<tr>
<td>Behavioral Health Prevention/Promotion Education</td>
<td>Available</td>
</tr>
<tr>
<td>Psycho Educational Services and Ongoing Support to Maintain Employment</td>
<td>Psycho Educational Services</td>
</tr>
<tr>
<td></td>
<td>Available</td>
</tr>
<tr>
<td></td>
<td>Ongoing Support to Maintain Employment</td>
</tr>
<tr>
<td></td>
<td>Available</td>
</tr>
<tr>
<td>Neurobehavioral Status Examinations and Neuropsychological Testing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Available</td>
</tr>
<tr>
<td><strong>MEDICAL SERVICES</strong></td>
<td></td>
</tr>
<tr>
<td>Medication Services**</td>
<td>Available**</td>
</tr>
<tr>
<td>Lab, Radiology and Medical Imaging</td>
<td>Available</td>
</tr>
<tr>
<td>Medical Management</td>
<td>Available**</td>
</tr>
<tr>
<td>Electro-Convulsive Therapy</td>
<td>Available</td>
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<tr>
<td>SUPPORT SERVICES</td>
<td></td>
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<tr>
<td>----------------------------------</td>
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</tr>
<tr>
<td>Case Management</td>
<td>Available</td>
</tr>
<tr>
<td>Personal Care</td>
<td>Available</td>
</tr>
<tr>
<td>Home Care Training (Family)</td>
<td>Available</td>
</tr>
<tr>
<td>Self Help/Peer Services</td>
<td>Available</td>
</tr>
<tr>
<td>Home Care Training to Home Care Client (HCTC)</td>
<td>Available</td>
</tr>
<tr>
<td>Respite Care</td>
<td>Available***</td>
</tr>
<tr>
<td>Supported Housing</td>
<td>Provided based on available funds*</td>
</tr>
<tr>
<td>Sign Language or Oral Interpretive Service</td>
<td>Provided at no charge to the Member</td>
</tr>
<tr>
<td>Transportation</td>
<td>Emergency</td>
</tr>
<tr>
<td></td>
<td>Non-Emergency</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CRISIS INTERVENTION SERVICES</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Crisis Intervention – Mobile</td>
<td>Available by RBHA</td>
</tr>
<tr>
<td>Crisis Intervention - Telephone</td>
<td>Available by RBHA</td>
</tr>
<tr>
<td>Crisis Intervention - Stabilization</td>
<td>Available by RBHA/Health Plan</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INPATIENT SERVICES</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>Available</td>
</tr>
<tr>
<td>Behavioral Health Inpatient Facility</td>
<td>Available</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RESIDENTIAL SERVICES</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health Residential Facility</td>
<td>Available</td>
</tr>
<tr>
<td>Room and Board</td>
<td>Provided based on available funds*</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BEHAVIORAL HEALTH DAY PROGRAMS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervised Day</td>
<td>Available</td>
</tr>
<tr>
<td>Therapeutic Day</td>
<td>Available</td>
</tr>
<tr>
<td>Medical Day</td>
<td>Available</td>
</tr>
</tbody>
</table>

* Services not available with TXIX/XXI funding, but may be provided based upon available grant funding and approved use of general funds

** See the Health Plan Formulary for further information on covered medications.

*** Respite Care – Respite care is offered as a temporary break for caregivers to take time for themselves. A member’s need is the basis for determining the number of respite hours used. The maximum number of hours available is 600 hours within a 12-month period of time. The 12 months will run from October 1 through September 30 of the next year.

General Mental Health/Substance Use (GMH/SU)

Members who are in the behavioral health category: General Mental Health/Substance Abuse (GMH/SU) and are also eligible for both Medicare and Medicaid (AHCCCS) are considered to be GMH/SU 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/SU Dual members 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 Covered Behavioral Health Services Guide at [http://www.banneruhp.com](http://www.banneruhp.com).

<table>
<thead>
<tr>
<th>Medicare Behavioral Health Covered Services (UCA)</th>
<th>Medicaid Behavioral Health Covered Services (Complete Care &amp; Long Term Care)</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.)</td>
<td>Inpatient Hospital Services</td>
</tr>
<tr>
<td>Psychiatric diagnostic interviews</td>
<td>Assessment, Evaluation and Screening Services</td>
</tr>
<tr>
<td>Individual/ Group/Family Psychotherapy</td>
<td>Individual, Group and Family Therapy and Counseling</td>
</tr>
<tr>
<td>Interactive psychotherapy</td>
<td></td>
</tr>
<tr>
<td>Pharmacologic management</td>
<td>Psychotropic Medication Adjustment and Monitoring</td>
</tr>
<tr>
<td>Part B Prescription Drugs</td>
<td>Psychotropic Medication</td>
</tr>
<tr>
<td>Out Patient Substance Abuse Services</td>
<td>Opioid Agonist Treatment (Covered under Counseling Services)</td>
</tr>
<tr>
<td>Electroconvulsive Therapy</td>
<td>Electroconvulsive Therapy</td>
</tr>
<tr>
<td>Diagnostic psychological and neuropsychological tests</td>
<td>(Covered under Assessment, Evaluation and Screening Services)</td>
</tr>
<tr>
<td>Hypnotherapy</td>
<td>(Covered under Counseling Services)</td>
</tr>
<tr>
<td>Narcosynthesis</td>
<td></td>
</tr>
<tr>
<td>Biofeedback Therapy</td>
<td></td>
</tr>
<tr>
<td>Individualized activity therapy (as part of a Partial Hospitalization Program that is not primarily recreational or diversionary)</td>
<td>Partial Care (supervised day program, therapeutic day program and medical day program)</td>
</tr>
<tr>
<td>Depression Screening with PCP (one per year)</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>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</td>
<td></td>
</tr>
</tbody>
</table>
### 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 care)
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

**Complete Care**
Members who are in enrolled in Complete Care: These members receive their integrated care addressing physical health and behavioral health for the following Title XIX/XXI populations:

- Adults who are not determined to have a Serious Mental Illness excluding DES/DDD enrolled members,
- Children, including those with special health care needs; excluding DES/DDD and DCS/CMDP enrolled members, an
- Members determined to have SMI who opt to transfer to the Contractor for the provision of physical health services.

**Long Term Care**
Members who are in enrolled in Long Term Care: These members receive their integrated care addressing physical health and behavioral health. In order to determine which entity is responsible for a member’s behavioral health services, the health plan contracted provider will need to check with AHCCCS On-Line, Member Eligibility Verification, under the behavioral health tab.

**Covered Physical Health Services for Title XIX/XXI Adults with SMI Opt- Out**
The table below lists physical health care services available for eligible Members determined to have a Serious Mental Illness (SMI), who are receiving both behavioral health and physical health care services from the Health Plan. These services must be provided by AHCCCS registered providers, AHCCCS only providers or Medicare registered providers. Physical health providers may reference the AHCCCS Medical Policy Manual for more detailed information.

<table>
<thead>
<tr>
<th>PHYSICAL HEALTH CARE SERVICES</th>
<th>TITLE XIX/XXI Adults with SMI</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Age 18-20</td>
</tr>
<tr>
<td>Audiology</td>
<td>X</td>
</tr>
<tr>
<td>Breast Reconstruction after Mastectomy</td>
<td>X</td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>X</td>
</tr>
<tr>
<td>Cochlear Implants</td>
<td>X</td>
</tr>
<tr>
<td>Emergency Dental Services</td>
<td>X</td>
</tr>
<tr>
<td>Preventative &amp; Therapeutic Dental Services</td>
<td>X</td>
</tr>
<tr>
<td>Limited Medical and Surgical Services by a Dentist (for Members Age 21 and older)</td>
<td>X</td>
</tr>
<tr>
<td>Supplemetal Dental Coverage Based on Criteria Established by the Health Plan</td>
<td>X</td>
</tr>
<tr>
<td>Dialysis</td>
<td>X</td>
</tr>
<tr>
<td>Emergency Services – Medical</td>
<td>X</td>
</tr>
<tr>
<td>Emergency Eye Exam</td>
<td>X</td>
</tr>
<tr>
<td>Service</td>
<td>X</td>
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<tr>
<td>------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Vision Exam/Prescriptive Lenses</td>
<td></td>
</tr>
<tr>
<td>Lens Post Cataract Surgery</td>
<td></td>
</tr>
<tr>
<td>Treatment for Medical Condition of the Eye</td>
<td></td>
</tr>
<tr>
<td>Health Risk Assessment &amp; Screening Tests (for Members age 21 and older)</td>
<td></td>
</tr>
<tr>
<td>Preventive Examinations in the Absence of any Known Disease or Symptom</td>
<td></td>
</tr>
<tr>
<td>HIV/AIDS Antiretroviral Therapy</td>
<td>X</td>
</tr>
<tr>
<td>Home Health Services</td>
<td></td>
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<tr>
<td>Hospice</td>
<td>X</td>
</tr>
<tr>
<td>Hospital Inpatient Medical</td>
<td>X</td>
</tr>
<tr>
<td>Hospital Observation</td>
<td></td>
</tr>
<tr>
<td>Hospital Outpatient Medical</td>
<td>X</td>
</tr>
<tr>
<td>Hysterectomy (medically necessary)</td>
<td>X</td>
</tr>
<tr>
<td>Immunizations</td>
<td>X</td>
</tr>
<tr>
<td>Laboratory</td>
<td>X</td>
</tr>
<tr>
<td>Maternity Services</td>
<td>X</td>
</tr>
<tr>
<td>Family Planning</td>
<td>X</td>
</tr>
<tr>
<td>Early and Periodic Screening, Diagnosis and Treatment (Medical Services)</td>
<td>X</td>
</tr>
<tr>
<td>Other Early and Periodic Screening, Diagnosis and Treatment Services Covered by Title XIX/XXI</td>
<td>X</td>
</tr>
<tr>
<td>Medical Foods</td>
<td>X</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>X</td>
</tr>
<tr>
<td>Medical Supplies</td>
<td>X</td>
</tr>
<tr>
<td>Prosthetic</td>
<td>X</td>
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<tr>
<td>Orthotic Devices</td>
<td>X</td>
</tr>
<tr>
<td>Nursing Facilities (up to 90 days)</td>
<td>X</td>
</tr>
<tr>
<td>Non-Physician First Surgical Assistant</td>
<td>X</td>
</tr>
<tr>
<td>Physician Services</td>
<td>X</td>
</tr>
<tr>
<td>Foot and Ankle Services</td>
<td>X</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>X</td>
</tr>
<tr>
<td>Primary Care Provider Services</td>
<td>X</td>
</tr>
<tr>
<td>Private Duty Nursing</td>
<td>X</td>
</tr>
<tr>
<td>Radiology and Medical Imaging</td>
<td>X</td>
</tr>
<tr>
<td>Occupational Therapy – Inpatient</td>
<td>X</td>
</tr>
<tr>
<td>Occupational Therapy – Outpatient</td>
<td>X</td>
</tr>
<tr>
<td>Physical Therapy – Inpatient</td>
<td>X</td>
</tr>
<tr>
<td>Physical Therapy – Outpatient</td>
<td>X</td>
</tr>
<tr>
<td>Speech Therapy – Inpatient</td>
<td>X</td>
</tr>
<tr>
<td>Speech Therapy – Outpatient</td>
<td>X</td>
</tr>
<tr>
<td>Respiratory Therapy</td>
<td>X</td>
</tr>
<tr>
<td>Total Outpatient Parenteral Nutrition</td>
<td>X</td>
</tr>
<tr>
<td>Non-Experimental Transplants Approved for Title XIX/XXI Reimbursement*</td>
<td></td>
</tr>
<tr>
<td>Transplant Related Immunosuppressant Drugs</td>
<td>X</td>
</tr>
<tr>
<td>Transportation – Emergency</td>
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</tbody>
</table>
Assisting Individuals with Eligibility Verification and Screening/Application for Public Health Benefits

Behavioral health providers are required to assist individuals with applying for Arizona Public Programs (Title XIX/XXI, Medicare Savings Programs, Nutrition Assistance, and Cash Assistance), and Medicare Prescription Drug Program (Medicare Part D), including the Medicare Part D “Extra Help with Medicare Prescription Drug Plan Costs” low income subsidy program, as well as verification of U.S. citizenship/lawful presence prior to receiving Non-Title XIX/XXI covered behavioral health services, at the time of intake for behavioral health services. Refer also to this policy section regarding documentation that may be needed during the behavioral health referral and intake process.

Eligibility status is essential for identification of the types of behavioral health services an individual may be able to access. For individuals who are not currently Title XIX/XXI eligible, a financial and eligibility screening and application shall be completed to determine eligibility. Verification of an individual’s identification and citizenship/lawful presence in the United States is completed through the AHCCCS Health-e-Arizona PLUS (HEAPlus) application process. Behavioral health providers are required to assist individuals in completing this screening and verification processes.

An individual who is not eligible for Title XIX/XXI covered services may still be eligible for Non-Title XIX/XXI services including services through the Substance Abuse Block Grant (SABG), the Mental Health Block Grant (MHBG), or the Projects for Assistance in Transition from Homelessness (PATH) Program. See this manual section on accessing Non TXIX nondiscretionary federal grants and the delivery of behavioral health services. An individual may also be covered under another health insurance plan, including Medicare. Individuals who do not have any insurance or entitlement status may be asked to pay a percentage of the cost of services.

If the individual is in need of emergency services, the individual may begin to receive these services immediately provided that within five days from the date of service a financial screening is initiated.

Individuals presenting for and receiving crisis services are not required to provide documentation of Title XIX/XXI eligibility nor are they required to verify U.S. citizenship/lawful presence prior to or in order to receive crisis services.

Medicare eligible individuals, including individuals who are eligible for Medicare and Medicaid (Dual Eligible(s)) are eligible for the Medicare Part D prescription drug benefit. The benefit also provides for Part D Extra Help for eligible individuals whose income and resources are limited. Dual Eligible individuals are automatically eligible for the Part D Extra H Help due to their Medicaid eligibility.

Coverage for Medicare Part D is provided by private prescription drug plans (PDPs) that offer drug-only coverage, or through Medicare Advantage health plans that offer both prescription drug and health care coverage (known as MA-PDs). Behavioral health providers are required to assist individuals in completing enrollment in Medicare Part D and with the Part D Extra Help application.
Title XIX/XXI Eligibility Verification and Screening/Application Process

Verify the individual’s current Title XIX/XXI eligibility status. The following verification processes are available 24 hours a day, 7 days a week:

1. AHCCCS web-based verification (Customer Support 602-417-4451) This web site allows the providers to verify eligibility and enrollment. To use the web site, providers shall create an account before using the applications. To create an account, go to: https://azweb.statemedicaid.us/Home.asp and follow the prompts. Once the providers have an account they can view eligibility and claim information (claim information is limited to FFS). Batch transactions are also available. There is no charge to providers to create an account or view transactions. For technical Web-based issues, contact AHCCCS Customer Support at 602-417-4451, Monday – Friday 7:00 a.m. to 5:00 p.m.
When providers use the web-based member verification system and enter a member’s social security number, the member’s photo, if available from the Arizona Department of Motor Vehicles (DMV), will be displayed on the AHCCCS eligibility verification screen along with other AHCCCS coverage information. The photo image assists providers to quickly validate the identity of a member.

2. Interactive Voice Response (IVR) system IVR allows unlimited verification information by entering the AHCCCS member’s identification number on a touch-tone telephone. This allows providers access to the AHCCCS Prepaid Medical Management Information System (PMMIS) for up-to-date eligibility and enrollment. Providers may also request a faxed copy of eligibility for their records. There is no charge for this service. Providers may call IVR within Maricopa County at (602) 417-7200 and all other counties at (800) 331-5090,

3. Medifax -Medifax allows providers to use a PC or terminal to access PMMIS for up-to-date eligibility and enrollment information. For information on Eligibility Verification Screening (EVS), contact Emdeon at (800) 444-4336,

4. If an individual’s Title XIX/XXI eligibility status cannot be determined using one of the above methods the provider shall:
   a. Call the BUHP Customer Care for assistance during normal business hours (8:00 am through 5:00 pm, Monday-Friday), or
   b. Call the AHCCCS Verification Unit, which is open Monday through Friday, from 8:00 a.m. to 5:00 p.m. The Unit is closed Saturdays and Sundays and on state holidays. Callers from outside Maricopa County can call (800) 962-6690 or call (602) 417-7000 in Maricopa County. When calling the AHCCCS Verification Unit, the provider shall be prepared to provide the verification unit operator the following information:

5. Provider identification number,

6. The individual’s name, date of birth, AHCCCS identification number and social security number (if known), and

7. Dates of service(s).
Interpret eligibility information

1. A provider will access the AHCCCS Codes and Values (CV) 13 Reference System when using the eligibility verification methods described above. This includes a key code index that may be used by providers to interpret AHCCCS’ eligibility key codes and/or AHCCCS rate codes.

2. For information on the eligibility key codes and AHCCCS rate codes refer to the AHCCCS Reference Subsystem Codes and Values on the AHCCCS website, and

3. If Title XIX/XXI eligibility status and provider responsibility is confirmed, the provider shall provide any needed covered behavioral health services in accordance with the AMPM and AHCCCS Covered Behavioral Health Services Guide.

4. For individuals who are not identified as Title XIX/XXI eligible, providers shall assist individuals with the AHCCCS screening/application process for Title XIX/XXI or other Public Program eligibility through HEAPlus at the following times:
   a. Upon initial request for behavioral health services,
   b. At least annually, if still receiving behavioral health services, and
   c. When significant changes occur in the individual’s financial status.

5. To conduct the AHCCCS screening/application for Title XIX/XXI or other Public Program eligibility through HEAPlus, behavioral health providers shall meet with the individual and complete the AHCCCS HEAPlus online application. Once completed, HEAPlus will indicate if the individual is potentially Title XXI/XXI eligible.

6. To the extent that it is practicable, the provider is expected to assist applicants in obtaining the required documentation of identification and U.S. citizenship/lawful presence within the timeframes indicated by HEAPlus,

7. For information regarding what documents are required in order to verify proof of U.S. citizenship/lawful presence refer to Arizona’s Eligibility Policy Manual for Medical, Nutrition, and Cash Assistance Manual Chapter 500, Policy 507 and Policy 524,

8. Documentation of Title XIX/XXI and other Public Program eligibility screening/application shall be included in the individual’s medical record including the Application Summary and final Determination of eligibility status notification printed from HEAPlus,

9. Pending the outcome of the Title XIX/XXI or other Public Program eligibility determination via HEAPlus the individual is eligible for covered Non-Title XIX/XXI services in accordance with the AHCCCS Covered Behavioral Health Services Guide and the AHCCCS Medical Policy 320-T.

10. Upon the final processing of a Title XIX/XXI and other Public Program screening/application, if the individual is determined ineligible for Title XIX/XXI or other Public Program benefits, regardless of verification of US Citizenship/Lawful Presence, the individual is eligible for covered Non-Title XIX/XXI services in accordance with the AHCCCS Covered Behavioral Health Services Guide and AMPM.

11. An individual found not to be eligible for Title XIX/XXI or other Public Program benefits may submit the application for review by AHCCCS and/or DES. Additional information requested and
verified by AHCCCS and/or DES may result in the individual subsequently receiving Title XIX/XXI or other Public Program.

**Medicare Part D Enrollment and Extra Help Application**

Behavioral health providers shall offer and provide assistance to Medicare-eligible individual with completing Medicare Part D enrollment and the Extra Help application as outlined below.

**Medicare Part D Enrollment**

1. If an individual is unsure of his/her Medicare eligibility, the provider, with the individual’s permission and needed personal information, may verify Medicare eligibility by calling 1-800-MEDICARE (1-800-633-4227),

2. The Centers for Medicare and Medicaid Services (CMS) has developed web tools to assist with choosing a Medicare Part D plan that best meets the individual’s needs. The web tools can be accessed at www.medicare.gov,

3. For additional information regarding Medicare Part D Prescription Drug coverage, call Medicare at (800) 633-4227 or Arizona’s State Health Insurance Assistance Program (SHIP) at 602-542-4446 or toll free at (800) 432-4040.

**Applying for the Extra Help Subsidy**

Medicare Part D Extra Help is a program in which the federal government pays all or a portion of the cost sharing requirements of Medicare Part D on behalf of the individual (42 CFR Part 422 and 42 CFR Part 423).

1. The provider shall determine if an individual may be eligible for Part D Extra Help. Refer to the Social Security Administration (SSA) website at www.ssa.gov for qualifying income and resource limits,

2. Dual Eligible members meeting the following conditions automatically qualify for Extra Help: a) Have full Medicaid coverage, b) AHCCCS pays Part B premiums (in a Medicare Savings Program), and c) Receive Supplemental Security Income (SSI) benefits.

3. Once Part D eligibility is determined, the provider shall offer assistance with completing the Part D Extra Help application,

4. The Part D Extra Help application can be obtained and submitted through the following means:
   i. On-line at: [https://secure.ssa.gov/apps6z/i1020/main.html](https://secure.ssa.gov/apps6z/i1020/main.html),
   ii. By calling the SSA at (800) 772-1213,
   iii. In person at a SSA local office, or
   iv. By mailing a paper application (Form SSA-1020) to the SSA.

**Refusal to Participate in The Screening/Application Process**

1. Arizona state law stipulates that individuals who refuse to participate in the AHCCCS screening/application process or to enroll in a Medicare Part D plan are ineligible for state funded behavioral health services. See A.R.S. §36-3408. As such, individuals who refuse to
participate in the AHCCCS screening/application or enrollment in Medicare Part D, if eligible, will not be assigned a Contractor during his/her initial request for services, or will be unassigned if the individual refuses to participate during an annual screening.

2. When an individual declines to participate in the AHCCCS screening/application process or refuses to enroll in a Medicare Part D plan, the provider shall actively encourage the individual to participate in the AHCCCS screening/application process.

3. The following conditions do not constitute an individual’s refusal to participate:
   a. An individual’s inability to obtain documentation required for the eligibility determination, and/or
   b. An individual is incapable of participating as a result of their mental illness and does not have a legal guardian.

4. If an individual refuses to participate in the AHCCCS screening/application process, or to enroll in a Medicare Part D plan, the provider shall:
   a. Request that the individual sign Attachment A, and
   b. Document the refusal to sign in the individual’s medical record.

5. Special considerations for individuals designated as SMI:
   a. If the individual is unwilling to complete the AHCCCS screening/application process or to enroll in a Medicare Part D plan, and does not meet the conditions above, the provider shall request a clinical consultation by a Behavioral Health Medical Professional,
   b. If, following the clinical consultation, the individual continues to refuse to participate, the provider shall request that the individual sign Attachment A.

6. Prior to the termination of behavioral health services for individuals who have been receiving behavioral health services and subsequently decline to participate in the AHCCCS screening/application process, or to enroll in a Medicare Part D plan, the Contractor shall provide written notification to the member of the intended termination as required by Contract.

7. For all individuals who refuse to cooperate with the AHCCCS screening/application process, the provider shall inform the individual who they can contact in the behavioral health system for an appointment if the individual chooses to participate in the AHCCCS screening/application process in the future.

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 episode.

The Regional Behavioral Health Authorities (RBHAs) are responsible for managing the crisis service delivery system for all AHCCCS members. The Health Plan 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 the Health Plan when any member has engaged with any crisis services in order to coordinate care.

Providers are required to coordinate care with any RBHA crisis provider/facility including inpatient facilities, the Health Plan, 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.

Health Plan’s Responsibility for Crisis Services

- Health Plan is responsible for 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 Behavioral Health Department and Medical Management Department
- Health Plan will be notified by the RBHA Crisis Provider when a member has engaged with the crisis service delivery system. The member will receive care management services until the member is psychiatrically stabilized. Providers are required to coordinate care for all 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 Health Plan 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 Health Plan 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.

Health Plan 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. Health Plan discourages providers from sending members to emergency
rooms for non-medical reasons. Arizona’s two major metropolitan areas have facilities specially
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**

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<tr>
<th>County Location</th>
<th>CALL THIS NUMBER FOR BEHAVIORAL HEALTH.</th>
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<tbody>
<tr>
<td>Pinal and Gila County</td>
<td>(800) 564-5465 (toll free)</td>
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<tr>
<td></td>
<td>Hearing Impaired TTY: 711</td>
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<tr>
<td></td>
<td>The Maricopa Crisis Line:</td>
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<tr>
<td></td>
<td>(602) 222-9444</td>
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<tr>
<td></td>
<td>(800) 631-1314 (toll free)</td>
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<tr>
<td></td>
<td>Hearing Impaired TTY:</td>
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<tr>
<td></td>
<td>(800) 327-9254</td>
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<tr>
<td>Maricopa County</td>
<td>(800) 564-5465 (toll free)</td>
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<td>Hearing Impaired TTY:</td>
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<td></td>
<td>(800) 327-9254</td>
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<tr>
<td>Pima, Cochise, Graham, Greenlee, Yuma,</td>
<td>NurseWise Crisis (866) 495-6735</td>
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<td>La Paz or Santa Cruz County</td>
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Section 3 – Service Delivery Requirements

Behavioral Health Homes and Specialty Providers

Definitions:

Behavioral Health Home (BHH): Contracted behavioral health provider or an integrated clinic that serves as an intake agency, provides or coordinates the provision of covered behavioral health services, and coordinates care with the primary care provider for adults and/or children with behavioral health needs.

Behavioral Health Specialty Provider: Behavioral Health provider that provides covered behavioral health services outside of the Behavioral Health Home.

Responsibilities of the Behavioral Health Home (BHH):

All Behavioral Health Homes have primary responsibility for ensuring members receive medically necessary covered behavioral health services and for coordination with specialty behavioral health providers and physical health providers. BHH must meet the following requirements:

1. Conduct intake including hospital based when indicted
2. Meet all enrollment and demographic requirements
3. Conduct Behavioral Health Assessment and reassessment including the following activities:
   - Comprehensive assessment which includes all the Health Plan required elements for Comprehensive Behavioral Health Assessment conducted by assessors that meet minimum AHCCCS assessor qualifications
   - CASII for youth 6 to 18
   - ECSII for youth birth through 5
   - Developmental Screening for youth birth through 5
   - Strength Needs and Cultural Discovery (SNCD) for youth who meet criteria for high needs
   - Screening for substance use disorders with standardized screens
   - SMI determinations for all adults and youth no later than age 17 who present with a diagnosis, impairment and history that may meet eligibility criteria
4. Provide support for all youth for successful transition to adulthood consistent with AHCCCS Practice Protocol Transitioning to Adulthood
5. Ensure Child and Family Team (CFT) and Adult Recovery Team (ART) process with fidelity to system of care polices with fidelity to the Adult Services Delivery System Nine Guiding Principles and the Arizona Vision and Twelve Principles for Children’s Behavioral Health Services
6. Provide case management for adult members when medically necessary

7. Provide case management for youth members when medically necessary with the exception of when a youth meets criteria for high needs case management and the parent/guardian chooses to receive case management services from a separate high needs case management provider. The option of one agency providing case management and additional services to meet a member’s needs is ideal as it streamlines the coordination of care and medical record documentation under one entity.

8. Has primary responsibility for Service Planning/Complete Care Planning to meet the comprehensive behavioral health needs of members with collaboration from specialty behavioral health and physical health providers. Enters Complete Care Plan information into the Banner Navigation Accelerator (BNA), when applicable.

9. Submit referrals for specialty services when medically necessary

10. Provide or coordinate transportation when medically necessary

11. Coordinate care with other specialty behavioral health and physical health providers

12. Conduct crisis planning and coordination with crisis providers

13. Conduct diversion planning

14. Conduct discharge planning

15. Implement the out-of-state protocol

16. Have 24/7 telephonic response to meet member’s emergent needs and coordinate with crisis providers

17. Designate an assigned point of contact for Health Plan staff for clinical and administrative functions and a medical director if psychiatric services are provided

18. Attend all meetings as required by the Health Plan

19. Submit all deliverables as required by the Health Plan

20. Submit requests for authorization for all services on the prior authorization grid

21. Participate in designated Quality Management audits, investigations and the Quality of Care Concern (QOC) process

22. Conduct Outreach, Engagement, Re-Engagement and Closure Activities as required

Responsibilities of the Behavioral Health Specialty Provider:

1. Include Compressive Behavioral Health Assessments in the clinical record

2. Conduct a Behavioral Health Services Jump Start to expedited initiation of care if unable to do a Comprehensive Behavioral Health Assessment for members without previous behavioral health services within the system of care

3. Provide medically necessary covered services
4. Enter Complete Care Plan information related to specialty services into the Banner Navigation Accelerator (BNA)

5. Coordinate with the BHH for the following:
   - To provide information related to specialty behavioral health covered services provided
   - To participate in the CFT or ART process

6. Participate in designated Quality Management audits, investigations and the Quality of Care Concern (QOC) process

7. Designate an assigned point of contact for the Health Plan staff for clinical and administrative functions and a medical director if psychiatric services are provided

8. Attend all meetings as required by the Health Plan

9. Submit all deliverables as required by the Health Plan

Appointment Standards and Timeliness of Services

It is vital that the Health Plan health care delivery system be responsive and accessible to all enrolled members. It is the expectation of the Health Plan 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. The Health Plan has organized responses into three categories: urgent, routine responses and appointments/referrals for psychotropic medications.

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

1. **Urgent Need Appointments**: As expeditiously as the member’s health condition requires but no later than 24 hours from identification of need

2. **Routine Care Appointments**:
   - Initial assessment within 7 calendar days of referral or request for service,
   - The first behavioral health service following the initial assessment as expeditiously as the member’s health condition requires but no later than 23 calendar days after the initial assessment, and
   - All subsequent behavioral health services, as expeditiously as the member’s health condition requires but no later than 45 calendar days from identification of need.

3. **Appointments/Referrals for psychotropic medications**
   Dual eligible members will access their medication benefit through their Medicare benefit. Although Medicaid/AHCCCS is not paying or authorizing psychotropic medications for the 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.

Urgent Engagement (UE) Program Requirements

Urgent Engagement is the process of engaging people into care who have experienced a crisis or have been admitted to an inpatient facility. It is intended to engage persons into care, rather than fulfilling an administrative function. The process includes ensuring effective coordination of care, engagement, discharge planning, a Serious Mental Illness (SMI) screening when appropriate, screening for eligibility, referral as appropriate, and prevention of future crises. Once the identified behavioral health provider completes the urgent engagement process, the provider is the entity that is responsible for coordination of necessary service and discharge planning. Urgent Engagements are required to be started within one hour (at a Community Observation Center) or 24 hours (at a Behavioral Health Inpatient Facility).

Behavioral Health Home Provider Urgent Engagement Responsibility

Behavioral Health Homes are contracted behavioral health providers or an integrated clinic that serves as an intake agency, provides or coordinates the provision of behavioral health covered services, and coordinates care with the primary care provider for adults and/or children with behavioral health needs. Behavioral Health Homes must accept referrals and requests for Urgent Engagements 24 hours a day and seven days a week. Providers are required to record, report and track completion of Urgent Engagements.

Urgent Engagement is a no wrong door approach and therefore, all persons are eligible, regardless of benefit or assigned health plan. If the member is enrolled with another health plan or private insurance, the Behavioral Health Home role is to coordinate care with the current provider and health plan, determine the need for an SMI evaluation, and work directly with the health plan to ensure the member is receiving needed services and follow up. For persons who are not yet enrolled in Medicaid, Block Grant programs or Behavioral Health Homes are required to continue to pursue coverage for the person for up to 45 days.

One Hour Engagement at a Community Observation Center (COC)

Every person who receives services at a Community Observation Center and is not in active care must be referred for urgent engagement. The Behavioral Health Home must arrive within one hour of the request. Once a Behavioral Health Home makes contact with the member, they are responsible for discharge planning for that member, including transportation and a follow up appointment. The urgent engagement at a COC should be the Banner Behavioral Health Jump Start, an abbreviated assessment, in order to quickly gather the information needed. The engagement process can be completed in a follow up appointment (preferably within the next 24-48 hours).

24-hour Urgent Engagements at a Behavioral Health Inpatient Facility (BHIF)

Every person who lives in the Health Plan covered service area and is hospitalized at a Behavioral Health Inpatient Facility for psychiatric reasons and is not in active care with a Behavioral Health Home,
is eligible for an urgent engagement. The Behavioral Health Home has 24-hours to arrive at the facility and complete the Urgent Engagement assessment. In the event the individual is sleeping or otherwise unable to participate in the Urgent Engagement process, the Behavioral Health Home shall reschedule the Urgent Engagement assessment within 24-hours and inform the Health Plan of the status.

**24-hour Urgent Engagements at a Physical Health Inpatient Facility**

Every person who lives in The Health Plan covered service area and is hospitalized at a Physical Health Inpatient Facility and is not in active care with a Behavioral Health Home, is eligible for an urgent engagement assessment. Behavioral Health Homes are required to arrive at the facility and complete the urgent engagement assessment within 24 hours of the request. In the event the individual is sleeping or otherwise unable to participate in the urgent engagement process, the Behavioral Health Home shall reschedule the urgent engagement assessment within 24-hours and inform The Health Plan of the status.

**24-hour SMI Evaluation at a Behavioral Health Facility (BHIF)**

Every person who lives in the Health Plan covered service area and is hospitalized at a Behavioral Health Inpatient Facility for psychiatric reasons and is not in active care with a Behavioral Health Home and presents with a need for an SMI evaluation is eligible to be assessed for an SMI diagnosis.

The Behavioral Health Home shall submit the SMI evaluation packet within seven days of the Urgent Engagement assessment to the designated SMI Evaluation provider, Community Response Network (CRN).

**SMI EMI Evaluation at the Arizona State Hospital (ASH)**

The purpose of the SMI evaluation services for persons from the Health Plan geographic area admitted to ASH are for discharge planning. The Behavioral Health Home has seven calendar days to complete the assessment.

**Urgent Engagement During the Court Order Evaluation Process**

Behavioral Health Homes activated by the Urgent Engagement process are required to enroll members and non-eligible members refusing services during the Court Ordered Evaluation process. Once the member is Court Ordered, the Behavioral Health Home is required to proceed with engagement and service delivery; including, an SMI screening.

**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.

Members are not required to be enrolled with an “intake agency” or “behavioral health home” in order to receive behavioral health services, however the provider must be contracted and follow all guidelines to serving AHCCCS members:
• ART or CFT practices
• Provide an assessment of needs
• Include a service plan in the clinical record
• Health Plan contracted providers must provide or refer members for high needs case management when CASII or ECSII scores are 4 or higher per guidelines.
• Provider must refer for additional covered services when clinically indicated
• Coordinate with other providers including PCP and physical health providers

Contracted Behavioral Health Provider Appointments:
• Urgent appointments are scheduled expeditiously no later than 24 hours from identification of need
• Routine care appointments:
  o Initial assessment within seven calendar days of referral or request for service,
  o The first behavioral health service following the initial assessment as expeditiously as the member’s health condition requires but no later than 23 calendar days after the initial assessment, and
  o All subsequent behavioral health services, as expeditiously as the member’s health condition requires but no later than 45 calendar days from identification of need.

Psychotropic Medications:
• Assess the urgency of the need immediately, and
• Provide an appointment, if clinically indicated, with a Behavioral Health Medical Professional within a timeframe that ensures the member does not run out of needed medications, or does not decline in his/her behavioral health condition prior to starting medication, but no later than 30 calendar days from the identification of need.

If the Health Plan network is unable to provide medically necessary services to Medicaid and Medicare eligible members, the Health Plan will ensure timely and adequate coverage of needed services through an out-of-network provider until a network provider is contracted.

Providers must not arbitrarily or prematurely reject or eject a Member from services/referrals without prior authorization of the Health Plan. Health Plan contracted providers must resolve referral disputes promptly. The Health Plan will promptly intervene and resolve any dispute between a provider and a referring source when those parties cannot informally resolve disputes regarding the need for emergency, urgent, or routine appointments.

A referral is any oral, written, faxed or electronic for behavioral health or physical 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, the Health Plan Contracted Providers
will maintain an effective process for the referral, intake and initiation of 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);
- Keeping information or documents collected in the referral process confidential and protected in accordance with applicable federal and state statues, regulations and policies.
- After obtaining appropriate consents, informing the referral source as appropriate about the final disposition of the referral.
- 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.
- 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 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 intake interviews that ensure the accurate collection of all the required information necessary for the receipt of services.

**Where to Send Referrals**

The Health Plan contracted providers will accept referrals in written format or provided orally. All referrals are documented.

The Health Plan maintains provider directories which can be accessed at:

- **AHCCCS Complete Care** - [https://www.bannerufc.com/acc](https://www.bannerufc.com/acc)
- **Arizona Long Term Care System** - [https://www.bannerufc.com/altcs](https://www.bannerufc.com/altcs)
- **Medicare Advantage** - [https://www.banneruca.com/](https://www.banneruca.com/)

These directories indicate which providers are accepting referrals. Providers are required to promptly notify **BUHP’s Network Provider Department**, at BUHPPROVIDERNOTIFICATIONS@bannerhealth.com or by fax at (520) 874-7144, of any changes that would impact the accuracy of the provider 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 required to be submitted three working days prior to the change.
Members may access services by directly contacting the Health Plan contracted behavioral health provider. The Health Plan contracted behavioral health providers are identified on the Health Plan website. Members may also call the Health Plan Customer Care department at (800) 582-8686, 24 hours a day/7 day a week, and receive a referral to a contracted behavioral health provider.

Choice of Providers

The Health Plan 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. In addition, providers must make available all Covered Services to all Title XIX/XXI eligible American Indians, whether they live on or off reservation. Eligible American Indian Members may choose to receive services through a RBHA/MCO/Health Plan, Tribal and Regional Behavioral Health Authorities, or through an IHS or 638 tribal provider.

Referral to a Provider for a Second Opinion

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 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. For purposes of this section, a “qualified health care professional” is (a) an AHCCCS registered provider of covered health services (b) who is a physician, a physician assistant, a nurse practitioner, a psychologist, or an independent Master’s level therapist.

A provider must maintain a record identifying both (1) the date of service for the second opinion and (2) the name of the provider who provided the second opinion. There must be documentation in the clinical chart of the following:

- Rationale for the use of two medications from the same pharmacological class;
- Rationale for the use of more than three different psychotropic medications in adults; and
- Rationale for the use of more than one psychotropic medication in the child and adolescent population.

Submit requests for out-of-network services via fax to the Health Plan 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 BUHP Customer Care at (800) 582-8686 8:00 a.m. – 5:00 p.m. Monday – Friday, for assistance.

Referrals Initiated by Department of Economic Security/Department of Child Safety (DES/DCS) Pending the Removal of a Child

Upon notification from DES/Department of Child Safety (DCS) that a child has been or is at risk of being taken into the custody of DES/Department of Child Safety (DCS), providers are expected to respond in an urgent manner (for additional information, see Section Appointment Standards and
Timeliness of Service and AHCCCS Practice Protocol, Unique Needs of Children, Youth and Families Involved with Child Protective Services).

Accepting referrals

1. Health Plan Contracted Providers are required to accept referrals for services 24 hours a day, seven days a week.

2. Timely triage and processing of referrals must not be delayed due to missing or incomplete information.

3. When psychotropic medications are a part of a member’s treatment or have been identified as a need by the referral source, Contracted Health Plan provider must ensure referrals meet the time requirements (see section Appointment Standards and Timeliness of Service).

4. When a SMI eligibility determination is being requested as part of the referral or by the member directly, the Health Plan contracted providers must conduct an eligibility evaluation for SMI and submit the evaluation to the Determining Entity (See section Determining Serious Mental Illness).

Referrals may be submitted in written format or provided orally. Oral referrals shall be documented in writing.

Don't Delay.... 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.

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, the Health Plan contracted provider shall ensure that the protocol used to obtain the necessary information about the member seeking services is engaging and welcoming.

Responding to Referrals

Follow-Up

When a request for services is initiated but the member does not appear for the initial appointment, the Health Plan contracted provider must attempt to contact the member and implement engagement activities consistent with Outreach, Engagement, Re-engagement and Closure section of this manual.

Documenting and tracking referrals

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

1. Date and time of referral;

2. Information about the referral source including name, telephone number, fax number, affiliated agency, and relationship to the member being referred;

3. 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;
4. Whether or not the member, parent or legal guardian is aware of the referral;
5. Special needs for assistance due to impaired mobility, visual/hearing impairments or developmental or cognitive impairment;
6. Accommodations due to cultural uniqueness and/or the need for interpreter services;
7. Information regarding payment source i.e., Banner – University Family Care/AHCCCS Complete Care (BUFC/ACC), Banner – University Family Care/Arizona Long Term Care System (BUFC/ALTCS), Banner – University Care Advantage (BUCA), other Medicare Plan, private insurance, or self-pay.
8. Name, telephone number and fax number of primary care provider (PCP);
9. 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
10. The names and telephone numbers of individuals the member, parent or guardian may wish to invite to the initial appointment with the referred member.

Final Dispositions

Within 30 days of receiving the intake evaluation, or if the member declines behavioral health services, the Health Plan contracted 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. Health Plan Behavioral Health Care Management Department
b. Primary Care Provider
c. Arizona Department of Child Safety and adoption subsidy
d. Arizona Department of Economic Security/ Division of Developmental Disabilities
e. Arizona Department of Corrections
f. Arizona Department of Juvenile Corrections
g. Administrative Offices of the Court
h. Arizona Department of Economic Security/Rehabilitation Services
i. Arizona Department of Education and affiliated school districts.

The final disposition must include:

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

1. Persons who are not already determined eligible for Title XIX/XXI must be screened at the time of the intake interview for Title XIX/XXI eligibility.

2. The individual conducting the intake interview must request the supporting documentation listed below and explain to the applicant supporting documentation will only be used for the purpose of assisting in applying for Title XIX/XXI benefits through AHCCCS.
   a. Verification of gross family income for the last month and current month (e.g., pay check stubs, social security award letter, retirement pension letter),
   b. For those who have other health insurance, bring the corresponding health insurance card (e.g., Medicare card),
   c. For all applicants, documentation to prove United States citizenship or immigration status and identity in accordance with AHCCCS Eligibility Policy and Procedure Manual,
   d. For those who pay for dependent care (e.g., adult or child daycare), proof of the amount paid for the dependent care, and
   e. Verification of out-of-pocket medical expenses.

Intake

Health Plan contracted providers are required to respond to referrals regarding members admitted to a hospital for psychiatric reasons or when requested by the Health Plan staff. Health Plan contracted 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, to best meet the needs of the member seeking services, an initial interview might be conducted over the telephone prior to the visit and the provider should 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.

The intake process must not delay the initiation of needed behavioral health covered services.

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

1. The collection of contact information, insurance information,
2. 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.);
3. The collection of required demographic information and completion of client demographic information sheet, including the member’s primary/preferred language.
4. The completion of any applicable authorizations for the release of information to other parties,
6. The dissemination of a Member Handbook to the member or member’s representative,
7. The review and completion of a general consent to treatment,
8. The collection of financial information, including the identification of third party payers and information necessary to screen and apply for Title XIX/XXI eligibility,
9. Advising members with an SMI designation if they are found to be Non-Title XIX/XXI they may be assessed a copayment,
10. The review and dissemination of the Health Plan 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.pdf compliance with 45 CFR 164.520 (c)(1)(B); and
11. The review of the member’s rights and responsibilities, including an explanation of the Title XIX/XXI member grievance and appeal process, if applicable. The member and/or the member’s legal guardian/family member, advocate, and/or person providing special assistance, may complete some of the paperwork associated with the intake evaluation, if acceptable to the member and/or the member’s legal guardian/family members, advocate, and/or person providing special assistance.

Health Plan contracted providers conducting intake interviews must be appropriately trained and must approach the member and family in a strength-based manner and possess a clear understanding of the information that needs to be collected.

**Referrals for High Needs Case Management for Children**

If the intake process indicates that the child and family are considered to have high needs, a referral to a high needs case manager must be initiated based on the following criteria:

1. Children 0 through five years of age with one or more of the following:
   - Other agency involvement; specifically: AzEIP, DCS, and/or DDD, and/or
   - Out of home placement (within past six months), and/or
   - Psychotropic medication utilization (two or more medications), and/or
   - Evidence of severe psycho-social stressors (e.g. family member serious illness, disability, death, job loss, eviction)
   - An ECSII level of 4, 5, or 6

2. Children six through 17 years of age: CASII level of 4, 5, or 6
   - High needs case managers must:
     - For a full FTE (1.0), have a caseload ratio of high needs children not less than 1:8 and not more than 1:20, with 1:15 being the desired target. The caseload cap is 20 to allow for continuity of care for children who have been receiving high needs case management but are not ready to begin transition from that level of care and for high needs case management of siblings.
Provide case management and other support and rehabilitation services to their assigned members.

To promote family choice, Health Plan contracted providers will ensure that the following options are offered when a member is identified as needing high needs case management:

- **Option 1:** The member’s originally assigned provider offers high needs case management. In these situations, the family may be offered to receive high needs case management and other needed services through a single provider agency. In these circumstances, the provider serves as the designated health home for that child.

- **Option 2:** The originally assigned provider does not offer high needs case management necessitating an external referral to another provider agency to access high needs case management services. In this situation the family has two additional options:
  - Responsibility for all services can be transferred to the high needs case management provider agency and this provider will become the member’s designated health home. This option is ideal as it streamlines the coordination of care and medical record documentation under one entity; OR
  - The child and family can choose to remain with the originally assigned provider (i.e. maintain established relationship, better alignment with family preferences or needs) and only receive high needs case management from the high needs case management provider agency. In these circumstances, the originally assigned provider shall function as the member’s designated health home. Health Plan contracted provider will be responsible for ensuring timely and efficient care coordination between all involved provider agencies. This may include referral expectations and allowable exceptions based on family preference.

**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 the Health Plan contracted 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.

**Community Outreach**

Outreach activities conducted by the Health Plan and the Health Plan contracted 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 the Health Plan’s behavioral health care management and/or primary care providers;
- Development of outreach programs to members experiencing homelessness;
- 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
- Regular interaction with agencies that have contact with pregnant women/teenagers who have a substance use disorder,
- 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 the Health Plan’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

The Health Plan contracted providers are required to actively engage the following in the treatment planning process:

- The member and/or member’s legal guardian;
- The member’s family/significant others, if applicable and amenable to the member
- Other agencies/providers as applicable; and
- For any ALTCS member with a SMI who is receiving Special Assistance, the person (guardian, family member, advocate or other) designated to provide Special Assistance.

Re-Engagement

The Health Plan contracted providers are required to ensure re-engagement attempts are made with members 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 based on a clinical assessment of need. All attempts to re-engage members must be documented in the comprehensive clinical record. The Health Plan contracted 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)
- When possible, contacting the member or the member’s legal guardian face to face if telephone contact 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 personal contact are unsuccessful, except when a letter is contraindicated due to safety concerns (e.g. domestic violence) or confidentiality issues. The Health Plan provider will note safety or confidentiality concerns in the progress notes section of the clinical record and include a copy of the letter sent in the comprehensive clinical record, and
- For members determined to have a SMI who are receiving Special Assistance, contacting the person designated to provide Special Assistance for his/her involvement in re-engagement efforts.

If the above activities are unsuccessful, the Health Plan contracted providers are expected to ensure further attempts are made to re-engage the following populations: persons determined to have a SMI, children, pregnant substance abusing women/teenagers, and any person determined to be at risk of relapse, decompensation, deterioration or a potential harm to self or others. Further attempts shall include at a minimum: contacting the member or member’s legal guardian face to face and contacting natural supports for whom the member as given permission to the Health Plan provider to contact. All attempts to re-engage these members must be clearly documented in the comprehensive clinical record.

If face to face contact with the member is successful and the member appears to be a danger to self, danger to others, persistently and acutely disabled or gravely disabled, the Health Plan provider must determine whether it is appropriate to engage the member to seek inpatient care voluntarily. If the member declines voluntary admission, the Health Plan contracted provider must initiate the pre-petition screening or petition for treatment process.

**Follow-Up after Significant and/or Critical Events**

The Health Plan contracted provider is required to ensure activities are documented in the clinical record and follow-up activities are conducted to maintain engagement within the following timeframes:

- Discharged from inpatient services, in accordance with the discharge plan and within seven days of the member’s release to ensure member 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 seven days,
• Refusing prescribed psychotropic medications within timeframes based upon the member’s clinical needs and individual history, and

• Changes in the level of care.

Assessment and Service Planning

The Health Plan supports a model for assessment, service planning, and service delivery that is consistent with AHCCCS Medical Policy Manual (AMPM 320-O) and driven by the Adult Service Delivery System Nine Guiding Principles and the Arizona Vision and Twelve Principles for Children’s Behavioral Health Services with a focus on strength-based, member and family centered, culturally and linguistically appropriate, evidence-based practice. Assessment and service planning address the member’s comprehensive needs with an integrated approach to physical, behavioral and social determinants of health. This model is based on important components including the following:

• Input from the member/guardian/designated representative regarding his/her individual needs, strengths, and preferences,

• Input from other persons involved in the member’s care who have integral relationships with the member,

• Development of a therapeutic alliance between the member/guardian/designated representative and behavioral health provider that promotes an ongoing partnership built on mutual respect and equality, and

• Clinical expertise/qualifications of person(s) conducting the assessment, service planning, and service delivery.

The concept of a “team”, established for each member receiving services. For adults this team is the Adult Recovery Team (ART) and for youth the Child & Family Team (CFT). The Adult Service Delivery System Nine Guiding Principles serve as a foundation for ART practice and the Arizona Vision and Twelve Principles serve as a foundation for CFT practice. The size, scope and intensity of the ART/CFT are driven by the needs of the member and as applicable family. The team may be limited to include the member, as applicable guardian and a behavioral health representative or a much broader group for members with more complex needs. Ongoing assessment of needs and service planning revisions must take place in a timely way to meet the member’s needs and always address lack of progress towards goals. At times there are delays in being able to schedule a formal ART or CFT meeting or face-to-face service. If such a delay presents, the ART/CFT process including ongoing needs assessment and service planning development must proceed remotely if needed with revisions being made in a timely way to ensure access to services without delays that can result from waiting for a formal meeting or face-to-face service. At a minimum, the functions of the ART and CFT 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:
  o Elicit information on the strengths, needs, and goals of the individual member and family members/guardians;
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 and CFT 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, as appropriate and, for children, services which are provided consistent with the Arizona Vision and Principles, and for adults, services which are provided consistent with the 9 Guiding Principles for Recovery Oriented Adult Behavioral Health Services and Systems;
- 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, specialty service provider, schools, child welfare, DDD, justice system, 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’ receiving Behavioral Health Services must have a behavioral health assessment upon initial request for services. For persons who continue to receive services, updates to the assessment must occur at least annually. A behavioral health assessment is the ongoing collection and analysis of the member’s medical, psychological, psychiatric and social conditions in order to initially determine if a health disorder exists, if there is a need for behavioral health services, and on an ongoing basis ensures that the member’s service plan is designed to meet the member (and family’s) current needs and long-term goals. 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 member.

- The behavioral health provider is responsible for maintaining the assessment and conducting periodic assessment updates to meet the changing behavioral health needs of members.
- Assessments must be updated at a minimum of annually.
- Assessments must be completed by Behavioral Health Professionals (BHPs) or Behavioral Health Technicians (BHTs) under the clinical supervision of a BHP that meets credentialing and training requirements outlined in AHCCCS AMPM Policy 950.
• The assessment process must facilitate timely service planning and access to services to meet individualized needs.

• This process must not create barriers to timely access to services.

• The assessment can be done by a variety of clinicians to support timely access to care as long as the minimum standards identified above and the minimum assessment required elements are met.

  o Assessments may include psychiatric assessments, psychological assessments, assessments completed as part of the initiation of therapy and counseling services, completed as part of an intake or with initiation of any other covered service.

• An assessment process is conducted to:

  o Elicit information on the strengths, needs and goals of the individual member and his/her family;

  o Identify the need for further or specialty evaluations; and

  o Support the development and updating of a service plan which effectively meets the member’s/family’s needs and results in improved health outcomes.

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

**Minimum elements of the Behavioral Health Assessment:**

• Presenting issue; including symptoms reported by the member, guardian and other information sources

• 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/ Behavioral health treatment history including medications, treatment modalities, therapeutic placements and hospitalization

• Substance use history; including type of substance, duration, frequency, route of administration, longest period of sobriety, and previous treatment history;

• Medical conditions/history

• PCP including name and contact information

• Current Medications including Over the Counter (OTC); including dosage

• Medication Allergies

• Developmental history

• Educational history/status

• Employment history/status; for adults and as applicable adolescents

• Housing status

• Social history

• Risks associated with Social Determinants of Health

• Legal history, including: Custody, Guardianship, Pending litigation, Criminal justice history; Court Ordered Treatment (COT)
- Family history
- State agency involvement (i.e. Probation, Adult Probation/Parole, DDD etc.); current involvement or history of involvement
- Trauma History
- Sexual History - as applicable
- Cultural/Spiritual needs
- Linguistic needs for limited English proficiency
- Mental Status Examination
- Risk assessment: the potential risk of harm to self or others
- Strengths
- Goals
- Diagnosis
- Recommendations and if applicable referral for further assessment or examination of the member’s needs; behavioral health services, physical health services, or ancillary services
- The signature and date signed of the personnel member conducting the behavioral health assessment documented in the member’s medical record;

The following Special Circumstances Assessments Components must be completed as applicable:

- Children Age 0 to 5 – Developmental screening must be conducted by the Behavioral Health provider for children age 0-5 with a referral for further evaluation when developmental concerns are identified and the Early Childhood Service Intensity Instrument (ECSII)
- Children Age 6 to 18 - The Child and Adolescent Service Intensity Instrument (CASII) must be completed by the Behavioral Health Home during the initial assessment and updated at a minimum of once annually,
- Children Age 6 to 18 - with CASII Score of four or Higher: Strength, Needs and Culture Discovery Document must be completed by the Behavioral Health Home, and
- Children Age 11 to 18 - Standardized substance use screen and referral for further evaluation when screened positive must be completed by the Behavioral Health Home.
- Serious Mental Illness (SMI) Determination shall be completed for persons who request an SMI determination in accordance with AMPM Policy 320-P and the SMI Determination section of this manual.

Behavioral Health Services Jump Start Assessment

A Behavioral Health Services Jump Start can be utilized by specialty and other behavioral health providers such as Peer and Family Run Organizations (PFROs) who may not have the ability to conduct a comprehensive behavioral health assessment. The purpose of the Behavioral Health Services Jump Start is for the behavioral health provider to obtain basic information related to the member’s chief complaint/presenting behavioral health symptoms and physical health history that includes sufficient detail to initiate timely behavioral health care, identify and address any immediate risks and refer to a behavioral health provider who can conduct a comprehensive behavioral health assessment and implement additional services and supports to meet the member’s needs. The Behavioral Health Services Jump Start form must be entered into the Banner Navigation Accelerator, when applicable. After completion the provider must refer to a behavioral health provider who can conduct a
comprehensive behavioral health assessment through the health plan referral process within the timeframes to meet the member’s needs consistent with AHCCCS requirements. Services rendered by the initiating provider should be continued by that provider until they are determined to no longer be clinically indicated.

The Behavioral Health Services Jump Start must include the following elements:

1. **Behavioral Health**: Identification of presenting symptoms/chief complaint categories in a. or b. below and provision of additional content detailed in c. through h. as follows:
   a. **Birth through 17 Behavioral Health Categories**:
      - Developmental delay
      - Psychosis
      - Depression
        - Suicidal ideation
        - Suicidal behavior
      - Mania
      - Anxiety/Panic
      - Obsessions/Compulsions
      - Trauma related symptoms
      - Eating disordered behaviors:
        - Significant weight loss
        - Binging/purging
        - Significant weight gain
      - Difficulty with attention, hyperactivity or impulsivity
      - Significant oppositional behaviors:
        - Aggression
        - Danger to others
        - Legal involvement
      - Substance Use:
        - Alcohol
        - Opioids
        - Simulants
        - Other
      - Other:
b. Adults (18 and older) Behavioral Health Categories:

- Psychosis
- Depression
  - Suicidal ideation
  - Suicidal behaviors
- Mania
- Anxiety/Panic
- Obsessions/Compulsions
- Trauma related symptoms
- Eating disordered behaviors:
  - Significant weight loss
  - Binging/purging
  - Significant weight gain
- Difficulty with attention, hyperactivity or impulsivity
- Significant aggressive behaviors:
  - Danger to others
  - Legal involvement
- Substance Use:
  - Alcohol
  - Opioids
  - Simulants
  - Other
- Personality disordered behavior
- Cognitive decline/dementia
- Other:
  - Describe

c. Detail describing onset, frequency, duration and severity associated with chief complaint/presenting symptoms selected
d. Risk factors including potential danger to self or others
e. Current/past behavioral health diagnosis (include if active or inactive)
f. Current treatments including psychotropic medications, psychosocial interventions and supports

g. Behavioral health hospitalizations, emergency department/crisis presentation for behavioral health conditions over the past 12 months including reason and dates

h. Therapeutic behavioral health placements in the past 12 months including reason and dates

2. Legal History: Including Court Ordered Treatment(COT)

3. Family History

4. Housing status

5. Physical Health: Diagnosis, treatment and history including the following:
   - Current and past physical health diagnosis (include if active or inactive)
   - Current physical health treatments including medications
   - Physical health hospitalizations, emergency department/crisis presentation over the past 12 months including reason and dates
   - Primary care provider(PCP)

6. Member Goals

7. Summary/Recommendations for follow up assessment: This must include recommendations and plans for coordination of a referral as indicated with a provider who can conduct a comprehensive behavioral health assessment with urgency of appointment as required by AHCCCS Contractors and Operations Manuel(ACOM) Policy 417

Service Planning

The Health Plan requires Service Plans that are based on the current assessment. Service Plans must meet all the requirements for service planning in accordance with AMPM 320-O including a complete written description of all covered health services and other informal supports which includes individualized goals, family support services, care coordination activities and strategies to assist the member in achieving an improved quality of life. In addition, the Service Plan must include behavioral health and physical health diagnosis and needs, social determinants of health(SDOH), takes into consideration BH and PH diagnosis and SDOH influence on each other and includes a focus on overall health and wellness. Behavioral health providers will obtain information about physical health diagnosis by member or guardian report, review of medical records or through physical health provider assessment in integrated settings. Behavioral health providers that do not provide physical healthcare should not make physical health diagnosis.

Service Plans must be included in the member’s medical record in accordance with AMPM Policy 940.

The required elements of the Service Plan include the following:
   - Physical Health(PH) and Behavioral Health (BH) Diagnosis
   - Member strengths
   - Member challenges/risks
• Social Determinants of Health (SDOH)
• Takes into consideration influence of PH/BH conditions and SDOH on one another
• Member needs/issues
• Individualized goals/progress/barriers
• Covered health services (BH and PH)
• Natural/informal/family supports
• Health and Wellness activities that address modifiable risk factors and health related behaviors
• Acknowledgement of if crisis plan has been developed
• Anticipated date of review

If a member is need of services before a Service Plan is developed an interim Service Plan must be developed to document services until a comprehensive Service Plan is completed. A Service Plan, however, must be completed no later than 45 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 plan. Providers must coordinate with the Health Plan contracted 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 behavioral health service planning and meet requirements in Section Training Requirements. In the event that a BHT completes the Service Plan, a BHP must review and sign the plan. The Service Plan must be documented in the comprehensive medical record in accordance with Section 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 care 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.
The treating BHMP as applicable must be included in development of the Service Plan through providing recommendations related to evidence based practices as well as supports to meet member’s needs. If a member is not making progress towards identified goals or if complex needs present, a behavioral health representative must reach out to the treating BHMP for input into ongoing care planning. If the member does not have a treating BHMP the behavioral health representative must reach out to the provider medical director as applicable.

**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/guardian, if applicable, that records a historical description of the significant events in the member’s life and how the member responded to the services/treatment provided during the past year. Following this updated assessment, the Service Plan must be updated as necessary. While the assessment and Service Plans must be updated at least annually, the assessment and care plan may require more frequent updates to meet the evolving needs and goals of the member and his/her family particularly for members that have experienced crisis, required hospitalization or other therapeutic levels of care, require transitions or who have new diagnosis.

**Determining Serious Mental Illness**

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 BUHP 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 the Health Plan 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.

**Health Plan 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. If a BUHP contracted provider does not have the staff capacity to conduct an SMI evaluation please contact the Health Plan for a referral to a Health Plan contracted provider that can
perform this evaluation.

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. This includes members at least the age of 17.5 years old.

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 found on the AHCCCS website under the AHCCCS Medical Policy Manual - **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 (800) 631-1314 or (TTY) (800) 327-9254.

The following documents, at a minimum, must be included in the SMI evaluation packet submitted to CRN:
1. Consent for Assessment – signed and dated within one business day of submission of SMI application to CRN.
2. Seriously Mentally Ill (SMI) Determination Form – Part C Additional Addenda of the Core Assessment, signed by a licensed clinician
3. Core Assessment – dated within six months of SMI application submission
4. Demographic Form
5. Releases of Information – allowing contact with the member’s emergency contact, and prior inpatient and outpatient care providers.
6. Waiver of the Three-Day Determination Form

The most up to date versions of these forms can be obtained at http://www.crisisnetwork.org/smi/provider/#forms.

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 the Health Plan 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.

**Issues Preventing Timely Completion of SMI Eligibility Determination**

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 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.

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 behavioral health provider shall 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.

BUFC/Arizona Long Term Care 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):
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.

**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;
- Admission for medical detoxification, an inpatient facility or a residential program (for members determined to have a Serious Mental Illness), and
- 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.

In addition to general and informed consent for treatment, state statute (A.R.S. §15-104) requires written consent from a child’s parent or legal guardian for any behavioral health survey, analysis, or evaluation conducted in reference to a school-based prevention program.

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

- Any member, aged 18 years and older, in need of behavioral health services must give voluntary general consent to treatment, demonstrated by the member’s or legal guardian’s signature on a general consent form, before receiving behavioral health services.

- For members under the age of 18, the parent, legal guardian, or a lawfully authorized custodial agency (including foster care givers A.R.S. 8.514.05(C)) must give general consent to treatment, demonstrated by the parent, legal guardian, or a lawfully authorized custodial agency representative’s signature on a general consent form prior to the delivery of behavioral health services.

- Any member aged 18 years and older or the member’s legal guardian, or in the case of members under the age of 18, the parent, legal guardian or a lawfully authorized custodial agency, after being fully informed of the consequences, benefits and risks of treatment, has the right not to consent to receive behavioral health services.

- Any member aged 18 years and older or the member’s legal guardian, or in the case of members under the age of 18, the parent, 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.

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

- All evidence of informed consent and general consent to treatment must be documented in the comprehensive clinical record.

- A foster parent, group home staff, foster home staff, relative, or other person or agency in whose care a child is currently placed may give consent for:
  - Evaluation and treatment for emergency conditions that are not life threatening, and
  - Routine medical and dental treatment and procedures, including Early Periodic Screening Diagnosis and Treatment (EPSDT) services, and services by health care providers to relieve pain or treat symptoms of common childhood illnesses or conditions (A.R.S. §8-514.05(C)).

- To ensure timely delivery of services, consent for intake and routine behavioral health services may be obtained from either the foster caregiver or the Department of Child Safety Specialist (DCSS) whomever is available to do so immediately upon request (A.R.S. § 8-514.05(C)).

- Foster or kinship caregivers can consent to evaluation and treatment for routine medical and dental treatment and procedures, including behavioral health services. Examples of behavioral health services in which foster or kinship can consent to include:
  - Assessment and service planning,
  - Counseling and therapy,
o Rehabilitation services,
o Medical Services,
o Psychiatric evaluation,
o Psychotropic medication,
o Laboratory services,
o Support Services,
o Case Management,
o Personal Care Services,
o Family Support,
o Peer Support,
o Respite,
o Sign Language or Oral Interpretive Services,
o Transportation,
o Crisis Intervention Services,
o Behavioral Health Day Programs.

• A foster parent, group home staff, foster home staff, relative, or other person or agency in whose care a child is currently placed shall not consent to:
  o General Anesthesia,
  o Surgery,
  o Testing for the presence of the human immunodeficiency virus,
  o Blood transfusions,
  o Abortions.

• Foster or kinship caregivers may not consent to terminate behavioral health treatment. The termination of behavioral health treatment requires Department of Child Safety (DCS) consultation and agreement.

• If the foster or kinship caregiver disagrees on the behavioral health treatment being recommended through the Child and Family Team (CFT), the CFT including the foster or kinship caregiver and DCS caseworker should reconvene and discuss the recommended treatment plan. Only DCS can refuse consent to medically recommended behavioral health treatment.

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 an intake. The Health Plan requires providers to ensure that intake and obtaining general consent facilitates timely access to care and does not result in delays in meeting member’s needs.
General consent 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 contracted Health Plan 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

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.

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.

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.

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.

Health Plan requires contracted providers to use the “Informed Consent/Assent for Psychotropic Medication Treatment”.

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. The use of Application for Voluntary Evaluation is required for members determined to have a Serious Mental Illness and is recommended as a tool to review and document informed consent for voluntary evaluation of all other populations, and
- 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 contracted Health Plan 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

- 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.

- 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.

- 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.

Special Requirement for Children Consent to Treatment

The Health Plan providers must ensure, in accordance with A.R.S. §36-2272, except as otherwise provided by law or a court order, no person, corporation, association, organization or state-supported institution, or any individual employed by any of these entities, may procure, solicit to perform, arrange for the performance of or perform mental health screening in a nonclinical setting or mental health treatment on a minor without first obtaining consent of a parent or a legal custodian of the minor child. If the parental consent is given through telemedicine, the health professional must verify the parent’s identity at the site where the consent is given. This section does not apply when an emergency exists that requires a person to perform mental health screening or provide mental health treatment to prevent serious injury to or save the life of a minor child.

Non-Emergency Situations

In cases where the parent is unavailable to provide general or informed consent and the child is being supervised by a caregiver who is not the child’s legal guardian (e.g., grandparent) and does not have power of attorney, general and informed consent must be obtained from one of the following:

- Lawfully authorized legal guardian,
- Foster parent, group home staff or other person with whom the Department of Child Safety (DCS) CS has placed the child, or
- Government agency authorized by the court.

If someone other than the child’s parent intends to provide general and, when applicable, informed consent to treatment, the following documentation must be obtained and filed in the child’s comprehensive clinical record:
<table>
<thead>
<tr>
<th>INDIVIDUAL/ENTITY</th>
<th>DOCUMENTATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal guardian</td>
<td>Copy of court order assigning custody</td>
</tr>
<tr>
<td>Relatives</td>
<td>Copy of power of attorney document</td>
</tr>
<tr>
<td>Other person/agency</td>
<td>Copy of court order assigning custody</td>
</tr>
<tr>
<td>DCS Placements (for children removed from the home by DCS), such as:</td>
<td>None required (see note)</td>
</tr>
<tr>
<td>• Foster parents</td>
<td></td>
</tr>
<tr>
<td>• Group home staff</td>
<td></td>
</tr>
<tr>
<td>• Foster home staff</td>
<td></td>
</tr>
<tr>
<td>• Relatives</td>
<td></td>
</tr>
<tr>
<td>• Other person/agency in whose care DCS has placed the child</td>
<td></td>
</tr>
</tbody>
</table>

NOTE: If Health Plan behavioral health providers doubt whether the individual bringing the child in for services is a person/agency representative in whose care DCS has placed the child, the Health Plan providers must ask to review verification, such as documentation given to the individual by DCS indicating that the individual is an authorized DCS placement. If the individual does not have this documentation, then the Health Plan providers must also contact the child’s DCS caseworker to verify the individual’s identity.

For any child who has been removed from the home by DCS, the foster parent, group home staff, foster home staff, relative or other person or agency in whose care the child is currently placed may give consent for the following behavioral health services:

- Evaluation and treatment for emergency conditions that are not life threatening, and
- Routine medical and dental treatment and procedures, including early periodic screening, diagnosis and treatment services, and services by health care providers to relieve pain or treat symptoms of common childhood illnesses or conditions (including behavioral health services and psychotropic medications).

Any minor who has entered into a lawful contract of marriage, whether or not that marriage has been dissolved subsequently, any emancipated youth or any homeless minor may provide general and, when applicable, informed consent to treatment without parental consent (A.R.S. §44-132).

Emergency Situations

- In emergencies involving a child in need of immediate hospitalization or medical attention, general and, when applicable, informed consent to treatment is not required.
- Any child, 12 years of age or older, who is determined upon diagnosis of a licensed physician, to be under the influence of a dangerous drug or narcotic, not including alcohol, may be considered an emergency situation and can receive behavioral health care as needed for the treatment of the condition without general and, when applicable, informed consent to treatment.
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, as 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 member is willing and able, even though the member remains under court order.

Consent for Behavioral Health Survey or Evaluation For School-Based Prevention Programs

The Health Plan contracted providers must obtain written consent from a child’s parent or legal guardian for any behavioral health survey, analysis, or evaluation conducted in reference to a school-based prevention program.

Substance Abuse Prevention Program and Evaluation Consent must be used to gain parental consent for evaluation of school-based prevention programs. Contracted Health Plan providers may use an alternative consent form only with the prior written approval of Health Plan. The consent must satisfy all of the following requirements:

- Contain language that clearly explains the nature of the screening program and when and where the screening will take place,
- Be signed by the child’s parent or legal guardian, and
- Provide notice that a copy of the actual survey, analysis, or evaluation questions to be asked of the student is available for inspection upon request by the parent or legal guardian.
- Completion of Substance Abuse Prevention Program and Evaluation Consent applies solely to consent for a survey, analysis, or evaluation only, and does not constitute consent for participation in the program itself.

Youth Assent for Psychotropic Medications

The Health plan contracted providers must ensure that youth members under the age of 18 are educated on options, allowed to provide input, and encouraged to assent to medication(s) being prescribed. Information should be discussed with the youth in a clear and age-appropriate manner consistent with the developmental needs of the youth. The information must be consistent with the information shared in obtaining informed consent from adults.

Discussion of the youth’s ability to give consent for medications at the age of 18 years old is begun no later than age 17½ years old, especially for youth who are not in the custody of their parents. Special attention must be given to the effect of medications on the reproductive status and pregnancy, as well as long term effects on weight, abnormal involuntary movements and other health parameters.

Evidence of the youth’s consent to continue medications after his/her 18th birthday must be documented.

Psychotropic Medication

AHCCCS has developed guidelines and minimum requirements designed to guide the Health Plans in
developing appropriate psychotropic medication use policies and procedures to:

- Promote the safety of persons taking psychotropic medications;
- Reduce or prevent the occurrence of adverse side effects;
- Promote positive clinical outcomes for behavioral health recipients who are taking psychotropic medications;
- Monitor the use of psychotropic medications to foster safe and effective use; and
- To clarify that medication will not be used for the convenience of the staff, in a punitive manner or as a substitute for other services and shall be given in the least amount medically necessary with particular emphasis placed on minimizing side effects which otherwise would interfere with aspects of treatment, as stated in R9-21-207(C).

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.

Reasonable clinical judgment, supported by available assessment information, must guide the prescribing of psychotropic medications. To the extent possible, candidates for psychotropic medication use must be assessed prior to prescribing and providing psychotropic medications. Psychotropic medication assessments must be documented in the person’s comprehensive clinical record per Medical Record Standards Section and must be scheduled in a timely manner consistent with Appointment Standards and Timeliness of Service Section. Behavioral Health Professionals (BHPs) can use assessment information that has already been collected by other sources and are not required to document existing assessment information that is part of the person’s comprehensive clinical record.

At a minimum, assessments for psychotropic medications must include:

- An adequately detailed medical and behavioral health history;
- A mental status examination;
- A diagnosis;
- Target symptoms;
- A review of possible medication allergies;
- A review of previously and currently prescribed psychotropic or other medications including any reported side effects and/or potential drug-drug interactions and all medications (including
medications prescribed by the PCP and medical specialists, OTC medications, and supplements) currently being taken for the appropriateness of the combination of the medications;

- For sexually active females of childbearing age, a review of reproductive status (pregnancy);
- For post-partum females, a review of breastfeeding status; and
- All BHMPs are required to register and utilize the Arizona State Board of Pharmacy Controlled Substance Prescription Monitoring Program (CSPMP) database. A review of the recipient’s profile in the CSPMP database must be completed when initiating a controlled substance (i.e. amphetamines, opiates, benzodiazepines, etc.) that will be used on a regular basis or for short term addition of agents when the member is known to be receiving opioid pain medications or another controlled substance from a secondary prescriber. In addition, a utilization report must be obtained for the preceding 12 months before prescribing opioid analgesics or benzodiazepines in the schedules II-IV. Practitioners are not required to obtain a report if the member is receiving hospice care or being treated for cancer or cancer-related illness; if the practitioner will administer the controlled substance; if the patient is receiving the controlled substance during the course of inpatient or residential treatment in a hospital, nursing care facility or mental health facility; or if the medical practitioner, under specific legislation, prescribed controlled substances for no more than five day after oral surgery. Documentation of CSPMP review must be included in the clinical record.

Reassessments require the prescribing clinician of psychotropic medication notes in the Member’s record the following (see Medical Record Standards Section):

- The reason for and the effectiveness of the medication;
- The clinical appropriateness of the current dosage;
- All medication (including medications prescribed by the PCP and medical specialists, over the counter medications, and supplements) being taken and the appropriateness of the combination of the medications;
- Any side effects such as weight gain and/or abnormal/involuntary movements if treated with an anti-psychotic medication; and
- Minimum requirements:
  - Rationale for the use of two medications from the same pharmacological class and
  - Rationale for the use of more than three different psychotropic medications in adults, and
  - Rationale for the use of more than one psychotropic medication in the child and adolescent population.

**Informed Consent**

Informed consent must be obtained from the person and/or legal guardian for each psychotropic medication prescribed. When obtaining informed consent, the BMHP must communicate in a manner that the person and/or legal guardian can easily understand. It is preferred that the prescribing clinician provide information forming the basis of an informed consent decision. In specific situations in
which this is not possible or practicable, information may be provided by another credentialed behavioral health medical practitioner or a registered nurse.

The comprehensive clinical record must include documentation of the essential elements for obtaining informed consent (see Medical Record Standards Section). Essential elements for obtaining informed consent for medication are contained within Provider Manual Form Informed Consent for Psychotropic Medication Treatment. The use of Provider Manual Form is recommended as a tool to document informed consent for psychotropic medications. If Provider Manual Form is not used to document informed consent, the essential elements for obtaining informed consent must be documented in the person’s individual comprehensive clinical record in an alternative fashion (see Medical Record Standards Section).

For more information regarding informed consent, see General and Informed Consent to Treatment Section.

**Youth and Psychotropic Medications**

- Youth under the age of 18 are to be educated on options, allowed to provide input, and encouraged to assent to medication(s) being prescribed. Information is discussed with the youth in a clear and age-appropriate manner consistent with the developmental needs of the youth.

- The information to be shared should be consistent with the information shared in obtaining informed consent from adults.

- Discussion of the youth’s ability to give consent for medications at the age of 18 years old is begun no later than age 17 ½ years old, especially for youth who are not in the custody of their parents.

- There should be special attention to the effect of medications on the reproductive status and pregnancy, as well as long term effects on weight, abnormal involuntary movements and other health parameters.

- Evidence of the youth’s consent to continue medications after reaching age 18 may be documented through use of AHCCCS Policy Form 108.1, Informed Consent/Assent for Psychotropic Medication Treatment, a recommended tool to review and document informed consent for psychotropic medications.

**Psychotropic Medication Monitoring**

Per national guidelines and to address the monitoring of psychotropic medications and metabolic parameters, the provider must establish policies and procedures for monitoring of lithium, valproic acid, carbamazepine, renal function, liver function, thyroid function, glucose metabolism, screening for metabolic syndrome and movement disorders. See Provider Manuel Attachment Minimum Laboratory Monitoring for Psychotropic Medication.

Medications prescribed must be monitored for efficacy, side effects and adverse events at each visit with a registered nurse, physician assistant, psychiatric nurse practitioner, or physician.
**Reporting Requirements**

Health Plan has established the AHCCCS system requirements for monitoring the following:

- Adverse drug reactions;
- Adverse drug event; and
- Medication errors.

The above referenced events must be identified, reported, tracked, reviewed and analyzed by the Health Plan.

An incident report must be completed for any medication error, adverse drug event and/or adverse drug reaction that results in harm and/or emergency medical intervention (See Reporting of Incidents, Accidents and Deaths for more information Section).

**Complementary and Alternative Medicine (CAM)**

Complementary and alternative medicine (CAM) is not AHCCCS reimbursable.

When a BHMP uses Complementary and Alternative Medicine (CAM), (See Arizona Medical Board’s Guidelines for Physicians Who Incorporate or Use Complementary Or Alternative Medicine In Their Practice) informed consent must be obtained from the person or guardian, when applicable, for each CAM prescribed. When obtaining informed consent, behavioral health medical practitioners must communicate in a manner that the person and/or legal guardian can easily understand. The comprehensive clinical record must include documentation of the essential elements for obtaining informed consent (see Medical Record Standards Section).

Essential elements for obtaining informed consent for medication are contained within Provider Manual Form, Informed Consent for Psychotropic Medication Treatment.

The use of Provider Manual Form, Informed Consent for Psychotropic Medication Treatment is recommended as a tool to document informed consent for CAM. If Provider Manual Form is not used to document informed consent, the essential elements for obtaining informed consent must be documented in the person’s individual comprehensive clinical record in an alternative fashion (see Medical Record Standards Section).

**Primary Care Physician (PCP) Medication Management Services**

In addition to treating physical health conditions, the PCP shall treat behavioral health conditions within their scope of practice. Such treatment shall include but not be limited to substance use disorders, anxiety, depression and Attention Deficit Hyperactivity Disorder (ADHD). For purposes of medication management, it is not required that the PCP be the member’s assigned PCP. PCPs who treat members with these behavioral health conditions may provide medication management services including prescriptions, laboratory and other diagnostic tests necessary for diagnosis, and treatment.

**Court Order Treatment**

At times it may be necessary to initiate civil commitment proceedings to ensure the safety of a member, or the safety of others, due to a member’s mental disorder, when that member is unable or unwilling to participate in treatment. In accordance with the A.A.C. R9-21-101 and A.R.S. § 36-533 any
responsible person may submit an application for pre-petition screening when another person is alleged to 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 is subject to the jurisdiction of an Indian tribe, 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 (ADHS/DLS) as a court-ordered evaluation or court-ordered treatment agency must adhere to ADHS licensing requirements.

Contracted behavioral health providers that receive an application for court-ordered evaluation must immediately refer the applicant for pre-petition screening and petitioning for court-ordered evaluation to the county designated pre-petition screening agency or county facility.

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. The screening agency, upon receipt of the application, is required to act as prescribed within 48 hours of the filing of the application, excluding weekends and holidays as described in A.R.S. §36-520.

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, 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. Before the court can order a mental health agency to supervise the member’s outpatient treatment, the agency’s medical director
must agree and accept responsibility by submitting a written treatment plan to the court.

**Licensing Requirements**

Behavioral health 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.

At every stage of the pre-petition screening, court-ordered evaluation, and court-ordered treatment process, a member is to 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.

Reimbursement of court-ordered screening and evaluation services are the responsibility of the County pursuant to A.R.S § 36-545. For additional information regarding behavioral health services refer to 9 A.A.C. 22, 2 & 12. Refer to ACOM Policy 437 for clarification regarding financial responsibility for the provision of medically necessary behavioral health services rendered after the completion of a Court-Ordered Evaluation (COE). The pre-petition screening includes an examination of the member’s mental status and/or relevant circumstances by a designated screening agency. County agencies 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

**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 the Health Plan. The Health Plan Behavioral Health Department is available to answer any questions the caller may have about the process and can 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;
- Offer assistance, if needed, to the applicant in the preparation of the application for the court-ordered evaluation.
- 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;

• Document 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.

• Only applications indicating DTS and/or DTO can be filed on an emergent basis

• Application must be completed by an applicant who has directly observed or witnessed the behavior of the member that is a danger to self or others, and not based on second hand information

• The applicant must complete AMPM Policy 320-U, 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.

• The applicant and all witnesses identified in the application as direct observers of the dangerous behavior, may be called to testify in court if the application results in a petition for COE.

• A member proposed for emergency admission for evaluation may be apprehended and transported to the facility under the authority of law enforcement using the written AMPM Policy 320

• The member 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 member must be released. If a petition is submitted, the hospital may hold the member for an additional seventy-two (72) hours to complete examinations by two (2) physicians.

During the emergency admission period of up to 24 hours the following will occur:

a. The member’s ability to consent to voluntary treatment will be assessed.

b. The member shall be offered and receive treatment to which he/she may consent. Otherwise, the only treatment administered involuntarily will be for the safety of the member or others,
i.e. seclusion/restraint or pharmacological restraint in accordance with A.R.S § 36-513.

c. The psychiatrist will complete the evaluation within 24 hours of determination that the member no longer requires involuntary evaluation.

**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 member requires court-ordered treatment for a mental disorder. If the medical director of the inpatient facility does not believe the member requires court-ordered treatment, the member 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 member 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);
- Title XIX/XXI funds must not be used to reimburse court-ordered evaluation services.
- For any Title XIX enrolled member, who has been admitted to an evaluation agency under a petition for court-ordered treatment, the evaluation period is deemed to end upon the filing of a Petition for Court-Ordered Treatment and is not automatically linked to the end of the 72-hour COE period.
- At that time, the Health Plan must pay for all medically necessary services associated with the period of time between the filing of the Petition for Court-Ordered Evaluation and the hearing set for the purposes of a judicial determination for the need for Court-Ordered Treatment.
- Any contracted 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 member’s residence, or in which the member 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 member 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.

**Voluntary Evaluation**

- Any Health Plan subcontracted provider that receives an application for voluntary evaluation must immediately refer the member to the facility responsible for voluntary evaluations.
- The Health Plan subcontracted provider must follow these procedures:
  - The evaluating agency must obtain the member’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 evaluating 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.

Based on the court-ordered evaluation, the evaluating agency may petition for court-ordered treatment. Behavioral health providers are required to follow these procedures:

- Upon determination that a person is DTS, DTO, GD, or PAD, and if no alternatives to court-ordered treatment exist, the Medical Director of the agency that provided the court-ordered evaluation must file a petition with the court for court-ordered treatment (see AMPM Policy 320-U, Exhibit 320-U-4),
- Any behavioral health provider filing a petition for court-ordered treatment must do so in consultation with the member’s clinical 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 (see AMPM Policy 320-U, Exhibit 320-U-5), and
- A copy of the petition, in cases of grave disability, must be mailed to the public fiduciary in the county of the person’s residence, or the county in which the member was found before evaluation, and to any person nominated as guardian or conservator.

Members who are Title XIX/XXI Eligible and/or Determined to have a Serious Mental Illness (SMI).
When a member referred for court-ordered treatment is Title XIX/XXI eligible and/or determined or suspected to have a SMI, the contracted behavioral health provider shall:

1. Submit a referral to designated contractor for an evaluation to determine if the person has a Serious Mental Illness in accordance with AMPM Policy 320-P. The contracted behavioral health provider is required to conduct a behavioral health assessment to identify the member’s service needs in conjunction with the member’s clinical team, as specified in AMPM Policy 320-O,

2. Provide necessary court-ordered treatment and other covered behavioral health services in accordance with the member’s needs, as determined by the member’s clinical team, the member, family members, and other involved parties, and

3. Perform, either directly or by contract, all treatment required by A.R.S. Title 36, Chapter 5, Article 5 and 9 A.A.C. 21, Article 5.

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 members 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 T36 proper execution of its procedures.

In serving as regional authority, the Health Plan is responsible for treatment of an eligible member* once placed under a Title 36 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.”

The Health Plan Court Coordinator will serve as the single point of contact for information specific to the court’s disposition for eligible members, will coordinate court-ordered evaluation and treatment, and will communicate court-related follow-up/requirements to contractor staff. When a member is court-ordered for evaluation and/or treatment, they will immediately be entered into the Health Plan Care Management program, and the Health Plan Care Manager will deploy a Peer Liaison, to support the member and his/her family. Peer Liaisons will educate members about their diagnosis and symptoms, give step-by-step explanation of the COE/COT process, and share their similar history to inspire hope. The Peer Liaison will remain with the member after conclusion of the COE and/or COT inpatient stay to help the member transition to community-based care while maximizing self-determination.

Contracted Behavioral Health Provider Responsibilities

Each contracted behavioral health provider per the Health Plan Contract Scope of Service is required to
A contracted behavioral health 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 the Health Plan enrolled members.

In all cases, the contracted behavioral health 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.**

Members 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 member to report for further evaluation. If a COT member misses an appointment, the contracted behavioral health provider must demonstrate attempts to see the member within two (2) business days. The Health Plan requires contracted behavioral health providers to consistently track all members on court-ordered treatment to facilitate continued adherence to the court order.

- Outreach and engagement with these members should be assertive and follow the reengagement processes within the Health Plan Behavioral Health Provider Manual. The goal is to avoid re-hospitalization and improve the quality of life for the member.
- A solid crisis plan must be developed that includes what works and does not work for this member, supports that can help, and types of outreach that should be attempted if the member has an increase in symptoms or disengages from treatment.
- Contracted behavioral health 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. Contracted behavioral health providers must ensure they understand the County’s interpretation of the COT Expiration date. Contracted behavioral health providers must monitor expiration dates to schedule annual reviews to determine if the member’s COT should continue for another year. Additionally, it gives the contracted behavioral health providers enough time to file a Petition for Continued Treatment with court for members who were found Persistently or Acutely Disable or Gravely Disabled. The Health Plan will monitor and audit COT requirements and will issue Corrective Action Letters and/or Sanctions for failure to follow the requirements.

**Title 36 Liaisons**

The Health Plan contracted behavioral health providers that serve as Supervising Agencies for court orders will appoint a Title 36 (T36) 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 the Health Plan. The contracted behavioral health provider’s 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 the Health Plan. The T36 Liaison will attend quarterly meetings with the Health Plan Court Coordinator to obtain notification of changes in
reporting and/or responsibilities.

**Contracted behavioral health provider T36 Liaison responsibilities will include:**

Coordinate policies and procedures with the Health Plan for enrolled members who have been and/or are in the process of a civil commitment. Reconcile, on a monthly basis with the Health Plan, the roster of members receiving court-ordered treatment. Due date of roster will be submitted no later than the 15th of each month to BUHPCareMgmtBHMailbox@bannerhealth.com. If an agency developed roster is not available, the Provider Manual Form - BUHP 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
- Health Plan identification number
- Mental Health number
- Date of court order
- Standard(s) under which the member 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), and ensure compliance with statutory requirements, (e.g. Judicial Reviews, Suspensions, Annual Examination, etc.).

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

Compliance with any additional requests by the Health Plan 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 member’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 courtroom. 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 or not 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 as to why the plan has not been completed, and the projected date of completion.

**Pima County:**

Contracted behavioral health providers are responsible for establishing a group generic email box to receive minute entries from the Court. An example is MinuteEntries@[provider name].com. The Health Plan 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 – 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. 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:

- Original for Judge/Commissioner
  - Copies to the following:
    - County Attorney,
    - Defense Attorney,
    - Hospital T-36 Liaison,
    - Member
    - Health Plan Court Coordinator or other designee

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 the Health Plan. 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 the Health Plan. 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 court-ordered outpatient treatment plan or needs to be hospitalized and refuses voluntary admission, the Medical Director of the contracted agency, or physician designee can rescind the court-ordered Outpatient Treatment Plan.

- It is important the contracted behavioral health 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 member requires continued court-ordered treatment. If the member is DTO/DTS the contracted behavioral health provider can follow the process for an Emergency Application for Evaluation for Admission. If the member is PAD/GD, the contracted behavioral health 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.

- BUFC/ALTCS members: Assigned ALTCS BHP is responsible for all clinical coordination with BHMP and filing with the Health Plan contracted law firm.

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

When the member is presenting with DTO/DTS behavior, requires immediate acute hospitalization, and refuses admission, 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 a court-ordered outpatient treatment plan, the contracted behavioral health 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 a member is hospitalized pursuant to an amended order, the contracted behavioral health provider must inform the member 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 contracted behavioral health provider determines that the member is not complying with the
terms of the order, or that the court-ordered 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. The Court, without a hearing and based on the court record, the member’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 member, may enter an order amending its original order.

If the member 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 member into protective custody and transport the member for inpatient treatment. When a member is hospitalized pursuant to an amended order, the contracted behavioral health provider must inform the member 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), Provider Manual forms -Law Enforcement Committal Information, and Request for Suspension of Outpatient Treatment Plan are required. The Request for Suspension of Court-Ordered Outpatient Treatment Plan must be signed by the supervising 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 Request for Suspension of Outpatient Treatment Plan is submitted to the Health Plan contracted law firm and copy to the Health Plan Behavioral Health Department a BUHPCareMgmtBHMailbox@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 provider 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, contracted provider 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 behavioral health provider is required to inform the member of the right to judicial review and right to consult with counsel, see Judicial Reviews below.

Quashing an Order to Transport/Suspension

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

Pima County:

If 90 days has expired since the last amendment, the contracted behavioral health provider is required
to submit a written statement to the Health Plan contracted law firm requesting to quash the previous amendment and transport order, and file a new amendment. If a member 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 contracted behavioral health provider is responsible for notifying Pima County’s Mental Health Support Team (MHST) of the change in location of the member. The contracted behavioral health 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 member is to be informed of his/her right to Judicial Review. In cases where the member’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 member of this right to Judicial Review and explain the process. It is the responsibility of the contracted behavioral health Provider to track the Judicial Review dates and ensure a Judicial Review is offered to a member under Court-Ordered Treatment (COT) every 60 days.

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

If the member requests a Judicial Review, the case manager completes Provider Manual Form - Notification of Individual’s Right to Request Judicial Review and Right to Speak to Legal Counsel. The member completes his/her current address and signs the form. Additionally, the supervising BHMP completes a psychiatric evaluation. The Provider Manual Form - 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 member needs continued court-ordered treatment. This can be in the form of a progress note.

BUFC/ALTCS members: Assigned ALTCS BHP is responsible for all clinical coordination with BHMP and filing with the Health Plan contracted law firm.

Pima County:

The completed Judicial Review Form and psychiatric report is submitted to the Health Plan 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 BUHPCareMgmtBHMailbox@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 supervising 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 the Health Plan a BUHPCareMgmtBHMailbox@bannerhealth.com. If the member declines a Judicial Review, the case manager completes the same Provider Manual form Notification of Individual’s Right to Request Judicial Review and Right to Speak to Legal Counsel, and the member signs this form. The member provides his/her current address and location. The contracted behavioral health provider maintains this form in the clinical record.

If the member is unavailable at the time the Judicial Review is due, the case manager completes the same Form - Notification of Individual's Right to Request Judicial Review and Right to Speak to Legal Counsel. The case manager must provide reasons why the member was not available for the Judicial Review and include a minimum of two outreach attempts made. The contracted behavioral health 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 behavioral health provider to submit two status reports to the Health Plan. 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 contracted behavioral health provider fails to complete the status report to the court, the judge can order the member and assigned case manager to appear in court to provide testimony regarding the treatment and process of the member.

- 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 – Court-Ordered Treatment Status form. The status report is completed by the case manager and reviewed and signed by the team supervisor and supervising BHMP.

Copy of the report is submitted to the Health Plan 7 days prior to due date ordered by the Court. Report is to be submitted to B-UHP at BUHPCareMgmtBHMailbox@bannerhealth.com.

BUFC/ALTCS members: Assigned ALTCS BHP is responsible for all clinical coordination with BHMP and filing with the Health Plan contracted law firm.

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

The contracted behavioral health provider shall ensure the supervising BHMP has completed an examination and review of a court-ordered member 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 the Health Plan requires the contracted behavioral health provider provide the Health Plan with the progress note from the contracted supervising BHMP showing the BHMP met with the member 30-90 days prior to expiration of the court order. This progress note will be collected by the Health Plan on a monthly basis.

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

Additionally, the member’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 behavioral health providers can request court orders for members determined to be PAD and GD be continued for another year based on an annual review and examination conducted by the member’s supervising BHMP and a petition to the court. For members determined DTS and/or DTO the contracted behavioral health 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 member. 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 member 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 member’s need for a guardian or conservator or both;
- Whether the member 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 member.
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 the Health Plan 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 supervising BHMP who completed the Annual Exam must testify at the hearing. The contracted behavioral health provider T-36 Liaison is responsible for informing the assigned staff and the supervising 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.

BUFC/ALTCS members: Assigned ALTCS BHP is responsible for all clinical coordination with BHMP and filing with the Health Plan contracted law firm.

**Pima County:**

For continued treatment examinations for members found to be GD, utilize the Health Plan Behavioral Health Manual Form, Psychiatric Examination for Annual Review of Gravely Disabled Members. For continued treatment examinations for members found to be PAD, utilize Form, Psychiatric Examination for Annual Review of a Persistently or Acutely Disabled.

The Health Plan contracted law firm will forward to the contracted behavioral health provider conformed copies of the petition and order that was filed in court. The contracted behavioral health provider is required to provide the paperwork to the member and obtain a signed B-UHP Form 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 submitted to the Health Plan’s contracted law firm. A copy of this form is to be submitted BUHPCareMgmtBHMailbox@bannerhealth.com.

**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 supervising BHMP.

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

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 supervising 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 Release from COT Worksheet.

BUFC/ALTCS members: Assigned ALTCS BHP is responsible for all clinical coordination with BHMP and filing with the Health Plan contracted law firm.

**Pima County:**
The original psychiatric evaluation is submitted to the Health Plan contracted law firm to be filed with court.

**All Counties:**
Copy of the psychiatric evaluation is to be submitted to the Health Plan at BUHPCareMgmtBHMailbox@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 supervising BHMP as to why the member 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 member is released from court order, the case manager must notify the member and the Title 36 Liaison must update its systems and the Health Plan at BUHPCareMgmtBHMailbox@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 the Health Plan Behavioral Health Department at BUHPCareMgmtBHMailbox@bannerhealth.com to review documentation of re-engagement attempts before the release or discharge of a member ordered to undergo COT (per Outreach, Engagement, Re-engagement and Closure Section of this Provider Manual).

**Change of Venue Counties other than Pima**
When a member transfers from one county to another, the receiving contracted behavioral health provider must agree to accept the member 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 contracted behavioral health 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 contracted behavioral health 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 contracted behavioral health provider is to follow process set forth by designated County Attorney or law firm.

BUFC/ALTCS members: Assigned ALTCS BHP is responsible for all clinical coordination with BHMP and filing with the Health Plan contracted 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 the Health Plan contracted law firm to file with Court.
- If the member is transferring from the Health Plan to a RBHA, the contracted behavioral health provider must contact the Health Plan Behavioral Health Department for assistance and coordination at BUHPCareMgmtBHMailbox@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 a member under COT can be transferred from one treating contracted behavioral health provider to another, the sending contracted behavioral health provider must have verification that the Medical Director of the receiving contracted behavioral health 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 member 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 behavioral health 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 member’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 the Health Plan Behavioral Health Department of all transfers.

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.

The Health Plan and Health Plan 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, the Health Plan and the contracted behavioral health 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 Health plan. This clinical communication and coordination with the 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.” The Health Plan 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 behavioral health services.

Due to the options American Indians have regarding their health care, including behavioral health services, behavioral health services for AHCCCS eligible American Indians may be covered and/or coordinated through a Contractor, Tribal ALTCS, or IHS/638 provider. See on the AHCCCS website under Tribal Court Procedures for Involuntary Commitment-Tribal Court Procedures for Involuntary Commitment for a diagram of payment structures.

**Arizona State Hospital (AzSH)**

When a need for a referral to the Arizona State Hospital has been identified, the contracted provider contacts the Health Plan Behavioral Health Department 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 member’s release into the community. This will often include a referral to the Health Plan where the member 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.

Responsibilities of contracted behavioral health provider must include at minimum the following:

a. Coordination with AzSH for discharge planning,

b. Participating in the development and implementation of Conditional Release Plans,

c. Participation in the modification of an existing or the development of a new Complete Care Plan that complies with the Conditional Release Plan (CRP),

d. Member outreach and engagement to assist the PSRB in evaluating compliance with the approved CRP,

e. Attendance in outpatient staffing at least once per month,

f. Care coordination with the member’s treatment team, and providers of both physical and behavioral health services to implement the Complete Care Plan and the CRP,

g. Routine delivery of comprehensive status reporting to the PSRB,

h. Attendance in a monthly conference call with AHCCCS Medical Management (MM),

i. In the event a member violates any term of his or her CRP the contracted behavioral health provider shall immediately notify the PSRB and provide a copy to AHCCCS and AzSH, and

j. The contracted behavioral health provider further agrees and understands it shall follow all obligations, including those stated above, applicable to it as set forth in A.R.S. §13-3994.

Any violation of the Conditional Release, psychiatric decompensation or use of alcohol, illegal
substances or prescription medications not prescribed to the member shall be reported to the PSRB and the AzSH immediately.

Contracted behavioral health providers must submit a monthly comprehensive status report for Complete Care members on Conditional Release to the PSRB, at BUHPCareMgmtBHMailbox@bannerhealth.com, and to BUHPALTCSBHP@bannerhealth.com for ALTCS members as specified in AMPM Attachment 1020-1. Contracted behavioral health providers must provide additional documentation at the request of AHCCCS Medical Management. In the event that a member’s mental status renders him/her incapable or unwilling to manage his/her medical condition, and the member has a skilled medical need, the contracted behavioral health providers must arrange ongoing medically necessary nursing services in a timely manner.

**Court-Ordered Treatment for Persons Charged with or Convicted of a Crime**

The Health Plan or contracted behavioral health providers may be responsible for providing evaluation and/or treatment services when a member 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 member is court-ordered to treatment, or programs, as a result of being charged with a crime as a result of a primary substance abuse diagnosis.

**Domestic Violence Offender Treatment**

Domestic violence offender treatment may be ordered by a court when a member 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, the Health Plan 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 the Health Plan receives a claim for such services, the claim will be denied with instructions to the contracted provider to bill the responsible county, city or town.

**Out of State Placements**

At times, it may be necessary to consider an out-of-state placement for a member to meet the member’s unique circumstances or clinical needs. The following circumstances need to be taken into account by the member’s Adult Recovery Team (ART) or Child & Family Team (CFT) to consider the temporary out-of-state placement:

- Member 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 unique cultural heritage of the members
- A lack of current in state bed capacity
• The geographic proximity of the out of state placement supports and facilitates family involvement in the member’s treatment.

• The member’s family/guardian/designated representative is in agreement with the out of state placement (for minors and members between 18 and under 21 years of age under guardianship).

• The out of state provider is an AHCCCS registered provider

• A plan for the provision of non-emergency medical care must be established prior to placement and the non-emergency care providers must be AHCCCS registered providers.

AHCCCS requires that decisions to place member in out-of-state placements for behavioral health care and treatment are examined closely and made after the Adult Recovery Team, Child and Family Team and the Health Plan 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 Service Plan or Complete Care Plan, when applicable, 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 member. In the event that an out-of-state placement is necessary and is supported by the Health Plan and the Adult Recovery Team or the Child & Family 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 Appointment Standards and Timeliness of Services section of this manual.

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:

• A minimum of three in state facilities have declined to accept the member.

• The CFT or ART has been involved in the service planning process and is in agreement with the out of state placement.

• The CRT or ART has documented how it will remain active and involved in the service planning once the out of state placement has occurred.

• A Service Plan/Complete Care Plan has been developed and includes a discharge plan that addresses the needs and strengths of the member.

• All applicable prior authorizations have been met.

• All less restrictive, clinically appropriate approaches have either been provided or considered by the Adult Recovery Team or Child & Family Team and found not to meet the member’s needs;

• Coordination has occurred with all other state agencies involved with the member
• For Child/Adolescent members, 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 the Health Plan 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 Complete Care Plan (CCP)
For a member placed out-of-state, the Complete Care plan developed by the Adult Recovery Team or Child & Family Team must require that:

• Discharge planning is initiated at the time of referral or notification of admission, including:
  o The measurable treatment goals being addressed by the out-of-state placement and the criteria necessary for discharge back to in-state services;
  o The possible or proposed in-state residence where the member will be returning;
  o The recommended services and supports required once the member returns from the out-of-state placement;
  o What needs to be changed or arranged to accept the member for subsequent in-state placement that will meet the member’s needs;
  o How effective strategies implemented in the out-of-state placement will be transferred to the members’ subsequent in-state placement; and
  o The actions necessary to integrate the member into family and community life upon discharge.

• The Adult Recovery Team or Child & Family 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 or Child & Family Team must ensure that essential and necessary health care services are provided;

• Home passes are allowed as clinically appropriate and in accordance with the Health Plan Medicaid Behavioral Health Covered Services Guide; and

• The member’s needs, strengths and cultural considerations have been addressed.

• Strategies and interventions to address and coordinate the care of the member’s physical health needs including dental, if applicable.
Initial notification to the Health Plan Behavioral Health Care Management Department

The Health Plan contracted providers are required to notify the Health Plan Behavioral Health Care Management Department and submit an Out of Home Request Packet prior to initiating a referral for an out-of-state placement. The Health Plan contracted providers are also required to assist the Health Plan 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 the Health Plan 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 the Health Plan criteria.

Process for Providing Initial Notification to the Health Plan

For providers contracted with the Health Plan, the provider notifies the Health Plan Behavioral Health Care Management Department of the intent to make a referral for out-of-state placement on the Health Plan Behavioral Health Provider Manual Form Out-of-State placement. The Health Plan 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 the Health Plan Behavioral Health Care 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 Health Plan Behavioral Health Care 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.

Special Assistance for Member Determined to Have SMI

Health Plan contracted providers shall identify and submit notification to the AHCCCS Office of Human Rights (OHR), members determined to have a Serious Mental Illness (SMI) who meet the criteria for Special Assistance. The provider shall submit a notification whether or not the member’s Special Assistance needs appear to be met by an involved family member, friend, designated representative or guardian. Health Plan contracted providers must also ensure that the person designated to provide Special Assistance is involved at key stages of the grievance and appeals process.

Health Plan contracted providers must adhere to the following requirements:

1. Criteria to deem a member to be in need of Special Assistance are as follows:
a. A member determined to have a SMI is in need of Special Assistance if he/she is also unable to do any of the following:
   i. Communicate preferences for services,
   ii. Participate effectively in Service Planning or Inpatient Treatment Discharge Planning (ITDP)
   iii. Participate effectively in the appeal, grievance or investigation processes, and iv. The member’s limitations described in i–iii above must also be due to any of the following:
      • Cognitive ability/intellectual capacity (i.e. cognitive impairment, borderline intellectual functioning, or diminished intellectual capacity),
      • Language barrier (an inability to communicate, other than a need for an interpreter/translator), and/or
      • Medical condition (including, but not limited to traumatic brain injury, dementia, or severe psychiatric symptoms).

b. A member who is subject to general guardianship has been found to be incapacitated under A.R.S. §14-5304, and therefore automatically satisfies the criteria for Special Assistance.

c. For a member determined to have SMI, the existence of any of the following circumstances should prompt the Health Plan contracted provider to more closely review whether the member is in need of Special Assistance:
   i. Developmental disability involving cognitive ability,
   ii. Residence in a 24-hour setting,
   iii. Limited guardianship, or the Health Plan contracted provider is recommending and/or pursuing the establishment of a limited guardianship, or
   iv. Existence of a serious medical condition, that affects his/her intellectual and/or cognitive functioning (such as dementia or traumatic brain injury).

2. The following may deem a member to be in need of Special Assistance:
   a. A qualified clinician providing treatment for the member,
   b. A case manager of a Health Plan contracted provider,
   c. A clinical team of a Health Plan contracted provider,
   d. The Health Plan,
   e. A program director of a Health Plan contracted provider (including AzSH),
   f. The Deputy Director of AHCCCS or designee, or
g. A hearing officer assigned to an appeal involving a member determined to have a SMI.

3. Health Plan contracted providers shall, on an ongoing basis, screen whether members determined to have a SMI are in need of Special Assistance in accordance with the criteria set out in Section A of this Policy. Minimally, this must occur at the following stages:
   a. Assessment and annual updates,
   b. Development of or update to the Service Plan,
   c. Upon admission to a psychiatric inpatient facility,
   d. Development of or update to an Inpatient Treatment and Discharge Plan (ITDP),
   e. Initiation of the grievance or investigation processes,
   f. Filing of an appeal, and
   g. Existence of a condition which may be a basis for a grievance, investigation or an appeal.

4. Documentation
   a. Health Plan contracted providers shall document in the clinical record each time a staff person screens a member for Special Assistance, indicating the factors reviewed and the conclusion. If the conclusion is that the member is in need of Special Assistance, they shall notify the OHR using Attachment A, in accordance with the procedures below.
   b. Before submitting Attachment A, Health Plan contracted providers shall check if the member is already identified as in need of Special Assistance. A notation of Special Assistance designation and a completed Attachment A should already exist in the clinical record. However, if it is unclear, Health Plan contracted providers must contact the Health Plan’s ALTCS Sr. Manager at: BUFCALTCSBHP@bannerhealth.com to inquire about current status.
   c. The Health Plan maintains a database on members in need of Special Assistance and will share data with providers on a regular basis (at a minimum quarterly).

Notification Requirements

1. If a member is not correctly identified as Special Assistance, Health Plan contracted providers shall submit Part A Notification of Member in need of Special Assistance to the OHR and the Health Plan within five working days of identifying a member is in need of Special Assistance. If the member has a Special Assistance need requiring immediate support, the notification form must be submitted immediately with a notation indicating the urgency. Health Plan contracted providers shall document on
Part A whether or not the member was informed of the notification and explain the benefits of having another person involved who can provide Special Assistance.

2. If the member is under a guardianship or one is in process, the documentation of such shall also be submitted to OHR. However, if the documentation is not available at the time of submission of the Part A Notification of Member in need of Special Assistance notification, the form is required to be submitted within the required timeframes, followed by submittal of the guardianship documentation within the allotted five days.

3. The OHR reviews the notification form to ensure that it contains sufficient information detailing the criteria and responds to the Health Plan or Health Plan contracted provider within five working days of receipt of the form. In the event the necessary information is not provided on the form, OHR contacts the staff person submitting the notification for clarification. In the event the notification is urgent, OHR will respond as soon as possible, but generally within one working day of receipt of the notification.

4. The notification process is not complete until OHR completes Part B of Notification of Member in need of Special Assistance and sends it back to the Health Plan or Health Plan contracted provider. The Health Plan contracted provider should follow up with OHR if no contact is made or Part B is not received within five working days.

5. OHR designates which agency/person will provide Special Assistance when processing the notification. When the agency/person providing Special Assistance changes, OHR processes an “updated Part B” to document the change.

6. In the event the member or agency currently identified as providing Special Assistance is no longer actively involved, the Health Plan contracted provider shall notify OHR. If an OHR advocate is also assigned, notification to the advocate is sufficient.

**Members No Longer In Need Of Special Assistance**

1. The Health Plan contracted provider shall notify the OHR within 10 days of an event or determination when a member receiving Special Assistance no longer meets criteria by completing Part C of the original notification form (with Parts A and B completed when first identified), noting:
   a. The reason(s) why Special Assistance is no longer required,
   b. The effective date,
   c. The name, title, phone number and e-mail address of the staff person completing the form, and
   d. The date the form is completed.

2. The following are instances that should prompt Health Plan contracted provider to submit a Part C:
   a. The original basis for the member meeting Special Assistance criteria is no longer applicable and the member does not otherwise meet criteria,
i. Health Plan contracted provider must first discuss the determination with the person or agency providing Special Assistance to obtain any relevant input, and

ii. This includes when a member is determined to no longer be a member with a SMI (proper notice and appeal rights must be provided and the period to appeal must have expired).

b. The member passes away.

c. The member moves out of state, and no longer receives services in Arizona.

d. Member elects not to receive services from the Health Plan and the member is not transferred to another Health Plan. Health Plan contracted provider shall first perform all required re-engagement efforts, including contacting the person providing Special Assistance. Proper notice and appeal rights must be provided and the period to appeal must have expired prior to the submission of the Part C.

3. Submission of a Part C is not needed when a member transfers to another Health Plan (Including ALTCS/EPD), as the Special Assistance designation follows the member.

4. Upon receipt of Part C of Attachment A, OHR reviews content to confirm accuracy and completeness and returns it to the provider that submitted it, copying any involved Health Plan or Health Plan contracted provider.

Requirement To Help Ensure The Provision Of Special Assistance

1. Health Plan contracted provider shall maintain open communication with the person (guardian, family member, friend, OHR advocate, etc.) assigned to meet the member’s Special Assistance needs. Minimally, this involves providing timely notification to the person providing Special Assistance to ensure involvement in the following:

   a. Service Plan development, updates and review including any instance when the member makes a decision regarding service options and/or denial/modification/termination of services (service options include not only a specific service but also potential changes to provider, site, physician and case manager assignment), which shall be in accordance with AHCCCS Medical Policy Manual Policy 320-0,

   b. ITDP planning including any time a member is admitted to a psychiatric inpatient facility and involvement throughout the stay and discharge,

   c. Appeal process including circumstances that may warrant the filing of an appeal, so all Notices of Adverse Benefit Determination (NOA) or Notices of Decision (NOD) issued to the member/guardian/designated representative must also be copied to the person designated to meet Special Assistance needs, and

   d. Investigation or Grievance: Including when an investigation/grievance is filed and circumstances when initiating a request for an investigation/grievance may be warranted.
2. In the event that the procedures outlined in the above section, a through d are delayed, in order to ensure the participation of the person providing Special Assistance, the Health Plan contracted provider shall document the reason for the delay in the clinical record, or the investigation, grievance or appeal file. If an emergency service is needed the Health Plan contracted provider shall ensure that the member receives the needed services in the interim and shall promptly notify the agency/person providing Special Assistance.

3. The Health Plan contracted provider shall timely provide relevant details and a copy of the original Attachment A (both Parts A and B) to the receiving entity and when applicable, Case Manager, when a member in need of Special Assistance is:
   a. Admitted to an inpatient facility,
   b. Admitted to a residential treatment setting, or
   c. Transferred to a different Health Plan or Case Manager.

4. The Health Plan contracted provider shall periodically review whether the member’s needs are being met by the person or agency designated to meet the member’s Special Assistance needs. If a concern arises, they should first address it with the person or agency providing Special Assistance. If the issue is not promptly resolved, they must take further action to address the issue, which may include contacting OHR Administration for assistance.

Confidentiality Requirements

Health Plan contracted providers shall grant access to clinical records of members in need of Special Assistance to the OHR in accordance with federal and state confidentiality laws.

Other Procedures

1. Health Plan contracted providers shall maintain a copy of the completed Attachment A, (Parts A and B and updated B, if any) in the member’s comprehensive clinical record. In the event a member was identified as no longer needing Special Assistance and Part C of the notification form was completed, the Health Plan contracted provider shall maintain a copy of the form in the comprehensive clinical record.

2. Health Plan contracted providers must clearly document in the clinical record and case management/client tracking system if a member is identified as in need of Special Assistance, the person/agency assigned currently to provide Special Assistance, the relationship, contact information including phone number and mailing address.

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.
The discharge plan must address immediate discharge needs and a post-acute component that includes at a minimum the 30 days post discharge. It must detail the services including intensity and frequency to support successful transition back to the community to minimize the risk of readmission.

Discharge planning, coordination and management of care shall include:

1. Follow-up appointment with the PCP and/or specialist within seven days,
2. Safe and clinically appropriate placement, and community support services,
3. Communication of the member’s treatment plan and medical history across the various outpatient providers,
4. Prescription medications,
5. Medical Equipment,
6. Nursing services,
7. End of Life Care related services such as Advance Care Planning,
8. Practical supports,
9. Hospice,
10. Therapies (AHCCCS limits outpatient physical therapy visits for members 21 years of age and older),
11. Referral to appropriate community resources,
12. Referral to Health Plan Disease Management or Health Plan care management (if needed),
13. Additional follow-up actions as needed based on the member’s needs, and
14. Proactive discharge planning regardless of the primary payer. (e.g. Fee for Services Medicare or commercial insurance as primary payor)

Inpatient and out-of-home residential facilities must complete and fax to 520-694-0599 the Discharge Plan Form, at 72 hours post admission, every 10 days (for inpatient facilities) or at concurrent review (for out-of-home facilities), and at discharge. If a required service is not currently available, the plan must clearly state this and identify the steps to be taken (when and by whom) to get the required service in place to prevent delays in discharge. Entries such as "deferred until patient stabilizes," "to be determined," or "placement pending," are not acceptable. Appropriate discharge plans must contain contingencies in case the primary plan cannot be executed or is delayed.

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 Health Plan contracted 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 the Health Plan.

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 or Child & Family 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.
  - Access to Durable Medical Equipment (DME)

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, the Health Plan 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, the Health Plan 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, the Health Plan will continue to authorize inpatient or out-of-home care but may sanction the outpatient provider for the cost of the avoidable bed days.

**Institution for Mental Disease 15 Day Limit**

Institution for Mental Disease (IMD) is a hospital, nursing facility or other institution of more than 16 beds that is primarily engaged in diagnosis, treatment or care of persons with mental diseases (including substance use disorders), including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for Individuals with Intellectual Disabilities is not an institution for mental disease. [42CFR 435.1010].

The Health plan covers medically necessary IMD stays for members under the age of 21 and for adults 65 years of age or older as long as the IMD stay is no longer than 15 cumulative days during a calendar month.

- The IMD limitation does not apply to a member who is admitted prior to age 21 and turns 21 during the IMD stay, until the member turns 22 years of age during the IMD stay.
- The Health Plan is not required to report an IMD stay greater than 15 days when the member is admitted prior to age 21 even if the member turns 21 during the same IMD stay as long as the member is discharged prior to age 22.
- For members who turn age 65 during an IMD stay all the days of the IMD stay while the member is age 64 will be counted against the 15-day limit and all the days of the IMD stay when the member is 65 will not be counted against the limit.
- Members remain enrolled and eligible for all medically necessary services during the entire IMD stay whether or not the stay exceeds 15 cumulative days during a calendar month.

The Health Plan contracted providers are expected to provide members with adequate access to behavioral services to ensure the member is receiving care in the most appropriate setting for the member’s needs. Coordination of services and discharge planning is to begin upon admit to avoid delays with discharge.

**Cultural Competence**

The Health Plan and its contracted 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 2000, the Office of Minority Health published the first National Standards for Culturally and Linguistically Appropriate Services in Health Care (National CLAS Standards), which provided a framework for all health care organizations to best serve the nation’s increasingly diverse communities. The Health Plan has adopted the CLAS Standards as its cultural competency framework to support a more consistent and comprehensive approach to cultural and linguistic competence in health care.
Health Equity & Culturally and Linguistically Appropriate Services (CLAS)

Health inequities in our nation are well documented, and the provision of culturally and linguistically appropriate services (CLAS) is one strategy to help eliminate health inequities. By tailoring services to an individual’s culture and language preference, health professionals can help bring about positive health outcomes for diverse populations. The provision of health care services that are respectful of and responsive to the health beliefs, practices and needs of diverse patients can help close the gap in health care outcomes. The pursuit of health equity must remain at the forefront of our efforts; we must always remember that dignity and quality of care are rights of all and not the privileges of a few.

What is Culture?

Culture refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious or social groups. Culture defines the preferred ways for meeting needs, and may be influenced by factors such as geographic location, lifestyle and age. Culture is dynamic in nature, and individuals may identify with multiple cultures over the course of their lifetimes.

AHCCCS defines Cultural Competency as “A set of congruent behaviors, attitudes and policies that come together in a system, agency, or among professionals, which enables that system, agency or those professionals to work effectively in cross-cultural situations. Competence implies having the capacity to function effectively as an individual and an organization with the context of the cultural beliefs, behaviors and needs presented by consumers and their communities.”

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 of and implement the CLAS standards to comply with Cultural Competency Health Care Requirements:

- **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

Health Plan and its contracted providers must ensure that cultural considerations are being integrated in approaches to member care. This includes, but is not limited to the following:

- Ethnicity
- Sex
- Race
- English Proficiency
- Physical Abilities and Limitations
- Family Roles
- Literacy
- Gender Identity
- National Origin
- Sexual Orientation
- Military Experience
- Economic Status
- Spiritual Beliefs and Practices
- Age
- Primary and Preferred Languages

To comply with the Culturally Competent Care requirements, the Health Plan and its contracted providers must:

- 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; Provide culturally relevant and appropriate services for Members of various populations including but not limited to: age groups, gender identity and sexual minorities, persons with disabilities, racial and ethnic groups, veterans, religious affiliations, socio-economic statuses, tribal nations, etc.
Organizational Supports for Cultural and Linguistic Need

To comply with the Organizational Supports for Cultural Competence, the Health Plan and contracted 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

Health Plan and its contracted providers must:

- Recruit, retain, promote, and support culturally and linguistically diverse representation within all levels of the organization that is responsive to the population in the service area(s) and reflects the cultural background of Members served;
- 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;

• Ensure all staff have access to resources for members with diverse cultural needs;

• Develop and implement cultural-related trainings/curriculums as determined by AHCCCS, Health Plan, Cultural Competence Committees, policies, and contract requirements.

BUFC’s Workforce Development (WFD) department implements, monitors, and regulates Provider WFD activities and requirements. In addition, BUFC evaluates the impact of the WFD requirements and activities to support Providers in developing a qualified, knowledgeable and competent workforce.

In collaboration with the Workforce Development Alliance, which consists of the Arizona Association of Health Plans, AHCCCS, and all seven ACC health plans, we ensure that all course content is culturally appropriate, has a trauma informed approach and is developed using adult-learning principles and guidelines. Additionally, it is aligned with company guidelines and WFD industry standards, the Substance Abuse and Mental Health Services Administration (SAMHSA) core competencies for WFD, federal and state requirements and the requirements of the following agencies, entities and legal agreements:

• Centers for Medicare and Medicaid Services (CMS)

• Culturally and Linguistic Appropriate Services (CLAS) Standards

• Arizona Health Care Cost Containment System (AHCCCS)

Behavioral Health ACC Providers:

Workforce Development Plan (WFDP) - The Workforce Development Alliance requires that all Behavioral Health AHCCCS Complete Care (ACC) contracted provider agencies complete a biannual Workforce Development Plan (WFDP). A WFDP Template is provided for this deliverable by the Workforce Development Alliance to providers. Due dates for these plans will be determined by the Workforce Development Alliance and communicated to Providers.

Exceptions to the above include: Individual practitioners, hospitals, transportation, housing, and prevention agencies.

Relias Learning - All AHCCCS Complete Care (ACC) Behavioral Health (BH) providers must have access to Relias Learning. This is the Learning Management System used by the ACC/RBHA Plans and their contracted BH providers through the Arizona Association of Health Plans (AzAHP). Agencies must manage and maintain their Relias Learning portal. This includes activating and deactivating users as well as enrollment and disenrollment of courses/events.

To request access to Relias, please contact your BUFC Provider Relations Representative who will forward the request to the BUFC Workforce Development Administrator for further
assistance. The request should include the following information:

- Provider Agency Name
- Contract Start Date
- Address
- Key WFD Contact
  - Name
  - Phone Number
  - Email Address
- Contract Type (ACC)
- Provider Type (GMH/SU, Children’s, Integrated Health Home, etc.)
- Number of Users (# employees at the agency who need Relias access)
- List of Health Plans provider is contracted with (if known)

BH provider agencies with 20 or more users will be required to purchase access to Relias Learning for a one-time fee of $1500 for full-site privileges. A full-site is defined as a site in which the agency may have full control of course customizations and competency development.

Provider agencies with 19 or fewer users will be added to AzAHP Relias Small Provider Portal at no cost with limited-site privileges. A limited-site is defined as one in which the courses and competencies are set-up according to the standard of the plan with no customization or course development provided. This can be done by contacting workforce@azahp.org.

Provider agencies that expand to 20 or more users will be required to purchase full site privileges to Relias Learning immediately upon expansion.

*Fee is subject to change if a Provider requires additional work beyond a standard sub-portal implementation.

**Documenting Clinical Cultural and Linguistic Need**

To advance health literacy, reduce health disparities, and identify the individual’s unique needs, Health Plan and contracted 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
Communication and Language Assistance

In accordance with Title Vi of the Civil Rights Act, Prohibition against national Origin Discriminations, the President’s Executive Order 131166, section 1557 of the Patient Protection and Affordable care Act, Health Plan and its contracted providers must make language assistance available to persons with Limited English Proficiency (LEP) at all points of contact. Oral interpretation and written translation are provided at no change to AHCCCS eligible persons. Members must be provided with information instructing them how to access these services.

All contracted providers must have their own interpretation and translation assistance resource available during all hours of operation. If a provider does not have certified bilingual staff or licensed American Sign Language interpreters for language assistance needs, the Provider is required to contract with language vendors to meet these needs.

The Health Plan has customer service representatives who are available le to speak to members/family members in their preferred language, or will conference in an interpreter. Anyone can call Customer Service at (800) 582-8686 for assistance and information. The Crisis Call Center, at 866-495-6735, also has the ability to conference in an interpreter, as needed.

To comply with the communication and language assistance requirements in the CLAS Standards, 42 CFR 438, and the Affordable Care Act Section 1557, providers must do the following:

- **Post nondiscrimination notices in lobbies and on websites.** Notices must include a nondiscrimination statement, the availability of interpretive services for patients with limited English proficiency (LEP), and the availability of auxiliary aids and services for individuals with disabilities, and informing them how to obtain the aids and services. The statement must include the availability of a grievance procedure for allegations of discrimination and information about how to file a grievance. The notice must also contain information regarding how to file a grievance with the Health and Human Services Office of Civil Rights (OCR).

- **Take reasonable steps to provide meaningful access to each individual with Limited English Proficiency:** Post language assistance tags in lobbies and on websites. These statements notify individuals of the availability of language assistance in at least the top 15 languages utilized in Arizona as identified by the ACA 1557 and include one tagline in large print (18 point
Providers must clearly inform Members of the availability of language assistance. This must occur in their preferred language, verbally and in writing to facilitate timely access to all health care services. **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.** Culturally competent care includes providing access to a qualified language interpreter, a person proficient in sign language for individuals who are deaf or hard of hearing, and written materials available in another language or Braille for individuals who are 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.

**Provide Written Translation.** – Contracted providers shall ensure written translations are provided in the following manner:

- Written materials that are critical to obtaining services (also known as vital materials) shall be made available in the prevalent non-English language spoken for each LEP population in the Health Plan’s service area. [42 CFR 438.3(d)(3)] Oral interpretation services shall not substitute for written translation of vital materials

- All written materials for members shall be translated into Spanish regardless whether or not they are vital. Critical materials include the following:
  - notices for denials, reductions, suspensions or terminations of services;
  - Individual Service Plans (ISPs);
  - assessments
  - 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 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. Service plans specifically incorporate a person’s rights to disagree with services identified on the plan. If the plan is not in the person’s preferred language, the person has not been appropriately informed of services they will be provided and afforded the opportunity to exercise their rights when there is a disagreement. Both the English and translated versions must be maintained in the member’s record. This will verify that if any persons, who must review the member’s
record for purposes such as coordination of care, emergency services, and auditing, have an English version available. The provider shall provide easy-to-understand print and member information materials as well as signage in the languages commonly used by the populations in the service area. This includes the production of materials with consideration of members with LEP or limited reading skills, those with diverse cultural and ethnic backgrounds, and those with visual or auditory limitations.

Health Plan contracted providers must ensure their websites meet compliance with Section 508 Accessibility Standards. Section 504 of the Rehabilitation Act of 1973 prohibits discrimination based on disability. Provider websites are required to be accessible per the 508 requirements.

- **Ensure Competence and Proficiency of Those Providing Language Assistance.** Provider must ensure that qualified language assistance vendors and qualified bilingual staff as well as licensed sign language interpreters provide access to oral interpretation, translation, sign language and disability-related assistance, 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 interpretation or to provide direct services in a language other than English. Health Plan requires that persons who provide oral interpretation are certified through language testing by ALTA Services or another approved language testing vendor with a score of eight (8) or higher, with a higher level of proficiency needed for the provision of more complex verbal interchange, such as psychiatric services and psychological testing. Providers can register for testing at www.Altalang.com. The charge for the testing is the provider agency’s responsibility. Certificates of proficiency indicating level/testing scores shall be maintained in personnel records and/or subcontractor’s files and made available to the Health Plan. Health Plan will audit providers to verify they are using certified bilingual staff at the appropriate level of proficiency to provide the language assistance or that they are using a language vendor.

- **Qualified interpreter for an individual with limited English proficiency as defined in section 1557 of the Affordable Care Act- means an interpreter who via a remote interpreting service or an on-site appearance:**
  - Adheres to generally accepted interpreter ethics principles, including client confidentiality;
  - Has demonstrated proficiency in speaking and understanding both spoken English and at least one other spoken language;
  - Is able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology.

- **Develop Policies for Staff to Provide Language Assistance.** Each agency must develop and have available at the time of the Administrative Audit, a policy outlining in detail the steps an employee should take to:
  - Provide American Sign Language (ASL) interpretation for individuals who are deaf or hard of hearing;
Provide oral interpretation and written translation for anyone whose preferred language is one other than English; and

Obtain certification that the employee meets the required level of proficiency to provide language assistance in either ASL or a language other than English.

Restricted use of certain persons to interpret or facilitate communication: A Provider shall not:

1. Require an individual with limited English proficiency to provide his or her own interpreter;
2. Rely on an adult accompanying an individual with limited English proficiency to interpret or facilitate communication, except:
   a. In an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available;
   b. Where the individual with limited English proficiency specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide such assistance, and reliance on that adult for such assistance is appropriate under the circumstances;
3. Rely on a minor child to interpret or facilitate communication, except in an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available;
4. Rely on staff other than qualified bilingual/multilingual staff to communicate directly with individuals with limited English proficiency.

Additional Provider Responsibilities

Health Plan contracted providers must ensure that language assistance meets the established requirements as follows:

- Utilize licensed interpreters for the Deaf and the Hard of Hearing.
- Ensure that interpreters are available at the time of the appointment.
- Ensure that members with limited English proficiency are not subject to unreasonable delays in the delivery of services including access to providers after hours.
- Extend the same participation opportunities in programs and activities to all members regardless of their language preferences.
- Provide services to LEP members that are as effective as those provided to others.

Accessing Interpretation Services For Individuals Who Are Deaf or Hard of Hearing

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 individuals who are deaf or hard of hearing based on the level of interpreting skills acquired by that person;
• Establishment of standards and procedures for the qualification and licensure of each classification of interpreters;

• Utilizing licensed interpreters for individuals who are deaf or 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 persons with hearing loss.

  o 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)).

  o Health Plan can be contacted via TDD/TTY line, 24 hours a day, 7 days a week at (800) 367-8939.

Translation of Written Materials

Behavioral Health providers must ensure that written materials disseminated to members meet cultural competence and LEP requirements. Behavioral Health 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 the provider’s members who also have LEP.

Behavioral Health providers must translate all vital materials when a language other than English is spoken by 1,000 people or 5%, whichever is less, of the provider’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 (CCPs);

• 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 the provider’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 (CCP) 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 (CCP) 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 Adverse Benefit Determination 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 CCP 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 the Health Plan and contracted 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
improving diverse communities, and the individuals accessing and receiving services.

- Continuous and ongoing reporting provides insight to strengths, gaps, and needs within communities served by the Health Plan and contracted providers with a goal of health and wellness for all.

**Cultural Competency Plan**

On an annual basis, the Health Plan 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 Health Plan 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 Health Plan’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.

Health Plan contracted providers must monitor the CCP at least quarterly and update the CCP annually and submit a copy of the update to the Health Plan as requested. The annual update must include an evaluation of the prior year’s efforts. Health Plan contracted 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**

The Health Plan and contracted 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;
- Section 1557 of the Patient Protection and Affordable Care Act is the nondiscrimination
provision of the Affordable Care Act (ACA). The law prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities. Section 1557 is the first federal civil rights law to prohibit discrimination on the basis of sex, including gender identity and sexual stereotypes. Section 1557 builds on long-standing and familiar Federal civil rights laws: Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975. Section 1557 extends nondiscrimination protections to individuals participating in any health program or activity any part of which receive federal funding.

- Department of Health and Human Services - Guidance to Federal Financial Assistance Members Regarding Title VI Prohibition Against National Origin Discrimination affecting Limited English Proficient Persons;
- 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 persons 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 persons with Limited English Proficiency 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 persons 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 persons 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 persons who have a disability. Providers must deliver services so that they are readily accessible to persons with a disability. Providers who employ less than fifteen persons and who cannot comply with the accessibility requirements without making significant changes to existing facilities may refer the person with a disability to other providers where the services are accessible. Provider who employs fifteen or more persons must designate at least one person to coordinate its efforts to comply with federal regulations that govern anti-discrimination laws.

**Children Rehabilitative Services Family Centered and Culturally Competent Care**

Health Plan contracted providers must ensure support of family-centered care include but are not limited to:

1. Recognizing the family as the primary source of support for the member’s health care decision-making process. Service systems and personnel should be made available to support the family’s role as decision makers,

2. Facilitating collaboration among recipients, families, health care providers, and policymakers at all levels for the:
   a. Care of the member,
   b. Development, implementation, evaluation of programs, and
   c. Policy development.

3. Promoting a complete exchange of unbiased information between recipients, families, and health care professionals in a supportive manner at all times,

4. Recognizing cultural, racial, ethnic, geographic, social, spiritual, and economic diversity and individuality within and across all families,

5. Implementing practices and policies that support the needs of recipients and families, including medical, developmental, educational, emotional, cultural, environmental, and financial needs,

6. Participating in Family-Centered Cultural Competence Trainings,

7. Facilitating family-to-family support and networking,

8. Promoting available, accessible, and comprehensive community, home, and hospital support systems to meet diverse, unique needs of the family,

9. Acknowledging that families are essential to the members’ health and well-being and are crucial allies for quality within the service delivery system, and

10. Appreciating and recognizing the unique nature of each recipient and their family.

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

**The Twelve Principles for Children’s Service Delivery (12 Principles):**

1. Collaboration with the child and family

2. Functional outcomes
3. Collaboration with others
4. Accessible services
5. Best practices
6. Most appropriate setting
7. Timeliness
8. Services tailored to the child and family
9. Stability
10. Respect for the child and family’s unique cultural heritage
11. Independence
12. Connection to natural supports

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

1. **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.

Children’s Rehabilitative Services

The Health Plan contracted providers must ensure coordination of care for CRS members that includes:

- Coordination of CRS member health care needs through a service plan,
- Collaboration with providers, communities, agencies, service systems, and members/guardians/designated representatives,
- Service coordination and communication, designed to manage the transition of care for a member who no longer meets CRS eligibility requirements or makes the decision to transition to another AHCCCS Health plan after the age of 21 years, and
- Appropriate notification to the Health Plan of pending completion or termination of treatment services for the CRS enrolled/eligible condition.

The Health Plan has an integrated team of behavioral health and physical health care managers, available to partner with you in the coordination of care and services for our CRS eligible, enrolled and former CRS members. To refer a member for Care Management and coordination of care or to speak to a Health Plan Care Manager, please contact our Customer Care department at 800-582-8686, or send an email to:

- Behavioral Health: BUHP Care Management BH Mailbox
  BUHPCareMgmtBHMB@bannerhealth.com
Service Plan Management for Children Rehabilitation Services

The Service Plan serves as a working document which integrates the member’s multiple treatment plans, including behavioral health, into one document that the CRS member/guardian/designated representative understands. The Service Plan identifies desired outcomes, resources, priorities, concerns, and strategies to meet identified goals.

The Service Plan must identify the immediate and long-term healthcare needs of each newly enrolled member and must include an action plan. The comprehensive Service Plan must be developed within 60 calendar days from date of the first CRS appointment and must include, but is not limited to all the required elements as follows:

- Member demographics and enrollment data,
- Medical diagnoses, past treatment, previous surgeries (if any), procedures, medications, and allergies,
- Action plan,
- The member’s current status, including current levels of functioning in physical, cognitive, social, and educational domains,
- The member/guardian/designated representative’s or family’s barriers to treatment, such as member’s or family’s ability to travel to an appointment,
- The member/guardian/designated representative’s and/or family’s strengths, resources, priorities, and concerns related to achieving mutual recommendations and caring for the family or the child,
- Services recommended to achieve the identified objectives, including provider or person responsible and timeframe requirements for meeting desired outcomes, and
- The Health Plan contracted provider must identify an interdisciplinary team to implement and update the Service Plan as needed.

The Health Plan contracted providers must modify and update the Service Plan when there is a change in the member’s condition or recommended services. This will occur periodically as determined necessary by the member/guardian/designated representative, or provider.

The Health Plan contracted providers must identify a care coordinator responsible for ensuring implementation of interventions and the dates by which the interventions must occur, and who identifies organizations and providers with whom treatment must be coordinated.

Specialty Referral Timelines for the CRS Health Plan Contracted Providers

The Health Plan contracted providers must follow the general behavioral health appointment standards for CRS members:

For Behavioral Health Provider Appointments:
• Urgent need appointments as expeditiously as the member’s health condition requires but no later than 24 hours from identification of need
• Routine care appointments:
  o Initial assessment within seven (7) calendar days of referral or request for service,
  o The first behavioral health service following the initial assessment as expeditiously as the member’s health condition requires but no later than 23 calendar days after the initial assessment, and
  o All subsequent behavioral health services, as expeditiously as the member’s health condition requires but no later than 45 calendar days from identification of need.

For Psychotropic Medications:
• Assess the urgency of the need immediately, and
• Provide an appointment, if clinically indicated, with a Behavioral Health Medical Professional within a timeframe that ensures the member
  o Does not run out of needed medications, or
  o Does not decline in his/her behavioral health condition prior to starting medication, but no later than 30 calendar days from the identification of need.

For Primary Care Provider Appointments:
• Urgent care appointments as expeditiously as the member’s health condition requires, but no later than two business days of the request.
• Routine care appointments within 21 calendar days of the request.

For Specialty Provider Referrals:
• Urgent care appointments as expeditiously as the member’s health condition requires, but no later than three business days of the request.
• Routine care appointments within 45 calendar days of the request.

For Dental Provider Appointments:
• Urgent appointments as expeditiously as the member’s health condition requires, but no later than three business days of the request.
• Routine care appointments within 45 calendar days of the request.

For Maternity Care Provider Appointments:
• Initial prenatal care appointments for enrolled pregnant members shall be provided as follows:
  o First Trimester – within 14 calendar days of the request
  o Second Trimester – within seven calendar days of the request
  o Third Trimester – within three business days of the request
High Risk Pregnancies – as expeditiously as the member’s health condition requires and no later than three business days of identification of the high risk by the Health Plan or Maternity Care Provider, or immediately if an emergency exists.

Transition to Adulthood

The transition into the adult behavioral health system must begin for any child involved in behavioral health care when the child reaches the age of 16. Planning must begin immediately for youth entering behavioral health care at 16 years of age or older.

A transition plan that starts with an assessment of self-care and independent living skills, social skills, work and education plans, earning potential and psychiatric stability must be incorporated in the child’s Service Plan.

For children who transfer to the adult delivery system as a person with Serious Mental Illness (SMI) or General Mental Health/Substance Use system, Health Plan contracted providers must develop a process and procedure to ensure and support the delivery of children and adult services during the transition period.

Health Plan contracted children’s providers shall ensure that adult system staff attend and participate in the Child and Family Team (CFT) and/or treatment team service planning process beginning four to six months prior to the child turning 18. For guidance related to transition planning refer to the AHCCCS Transition to Adulthood Practice Tool.

- Health plan providers are trained in the requirements outlined in the AHCCCS Transition to Adulthood Practice Tool.
- Transition planning must focus on the youth’s transition to adulthood in addition to transition from the children’s system of care to the adult system of care.
- The health plan providers shall begin the evaluation and assess for appropriateness to refer the youth to an eligibility determination for Serious Mental Illness beginning at 17.5 years old.
- Determine Medicaid eligibility for young adults. If not Medicaid eligible, services that can be provided under Non-Medicaid funding will follow policy guidelines.
- Transition planning shall incorporate the following elements: (Additional detail in each listed category can be found in Transition to Adulthood Practice Tool and Attachment A, Transition to Adulthood Resources).
  - Team coordination from CFT to ART or the options to remain with current CFT up to the age of 21;
  - Family Involvement and cultural considerations to determine the role of family and culture in the transition aged youth’s (TAY) care as an adult;
  - Clinical and service planning tie to needs as TAY prepares for the adult system of care;
  - An assessment of the necessity to transition from the current level of care and/or service provider(s);
  - Crisis and safety planning;
- Special education needs planning through the IDEA Law and Regulation;
- Employment; and
- An assessment of self-care and independent living skills, social skills, work and education planning, earning potential, and psychiatric stability shall be incorporated into Service Planning. Living arrangements, financial, and legal considerations are additional areas that require advance planning.

Based on the assessment, Child and Family Teams (CFT) should ensure that a transition age youth is involved with transition aged youth services. The Health Plan contracted provider should provide transition to independence services that include independent living skills training, social skills training, and that promotes wellness, recovery, using the Transition to Independence (TIP) model.

For children who transfer to the adult Serious Mental Illness (SMI) or General Mental Health/Substance Use (GM/SU) services, The Health Plan contracted behavioral health providers serving the transition age youth population must ensure support for the delivery of children and adult services during the transition period.

**Transition to SMI Services**

The Health Plan contracted providers serving transition aged youth must ensure members receiving behavioral health services are evaluated when they reach the age of 17 to determine if they may be eligible for services as an adult with SMI. If so, the member must be referred for an SMI eligibility determination. For guidance related to referring the member for SMI determination, refer to the AHCCCS Transition to Adulthood Practice Tool.

**First Episode Psychosis Programs**

First episodes of psychosis typically occur in young people ages 15 to 30, and the experience is different for each person. The member may experience a decline at school or work, withdraw from family and friends or experience other symptoms of psychosis. The Health Plan contracted provider must consider referring members who present with first episode psychosis to a Health Plan contracted specialty provider serving members with first episode psychosis.

**Requirements for Providers of Intravenous Drug**

Intravenous Drug and Opioid Treatment Providers must comply with all Opioid Treatment Regulations at [42 CFR Part 8](https://www.hhs.gov/csu/federal/department-of-health-human-services/hhs-library/csu-42-cfr-part-8.html), AHCCCS Licensing regulations, and the Health Plan 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 Process**

IV Drug and Opioid Treatment Providers must participate in ART process 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.

**Child and Family Team Process**

IV Drug and Opioid Treatment Providers must participate in CFT process 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 Health Plan provider network. Services may be available at the provider’s facility or may be provided by a Health Plan provider or a private or public agency, organization, practitioner, or institution for which a formal agreement has been obtained with the Health Plan. 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 Health Plan contracted provider network and provided in accordance with the member's 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 Health Plan contracted 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 5), 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 disorders, dermatologic sequelae of addiction, and possible concurrent surgical and other problems by conducting testing or referring patients for consultation and testing.

History and Physical evaluation must be completed to help determine the appropriate intervention such as 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 evaluate any potential 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 or Child and Family 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 the Health Plan. 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 or Child and Family Team to make appropriate referrals. Please contact the Health Plan'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 therapy and counseling services.

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.

Requirements for Medication-Assisted Treatment (MAT) for Opioid Use Disorder (OUD)

The Primary Care Providers (PCP) may treat members with medication-assisted treatment (MAT) for opioid use disorder (OUD). PCPs providing MAT shall meet all regulatory requirements established for the medication type administered. PCPs must refer the member to a behavioral health provider for the psychological and/or behavioral therapy component of the MAT model and coordinate care with the behavioral health provider.

As a behavioral health provider, you may receive referrals directly from PCPs, who provide medication management alone for OUD, for the psychological and/or behavioral therapy component of the MAT model. If the behavioral health provider accepts the referral from the PCP to provide services to a member receiving treatment from the PCP for opioid use disorder, the provider must coordinate care with the PCP including communication regarding the member’s status and progress, and member engagement such as no shows or repeated cancellations.

Employment Services

Employment services are available to all members who are interested in competitive employment. There are no exclusions for substance use, homelessness, diagnosis, or symptoms. Banner members can self-refer for employment services at any time to any Banner contracted organization.

Provider Expectations

Organizations shall provide services which include the provision of coaching, training, demonstrating, as well as securing and maintaining employment.

Organizations who provide employment services are required to have at minimum one fully dedicated Employment Specialist whose only duties are employment and rehabilitation-related activities for all members. Contracted behavioral health providers and integrated health care providers who bill for...
employment services are also required to employ a sufficient number of employment staff to meet the needs of their members seeking these services. It may be permissible for the employment/rehabilitation staff to cover more than one clinical team or split time with other duties, based on staffing availability, regional locations, and enrollment numbers. Providers may contact Banner’s Employment Administrator for additional information.

Providers must ensure that their fully dedicated employment/rehabilitation provider staff is competent providing employment services, including and especially with utilizing the following resources and tools:

- AHCCCS Covered Behavioral Health Services Guide,
- Disability Benefits 101 (DB101),
- Employment Status within the Supplemental Member Data Provider (DUG) Portal, and
- RSA Vocational Rehabilitation, and
- Other ADES Employment Services, including ARIZONA@WORK and Arizona Job Connections (AJC)

Providers are encouraged to make reasonable efforts to become mutually contracted with Arizona Department of Economic Security/Rehabilitative Services Administration (DES/RSA) in order to provide continuity of care and the full array of employment services to members.

Supported Employment

Service providers are expected to implement the philosophy of Supported Employment and maintain fidelity around the SAMHSA Supported Employment model that emphasizes helping them find competitive work in the community as well as providing supports to ensure their success. These programs help consumers obtain jobs paying competitive wages in integrated settings in the community. The primary goal is to find the natural “fit” between a member’s strengths and experiences and jobs in their community setting.

Supported Employment emphasizes:

- Consumer choice: No one is excluded from participating.
- Integrated services: Employment specialists closely coordinate with other rehabilitation and clinical treatment practitioners, creating a comprehensive treatment program.
- Competitive jobs: Employment specialists assist people obtain jobs in the open labor market that pay at least minimum wage in an integrated work setting.
- Benefits counseling: Employment specialists help people understand how benefits, such as Social Security or Medicaid, are affected by working. Most people can work and continue to receive some benefits.
- Timely support: Employment specialists help people look for jobs soon after they enter the program.
- Continuous supports: Once a job is found, employment specialists provide ongoing employment support services, as needed.
● Consumer preferences: Choices about work are based on a person’s preferences, strengths, and experiences.

Covered Services
Psychoeducational (Pre-job training and development) services and Ongoing Support to Maintain Employment services are designed to assist members to select, acquire, and maintain employment or other meaningful community activity. Providers must deliver services using tools, strategies and materials which meet the individual’s needs. For additional information, please see the AHCCCS Covered Behavioral Health Services Guide.

Referrals
Members may access Employment Services at any time, at any contracted provider of their choosing.
Section 4 – Coordination of Care Requirements

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.

The Health Plan recognizes the importance of a responsive behavioral health system, especially when the needs of vulnerable members have been identified by other government entities. For example, the State strongly supports the timely response and coordination of services for children who have been, or imminently will be, removed from their homes by the Arizona Department of Child Safety. The State expects all providers to collaborate and provide any necessary assistance when DCS initiates requests for covered services or supports.

The intent of this section is to communicate the Health Plan’s expectations for providers who must cooperate and actively work with other agencies serving members. The Health Plan expects any system partner involved with a member to be invited to Child and Family Team (CFT)/Adult Recovery Team (ART) process.

Children’s Services

All Health Plan contracted providers must ensure collaborative and consistent goals established by other agencies serving the child and family.

Behavioral health Service Plans shall be directed by the Child and Family Team (CFT) or Adult Recovery Team (ART) and the team should seek the inclusion of other involved agencies in the planning process.

The Health Plan contracted providers must ensure that service delivery is consistent with the AHCCCS Child and Family Team Practice Tool and the Arizona Vision Twelve Principles for Children Service Delivery.

Department of Child Safety (DCS)

When a child member receiving services is also receiving services from DCS, the Health contracted providers must work toward effective coordination of services with the DCS Specialist.

DCS Arizona Families F.I.R.S.T. (Families In Recovery Succeeding Together) Program

The Health Plan contracted providers must ensure coordination for parents/families referred through the Arizona Families F.I.R.S.T (AFF) program.
The AFF program provides expedited access to substance abuse treatment for parents and caregivers referred by Department of Child Safety and the ADES/ Family Assistance Administration (FAA) Jobs Program. AHCCCS participates in statewide implementation of the program with ADES (see A.R.S. § 8-881).

The Health Plan Contracted providers who are contracted with AFF are required to:

- Accept referrals for Title XIX/XXI eligible and enrolled members and families referred through AFF;
- Accept referrals for Non-Title XIX and Non-Title XXI persons and families referred through AFF and provide services, if eligible;
- Ensure that services made available to persons who are Non-Title XIX and Non-Title XXI eligible are provided by maximizing available federal funds before expending State funding as required in the Governor’s Executive Order 2008-01;
- Collaborate with ADES/DCS, the ADES Family Assistance Administration (FAA) Jobs Program and Substance Use Treatment providers to minimize duplication of assessments and achieve positive outcomes for families; and

The goal of the AFF Program is to promote permanency for children, stability for families, protect the health and safety of abused and/or neglected children and promote economic security for families. Substance abuse treatment for families involved with DCS must be family centered, provide for sufficient support services and must be provided in a timely manner per Appointment Standard & Timeliness of Services section.

The Health Plan contracted providers are expected to collaborate and coordinate care for members with behavioral health needs involved with Arizona Department of Juvenile Corrections (ADJC) and the Administrative Offices of the Court (AOC).

**Arizona Department of Education (ADE), Schools, or Other Local Educational Authorities**

The Health Plan contracted providers serving children can gain valuable insight into an important and substantial element of a child’s life by soliciting input from school staff and teachers. The Health Plan contracted providers can collaborate with schools and help a child achieve success in school by:

- Working in collaboration with the school and sharing information to the extent permitted by law and authorized by the child’s parent or legal guardian;
- For children receiving special education services, actively consider information and recommendations contained in the Individual Education Plan (IEP) during the ongoing assessment and service planning process;
- For children receiving special education services, ensuring that the provider or designee participates with the school in developing the child’s IEP and share the behavior treatment plan interventions, if applicable;
- Inviting teachers and other school staff to participate in the CFT process if agreed to by the child and legal guardian;
• Having a clear understanding of the Individualized Education Plan (IEP) requirements as described in the Individuals with Disabilities Education Act (IDEA) of 2004;

• Ensuring that students with disabilities who qualify for accommodations under 504 of the Rehabilitation Act of 1973 are provided adjustments in the academic requirements and expectations to accommodate their needs and enable them to participate in the general education program; and

• Ensuring that transitional planning occurs prior to and after discharge of an enrolled child from any out-of-home placement.

Department Of Economic Security (DES) - Arizona Early Intervention Program (AzEIP)

The Health Plan contracted providers must ensure the following:

• Children birth to three years of age are referred to AzEIP in a timely manner when information obtained in the child’s behavioral health assessment reflects developmental concerns,

• Children found to require behavioral health services as part of the AzEIP evaluation process receive appropriate and timely service delivery,

• If an AzEIP team has been formed for the child, the behavioral health provider will coordinate team functions so as to avoid duplicative processes between systems.

Courts and Corrections

The Health Plan and its contracted providers are expected to collaborate and coordinate care for members involved with the justice system including:

• The Arizona Department of Corrections (ADOC);

• Arizona Department of Juvenile Corrections (ADJC),

• Administrative Offices of the Court (AOC).

• County Jails

• Sheriff’s Offices

• Correctional Health Services

• Community Supervision and Probation Departments

• Parole Offices

The Health Plan contracted providers may also call the Customer Care Center at 800-582-8686 and ask to speak to court coordinator for assistance.

When a member receiving services is also involved with a court or correctional agency or the Health Plan 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 representatives to participate in the development of the complete care plan and all subsequent planning meetings for the Adult Recovery Team (ART) with the
member’s approval;

- Actively considering information and recommendations contained in probation or parole case plans when developing the complete care 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 the Health Plan’s contracted providers to coordinate care as outlined below. The Health Plan’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 the Health Plan’s Care Management Department to ensure the member has a scheduled assessment or intake appointment, as per instructed by the Health Plan 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; and

- Collaborate with Health Plan’s Care Management Department regarding coordination of care for at risk members that have been identified by the Health Plan as having complicated/complex health care conditions that require high touch case management.
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.

- Working in collaboration with the vocational rehabilitation counselors or employment specialists in the development and monitoring of the member’s employment goals;
- Ensuring that all related vocational activities are documented in the comprehensive clinical record;
- Inviting ADES/RSA staff to be involved in planning for employment programming to ensure that there is coordination and consistency with the delivery of vocational services;
- Participating and cooperating with ADES/RSA in the development and implementation of a Regional Vocational Service Plan inclusive of ADES/RSA services available to adolescents; and
- Allocating space and other resources for vocational rehabilitation counselors or employment specialists working with enrolled members who have been determined to have a Serious Mental Illness.

Supportive employment services available through the AHCCCS system are distinct from vocational services available through RSA.

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

The Health Plan expects its providers to proactively collaborate with municipal first responders: police, fire, EMS, Regional Behavioral Health Authority (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).

The Health Plan members with Veteran benefits can receive services from Health Plan contracted providers. Veterans have a choice from whom they prefer to receive services. Veterans can receive mental health benefits through the Health Plan’s network and physical health services through the VA, or medication only from one or the other, or any combination thereof. The Health Plan and its
contracted providers are responsible to work collaboratively with the VA to share information and coordinate care.

The Health Plan 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/638 licensed facility are also eligible to receive services from the Health Plan’s contracted providers. Individuals have a choice where to receive services. American Indian and Alaskan Natives can receive mental health benefits through the Health Plan’s network and physical health services through the IHS, or medication only from one or the other, or any combination thereof. The Health Plan and its contracted providers are responsible to work collaboratively with IHS to share information and coordinate care.

Coordination of Care with Primary Care Providers

Members enrolled with the Health Plan may be enrolled with a Health Plan Medicare Advantage Plan, such as Banner – University Care Advantage or; they may be enrolled in another Medicare Advantage Plan. Due to this separation in responsibilities, communication and coordination between providers: Arizona Health Care Cost Containment System (AHCCCS), the Health Plan Primary, Specialty Care Providers and the Health Plan Complete Care Management Department is essential to ensure the well-being of member’s physical health and behavioral health through an integrated approach.

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, behavioral health and attention to Social Determinants of 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 the Health Plan’s Customer Care Department at (800) 582-8686 to determine the name of the member’s assigned PCP.

- The Health Plan enrolled members, who have never contacted their PCP prior to receiving behavioral health services should be encouraged to seek a baseline medical evaluation. The Health Plan 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

- Providers are required to document information into the member’s Service Plan which provides a longitudinal single view of care planning of all providers including physical and behavioral health last hospitalization. If the PCP does not respond to the request, contact The Health Plan’s Customer Care for assistance at (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 The Health Plan’s Customer Care at (800) 582-8686.

**The Health Plan Complete Care Management Department**

The Health Plan Complete Care Management Department has expertise in both behavioral and physical health with care managers who gather, review and communicate clinical information requested by providers and provide technical assistance and support.

**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 eligible members to the assigned PCP, the Health Plan, other treating professionals and other involved stakeholders within the following required
timeframes:
- “Urgent” – requests for intervention, information, or response within 24 hours.
- “Routine” – requests for intervention, information, or response within 10 days.

**Coordination of Care for Members with a Serious Mental Illness**

For all members referred by the PCP and determined to have a Serious Mental Illness and/or a diagnosis of a chronic medical condition, the following information must be provided to the person’s assigned PCP:

- The member’s diagnosis;
- Critical lab results as defined by the laboratory and prescribed medications; and
- Changes in class of medications.

Health Plan contracted providers with the assistance of the Health Plan must provide the required information annually, and/or when there is a significant change in the person’s diagnosis and/or prescribed medications.

Health Plan contracted providers are required to pro-actively coordinate behavioral health and medical care for members with a Serious Mental Illness and/or a diagnosis of a chronic medical condition. This includes helping members identify their health and wellness goals, include those goals in the members’ Service Plans, and coordinating with medical professionals to help members achieve those goals.

**Coordination of Care for Title XIX/XXI Members**

For all Title XIX/XXI enrolled persons, providers are required to:

- Notify the assigned PCP of the results of PCP initiated behavioral health referrals;
- Provide a final disposition to the health plan Behavioral Health Coordinator in response to PCP initiated behavioral health referrals, (for more information on the referral process, see Referral and Intake Process Section);
- Coordinate the placement of persons in out-of-state treatment settings;
- Notify, consult with, or disclose information to the assigned PCP regarding persons with Pervasive Developmental Disorders and Developmental Disabilities, such as the initial assessment and treatment plan and care and consultation between specialists;
- Provide a copy to the PCP of any executed advance directive, or documentation of refusal to sign an advance directive, for inclusion in the Member’s medical record; and
- Notify, consult with, or disclose other events requiring medical consultation with the person’s PCP.

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.
Coordination of Care must be properly documented. To be considered properly documented the progress note must:

- Include a header that states “Coordination of Care”;
- Be legible; and
- Include all 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

Pre-Petition Screenings and Court Ordered Evaluations

The Health Plan works closely with each county to collaborate regarding pre-petition screenings and court ordered evaluations. Payment for pre-petition screenings and court ordered evaluations are the responsibility of the county except for Pima County. The Health Plan facilitates and pays for pre-petition screenings in Pima County.

Emergency Behavioral Health Services

When a member presents in an emergency room setting, the Health Plan 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, the Health Plan is responsible for psychiatric and/or psychological evaluations in emergency room settings provided to all eligible members enrolled with the Health Plan.

The Health Plan is responsible for providing all inpatient emergency services to members with psychiatric or substance abuse diagnoses for all eligible members.

Emergency transportation of an eligible to the emergency room (ER) is the responsibility of the Health Plan. Emergency transportation of 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 the Health Plan. If an eligible member is assessed as needing inpatient psychiatric services by the Health Plan 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 Securing Services and
Prior Authorization Section 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 an eligible member to an initial behavioral health intake appointment is the responsibility of the Health Plan.

Long Term Care Non-Emergency Transportation

Non-emergency transportation of Long Term Care members who are unable to provide or secure their own transportation for medically necessary services using the appropriate mode based on the needs of the member is the responsibility of the Health Plan.

Medical Treatment for Members in Behavioral Health Treatment Facilities

When a 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 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. The Health Plan is responsible for Medicaid medically necessary services received at the medical facility.

PCPs prescribing psychotropic medications

Within their scope of practice and comfort level, the Health Plan PCP may elect to treat select behavioral health disorders. The select behavioral health disorders that the Health Plan PCP’s can treat are:

- Attention-Deficit/Hyperactivity Disorder;
- Uncomplicated depressive disorders;
- Anxiety disorders; and
- Opioid Use 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:

- 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. The Health Plan 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 Health Plan Contracted 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 BUHPCareMgmtBHMailbox@bannerhealth.com.

The Health Plan 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.

**The Health Plan contracted 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 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.

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

The Health Plan’s 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 the Health Plan’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 an eligible member upon his/her primary provider request in accordance with *Appointment Standards and Timeliness of Service Section* 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.

The Health Plan contracted providers must supply information to the Health Plan and/or the Health Plan contracted primary care providers’ current information about how to access psychiatric evaluation services.

**Partnerships with Families and Family Run Organizations**

Arizona holds a distinction in the United States for promoting various family roles within the children’s behavioral health system. The involvement of families is credited as making a significant contribution in improving the service system. The following information addresses the types of roles available to families including parents/caregivers with children receiving services, when they are employed, volunteer, or compensated in other ways, such as stipends or subcontracted work, and the elements that help families become effective in these roles.

Three categories of roles for families:
• Families are encouraged to participate and are supported as active and respected members of their child’s Child and Family Team (CFT). In this capacity, families drive the development and implementation of a service plan that will respond to the unique strengths and needs of the child and family;

• Families participate in various activities that influence the local, regional and State service system. This type of activity is commonly called “Family Involvement”. In Arizona, families have a range of opportunities to offer their unique insight and experience to the development and implementation of programs and policies. This includes various advisory activities on Boards, committees, and policy making groups that work to improve children’s services; and

• Family members work in a professional capacity in the children’s behavioral health system. In this capacity, family members offer a special type of support (peer delivered) to the families and children that they serve. Further, families who work in the service system influence the system by contributing the family perspective.

• The Health Plan’s contracted family-run organizations are expected to serve in a role of helping with the recruitment, training, and support of family members. Procedures outlined in this policy section are aimed at achieving the following outcomes:

• Increased adherence to statewide practice in accordance with the Twelve Principles for Children Service Delivery;

• Improved functional outcomes for children, youth, young adults, and families;

• Improved engagement and collaboration in service planning between children, youth, young adults, families, community providers and other child serving agencies;

• Improved identification and incorporation of strengths and cultural preferences into planning processes;

• Coordinated planning for seamless transitions; and

• A stronger partnership with families in the process of supporting their child’s/youth’s behavioral health needs.

Effective Family Participation in Service Planning and Service Delivery

Through the CFT process, parents/caregivers and youth are treated as full partners in the planning, delivery, and evaluation of services and supports. Parents/caregivers and youth are an equal partner in the local, regional, tribal, and State representing the family perspective as participants in systems transformation. Providers must:

• Ensure that service planning and delivery is driven by family members, youth, and young adults;

• Approach services and view the enrolled child in the context of the family rather than isolated in the context of treatment;

• Provide culturally and linguistically relevant services that appropriately respond to a family’s unique needs

• Offer family peer to peer support to families and make peer representation available to the CFT when requested;
• Provide information to families on how they can contact staff at all levels of the service system inclusive of the provider agency, the Health Plan and AHCCCS at intake and throughout the CFT process; and
• Work with the Health Plan to develop training in family engagement and participation, roles and partnerships for provider staff, parents/caregivers, youth and young

Responsibilities of the Health Plan Integrated Care and Its Providers

Family members, youth, and young adults must be involved in all levels of the behavioral health system, whether it be serving on boards, committees and advisory councils, or as employees with meaningful roles within the system. To ensure that family members, youth, and young adults are provided with training and information to develop the skills needed, the Health Plan and the Health Plan contracted providers must:

• Support parents/caregivers, youth and young adults in roles that have influence and authority;
• Establish recruitment, hiring, and retention practices for family, youth, and young adults within the agency that reflect the cultures and languages of the communities served;
• Provide training for families, youth, and young adults in cultural competency;
• Assign resources to promote family, youth, and young adult involvement including committing money, space, time, personnel and supplies; and
• Demonstrate a commitment to shared decision making.

Organizational Commitment to Employment of Family Members

Providers must demonstrate commitment to employment of parents/caregivers, and young adults by:

• Providing positions for parents/caregivers and young adults that value the first-person experience;
• Providing compensation that values first-person experience commensurate with professional training;
• Establishing and maintaining a work environment that values the contribution of parents/caregivers, youth, and young adults;
• Providing supervision and guidance to support and promote professional growth and development of parent/caregivers and young adults in these roles; and
• Providing the flexibility needed to accommodate parents/family members and young adults employed in the system, without compromising expectations to fulfill assigned tasks/roles.

Provider Commitment to the Functions of Family-Run and Parent Support Organizations

Family-run and parent support organizations play a crucial role in supporting families, youth, and young adults involved in the children’s behavioral health system. They are key partners in transforming Arizona’s behavioral health system and are vital to the process of identifying meaningful roles and opportunities for family members, youth, and young adults to actively contribute to that transformation.

Family-run and parent support organizations not only support the current involvement and roles of
family members, youth, and young adults, but also work toward identifying and developing the next generation of community leaders. In order to demonstrate commitment to the importance and functions of family-run and parent support organizations, providers must:

- Establish partnerships with family-run and parent support organizations;
- Connect family members with family-run and parent support organizations as soon as the child is enrolled in the behavioral health system to provide information and parent peer-to-peer support;
- Model an environment that encourages and promotes the ability of family-run and parent support organizations to provide coaching, mentoring, and training to family members; and
- Providers designated as Behavioral Health Homes are encouraged to refer family members to Family Run Organizations for ongoing family support.

Commitment to Family and Youth Involvement in the Children’s Behavioral Health System

The Health Plan’s contracted behavioral health service providers will provide training and structural opportunities for family and youth input and involvement in the delivery of services to children and families. Behavioral Health Service Providers will:

- Have Family Advisory Committees that meet regularly that gathers family member feedback and ideas regarding services;
- Have a Youth Advisory Committee that meets regularly to solicit youth feedback and ideas regarding services;
- Offer opportunities for youth leadership education and activities regularly; and
- Utilize Certified Family Support Specialist services in the roles in which they are trained to deliver.
Section 5 – Credentialing and Re-Credentialing Requirements

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 credentialled prior to providing services.

This section applies to providers providing services to members enrolled with the Health Plan. 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, the Health Plan 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.

The Health Plan 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.

The Health Plan 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, the Health Plan 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.

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

Practitioners and facilities **CURRENTLY** 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 the Health Plan 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, the Health Plan 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. Banner University Health Plans (520) 874-5290 or (800) 582-8686. www.banneruhp.com, www.bannerufc.com.
Section 6 – Finance/Billing

Copayments

The purpose of this section is to describe copayment requirements for health care services covered by the Health Plan. This section 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 for example Long Term Care members are required to pay for 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;
3. People determined to be Seriously Mentally Ill (SMI),
4. An individual eligible for the Children’s Rehabilitative Services program under A.R.S. § 36-2906(E),
5. Acute care members who are placed in nursing facilities or residential facilities such as an Assisted Living Home when such placement is made as an alternative to hospitalization. The exemption from copayments for these members is limited to 90 days in a contract year.
6. People who are enrolled in the Arizona Long Term Care System (ALTCS),
7. People who are eligible for Qualified Medicare Beneficiary (QMB) A.A.C. Title 9, Chapter 29,
8. American Indian members who are active or previous users of the Indian Health Service, tribal health programs operated under Public Law 93-638, or urban Indian health programs,
10. An individual with respect to whom child welfare services are made available under Part B of Title IV of the Social Security Act on the basis of being a child in foster care, without regard to age,
11. An individual with respect to whom adoption or foster care assistance is made available under Part E of Title IV of the Social Security Act, without regard to age.

AHCCCS copayments are not charged for the following services:

- Family planning services and supplies
- Pregnancy related health care including tobacco cessation treatment for pregnant women
- Emergency services
• Services paid on a fee-for-service basis
• Preventive services, such as well visits, immunizations, pap smears, colonoscopies, and mammograms
• Provider preventable 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. State Adoption Assistance for Special Needs Children,
3. Individuals receiving Supplemental Security Income (SSI) through Social Security Administration for people who are age 65 or older, blind or disabled;
4. Individuals in the Freedom to Work (FTW) program.
5. 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);
6. 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

<table>
<thead>
<tr>
<th>Nominal (Optional) Copayments</th>
<th>Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriptions</td>
<td>$2.30</td>
</tr>
<tr>
<td>Out-patient services for physical, occupational and speech therapy</td>
<td>$2.30</td>
</tr>
<tr>
<td>Doctor or other provider outpatient office visits for evaluation and management of your care. This excludes emergency room/emergency department visits</td>
<td>$3.40</td>
</tr>
</tbody>
</table>

Mandatory Copays (also known as "required"):

If a member has a mandatory copay, providers CAN deny services if the member does not pay the mandatory copay. There are certain services and populations which are exempt from any copays as
described below, which means that no copay can be charged. Members who can be charged mandatory copays are persons in the:

1. Adult Group who have income above 106% FPL *(PROPOSED; SEE CHART BELOW) and
2. Transitional Medical Assistance (TMA) program- individuals who were receiving AHCCCS in the Caretaker Relative category who become ineligible due to the increased earnings.

| AHCCCS Copayments |
|--------------------|------------------|
| **Service**        | **Population and Copay Amounts** | **MANDATORY COPAYS** | **OPTIONAL COPAYS** |
|                    |                  | Adult Group over 106% FPL (PROPOSED) | TMA (current) | Other (current) |
| Prescription Drugs | $4.00 per drug   | $2.30 | $2.30 |
| *Office Visits     | $5.00 or $10.00\(^1\) per visit | $4.00 | $3.40 |
| *Outpatient professional therapies | $2.00, $4.00 or $5.00\(^2\) per visit | $3.00 | $2.30 |
| *Non-emergency surgery\(^3\) | $30.00 or $50.00\(^4\) per surgery | $3.00 | None |
| Inpatient Hospital Stay | $75 per stay | None | None |
| Non-emergency use of the Emergency Room | $8.00 per visit | None | None |
| Taxis for Non-Emergency Medical Transportation in Pima and Maricopa Counties | $2.00 per trip | None | None |

**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.

**Non-Emergency Use of the Emergency Room**

As part of the proposed copay request, all hospitals in Arizona will have their payments reduced by the copay amounts for Non-emergency use of the Emergency Room as described above. As such, it is expected that all hospitals will charge members in the Adult Group for Non-emergency use of the Emergency Room, upon CMS approval.
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. Pursuant to federal and State law, Medicaid is the payer of last resort except under limited situations, meaning that Medicaid funds shall be used as a source of payment for covered services only after all other Sources of payment have been exhausted.

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

- The Health Plan 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. The Health Plan may deny payment to a provider if a provider is aware of third party liability and submits a claim or encounter to the Health Plan. The Health Plan 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 Explanation of Benefits (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 the Health Plan or the provider are unaware of third party coverage at the time services were rendered or paid for, or when the Health Plan 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 https://ecenter.hmsy.com/.

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 the Health Plan 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.

Children who qualify for Adoption Subsidy will be eligible for Title XIX/XXI benefits. In addition, their families may also have private insurance. Simultaneous use of the private insurance and Title XIX/XXI coverage may occur through the coordination of benefits. Following an intake and assessment, providers must determine the services and supports needed. Any necessary services that are not covered through the private insurance, including copayments and deductibles, may be covered under Title XIX.

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: https://ecenter.hmsy.com/. From this link, one will be directed to Health Management Systems (HMS), where one can enter members’ TPL information.

The Health Plan will receive notification of updated information on the TPL files. The Health Plan 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, the Health Plan 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. The Health Plan may deny payment to a provider if a provider is aware of third-party liability and submits a claim or encounter to the Health Plan. 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, the Health Plan is responsible for covering those costs for Title XIX/XXI eligible members if the third-party payer is not another state agency. The Health Plan 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, the Health Plan 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 the Health Plan 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.

- The Health Plan may deny payment to a provider if a provider is aware of third-party liability and submits a claim to the Health Plan. 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. The Health Plan 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 the Health Plan 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 the Health Plan, 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 the Health Plan 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.

The Health Plan 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.

Non-emergency medically necessary transportation is covered consistent with A.A.C. R9-22-211 when furnished by non-emergency transportation providers to transport the member to and from a covered physical or behavioral health service. Such transportation services may also be provided by Emergency Transportation providers after an assessment by the Emergency Transportation team or Paramedic team determines that the member’s condition requires medically necessary transportation.

Medically Necessary Non-Emergency Transportation Services are covered under the following conditions:

- The physical or behavioral health service for which the transportation is needed is a covered AHCCCS service,
- If the member is not able to provide, secure or pay for their own transportation, and free transportation is not available, and
- The transportation is provided to and from the nearest appropriate AHCCCS registered provider.

If a member is not able to provide, secure or pay for their own transportation, and free transportation is not available, non-emergency transportation services are also covered under the following circumstances:
• To transport a member to obtain Medicare Part D covered prescriptions, and
• To transport a member to participate in local community-based support programs as identified in the member’s service plan or complete care plan. Transportation coverage to these programs is limited to transporting the member to the nearest program capable of meeting the member’s needs as identified on the member’s service plan or complete care plan such as:
  o Alcoholics Anonymous (AA)
  o Narcotics Anonymous (NA)
  o Cocaine Anonymous
  o Crystal Meth Anonymous
  o Dual Recovery Anonymous
  o Heroin Anonymous
  o Marijuana Anonymous
  o Self-Management and Recovery Training (SMART Recovery)
  o National Alliance on Mental Illness (NAMI) Family Support
  o Living Well with a Disability and Working Well with a Disability Program

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. The Health Plan is responsible for payment of Medicare cost sharing for all Medicare covered services regardless of whether the services are covered by AHCCCS. The Health Plan 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 the Health Plan’s network or prior authorization has been obtained.

**QMB Dual Cost Sharing Matrix**

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Health Plan Responsibility</th>
<th>In Network</th>
<th>Out of Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Only—not covered by AHCCCS</td>
<td>Cost sharing responsibility only</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>AHCCCS Only—not covered by Medicare, including pharmacy and other prescribed services</td>
<td>Reimbursement for all medically necessary services</td>
<td>YES</td>
<td>NO*</td>
</tr>
<tr>
<td>AHCCCS and Medicare covered Service (except for emergent)</td>
<td>Cost sharing responsibility only</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Emergency Services</td>
<td>Cost sharing responsibility only</td>
<td>YES</td>
<td>YES</td>
</tr>
</tbody>
</table>

*Subject to Health Plan Policy*

The Health Plan 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 the Health Plan’s network.

**Non-QMB Dual Cost Sharing Matrix**

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Health Plan Responsibility</th>
<th>In Network</th>
<th>Out of Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Only—not covered by AHCCCS</td>
<td>No cost sharing responsibility</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>AHCCCS Only—not covered by Medicare, including pharmacy and other prescribed services</td>
<td>Reimbursement for all medically necessary services</td>
<td>YES*</td>
<td>NO*</td>
</tr>
</tbody>
</table>
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:**

The Health Plan will have no cost sharing obligation if the Medicare payment exceeds the Health Plan’s contracted rate for the services. The Health Plan’s liability for cost sharing plus the amount of Medicare’s payment will not exceed the Health Plan’s contracted rate for the service. There is no cost sharing obligation if the Health Plan has a contract with the provider, and the provider’s contracted rate includes Medicare cost sharing.

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

For QMB Dual members, the Health Plan 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, the Health Plan is not liable for any Medicare cost sharing unless the Health Plan has authorized the member to obtain services out of network. If a member has been advised of the Health Plan’s network, and the member’s responsibility is delineated in the member handbook, and the member elects to go out of network, the Health Plan is not responsible for paying the Medicare cost sharing amount.
Section 7 – Quality Management Requirements

Medical Institution Reporting of Medicare Part D

Duals eligible members 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 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 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)
Medical Records Standards

Banner – University Family Care/ACC treats member medical records as confidential and complies with all federal and state laws, AHCCCS policy and contracts, Health Insurance Portability and Accountability Act (HIPAA) requirements 42 CFR Part 2 and 42 CFR 431.300 et seq., regarding privacy, confidentiality and disclosure of patient/member medical records. Provider offices must have established procedures to ensure:

- Information from, or copies of, records may only be released to authorized individuals, and the provider must implement a process to ensure unauthorized individuals cannot gain access to, or alter, member records.
- Original and/or copies of medical records must be released only in accordance with federal or state regulations, policy and contracts, HIPAA, 42 CFR Part 2 and 42 CFR 431.300 et seq. requirements.
- Maintenance of medical records and information in an accurate and timely manner.
- Timely access by members to the medical records and the information that pertain to them.

Exchange of Member Information

In order to promote continuity of care, member information must be exchanged as follows:

- A provider making a referral must transmit necessary information to the provider receiving the referral
- A provider furnishing a referral service must report appropriate information back to the referring provider
- Providers request information from other treating providers as necessary in order to provide timely and appropriate care
- Information about services provided to a member by a non-network provider (i.e., emergency services) is transmitted to the member’s PCP
- Member records are transferred to the new provider in a timely manner that ensures continuity of care when a member chooses a new PCP
- If a member enrolls with a new contractor, sharing of the member record is accomplished in a confidential manner which promotes continuity of care.

Requests for Member Information

The Banner – University Family Care/ACC network providers may disclose member information without their authorization as outlined in HIPAA 45 CFR 164.512, which states that it is allowed for the
following reasons:

- As required by law
- For public health activities,
- About victims of abuse, neglect, or domestic violence,
- For health oversight activities,
- For judicial and administrative proceedings,
- For law enforcement purposes,
- About decedents,
- For cadaveric organ, eye, or tissue donation,
- For research purposes,
- To avert a serious threat to health or safety, and
- For specialized government functions

**Contracted Provider Medical Record Required Policies**

- The contractors shall ensure that each member is guaranteed the right to request and receive one copy of the member’s medical record at no cost to the member.
- The Contractors shall have written policies guaranteeing each member’s right to request and receive a copy of his or her medical records, and to request that they be amended or corrected [45 CFR Part 160, 164, 42 CFR 438.100(a)(1); 42 CFR 438.100(b)(2)(vi)].
- The Contractors shall have written policies and procedures to maintain the confidentiality of all medical records.

**Electronic Records Standard:**

Contracted providers who utilize electronic medical records must have policies and procedures in place which:

- Identify each provider’s original signature
- Establish a method for indicating the initiator of information
- Ensure a means that information is not altered
- Develop an ongoing compliance program to ensure signatures and initials are documented for each service.
- Include the name(s) of the provider(s) who entered the information as well as the date for each entry in the electronic record.
- Establish a method of indicating the initiator of information and a means to ensure that information is not altered inadvertently among electronic files of the provider.
- Ensure there is a system in place to track any revisions to the information including both the date(s) of revision(s) and the source(s) responsible for the revision(s).
• Additionally, maintain a backup system including initial and revised information as required.

**Continuous Monitoring and Improvement**

The Health Plan requires contracted providers to abide by the above standards to safeguard and protect the confidentiality of member health and enrollment information. The Health Plan audits providers for medical record keeping practices using standard criteria. Compliance to this standard is documented and corrective action plans are developed as necessary.

**Advance Directives**

Health Plan members have the right to make decisions about their health care, including the right to accept or refuse medical care and the right to execute an Advance Directive. Members can exercise his or her rights, and the exercising those rights shall not have an adverse effect on service delivery to the member. Also, members must be given the opportunity to document their wishes should the member become incapacitated and unable to make those wishes known, please refer to 42 CFR § 422.128 and AHCCCS Medical Policy Manual, Policy 640.

**Provider Responsibilities**

- Provide written information to adult members regarding their rights under state law to make decisions regarding their medical care and the provider’s policies concerning advanced directives, including conscientious objections, if applicable.

- Document in the member’s medical record whether or not the adult member has been provided with the above information and whether or not an advanced directive has been executed.

- Not discriminate against a member because of his or her decision to execute or not execute an advanced directive and not make it a condition of or the provision of health care.

- Provide education to staff on issues concerning advanced directives, including notification of direct care providers of services, such as home health care and personal care providers, of any advance directives executed by the member to whom they are assigned to provide services.

Providers must assist adult members or their legal guardians who are interested in developing and executing an advance directive. Providers must maintain written policies that address the rights of adult members to make decisions about medical care, including the right to accept or refuse medical care and the right to execute an advance directive. Members must be provided information about formulating advance directives (see AHCCCS Medical Policy Manual, Policy 930).

Providers are encouraged to obtain a copy of the member’s executed advanced directive from a hospital, nursing facility, home health agency, hospice or any organization responsible for providing personal care for inclusion in their medical record.

End-of-Life Care (EOL) is a member-centric concept of care that focuses on quality of life through the delivery of health care services, practical supports, and Advance Care

**Duty to Report Abuse, Neglect, Exploitation, Injuries, Denial or Deprivation of Medical or Surgical Care or Nourishments, and Unexpected Death of a Minor**

Any provider who reasonably believes that any of the following incidents has occurred shall
immediately report this information to a peace officer or to a Department of Child Safety (DCS) worker by calling the Arizona Child Abuse Hotline, and must also notify the Health Plan of:

- Any physical injury, abuse, reportable offense or neglect involving a minor that cannot be identified as accidental by the available medical history; or
- A denial or deprivation of necessary medical treatment, surgical care or nourishment with the intent to cause or allow the death of an infant.

In the event that a report concerns a person who does not have care, custody or control of the minor, the report shall be made to a peace officer only. Reports shall be made immediately by telephone or in person and shall be followed by a same-day progress note in the member’s Health Record. The report shall contain:

- The names and addresses of the minor and the minor’s parents or the person(s) having custody of the minor, if known;
- The minor’s age and the nature and extent of the minor’s abuse, physical injury or neglect, including any evidence of previous abuse, physical injury or neglect; and
- Any other information that the person believes might be helpful in establishing the cause of the abuse, physical injury or neglect.

If a physician, psychologist, or behavioral health professional receives a statement from a person other than a parent, stepparent, or guardian of the minor during the course of providing sex offender treatment that is not court ordered or that does not occur while the offender is incarcerated in the State Department of Corrections or the Department of Juvenile Corrections, the physician, psychologist, or behavioral health professional may withhold the reporting of that statement if the physician, psychologist, or behavioral health professional determines it is reasonable and necessary to accomplish the purposes of the treatment.

Upon written request by the investigating peace officer or DCS worker, the person who has custody or control of medical records of a minor for whom a report is required shall make the records, or a copy of the records, available. Records are confidential and may be used only in a judicial or administrative proceeding or investigation resulting from the required report. If psychiatric records are requested, the custodian of the records shall notify the attending psychiatrist, who may remove the following information before the records 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 by a peace officer or DCS worker, may order that the entire record or any portion of the record that contains information relevant to the reported abuse, physical injury or neglect be made available for purposes of investigation. Additionally, providers must report to the Health Plan healthcare acquired conditions, abuse, neglect, exploitation, injuries, high profile cases, denial or deprivation of medical or surgical care or nourishment, and unexpected death of minors as required.
Duty to Warn

Any Health Plan contracted provider, having determined that a member poses a serious danger of violence to others, shall take reasonable actions to protect the potential victim(s) of that danger under A.R.S. §36-517.02. With respect to the legal liability of a behavioral health provider, A.R.S. §36-517.02 provides that no cause of action or legal liability may be imposed against a provider for breaching a duty to prevent harm to a person caused by a patient unless both of the following occur:

- The member has communicated to the Health Plan contracted provider an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim or victims, and the member has the apparent intent and ability to carry out such threat, and
- The Health Plan contracted provider fails to take reasonable precautions.

Duty to Protect Potential Victims of Physical Harm

All Health Plan contracted providers have a duty to protect others against the violent conduct of a member. When a Health Plan contracted provider determines, or under applicable professional standards, reasonably should have determined that a member 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 member but may be someone who would be the most likely victim of the member’s violent conduct.

While the discharge of this duty may take various forms, Health Plan contracted providers 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 Health Plan contracted provider to take reasonable precautions to prevent harm threatened by a member 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 behavioral health provider would take under the circumstances.

The Health Plan contracted providers are required to immediately notify by telephone the Health Plan crisis line providers when a member 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. Health Plan contracted providers are required to report to the crisis line all relevant information:

- 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 Maricopa County call the Crisis Response Network at (800) 631-1314.
For Pima, Graham, Greenlee, Santa Cruz, Yuma, Pinal, Cochise, La Paz Counties call Nursewise at (866) 495-6735.
For Gila County call the Crisis Response Network at (800) 631-1314.

**Incident, Accidents and Deaths (IADs), HCACs and OPPCs**

Banner – University Family Care/ACC requires Contractors to report all Incidents, Accidents and Deaths (IADs), Health Care Acquired Conditions (HCAC) and Other Provider Preventable conditions (OPPC) according to AHCCCS requirements. The standard requires providers to report as soon as they are aware of the incident, or no later than 48 hours after learning of the incident.

**Reporting Requirements**

Incident, Accident and Death (IADs) relate to situations that include deaths, possible abuse, neglect or denial of rights. The bulleted list below details the situations that must be reported to AHCCCS and Banner – University Family Care/ACC according to AHCCCS and contract requirements.

- Deaths;
- Medication error(s)/Adverse Drug Events;
- Abuse or neglect allegation made about staff member(s);
- Suicide attempt;
- Self-inflicted injury;
- Injury requiring emergency treatment;
- Physical injury that occurs as the result of personal, chemical or mechanical restraint;
- Unauthorized absence from a licensed behavioral health facility, group home of children or recipients under court order for treatment;
- Suspected or alleged criminal activity;
- Discovery that a client, staff member, or employee has a communicable disease as listed in R9-6-202

A Hospital Acquired Condition (HCAC) which occurs in any inpatient hospital setting and is not present on admission (Refer to the current CMS list of Hospital-Acquired Conditions.)

Other Provider Preventable Condition (OPPC) is a condition occurring in the inpatient and outpatient health care setting which AHCCCS has limited to the following: Surgery on the wrong member, wrong surgery on a member and wrong surgery site.

IAD’s are reported to AHCCCS electronically via their website at: https://qmportal.azahcccs.gov

Staff responsible for reporting must register through AHCCCS prior to submitting a report. Instructions for registering are included on the AHCCCS website. The Registration Guide is entitled IAD-QOC Web
Portal – User Registration Guide. The AHCCCS website also includes a QuickStart Guide containing the instructions on how to report incidents.

Reports are entered into https://qmportal.azahcccs.gov.

**Seclusion and Restraints**

It is the policy of the Banner – University Family Care to ensure that the organization and its providers have the necessary information to ensure that Behavioral Health Inpatient Facilities (BHIFs) authorized to conduct Seclusion and Restraint to report to the proper authorities as well as the Plan of such all Seclusion and Restraints of plan members.

The use of seclusion and restraint can be high-risk behavioral health interventions; facilities should only implement these interventions when less restrictive and less intrusive approaches have failed. The Plan delineates these requirements, by reference, in contracts.

The Health Plan requires BHIFs to submit each individual reports of incidents of seclusion and restraint to the Plan within (5) five days of the incident utilizing AHCCCS Seclusion and Restraint Individual Reporting Form, please follow link below:


Please submit the completed form to BUHP:

Email: BHQOCReferral@bannerhealth.com

Fax: 520-874-3567

The Health Plan also requires BHIFs to report the total number of incidents of the use of Seclusion and Restraint involving AHCCCS members in the prior month to the Health Plan by the fifth calendar day of the month. If there are no incidents of seclusion or restraint, the report should so indicate.

**Seclusion and/or Restraints Resulting in Reportable Incident**

If the Seclusion or Restraint episode results in a reportable injury to the member, the contractor is required to submit a separate Incident/Accident/Death (IAD) report to the Plan and to the AHCCCS Quality Team. Contracted BHIFs must submit these IADs to AHCCCS and the Plan through the QM Portal within 48 hours of becoming aware of the incident via QM Portal

Link: https://qmportal.azahcccs.gov

**Peer Review**

The purpose of peer review is to improve the quality of medical care provided to members by practitioners and providers by analyzing and addressing clinical issues. The peer review scope includes cases where there is evidence of deficient quality, or the omission of the care or service provided by a participating, or non-participating health care professional or provider whether delivered in or out of state. In addition, this ensures there are established guidelines for referring and conducting the peer review process. It is the policy of the Health Plan to utilize a peer review process of which the purpose is to improve the quality of medical care provided to members by our practitioners and providers. The scope of the peer review process includes cases where there is evidence of a quality deficiency in the care or service provided, or where there is the omission of care or service by a participating or non-
participating health care professional or provider. Patient safety and quality medical care are the focus of all peer review activities. The review process is designed to provide an independent review by an objective group of physicians using evidence-based guidelines or practice parameters developed by nationally recognized medical specialty societies to determine whether accepted medical standards of care have been met.

Roles and Responsibilities of Peer Review Committee

The Peer Review Committee will be chaired by the Health Plan Chief Medical Officer (CMO), or Medical Director Designee. The Peer Review Committee is scheduled to meet at least quarterly as needed. The Peer Review Committee is carried out in an executive session of the Credentials Committee. The Peer Review Committee shall consist of, at a minimum, the Health Plan CMO as Chair and contracted providers from the community. The peer review process ensures that providers of the same or similar specialty participate in review and recommendation of individual peer review cases.

If the specialty being reviewed is not represented on the contractor’s Peer Review Committee, the Peer Review Committee may utilize peers of the same or similar specialty through external consultation. A Behavioral Health provider must be part of the Peer Review Committee when a behavioral health case is being reviewed.

If necessary, an external consultant is used in the peer review process should there be a need for a particular specialty that is not represented on the Peer Review Committee.

The Peer Review Committee members sign a confidentiality and conflict of interest statement at each Peer Review Committee meeting.

Committee members must not participate in peer review activities in which they have a direct or indirect interest in the peer review outcome. All information used in the peer review process is kept confidential and not discussed outside the peer review process. All documents generated for the peer review process are protected under ARS § 36-2917. All names and personal identity of providers and patients are protected and omitted from the documentation presented for review, as appropriate.

The Peer Review Committee is responsible for making recommendations to the Health Plan’s CMO. Together they must determine appropriate action which may include, but are not limited to, peer contact, education, credentials, limit on new provider enrollment, sanctions, or other corrective actions. The Medical Director or CMO is responsible for implementing the actions.

The Peer Review Committee is responsible for making appropriate recommendations to the Health Plan’s Medical Director to make referrals to the Department of Child Safety, Adult Protective Services, the Department of Health Services, Licensure Unit, the appropriate regulatory agency or board and AHCCCS for further investigation or action if not already referred during the Quality of Care (QOC) process.

Notification to a regulatory agency or board if the peer review committee determined care was not provided according to community standards will occur. Notification must occur when the peer review committee determines care was not provided according to community standards. Initial notification may be verbal but must be followed by a written report within 24 hours.
Case Identification

Referral of cases for peer review may be received from internal and/or external sources. The Peer Review Committee must evaluate cases referred to peer review based on all information made available through the quality review process.

Provider Notification of Peer Review Process

Providers are notified of the Health Plan Peer Review Process through the Provider Manual and the Health Plan websites. Providers are given a copy of the Health Plan Peer Review policy upon request. Providers are notified regarding any substantiated quality of care grievance, complaint or allegation lodged against them, and are given the opportunity to respond to the complaint or allegation.

Provider Peer Review of Notification of Grievance Procedure

All providers are given due process (grievance) rights to any recommendations taken by the Peer Review Committee that may affect or limit their ability to practice within the Plan. At the conclusion of the peer review process, the provider is notified if such action has been recommended. Such communication is sent by certified mail sent within 10 calendar days of the Peer Review Committee’s recommendation. The provider may file a grievance in response to the findings of the committee. The grievance must be submitted to the Health Plan CMO within 14 calendar days of the notification of the recommendations of the Peer Review Committee. The Health Plan CMO is responsible for reviewing the grievance submitted by the provider. The CMO then makes a determination on the appropriate course of action to be taken.

Reporting

The findings of the peer review process are filed in the provider’s credentialing file and reviewed at the time of recredentialing. Reports are submitted to appropriate federal and state agencies including the National Practitioner Data Bank of any actions which adversely affect the provider’s privileges or professional status as required by state and or federal law. Peer review documents are available to regulatory agencies for purposes of quality management, monitoring and oversight.

Performance Improvement (PIPS) and Quality Improvement Projects

PIPs are mandated by AHCCCS. However, Banner – University Family Care/ACC will also self-select additional projects based on opportunities for improvement identified by our internal data and information. Banner – University Family Care/ACC will report the status and results of each project to AHCCCS, either no less than once per year or as requested using the AHCCCS PIP Reporting Template included in the AMPM Policy 980. Each PIP must be completed in a reasonable time period to allow information on the success of PIPs in the aggregate to produce new information on quality of care every year [42 CFR 438.240(c)(2); 42 CFR 438.330(d)(1); 42 CFR 438.330(d)(3)]. All contracted providers are required to participate in the PIPs and QIPs as needed.

Plans and interventions for chosen PIPs, Performance Measures and achievement of Minimum Performance Standards will be based on evidence based best practices as defined by credible national standards and regulatory agencies. A process for identifying Best Practices related to all above will be accomplished with the QM and clinical staff who will be responsible for reviewing the appropriate national standards/evidence-based guidelines and identify best practices.
QIPs and PIPs are designed, through ongoing measurement and intervention, to achieve:

Demonstrable improvement, sustained over time, in significant aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and member satisfaction

Correction of significant systemic problems

Clinical focus topics may include the following:

- Primary, secondary, and/or tertiary prevention of acute conditions
- Primary, secondary, and/or tertiary prevention of chronic conditions
- Care of acute conditions
- Care of chronic conditions
- High-risk services, and
- Continuity and coordination of care.
- Non-clinical focus topics may include the following:
  - Availability, accessibility and adequacy of the Health Plan’s service delivery system
  - Cultural competency of services
  - Interpersonal aspects of care (i.e., quality of provider/member encounters), and
  - Appeals, grievances, and other complaints.

The QIP or PIP begins on a date, established by the regulator and will correspond with the contract year. Baseline data will be collected and analyzed at the beginning of the PIP. During the first year of the QIP or PIP, the Health Plan will implement interventions to improve performance, based on an evaluation of barriers to care/use of services and evidence-based approaches to improving performance, as well as any unique factors such as its membership, provider network, or geographic area(s) served.

Banner – University Family Care/ACC’s participation in the QIP or PIP will continue until demonstration of significant improvement and the improvement has been sustained for one year for the identified population or subpopulation. After the first year of the QIP or PIP, Banner – University Family Care/ACC will report to the regulators annually on interventions, analysis of interventions and internal measurements, changes or refinements to interventions and actual or projected results from repeat measurements. Banner – University Family Care/ACC will use the regulator template to submit annual reports.

**Corrective Action Plans for Performance Measures, QIPS and PIPs**

Banner – University Family Care/ACC will achieve at least the Minimum Performance Standards (MPS) established by AHCCCS for each AHCCCS measure by Line of Business and applicable subpopulations, or, reach the benchmark established by CMS for each Medicare measure, or reach the goal as outlined in the QIP or PIP. When deficiencies are noted, there is documented evidence of the following:

- Identified issues by Lines of Business and applicable subpopulation.
- Responsible party
• Proposed actions
• Evaluation of the actions taken by Lines of Business and applicable subpopulation.
• Start and end dates

Develop an evidence-based Corrective Action Plan (CAP) for each measure by Line of Business and applicable subpopulation not meeting the standard, benchmark or goal. The goal of each CAP will be to demonstrate sustained improvement over time. Each CAP will be submitted to the QM/PI Committee and AHCCCS for approval prior to implementation and will include the following elements:

• Evaluation of current interventions
• Development of new or improved interventions
• Identification of staff responsible for implementation and follow through according to specified timeframes
• Appropriate allocation of administrative resources
• Ongoing measurement of results
• Continued evaluation of intervention effectiveness until desired outcome is achieved
• Banner – University Family Care/ACC will track, trend and notify AHCCCS regarding inaccuracies with data and corrective action plans related to the errors. The HPIS Department will monitor all data reports to ensure accuracy and any identified inaccuracy based on trends or unexpected outcomes or statistically significant change shall be discussed at Quality Improvement and Performance Committee for resolution.

A process is in place to notify AHCCCS and an appropriate corrective action plan (CAP) will be created. The CAP will be tracked until the issue is fixed and AHCCCS will be notified of the final outcome.

**Continuous Quality Improvement (PDSA) Cycle**

The plan will engage in continuous quality improvement through the use of Performance Improvement Plans, Corrective Actions, implementation of new initiatives, provider trainings, etc. Each continuous quality improvement effort will utilize a Plan Do Study Act (PDSA) and Repeat cycle as described below.

**Plan:** Document the results of an evaluation, by Line of Business and applicable subpopulations, of existing interventions to achieve a satisfactory level of performance on the identified project, including barriers to utilization of services, improved member satisfaction, member outcome and/or reasons why the interventions have not had the desired effect. Achieve performance up to at least the minimum level established by internal or external standards, including evidence-based practices that have shown to be effective in the same/similar populations/subpopulations.

**Do:** Demonstrate that the Health Plan is allocating increased administrative resources to improving rates for a particular measure or service area (do). Identify staff positions responsible for implementing/overseeing interventions with specific timeframes for implementation (do)

**Study:** Analyze the data and study the results by Line of Business and applicable subpopulations. Compare the data to predictions and summarize what was learned. Provide a means for measuring the results of new/enhanced interventions on a frequent basis
Act: Refine the change(s)/intervention(s), based on what was learned, and prepare a plan for retesting the intervention(s) based on Lines of Business and applicable subpopulations. Provide a means for refining interventions based on what is learned from testing different approached or activities.

Repeat: Continue the cycle as new data becomes available until improvement is achieved. Describe a process for repeating the cycle until the goal is achieved.

Measurement of Demonstrable Improvement

Banner – University Family Care/ACC will initiate interventions that result in significant demonstrable improvement, sustained over time, in its performance for each performance measure. Banner – University Family Care/ACC will strive to meet a benchmark level of performance defined in advance by the regulator. Banner – University Family Care/ACC will have demonstrated improvement with a QIP or PIP when:

- It meets or exceeds the regulator overall average for the baseline measurement if its baseline rate was below the average and the increase is statistically significant
- It shows a statistically significant increase if its baseline rate was at or above the overall average for the baseline measurement, or
- It is the highest performing (benchmark) plan in any re-measurement and maintains or improves its rate in a successive measurement.

Banner – University Family Care/ACC will have demonstrated sustained improvement when Banner – University Family Care/ACC maintains or increases the improvements in performance for at least one year after the improvement in performance is first achieved. Banner – University Family Care/ACC must demonstrate how the improvement can be reasonably attributable to interventions undertaken by the organization (i.e., improvement occurred due to the project and its interventions, not another unrelated reason).

The Health Plan strives to exceed the regulatory performance requirements for the Medicaid lines of business. The plan requires the adoption of the Adult System of Care Principles and use of the ASAM to assess and determine service intensity for individuals with substance use or substance additions. The plan requires that providers adhere to the guidelines established by AHCCCS and the Health Plan.

CASII, ESCII, and High Needs Case Management

The Health Plan requires providers to have sufficiency of properly trained and qualified staff to function as High Needs Case Managers to serve children ages 0-5 who are determined High Needs by the ESCII, or other approved assessment, and children ages 6 up to the age of 18 whose Child and Adolescent Service Intensity Instrument (CASII) scores are greater than 3 or through clinical assessment.

The plan requires the use of the CASII to determine service intensity and case management assignment. The plan requires that providers serving children with high needs have designated case managers to serve in this role. The provider must adhere to the guidelines established by AHCCCS and the plan.

The plan contracts with providers to assess and provide services in collaboration with the member, the member’s family and all others involved in the member’s care, including other agencies or systems.
These providers will also be prepared to accept referrals to High Needs Case Management.

- BH providers shall assess all children and provide or make services accessible to children.
- BH providers shall provide these services by competent individuals who are adequately trained and supervised.
- The plan contracts with behavioral health providers (BH providers) to provide high-needs case management services to children with complex needs.
- Children must be provided all medically necessary covered services at the specified intervals as determined by their service plan in collaboration with the Child Family Team.

**Assessment for Children Birth to Five**

The ECSII (or other assessment of the intensity of needed services as directed by AHCCCS) shall be utilized in determining the level of acuity and need for children Birth through age Five. The ECSII evaluates across six dimensions: 1) Degree of safety, 2) Child-caregiver relationship(s), 3) Caregiving environment, 4) Functional/developmental status, 5) Impact of the Child’s medical, developmental and emotional/behavioral problems and 6) Services profile (involvement, fit and effectiveness). The ECSII shall be administered by staff person(s) deemed as trained in the administration of the ECSII and have expertise in early childhood development or mental health. All individuals administering the ECSII shall complete initial training, pass initial and ongoing inter-rater reliability (IRR) testing with a minimum score of 85%.

The ECSII shall be administered within 30 days of intake, at least every 6 months and at discharge from care.

In lieu of the ECSII (or as otherwise directed by AHCCCS), the following criteria shall be evaluated to determine if a child birth to five is considered high needs and requires further assessment and targeted services. Children birth through five years of age shall demonstrate one or more of the following:

- Other agency involvement; specifically: AzEIP, DCS, and/or DDD; and/or
- Out of home placement (within past six months); and/or
- Psychotropic medication utilization (two or more psychotropic medications); and/or
- Evidence of severe psycho-social stressors (e.g. family member serious illness, disability, death, job loss, eviction).
- Children ages 0 up to the age of 5 meeting high needs determination must be assigned to a High needs case manager.

**Assessment of Children ages six up to the age of 18 years of age**

The CASII shall be utilized in determining the level of acuity and need for children ages 6 up to the age of 18 years of age. The CASII (or other assessment as directed by AHCCCS) shall be utilized in determining the level of acuity and need for children ages six through 18. The CASII evaluates across six dimensions: 1) Risk of Harm, 2) Functional Status, 3) Co-Morbidity, 4) Recovery Environment (stress and support), 5) Resiliency and Treatment, and 6) Acceptance and engagement (for the child and the primary caretaker). Each dimension has its own set of criteria and is rated on a 5-point scale. Overall scoring informs the recommended level of acuity across one of seven levels.
• Level 0 – Basic Services
• Level 1 – Recovery Maintenance and Health Management
• Level 2 – Outpatient Services
• Level 3 – Intensive Outpatient
• Level 4 – Intensive Integrated Service Without 24-Hour Medical Monitoring
• Level 5 – Non-Secure 24-Hour, Medically Monitored Services
• Level 6 – Secure, 24-Hour, Medically Managed Services

In addition to the CASII (or other assessment as directed by AHCCCS) level of acuity and need for children ages six through 18 may be assessed through clinical evaluation. This identification shall also trigger an updated CASII assessment and review the current service plan. The CASII shall be administered by staff person(s) deemed as trained in the administration of the CASII and have expertise in childhood development or mental health. All individuals administering the CASII shall complete initial training, pass initial and ongoing inter-rater reliability (IRR) testing with a minimum score of 85%. Children ages 6 up to the age of 18 with a CASII score of 4, 5, or 6 must be assigned to a High needs case manager.

Across all ages, high needs determination may also be made by through clinical presentation and assessment or for children identified as a member with a Special Health Care Need (e.g., CRS designation, SED flag, diagnosis or risk of autism) Children with Special Health Care Needs assessed as needing high needs case management must be assigned to a High needs case manager.

High Needs Case Management Assignment

The plan requires providers to have mechanisms in place to refer to or to provide high case management and other support and rehabilitation services to their assigned high needs members.

Case load sizes for High Needs Children must abide by the following:

• For a full FTE (1.0), have a caseload ratio of high needs children not less than 1:8 and not more 1:20, with 1:15 being the desired target.
• The caseload cap is 20 to allow for continuity of care for children who have been receiving high needs case management but are not ready to begin transition from that level of care and for high needs case management of siblings.

ASAM implementation

BUFC/ACC requires providers serving youth and adults with substance use disorders to utilize the American Society of Addiction Medicine (ASAM) in assessing persons with substance use disorders and to train all staff conducting ASAM assessments. In addition, the Behavioral Health Home or other provider acting as the member’s Behavioral Health Home must ensure that services are delivered by staff competent to assess and treat substance use disorders in individuals and families.

Required Screenings

In addition, the provider must screen all persons with substance use disorders for the need for residential treatment services and document the screening. All Members seeking treatment for
Substance Use Disorders must receive an ASAM assessment at intake and at least every six months during treatment.

Providers must promote the use of Motivational Interviewing Principles in substance use treatment; verify access to new treatment alternatives targeted to the needs of specific high-risk populations, such as Members with co-occurring substance use and mental illness, according to the Arizona Principles for behavioral health care as well as:

- Demonstrate which evidence-based practice is utilized, how training is conducted and how fidelity is monitored;
- Document in each member record which evidence-based practice is being utilized during treatment of the member, and;
- Be provided by clinicians who are overseen by a Behavioral Health Professional (BHP) with experience in substance use disorders and treatment.

Providers must maintain the capacity to conduct drug screening/testing on members, as defined by AHCCCS Covered Behavioral Health Services Guide and as deemed clinically appropriate by the member’s treatment team.

Residential Substance Use Treatment services are available to adults and adolescents who are TXIX eligible and to individuals who are NTXIX, but eligible for Substance Abuse Block Grant (SABG) funds, Special Populations, and who are screened using the ASAM as needing this level of care. Behavioral health residential facilities (BHRFs) providing substance use treatment must ensure length of stay is consistent with member’s needs and meets medical necessity. Treatment must remain individualized for each member, dependent upon ASAM placement criteria and treatment needs.

**EPSDT**

Banner – University Family Care/ACC (BUFC/ACC) providers are required to provide comprehensive health care and preventive services to eligible members. Those members are AHCCCS and children under the age of 21. These services are offered under the Early Periodic Screening Diagnosis and Treatment (EPSDT) program, which is governed by Federal and State regulations and community standards of practice.

**BUFC/ACC Provider Requirements**

1. Provide early and periodic screening, diagnosis, and treatment services for all assigned members from birth through twenty years of age. All services must be provided according to the AHCCCS Periodicity Schedule and community standards of practice. The service intervals represent minimum requirements, and any services determined by the primary care provider, to be medically necessary, must be provided regardless of the interval.

2. Document services provided and compliant with AHCCCS’ standards on the AHCCCS standardized EPSDT Tracking Forms. BUFC/ACC providers should send a copy to the Health Plan EPSDT Department at 2701 E. Elvira Road, Tucson AZ. If the member chooses not to participate in the EPSDT program, document the decision in the medical record.

3. Coordinate care and refer eligible members to Children’s Rehabilitative Services (CRS). The Health Plan can assist in the referral process if the need is identified on the EPSDT tracking
form.

4. Schedule the next EPSDT appointment at the time of the current visit for children 24 months of age and younger.

5. Comply with the State requirements to report all childhood immunizations to Arizona Department of Health Services (ADHS)/Arizona State Immunization Information System (ASIIS).

6. Agree to participate in an annual review, which may include on-site visits and medical record audits.

7. Report all EPSDT encounters on CMS 1500 claim forms, using Preventive Medicine Codes with the appropriate modifier.

8. Be registered and participate in the Vaccinations for Children (VFC) Program Report blood lead levels equal to or greater than ten micrograms of lead per deciliter of whole blood to ADHS

Screening and Physical Exam Requirements

1. A comprehensive health and developmental history (including growth, developmental screening, physical, nutritional, and behavioral health assessments).

2. Nutritional Assessment provided by a PCP: Nutritional assessments are conducted to assist EPSDT members whose health status may improve with nutritional intervention. Payment for the assessment of nutritional status provided by the member’s PCP is part of the EPSDT screening. Payment for nutritional assessments is included in the EPSDT visit and is not a separate billable service.

3. Behavioral health services are covered for members eligible for EPSDT. PCPs may treat Attention Deficit Hyperactivity Disorder, depression and anxiety. All other behavioral health conditions must be referred to the Regional Behavioral Health Authority. PCPs that elect to prescribe medications to treat ADHD depression, or anxiety disorders must complete an annual assessment of the member’s behavioral health condition and treatment plan. Payment for behavioral health screenings and assessments are included as part of an EPSDT visit and are not separate billable services.

4. A comprehensive unclothed physical examination: Appropriate immunizations according to age and health history: Administration of immunizations may be billed in addition to the EPSDT visit using the CPT-4 code appropriate for the immunization with an SL modifier. Providers must be registered as Vaccines for Children providers and VFC vaccines must be used.

5. Immunizations must be reported at least monthly to the Arizona Department of Health Services. Immunizations must be provided according to the recommended Childhood Immunization Schedule.

6. Reported immunizations are held in a central database known as the Arizona State Immunization Information System (ASIIS). Providers can access this database to obtain complete and accurate immunization records at https://asiis.azdhs.gov/.

7. Laboratory tests (including blood lead screening and assessment appropriate to age and risk, anemia testing and diagnostic testing for, sickle cell trait if a child has been previously tested
with sickle cell, preparation or hemoglobin solubility test).

8. EPSDT covers blood lead screening. Required blood lead screening for children less than six years of age is based on the child’s risk as determined by either the member’s residential zip code or presence of other known risk-factors, as specified in the Arizona Department of Health Services Targeted Lead Screening Plan for the Prevention of Childhood Lead Poisoning.

9. Providers must report blood lead levels equal to or greater than ten micrograms of lead per deciliter of whole blood to ADHS.

10. Hemoglobin/Hematocrit – Must be performed according to periodicity schedule.

11. Sickle cell trait – Screening should be done when indicated.

12. Tuberculosis Screening – Must be performed on children who are at risk at intervals indicated in the attached EPSDT Periodicity Schedule.

13. Health Education, counseling and chronic disease self-management. These are not considered separately billable services and are considered part of the EPSDT visit payment.

14. Oral health screening intended to identify oral pathology, including tooth decay and/or oral lesions, and the application of fluoride varnish conducted by a physician, physician’s assistant or nurse practitioner. Application of fluoride varnish may be billed separately from EPSDT using CPT Code 99188. Fluoride varnish is limited in a primary care provider’s office to once every six months, during an EPSDT visit for children who have reached six months of age with at least one tooth erupted, with recurrent applications up to two years of age. Referrals to a dentist should be encouraged by one (1) year of age. AHCCCS members are assigned to a dental home within the BUFC/ACC provider network. Covered dental services include emergency, preventive and therapeutic treatment. The dentist will perform an evaluation on members and report findings and treatment to the PCP. The PCP will include documented dental findings and treatment in the member’s medical record.

15. Vision, hearing and speech screenings are covered during an EPSDT visit. EPSDT covers eye examinations as appropriate to age according to the AHCCCS Periodicity Schedule and as medically necessary using standardized visual tools. Payment for vision and hearing exams, or any other procedure that may be interpreted as fulfilling the vision and hearing requirements provided in a PCP’s office during an EPSDT visit are considered part of the EPSDT visit and are not separately billable services.

16. Ocular photo screening with interpretation and report, bilateral (CPT code 99174) is covered for children age’s three to five as part of the EPSDT visit due to challenges with a child’s ability to cooperate with traditional visitation screening techniques. Limited to a lifetime coverage limit of one.

**Developmental Screening Tools**

AHCCCS approved developmental screening tools should be utilized for developmental screening by all contracted PCPs who care for EPSDT-age members. PCPs must be trained in the use and scoring of the developmental screening tools, as indicated by the American Academy of Pediatrics.

1. The developmental screening should be completed for all EPSDT members from birth through
age three years of age during the 9, 18, and 24-month EPSDT visits.

2. A copy of the developmental screening tool must be kept in the medical record.

3. Use of AHCCCS approved developmental screening tools may be billed separately using CPT-4 code 96110 for a 9-month, 18 month and 24 month visit when the developmental screening tool is used.

4. A developmental screening CPT code with EP modifier must be listed in addition to the preventative medicine CPT code.

5. To receive the developmental screening tool payment, the modifier EP must be added to the 96110.

6. For claims to be eligible for payment, the provider must have satisfied the training requirements, the claim must be a 9, 18 or 24-month EPSDT visit, and an AHCCCS approved developmental screening tool must have been completed.

7. Providers should send verification of training completion directly to the Council for Affordable Quality Healthcare (CAQH)

8. AHCCCS approved developmental screening tools include:
   a. The Parent’s Evaluation of Developmental Status (PEDS) tool which may be obtained from http://www.pedstest.com/default.aspx or https://pedstestonline.com/
   b. Ages and Stages Questionnaire (ASQ) tool which may be obtained from www.agesandstages.com
   c. The Modified Checklist for Autism in Toddlers (MCHAT) may be used only as a screening tool by a primary care provider, for members 16-30 month of age, to screen for autism when medically indicated.

AzEIP Service Coordination Requirements

When the primary care physician (PCP) identifies a member under the age of 21 as having a potential developmental delay, he/she may arrange an evaluation with an in-network provider and prior authorization is not required. Should the PCP arrange an evaluation with an out of network provider, prior authorization is required and medical documentation and continuity of care need, if applicable, is required. Based on the evaluation, medically necessary services can be arranged by the PCP with an in-network provider and prior authorization may not be required. Prior authorization is required for out-of-network providers.

Regardless of member’s AzEIP status, the Health Plan will pay for medically necessary services for EPSDT members.

According to the AHCCCS/AzEIP agreement, when services are identified for an AzEIP eligible child’s Individual Family Service Plan (IFSP), the Health Plan will fax the PCP the AzEIP EPSDT Service Request Form for approval or denial of the services within two (2) days of receiving it from AzEIP.

THE PCP MUST RETURN THE AzEIP EPSDT SERVICE REQUEST FORM WITHIN FIVE (5) DAYS OF RECEIPT.

According to Federal law, AzEIP service implementation is required within 45 days of the IFSP
origination date. The AzEIP provider and coordinator, parent or guardian and PCP are provided the completed AzEIP Request Form for EPSDT services by the Health Plan. The denied or the approved type(s) of therapy, duration and frequency is included on the form.
Section 8 – Medical Management/Utilization Management Requirements

Securing Services and Prior Authorization/Retrospective Authorization

The clinical team is responsible for identifying and securing the service needs of each behavioral health or integrated member through the assessment and service planning processes. During the treatment planning process, the clinical team may use established tools and nationally recognized standardized criteria to guide clinical practice and to help determine the types of services and supports that will result in positive outcomes for the member. Clinical teams such as the Adult Recovery Teams (ARTs) or Child/Family Teams (CFTs) should make decisions based on a member’s unique and individual identified needs and should not use these tools as criteria to deny or limit services. Rather than identifying pre-determined services, the clinical team should focus on identifying the underlying needs of the behavioral health or integrated member, including the type, intensity, and frequency of support and treatment needed.

As part of the Service Planning/Complete Care process, it is the clinical team’s responsibility to identify available resources and the most appropriate provider(s) for services using the Health Plan’s network of participating healthcare providers. This is done in conjunction with the clinical team, the Primary Care Provider (PCP) (as needed), the behavioral health member, family, and/or natural supports. If the service is available through a contracted provider and does not require prior authorization the member can access the services directly. If the requested service is only available through a non-contracted provider or requires prior authorization the clinical team is responsible for coordinating with the Health Plan to obtain the requested services as outlined below.

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, the Health Plan also requires prior authorization for certain other covered behavioral health services. For members with dual coverage (Medicare and AHCCCS) the Medicare plan is the primary payer for all services covered under the Medicare benefit. If the service is not covered under the Medicare plan, the AHCCCS Health Plan would be the primary payer for services covered by AHCCCS.

BUHP Evidence-Based Care Guidelines

The Health Plan utilizes MCG evidence-based care guidelines and criteria and licensed behavioral health professionals, and when applicable, any requirements from AHCCCS to determine medical necessity and when applicable, any requirements from AHCCCS.

Prior authorization procedures for providers contracted by the Health Plan

Go to [www.bannerufc.com](http://www.bannerufc.com) for the most current Behavioral Health Prior Authorization Grid.
<table>
<thead>
<tr>
<th>Requires Prior Authorization Before Receipt of Services</th>
<th>Requires Authorization After Admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Emergent admission to and continued stay for eating disorder facilities</td>
<td>Emergent admission to and continued stay for inpatient medical facility, psychiatric or detoxification acute inpatient facility</td>
</tr>
<tr>
<td>Non-Emergent admission to and continued stay in Behavioral Health Inpatient Facility (BHIF)</td>
<td>Emergent admission to and continued stay in Behavioral Health Inpatient Facility (BHIF)</td>
</tr>
<tr>
<td>Non- Emergent Admission to and continued stay in Behavioral Health Residential Facility (BHRF) (adult/child); (Effective January 18, 2019, per AHCCCS, all non-emergent BHRF requests are to be expedited)</td>
<td>Emergent admission to and continued stay in Behavioral Health Residential Facility (BHRF)</td>
</tr>
<tr>
<td>Non-Emergent Admission to and continued stay in Home Care Training to Home Care Client (HCTC) (adult/child)</td>
<td>Emergent Admission to and continued stay in Home Care Training to Home Care Client (HCTC) (adult/child);</td>
</tr>
<tr>
<td>Psychotropic medications (per formulary)</td>
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<td>Initiation and continuation of Out of Network outpatient services</td>
<td></td>
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<tr>
<td>Non-emergency medical transportation to and from covered behavioral health services when the trip exceeds 100 miles one way or round trip.</td>
<td></td>
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<tr>
<td>Electroconvulsive Therapy (includes necessary monitoring)</td>
<td></td>
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</tbody>
</table>

**Prior Authorization Decisions**

The Health Plan has staff available 24 hours a day, seven days a week to receive requests for any service that requires prior authorization. The Health Plan utilizes MCG evidence-based guidelines and Arizona-licensed staff with appropriate training to apply the Health Plan prior authorization criteria and make prior authorization decisions. The Health Plan will request additional information from the requesting provider, as needed, to make a determination. A decision to deny for medical necessity must be made by the Health Plan physician.
Securing services that do not require prior authorization

The ART/CFT is responsible for identifying and securing the service needs of each member through the assessment and Service Planning/Complete Care planning processes. The ART/CFT 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/Complete Care Planning process, it is the ART/CFT’s responsibility to identify available resources and the most appropriate provider(s) for services. This is done in conjunction with the member, family, natural supports, and others who comprise the ART/CFT. 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 ART/CFT requests services from a non-contracted provider, the provider must submit a Behavioral Health Prior Authorization for consideration.

Emergency Services

Prior authorization for inpatient services must never be applied in an emergency. 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.

23 Hour Observation/Care Transitions/Discharge Planning

Email to: BUHPCareMgmtBHMailbox@bannerhealth.com

Prior authorization is not required for admission to a psychiatric 23-hour observation facility. The Regional Behavioral Health Authorities (RBHAs) continue to be responsible for the oversight and reimbursement of this level of care up to the 24th hour. Providers of 23-hour observation services are required to notify the Health Plan upon admission to this level of care. This notification allows the Health Plan to assist the facility in ongoing member care for continued stay after the initial 23 hours, facilitate another level of care that the member requires upon assessment and evaluation, and to ensure appropriate discharge planning and follow up services are in place upon discharge. If the member requires further care at the 23-hour observation facility, only notification is required. The Health Plan requires these providers to report the notifications on a Health Plan template.

Notifications should be submitted on Banner approved template and sent to: BUHPCareMgmtBHMailbox@bannerhealth.com. The information submitted should include:

1. Member Name
2. AHCCCS Identification Number
3. Date of Birth
4. Date of Admission
5. Diagnosis and Reason for Admission
6. Disposition, if applicable
<table>
<thead>
<tr>
<th>Level of Care/Code</th>
<th>Fax Number</th>
<th>Documentation to Submit</th>
<th>Time of Submission</th>
</tr>
</thead>
</table>
| Level 1 Psychiatric Hospital Admission (excluding BHIF/RTC) | 520-874-3420 (Banner UM) | **For Admission Notification:** All of the following information is required for all inpatient notifications/requests:  
1) Admission Face Sheet, which includes the following:  
a) Member's name and Member’s identification number, and  
b) Member’s date of birth, and  
c) Admission date, and  
d) National Provider Identification (NPI) of Facility, and  
e) Attending physician name and admitting hospital name, and  
f) Admitting diagnosis and ICD 10 Code, and  
g) Level of care admitted to, and  
h) Contact name and phone number/e-mail of inpatient Utilization Reviewer, and  
i) Other Insurance  
2) Certificate of Need (CON) Certification of Need (CON)  
   Clinical documentation submitted prior to the submittal of Notification of admission will not be saved and considered for the medical necessity review. | Within 72 hours of admission |
| Level 1 Psychiatric Hospital Initial Authorization | 520-874-3411 (BH UM) | 1) Attending/Psychiatrist admitting evaluation. Initial evaluation is to include:  
a) Admitting diagnosis  
b) Differential diagnosis, or possible impact of medical conditions/symptoms (e.g. UTI, Dehydration)  
c) Mental status examination  
d) ELOS (estimated length of stay) | Within 24 hours of request from UM Reviewer |
| **Emergent BHIF Admission** | **520-694-0599** *(Banner BH PA)* | 1) Behavioral Health Prior Authorization Form  
2) Certificate of Need (CON)  
3) Request for Out of Home Application, and  
4) Out of Home Admission Notification Form | **Within 2 business days of admission** |
|---|---|---|---|
| **Non-Emergent Admission for BHIF** | **520-694-0599** *(Banner BH PA)* | **Prior to Admission:** Submit all of the following:  
1) Behavioral Health Prior Authorization Form,  
2) Updated Service Plan/Complete Care Plan,  
3) Recent psychiatric progress notes,  
4) Out of Home Application,  
5) The most recent assessment, or an assessment updated within the past year,  
6) Child and Family Team note indicating team recommendation,  
7) Other reports from outpatient providers,  
8) Any psychological reports or other relevant reports from specialty provider, and  
9) **Submit a CON within 72 hours of admission.** |
|  |  | If approved, the authorization is valid up to 45 days only. Submit additional clinical | **Prior to Admission to BHIF** |
| Non-Emergent Admission for Behavioral Health Residential Facility (H0018) | 520-694-0599 (Banner BH PA) | 1) Behavioral Health Prior Authorization Form, and  
2) Out of Home Application with supporting clinical documentation  
3) If Substance abuse- ASAM and/or related clinical documentation  
If approved, authorization is valid up to 45 days only. Submit additional clinical documentation if the member does not admit within 45 days of approval. | Submit Up to 45 days Prior to Admission |
|---|---|---|---|
| Emergent Admission For Behavioral Health Residential Facility (H0018) | 520-694-0599 (Banner BH PA) | 1) Behavioral Health Prior Authorization Form,  
2) Out of Home Admission Notification Form, and  
3) Out of Home Application Form  
If member requires a continued stay, the out of home provider must submit a Concurrent Review Form by the last covered day. | Submit within 2 days |
| Non-emergent Admission to HCTC (TFC) (S5109-HB, ages 18-64) (S5109-HC, over 65) (S5109-HA, ages 0-17) | 520-694-0599 (Banner BH PA) | 1) Behavioral Health Prior Authorization Form, and  
2) Out of Home Application Form with supporting clinical documentation | Up to 45 days Prior to Admission  
(If approved, the authorization is valid up to 45 days only) |
| Emergent Admission to HCTC (TFC) (S5109-HB, ages 18-64) (S5109-HC, over 65) (S5109-HA, ages 0-17) | 520-694-0599 (Banner BH PA) | Submit all of the following within 2 days:  
1) Behavioral Health Prior Authorization Form,  
2) Out of Home Admission Notification Form, and  
3) Out of Home Application Form  
If member requires a continued stay, the out of home provider must submit a Concurrent Review Form by the last covered day | Within 2 days of admission |
<table>
<thead>
<tr>
<th>Concurrent Review Requirements for Inpatient, BHIF, BHRF, HCTC</th>
<th>Fax Number</th>
<th>Documentation to Submit</th>
<th>Time of Submission</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Concurrent Review</strong></td>
<td>520-874-3411 or Banner Behavioral Health UM Reviewer will contact facility and provide email address. Facility must send documentation securely to UM reviewer email address when requested.</td>
<td>Submit all of the following clinical documentation to support medical necessity: 1) A. Attending Behavioral Health Medical Practitioner (BHMP) notes for each day of hospitalization and subacute detox level of care. B. For subacute facilities not providing detox, BHMP notes must be provided at a minimum for 5 days (M-F) out of the week 2) Estimated length of stay 3) Medication Administration Record (MARS) 4) CIWA/CINA/COWS protocols as applicable 5) All physician orders 6) RN notes 7) Lab results, if indicated 8) Discharge plan/barriers, including updates every 24 hours if barriers are resulting in avoidable days.</td>
<td>Submit clinical documentation prior to noon on the last covered day (LCD) of the current authorization; delayed submittals may result in a denial.</td>
</tr>
<tr>
<td><strong>Behavioral Health Inpatient Facility Concurrent Review</strong></td>
<td>520-874-3411 or Banner Behavioral Health UM Reviewer will contact facility and provide email address. Facility must send documentation securely to UM reviewer email address when requested.</td>
<td>Submit all of the following clinical documentation to support medical necessity: 1) Psychiatric notes, 2) Concurrent Review Form, 3) CFT notes, 4) Medication Administration Record (MARS), 5) Discharge plan, and 6) After 30 days submit a Recertification of Need (RON)</td>
<td>Submit clinical documentation prior to noon on the last covered day (LCD) of the current authorization; RON Submitted every 30 days.</td>
</tr>
<tr>
<td><strong>Behavioral Health Residential Facility (BHRF) Concurrent Review</strong></td>
<td>520-874-3411 or Banner Behavioral Health UM Reviewer will contact facility and provide email address. Facility must send documentation securely to UM reviewer email address when requested.</td>
<td>1) Out of Home Concurrent Review Form 2) CFT/ART notes 3) Medication and psychiatric progress notes, if applicable 4) Revised Service Plan/Complete Care Plan (as applicable)- The revised</td>
<td>Within 14 calendar days of the last covered day</td>
</tr>
</tbody>
</table>
For more information please refer to the Banner Behavioral Health Provider Manual, Medical Management/ Securing Services and Prior Authorization at:

Hospital/Inpatient Level of Care

(AHCCCS Provider Types: 02- Level 1 Hospital, 71- Level 1 Psychiatric Hospital- IMD, 78- Level 1 Residential Treatment Center/Secure/Non- IMD, B1-Level 1 Residential Treatment Center/Secure/IMD, B2- Level 1 Residential Treatment Center/Non-Secure/IMD, B5-Level 1 Subacute Facility/Non IMD, B6- Level 1 Subacute Facility/IMD)

Notification of Inpatient Admission

Inpatient notification for all providers licensed as a Level 1 Hospital, Level 1 Residential Treatment Center or Level 1 Sub-Acute Facility are required for all inpatient mental health admissions within 72 hours of admission. It is the admitting facility’s responsibility to submit notification via facility face sheet of a member’s admission:

• By fax: 520-874-3420
• Notifications can be faxed 24 hours a day, 7 days a week.
• The following information is required for all inpatient notification requests:
  o Member’s name
  o Member’s identification number
  o Member’s date of birth
  o Admission date
  o National Provider Identification (NPI) of Facility
  o Attending physician name and Admitting hospital name
  o Admitting diagnosis/ICD 10 Code
  o Level of care admitted to
  o Contact name and phone number/email of in-patient Utilization Reviewer
  o Other Insurance, and
  o Certification of Need (CON) for Medicaid (BUFC) members

• Please note, clinical information submitted prior to the notification or prior to the Health Plan issuing an authorization will not be acknowledged. Facilities must send the clinical documentation upon request of the Utilization Management (UM) reviewer.

Certification of Need (CON)

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. 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.
The following documentation is needed on a CON:

CONs must have a dated physician’s signature and must include documentation of the elements of medical necessity contained in 42 CFR 441.152, including the following:

1. Ambulatory care resources available in the community do not meet the treatment needs of the recipient
2. Proper treatment of the recipient’s psychiatric condition requires services on an inpatient basis under the direction of a physician
3. The services can reasonably be expected to improve the recipient’s condition or prevent further regression so that the services will no longer be needed.

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.

*(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.)*

**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 the Health Plan’s Medical Management Department via fax: 520-874-3420 prior to the authorization of payment. Federal rules set forth additional requirements for completing CONs when members age 18-20 are admitted to a Behavioral Health Inpatient Facility and are receiving services. These requirements include the following:

- For a member who is Title XIX/XXI eligible when admitted, the CON must be completed by the ART/CFT 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. 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 for which claims for payment are made.

Most psychiatric admissions to a Level 1 Inpatient Hospital are considered emergency admissions. The Health Plan defines an emergency medical condition as a medical condition, including psychiatric conditions, manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in, a) placing the health of the member in serious jeopardy, b) serious impairment to bodily functions, c) serious dysfunction of any bodily organ or part.
Hospital/Inpatient 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.

Additional modifiers: The member’s history of response to prior treatment, their personal resources such as intellect, characterological issues, and history of violence or self-harm may influence the decision about which level of care is medically necessary. However, the preferred treatment is provided in the least restrictive setting.

4. Primary diagnosis: A valid diagnosis causing the symptoms that require professional intervention and the intensity of services needed. At least one valid DSM-5 diagnosis/ICD 10 code 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. Professional intervention is considered likely to be effective and is essential to contain risks presented and provide for improvement.

**Detoxification Admissions:** Documentation of an appropriate psychiatric evaluation in conjunction with a patient’s admission to a detox facility is an accepted standard of care. This same standard of care is reiterated by SAMHSA in a Detoxification and Substance Abuse Treatment monograph, TIP 45, which specifically references and incorporates the above position of ASAM, and further states that: “Patients entering detoxification are undergoing profound personal and medical crisis. Withdrawal itself can cause or exacerbate current emotional, psychological, or mental problems. The detoxification staff needs to be equipped to identify and address potential problems.” MCG criteria also indicate that, on Day 1 of Inpatient Care for Substance-Related Disorders, an evaluation is completed that includes: substance use, psychiatric, medical, and social histories; psychiatric consultation (if the attending physician is
not a psychiatrist); and mental status and physical examinations. The criteria for Day 2 specify that a “psychiatric assessment has been completed and reviewed.” Since psychiatric assessments are consistent with accepted standards of care, failure to complete the assessment within 24 hours of admission may result in a referral as a Quality of Care Concern and/or denial.

**Hospital Inpatient Admission Criteria for Eating Disorders**

An inpatient admission for the treatment of an eating disorder requires a prior authorization and is not considered an emergent admission. The Adult Recovery Team or Child/Family Team should collaborate on determining if the member requires this level of care.

Admission Criteria for Eating Disorders 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 for all of the following:

1. **Member risk and clinical condition are appropriate for inpatient treatment as indicated by 1 or more of the following:**
   
   a) Subnormal BMI or low expected body weight for height, age, sex and need for medical treatment of unstable physical condition and urgent refeeding is present
   
   b) Subnormal low weight indicated by BMI less than 14 or weight less than 75% of expected body weight for height, age and sex.
   
   c) Current rate of weight loss is greater than 2 pounds per week and has created unstable physical condition
   
   d) Documented weight loss rate indicating severe low weight threshold (BMI less than 14 or weight less than 75% of expected body weight for height, age and sex) will be reached imminently
   
   e) Core body temperature less than 96 degrees F
   
   f) Heart rate less than 40 beats per minute
   
   g) Hypotension
   
   h) Orthostatic vital sign changes not responsive to appropriate outpatient treatment (e.g. hydration)
   
   i) Prolonged corrected QT interval
   
   j) Severe muscle weakness
   
   k) Serum phosphorus less than 1.5 mg/dl
   
   l) Electrolyte abnormality that cannot be corrected (to near normal) in emergency department or other ambulatory setting (e.g. serum potassium less than 2.5 mg Eq/L, serum sodium less than 130 mEq/L
   
   m) Significant injury due to purging (e.g. mucosal (Mallory-Weiss) tear, hematemeses due to ongoing frequent vomiting or colonic injury to enema misuse)
n) Malnutrition-related severe organ dysfunction or damage findings (e.g. heart failure, arrhythmia, or altered mental status)

2. Supervisory needs, motivation to recover, weight related behaviors and comorbidities are appropriate for inpatient treatment as indicated by all of the following:
   a) Strict staff supervision of meals (may include monitoring of specialized feeding modality, such as nasogastric tube) and bathroom use (direct monitoring in bathroom is necessary.
   b) Motivation to recover is very poor to poor (member condition requires involuntary treatment, or if voluntary member, highly structured, inpatient setting is necessary for compliance with care.)
   c) Behaviors or clinical findings (e.g. weight gain pattern, food refusal, purging, medication use for weight control) are appropriate for inpatient level of care.

3. Behaviors or clinical findings (e.g. weight gain pattern, food refusal, purging, medication use for weight control) are appropriate for inpatient level of care as indicated by 1 or more of the following:
   a) There has been substantial inability to achieve or maintain clinically appropriate weight goals.
   b) There has been continued or renewed compensatory weight-loss behavior (e.g., food refusal, self-induced vomiting, or excessive exercise).
   c) There has been continued or renewed use of pharmaceuticals with intent to control weight (e.g., laxatives, diuretics, stimulants, cocaine, or over-the-counter weight loss preparations).

4. Treatment services at proposed level of care are indicated due to presence of 1 or more of the following:
   a) Specific condition related to admission diagnosis is present that is judged likely to further improve at proposed level of care.
   b) Specific condition related to admission diagnosis is present and judged likely to deteriorate in absence of treatment at proposed level of care.
   c) Member is receiving continuing care (e.g. transition of care from less intensive level of care) and services available at proposed level of care are necessary to meet member needs.

5. Situation and expectations are appropriate for inpatient care as indicated by 1 or more of the following:
   a) Member is unwilling to participate voluntarily and requires treatment (e.g. legal commitment) in an involuntary unit.
   b) Voluntary treatment at lower level of care is not feasible (e.g. residential care unavailable or unacceptable for member condition).
c) Around the clock medical or nursing care to address symptoms and initiate intervention if required, specific need must be identified.

d) Member management at lower level of care is not feasible or is inappropriate (e.g. less intensive level of care is unavailable or not suitable for member condition or treatment history).

**Required Documentation for All Inpatient Admission Initial Authorization**

Providers must submit the following clinical information to support the medical necessity for an inpatient admission within 24 hours upon request from the UM Reviewer. Information is to be faxed to 520-874-3411.

1) Attending/Psychiatrist admitting evaluation. Initial evaluation is to include:
   a. Admitting diagnosis
   b. Differential diagnosis, or possible impact of medical conditions/symptoms (UTI, Dehydrated)
   c. Mental status examination
   d. Medication Administration Record (MARS)
   e. CIWA/CINA/COWS protocols, as applicable
   f. ELOS (estimated length of stay)
   g. Proposed treatment plan (titration of meds, initiating injectable, etc.),
   h. Proposed discharge plan (BHFR, med boxes, etc.)
   i. Discharge criteria.
   j. Justification for current level of care and why member is not able to be discharged to lower level of care.

2) History and Physical

3) Admission/Intake

**Court Ordered Evaluation/Court Ordered Treatment**

Reimbursement of court-ordered screening and evaluation services are the responsibility of the County pursuant to A.R.S § 36-545. In addition, if the county is responsible to pay (as stated in ARS 36-545.04), then per SSA Sec. 1862, paragraph 3, Medicare will not pay if paid for directly or indirectly by a governmental entity. Banner-UFC has no current financial agreements with counties or RBHAs for blended payments for Court Ordered Evaluations.

Banner-UFC will reimburse for court ordered treatment when services are medically necessary. However, for members undergoing Court Ordered Evaluation, medical necessity is not established until the required Psychiatric Evaluations have been completed, since the initial admission of the member is based on statutory processes, rather than a clinical determination. It is the responsibility of the facility to notify the Health Plan when there is a change of payer related to the end of Court Ordered Evaluation. The issue of voluntarily participating in treatment is not, in and of itself, a factor in the
determination of medical necessity. Furthermore, the refusal of a Title XIX/XXI member to accept medication is not, in and of itself, a factor in determining the medical necessity of the service, responding to a prior authorization request, or adjudicating the claim.

Per AHCCCS Contractors Operations Manual Policy 437, the Health Plan reimburses for medically necessary services when the Court Ordered Evaluation ends and when one of the following occur:

1) The Petition for Court Ordered Treatment is filed with the court, or
2) The individual agrees to voluntary status, or
3) The individual is released from Court Ordered Evaluation.

The Health Plan must have legal documentation submitted to evidence one of the three items above has taken place to initiate the authorization of services.

Hospital/Inpatient Concurrent Review

It is always the responsibility of the provider to request authorization for specific days. Failure to request further authorization and timely submittal of clinical documentation will result in an Administrative Denial. If the facility is requesting additional days, clinical documentation is due by noon on the last covered day to the assigned UM Reviewer whether they request it or not. Any additional requests from the UM Reviewer must be submitted within 24 hours or will be considered untimely and subject to an Administrative Denial.

Required Documents for Concurrent Review

Providers must submit the following clinical information to support the medical necessity for concurrent review prior to noon on the last covered. Information is to be faxed to 520-874-3420 or directly to the UM Reviewer per their request. If the UM Reviewer and the facility agree to send concurrent review documents directly to the UM Reviewer’s email, the facility must send these documents securely.

1) Attending Behavioral Health Medical Practitioner (BHMP) notes for each day of hospitalization and subacute detox level of care, including a specific description of the member’s residual symptoms and level of risk/impairment, as well as a detailed plan, specific to the individual member, that describes the medication changes or other treatment interventions that are to be employed to address remaining clinical needs.

2) For sub-acute facilities not providing detox, BHMP notes must be provided at a minimum for Monday through Friday.

3) Estimated length of stay.

4) Medication Administration Record (MARS).

5) CIWA/CINA/COWS protocols, as applicable.

6) All physician orders.

7) Lab results, if clinically indicated.

8) Discharge barriers (including updates every 24 hours if barriers are resulting in avoidable days).
To facilitate effective collaboration, the appropriate and efficient utilization of health care resources, and optimal care management, all inpatient psychiatric providers are required to participate in timely submittal of clinical information to support the concurrent review of the services provided for which reimbursement is sought.

To justify remaining in an inpatient level of care, submission of all required clinical information/documentation 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/ICD 10 code, and the following:

1) The intensity of service being delivered should be appropriate to the risk level that justified the admission
2) Documentation of medical necessity throughout the member’s hospital stay, including ongoing symptoms and specific responses to medication changes and other therapeutic interventions, including 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.

The Health Plan bases concurrent review determinations solely on the medical information obtained by the reviewer at the time of the review determination. Frequency of the reviews are 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 MCG criteria. Authorization for hospital stays may 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.

Psychiatric inpatient admissions now are characterized as acute care hospitalizations, rather than long term hospital stays. The associated expectation is that the care of psychiatric patients who are admitted to these acute care facilities will be managed in a manner that is consistent with short-term hospitalization, including daily clinical assessments by an attending provider, accompanied by any clinically appropriate modifications to the patient’s treatment regimen and care plan. If a patient is admitted to an inpatient psychiatric unit on a Friday afternoon (typically with only standard admission orders, and at best, perhaps the continuation of outpatient medication orders that have not been effective in treating or controlling the patient’s mental health symptoms in the community), but with no follow-up by a psychiatric clinician or assigned treatment team until the following Monday, the stay of that patient inevitably will be prolonged, secondary to this 2-day delay in initiating meaningful care. With a median length of stay of just 4.5 days, the lack of weekend coverage by a psychiatric clinician could potentially extend the patient’s hospitalization (which frequently has occurred on an involuntary basis) in a locked and highly restricted environment to 6.5 days or more (with continued
decompensation of the patient, even in an inpatient setting, while awaiting the initiation of treatment that presumably cannot be provided at a lower level of care). In addition, the more symptomatic a patient becomes while awaiting additional clinical assessment and treatment, the more difficult (and time-consuming) his/her symptoms ultimately will be to control, potentially requiring an even lengthier period of hospitalization.

**Administrative Denials During Inpatient Hospitalization**

An Administrative Denial is based on the following:

- Failure of the facility to submit ALL of the required documentation/clinical information to conduct comprehensive utilization review activities to determine medical necessity for admission and/or concurrent review/continued stay within the required time frame and/or:
  - Failure to provide the services required

Administrative denials are based on the lack of information timely submitted and/or deficiency in provision of services required and not based on medical necessity criteria. As a result, they do not require physician review or involvement in the denial decision. These denials will result in the termination of the authorization where there is a deficiency in documentation/information or services for the entire or remaining length of stay or denial of specified days where required documentation/information or services, for example a BHMP note is not provided during specified days.

After an Administrative Denial has been issued, the facility can submit the claim/request as a Retrospective Review through the Claims Department. However, Retrospective Review cannot be utilized in lieu of good faith participation in the Concurrent Review process. The request for reimbursement through a Retrospective Review must include an explanation as to why the facility was unable to submit timely and comprehensive clinical documentation required to determine medical necessity at the time of admission, concurrent review or the UM reviewers request. The facility must also include information related to the member being admitted on Court Ordered Evaluation and provide legal documentation to support the end of the Court Ordered Evaluation. Requests for Retrospective Reviews that include the days the member was under a Court Ordered Evaluation will be denied as the county is the payer. See Section on Retrospective Reviews.

For concurrent review/continued stay Administrative Denials will be issued in the following situations:

- **For Psychiatric hospitalization and sub-acute detox**: Administrative Denials will be issued when there is lack of documentation/information to demonstrate appropriate BHMP services daily for each day, including weekends and holidays. This includes documentation of a Psychiatric Evaluation and H & P within 24 hours of the member’s admission. All Psychiatric hospitals and sub-acute facilities providing detoxification services are required to submit BHMP progress notes for each day.

- **For sub-acute facilities that do not conduct detox**: Administrative Denials will be issued when there is lack of documentation/information to demonstrate BHMP services for any weekday or if a psychiatric assessment has not been conducted within 24 hours of admission. All sub-acute facilities that are providing services that exclude detoxification services must submit BHMP progress notes at a minimum of all weekdays and a psychiatric assessment within 24 hours of
admission.

- Administrative Denials of reimbursement for weekend days when no clinical coverage is provided is not intended to be punitive. Such denials rather represent advocacy on behalf of our members with mental health disorders. These members are entitled to receive appropriate care and treatment, on par with the services received by patients on other medical units. They are entitled to remain on locked and highly restricted units for the minimum amount of time necessary to safely and adequately treat their symptoms, and to allow for a transition to a lower level of care.

**Hospital Avoidable Days**

At times, potentially avoidable delays may occur in discharging members from an acute level of behavioral health care to a less restrictive treatment setting. Such delays typically occur because the less restrictive, community-based treatment and supports that are necessary for a safe and successful discharge are not yet fully arranged or available. Potentially avoidable inpatient days are periods of continued hospitalization on a Level I or subacute behavioral health unit that are authorized by the health plan when medical necessity no longer is demonstrated, but services at a lower level of care are not yet available, despite active, comprehensive, and timely discharge planning efforts by the facility or provider. Potentially avoidable inpatient days will be authorized only when discharge planning activities are documented appropriately by the facility or provider from the time of the member’s initial admission, and when evidence of continued, comprehensive discharge planning efforts is submitted daily to the health plan for review, until discharge of the member occurs.

Potentially avoidable inpatient days must be preceded by at least one acute inpatient day (24 hours in duration) that meets medical necessity criteria. Authorization will not be provided for direct admission from an outpatient or residential treatment setting to a more acute level of care for which medical necessity has not been demonstrated, or for which prior authorization has not been obtained. Potentially avoidable inpatient days also will not be authorized solely for convenience, or when appropriate services in an alternative setting are available, but refused or declined by the member, the member’s family, or the inpatient treatment team.

When potentially avoidable inpatient days are authorized, the facility or provider must continue to assure that appropriate behavioral health treatment and services are provided to the member until the time of discharge to a lower level of care. Types of potentially avoidable inpatient days include: (1) lack of an available residential treatment bed in a BHRF, BHIF, or HCTC level of care; (2) lack of available specialty services (such as those that are medically necessary for members with an autism spectrum diagnosis, sexually maladaptive behaviors, cognitive limitations, a significant history of aggression toward others, accompanying medical disorders, or other similar conditions), and (3) lack of access to other community-based treatment and supports that are necessary to sustain adequate functioning in the community.

**Required Reporting of Avoidable Days**

To justify avoidable/administrative bed days the following must be provided to the UM Reviewer during concurrent review. Failure to provide this information may result in an Administrative or Medical Necessity Denial:

- Clinical documentation must support that alternative discharge arrangements available are not
adequate to safely meet the needs of the member.

- If a required service is not currently available, the Discharge Plan must clearly state this and identify the steps to be able to access needed services. Entries such as "deferred until patient stabilizes," "to be determined," or "placement pending," are not acceptable.

- Evidence of active attempts to effectuate discharge to a specified placement/level of care or community-based service must be provided and resubmitted/updated and reviewed by staff every 24 hours. If there are insufficient discharge planning activities a denial may be issued.

**Hospital/Inpatient 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 Discharge Planning in this manual*

**Hospital Discharge Planning**

Discharge planning is expected to begin on the date of admission. If the member is not enrolled with an outpatient behavioral health provider, the inpatient team must initiate a request to enroll the member with an outpatient agency chosen by the member or by zip code. Timely identification and documentation of the member’s outpatient behavioral health provider must also include active engagement of such providers in the discharge process. The Health Plan Behavioral Health Department can provide assistance with facilitating urgent enrollment and the referral process by contacting: BUHPcareMGMTBHMailBox@bannerhealth.com.

Contracted behavioral health providers must develop and implement a discharge planning process to address the post-discharge clinical and social needs of members upon discharge. The process shall be initiated by a qualified health care professional who is expected to participate in development of the discharge plan and update the plan periodically during the inpatient admission to ensure that continuing care needs have been accurately determined. The following must be included 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 must include as applicable:
o 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.

o 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.

o Coordination with the member’s outpatient clinical team to explore interventions to address the member’s needs such as case management, disease management, placement options, intensive community-based services and community supports. This must include a post-acute transition plan to enhance support and intensive community-based services for at least 30 days post discharge or until stabilization.

o Adherence to all prior authorization requirements before transfer of a member to another Level I inpatient psychiatric facility or to an alternative level of care (including a BHRF).

o Access to prescribed discharge medications.

o Coordination of care with the Health Plan including submission of prior authorization, when applicable.

o Post discharge follow up contact to assess the progress of the discharge.

Requirements for Discharge Plan/Summary

All facilities are required to submit the Discharge Plan/Summary to the Health Plan and the outpatient behavioral health provider within 24 hours of discharge. Discharge Plan/Summary must be submitted to: BUHPUMPAMailbox@bannerhealth.com.

At a minimum the Discharge Plan/Summary must contain the following information:

- Date of discharge
- Discharge diagnosis
- Discharge instructions, including follow up services and discharge appointments (required to have an appointment with prescriber or BHMP within 7 days)
- Discharge medications including the following: dosage, instructions and number of days of medications provided if applicable (for hospitals and BHIFs)

Delays in submitting the Discharge Summary to the Health Plan may result in a delay of claims payment. The Health Plan must have accurate documentation to confirm the date of discharge and the discharge information.

Behavioral Health Inpatient Facility (BHIF)

BHIF services provide treatment for children and adolescents who demonstrate severe and persistent psychiatric disorders, when ambulatory care services in the community or services in a less restrictive therapeutic level of care do not meet their treatment needs and they require services under the
direction of a Behavioral Health Medical Professional (BHMP). These services are designed for children and adolescents who have a DSM 5/ICD-10 psychiatric diagnosis, significant deficits in functioning, and who require active treatment in a controlled environment with a high degree of psychiatric oversight, 24-hour nursing services, comprehensive programming and treatment. Active treatment focuses on specific targeted goals identified by the Child and Family Team (CFT) and are designed to enable the child/adolescent to be discharged at the earliest possible time. A lack of available outpatient services or services in a less restrictive therapeutic level of care is not, in and of itself, the sole criterion for admission to a BHIF.

Admissions to a BHIF level of care can be either Emergent or Non-Emergent. But all admissions must meet medical necessity criteria.

There are two types of BHIFs as follows:

Secure - A BHIF which may employ security guards and/or uses monitoring equipment and alarms
Non-secure – A BHIF that is unlocked, and continuous supervision is provided by professional behavioral health staff.

Admission Criteria for BHIF Level of Care for Emergent/Non-Emergent Admissions

1) **Diagnosis:** There is clinical evidence and documentation that the child/adolescent has a primary psychiatric ICD-10/DSM 5 diagnosis that is amenable to active treatment. Any co-occurring diagnosis or diagnoses must be identified and documented prior to admission.

2) **Behavior and functioning:** Criteria a, b and c below must all be met as follows:
   a) Symptoms or functional impairment of the individual’s psychiatric condition are of a severe and persistent nature and
   b) Result in the member being a Danger to Self (DTS), Danger to Others (DTO) or unable to engage in daily activities safely in a less restrictive setting and
   c) All the following in i-iii must be met to ensure appropriate, cost-effective treatment in the least restrictive and most appropriate setting:
      i. Ambulatory care resources (outpatient behavioral health services in the community) or services in a less restrictive therapeutic level of care do not meet the treatment needs of the child/adolescent as demonstrated by at least one of the following:
         o Unsuccessful treatment within the last month in at least one of the following:
            a. Intensive community-based treatment
            b. HCTC services
            c. Behavioral Health Residential Facility
            d. Psychiatric hospital or,
         o Professional judgement that the youth’s clinical needs cannot safely and comprehensively be met in a lower level of care and,
The support system is unable to manage the intensity of child/adolescent symptoms to ensure safety and,

i. The child/adolescent does not require a level of medical or professional supervision that surpasses that which is available at the BHIF

iii. The child/adolescent’s Service Plan/Complete Care Plan (as applicable) must be aligned with the facility care plan. Comprehensive and ongoing assessment and treatment is planned for prior authorization and being provided for concurrent review authorization.

BHIF Exclusion Criteria

The admission cannot be used as an intervention for any of the following:

- An alternative to incarceration, preventative detention, or to ensure community safety in a child/adolescent exhibiting primarily delinquent/antisocial behavior including runaway behavior; or
- The equivalent of safe housing, permanency placement, or
- An alternative to parents’/guardian’s or another agency’s capacity to provide for the child or adolescent; or
- An intervention when other less restrictive alternatives are available and not being utilized.

BHIF Non-Emergent Admissions

Prior authorization must occur prior to admission to a BHIF for non-emergent admissions. The Health Plan determines medical necessity for standard decisions within 14 calendar days upon receipt of the request. If appropriate, the Health Plan may issue an extension of an additional 14 calendar days to request additional information. The Health Plan requires active involvement of the CFT to facilitate discussion of admission for all levels of care. Expedited authorization may be requested when the provider determines that using the standard timeframe could seriously jeopardize the member’s life and/or health or ability to attain, maintain or regain maximum function. The Health Plan will look to the CFT to facilitate discussion of admission in consideration of the member when the member is in an inpatient hospital setting- expedited authorization may be granted. If approved, the Health Plan will issue an authorization for up to 45 days. Upon admission during the 45-day period, another authorization is activated to secure the date range. Providers are required to submit additional clinical documentation if the member does not admit within 45 days of approval.

Request for Prior Authorization for Non-Emergent Admission to a BHIF must include the following, and submitted via fax to 520-694-0599:

- The Behavioral Health Prior Authorization Form,
- An updated Individual Service Plan (or Complete Care Plan, when applicable) indicating the goal for the admission to the BHIF,
- A recent psychiatric evaluation or psychiatric progress note that reflects current behaviors and functioning and diagnoses, and
• Certificate of Need (CON) (from the facility upon admission/ no later than 72 hours after admission)
• Out of Home Application,
• The most recent assessment or an assessment that has been updated in the past year,
• The Child Family Team (CFT) note indicating the team’s recommendations,
• Any other reports from outpatient providers or other treatment providers, and
• Any psychological reports or other reports from specialty providers.

BHIF Emergent Admissions

Notification of Emergent Admission to a BHIF must include the following and be submitted via fax to 520-694-0599 within two business days of admission:

For emergent admissions, a member may be placed in the facility if the referring provider and accepting facility have documented information to suggest medical necessity criteria are met as stated above (Diagnosis and Behavior and Functioning). For emergent admissions, when documentation supports medical necessity, an authorization will be issued when the notification has been received within no later than two business days of the admission. Initial authorizations that meet medical necessity for an emergent admission will receive a short-term authorization to address the emergent admission and then ongoing concurrent review is needed for any additional days that are requested. If the notification is received later than the two business days, then authorization will be effective the date of receipt of the notification.

Documentation Required for Emergent Admission to a BHIF within 2 business days of the admission:

• Behavioral Health Prior Authorization,
• Out of Home Admission Notification,
• Out of Home Application, and
• Submit a CON within 72 hours of admission.

Concurrent Review for Emergent BHIF

If the member requires a continued stay past the initial authorized days, submit the following via fax to 520-694-0599.

• Concurrent Review Form prior to noon on the last covered day.

Concurrent Review for Non-Emergent BHIF

Continued stay requests for the BHIF level of care must be submitted by noon, 7 calendar days prior to the last covered day of the current authorization for concurrent review.

Documents that must be submitted to support medical necessity for concurrent review:

1. Psychiatric notes,
2. Concurrent Review Form,
3. CFT notes,
4. Medication List,
5. Discharge plan, and
6. After 30 days submit a Recertification of Need (RON).

For concurrent review authorization, if the youth is not demonstrating improvement, the facility care plan must be revised as part of the CFT process resulting in an expectation of improvement to achieve discharge from the BHIF at the earliest possible time and facilitate return to outpatient care or less restrictive therapeutic level of care. The child/adolescent must be actively participating in treatment.

The Health Plan bases concurrent review determinations solely on the medical information obtained by the reviewer at the time of the review determination. Frequency of the reviews are 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 MCG criteria. Authorization for BHIF will have a specified date and time by which requested clinical information/documents will be required for review. This information will be provided to the requesting provider to ensure coordination and understanding of when additional member condition updates are required. Please note section on issuance of Administrative Denials when clinical information is not submitted timely or fully.

To justify remaining in a BHIF 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/ICD 10 code, 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. Persistence of symptoms such that continued observation or treatment is required
3. Increased risk of complications as a result of intervention or as a product of newly discovered conditions
4. 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.

Concurrent review documentation should include a description of the active treatment and interventions that are being provided (and documented in the clinical record) that is assisting the member in achieving identified Service Plan/Care Planning goals for a successful discharge. Active treatment services should include the following:

1) Psychiatric services at a minimum of every other week, or more as indicated, to provide active psychiatric treatment including a focus on psychosocial interventions and pharmacotherapy to meet individualized needs
2) Clinical assessment at a minimum on a daily basis that includes close, continuous, 24 hour skilled medical/nursing supervision
3) Individual and family therapy each a minimum of once a week or more to meet individualized
needs. If family therapy is not being provided rationale must be documented in the clinical record

4) Group therapy and/or an individualized or family therapy service on a daily basis

5) Active and individualized ongoing positive behavioral management

6) School or vocational programming

Re-certification Of Need (RON)

A RON is a re-certification made by a physician, a nurse practitioner or physician assistant. The RON must recertify for each applicant or beneficiary that continued inpatient services in a BHIF are needed. A RON must be completed at least every **30 days for a member under the age of 18 who is receiving services in a Behavioral Health Inpatient Facility**. The completion and review of the Service Plan/Complete Care Plan in this circumstance meets the requirement for the re-certification of need. For a sample RON form see **Provider Manual Form - Recertificate of Need**.

The following documentation is needed on a RON:

- Fax RONS to 520-874-3411.
- 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;
- RONs must have a dated signature by a physician, nurse practitioner or physician assistant.

Administrative Denials During BHIF Hospitalization

An Administrative Denial is based on the following:

- Failure of the facility to submit ALL of the required documentation/clinical information to conduct comprehensive utilization review activities to determine medical necessity for admission and/or concurrent review/continued stay **and/or**
- Failure to provide the services required

Administrative denials are based on the lack of information timely submitted and/or deficiency in provision of services required and not based on medical necessity criteria. As a result, they do not require physician review or involvement in the denial decision. These denials will result in the termination of the authorization where there is a deficiency in documentation/information or services for the entire or remaining length of stay or denial of specified days where required documentation/information or services, for example a BHMP note is not provided during specified days.

After an Administrative Denial has been issued, the facility can submit the claim/request as a Retrospective Review through the Claims Department. The request for reimbursement through a
Retrospective Review must include an explanation as to why the facility was unable to submit timely and comprehensive clinical documentation required to determine medical necessity at the time of admission, concurrent review or the UM reviewers request.

**BHIF Administrative Denials**

Administrative denials will be issued for concurrent review/continued stay of BHIFs when there is lack of documentation/information to demonstrate required services have been provided consistent with the required interventions including the following:

1. Psychiatric services at a minimum of every other week, or more as indicated, to provide active psychiatric treatment including a focus on psychosocial interventions and pharmacotherapy to meet individualized needs
2. Clinical assessment at a minimum on a daily basis that includes close, continuous, 24 hour skilled medical/nursing supervision
3. Individual and family therapy each a minimum of once a week or more to meet individualized needs. If family therapy is not being provided rationale must be documented in the clinical record
4. Group therapy and/or an individualized or family therapy service on a daily basis’
5. Active and individualized ongoing positive behavioral management
6. School or vocational programming

**Discharge Criteria**

The member is ready for discharge when any of the following criteria have been satisfied:

1. The planned course of treatment has been completed.
2. The member’s 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 Discharge Planning in this manual

**Hospital/BHIF Discharge Planning**

Discharge planning is expected to begin on the date of admission. If the member is not enrolled with an outpatient behavioral health agency, inpatient team is to initiate a request for enrollment with an outpatient agency chosen by the member or by zip code. The Health Plan Behavioral Health Department can provide assistance with referral process by contacting: BUHPCareMGMTBHMailbox@bannerhealth.com.

Discharge planning should include a written plan for discharge with specific discharge criteria and recommendations for aftercare treatment that includes involvement of the Child and Family Team and complies with current standards for medically necessary covered behavioral health services, cost effectiveness, and least restrictive environment and is in conformance with 42 CFR.1. Discharge plans
must continue to be refined throughout treatment to ensure all needs have been addressed to prepare for a safe and supported transition to lower level services.

Contracted providers must develop and implement a discharge planning process to address the post-discharge clinical and social needs of members upon discharge. The process shall be initiated by a qualified healthcare professional who is expected to participate in development of the discharge plan and update the plan periodically during the inpatient admission to ensure that continuing care needs have been accurately determined. The following must be included 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:
  
  o 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.

  o 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.

  o Coordination with the member’s outpatient clinical team to explore interventions to address the member’s needs such as case management, disease management, placement options, and community support services.

  o Access to prescribed discharge medications.

  o Coordination of care with the Health Plan, when applicable

  o 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.

Requirements for Discharge Plan/Summary

All facilities are required to submit the Discharge Plan/Summary to the Health Plan and the outpatient behavioral health provider within 24 hours of discharge. Discharge Plan/Summary must be submitted to: BUHPUMPAMailbox@bannerhealth.com.

At a minimum the Discharge Plan/Summary must contain the following information:

- Date of discharge

- Discharge diagnosis

- Discharge instructions including follow up services and discharge appointments (required to
have an appointment with prescriber or BHMP within 7 days)

- Discharge medications including the following: dosage, instructions and number of days of medications provided if applicable (for hospitals and BHIFs)

*Delays in submitting the Discharge Summary to the Health Plan may result in a delay of claims payment. The Health Plan must have accurate documentation to confirm the date of discharge and the discharge information.*

**BHIF Avoidable Days**

At times, potentially avoidable delays may occur in discharging members from an acute level of behavioral health care to a less restrictive treatment setting. Such delays typically occur because the less restrictive, community-based treatment and supports that are necessary for a safe and successful discharge are not yet fully arranged or available. Potentially avoidable inpatient days are periods of continued hospitalization on a BHIF level of care that are authorized by the health plan when medical necessity no longer is demonstrated, but services at a lower level of care are not yet available, despite active, comprehensive, and timely discharge planning efforts by the facility or provider. Potentially avoidable inpatient days will be authorized only when discharge planning activities are documented appropriately by the facility or provider from the time of the member’s initial admission, and when evidence of continued, comprehensive discharge planning efforts is submitted daily to the health plan for review, until discharge of the member occurs.

Potentially avoidable inpatient days must be preceded by at least one acute inpatient day (24 hours in duration) that meets medical necessity criteria. Authorization will not be provided for direct admission from an outpatient or residential treatment setting to a more acute level of care for which medical necessity has not been demonstrated, or for which prior authorization has not been obtained. Potentially avoidable inpatient days also will not be authorized solely for convenience, or when appropriate services in an alternative setting are available, but refused or declined by the member, the member’s family, or the inpatient treatment team.

When potentially avoidable inpatient days are authorized, the facility or provider must continue to assure that appropriate BH treatment and services are provided to the member until the time of discharge to a lower level of care. Types of potentially avoidable inpatient days include: (1) lack of an available residential treatment bed in a BHRF, or HCTC level of care; (2) lack of available specialty services (such as those that are medically necessary for members with an autism spectrum diagnosis, sexually maladaptive behaviors, cognitive limitations, a significant history of aggression toward others, accompanying medical disorders, or other similar conditions), and (3) lack of access to other community-based treatment and supports that are necessary to sustain adequate functioning in the community.

**Required Reporting of Avoidable Days**

To justify avoidable/administrative bed days the following must be provided during the UM Reviewer during concurrent review, failure to provide this information may result in an Administrative or Medical Necessity Denial:

- Clinical documentation must support that alternative discharge arrangements available are not adequate to safely meet the needs of the member
• If a required service is not currently available, the discharge plan must clearly state this and identify the steps to be able to access needed services. Entries such as "deferred until patient stabilizes," "to be determined," or "placement pending," are not acceptable.
• Evidence of active attempts to effectuate discharge to a specified placement/level of care or community-based service must be provided and resubmitted/updated and reviewed by staff every 24 hours. If there are insufficient discharge planning activities a denial should be issued.

The Health Plan Behavioral Health UM staff will expedite services requiring prior authorization to ensure prompt placement to lower level of care. The Health Plan may assign a Behavioral Health Care Manager to assist a contracted provider in securing lower level of care and submission of out of home packet.

Retrospective Review for Inpatient Hospitalizations

Retrospective Review is a process that occurs after a treatment has been completed and discharge from the service has been accomplished that encompasses appropriateness, coverage, efficiency and medical necessity of services. The retrospective review process may be initiated upon receipt of delayed notification and/or service and/or admission and must be received within 30 days from completion of the service. Administrative Denials are issued when the request for a Retrospective Review exceeds the 30-day time frame from the completion of service with the exception of Prior Period Coverage. For purposes of this document, retrospective review refers to claims submission that occurs following an inpatient psychiatric admission, after treatment has been completed and the member has discharged. Retrospective review will not serve as an alternative to or a substitute for mandatory concurrent review.

The Health Plan does not conduct retrospective reviews for any other level of care except for inpatient psychiatric hospitalizations.

Delayed notification of admission to a psychiatric facility while the member is still hospitalized and receiving active treatment must be submitted through the Notification of Admission process for consideration of admission and concurrent review. The Health Plan reserves the right to determine when a delayed notification of admission should be considered a retrospective review and submitted through the Claims department.

Requests for retrospective reviews must include ALL of the following:

• Requests for Retrospective Reviews must include the date ranges being requested for review.
• The request must be submitted within 30 days of the date of discharge/completion of service. If past 30 days, the record will not be reviewed and returned to the provider.
• The request must include a reasonable explanation of why the provider was not able to notify Banner-UFC of the admission or was not able to provide timely clinical documentation to participate in the utilization management concurrent review process at the time of the hospitalization. If the provider indicates that attempts were made to contact the Health Plan upon admission and no response was received, the provider must submit evidence of the attempts to contact the Health Plan during the hospitalization.
• If a Denial Letter was issued, the provider must submit a copy of the Denial Letter with the
• The provider must submit legal documentation if the member was admitted under a Court Ordered Evaluation with the dates of the initiation and completion of the Court Ordered Evaluation period. This must include why the Court Ordered Evaluation was ended (time expired, discharged, voluntary etc.) All requests for Retrospective Review that include the Court Ordered Evaluation period time frame for reimbursement will be denied. All Court Ordered Evaluations are funded by the county. Medicaid is the payer of last resort and does not reimburse for Court Ordered Evaluation.

• All requests for Retrospective Reviews or Appeals must include the required clinical documentation as indicated in the Banner Behavioral Health Provider Manual Supplement for initial authorization, concurrent review and discharge. The entire medical record is not requested for Retrospective Reviews. Providers are to only send the required documents. Records submitted in entirety will be denied. If the provider fails to submit sufficient information to render an authorization determination, the Health Plan will notify the provider and specifically describe the information needed. The facility will be given up to fourteen (14) calendar days to submit the additional information or to inform the Health Plan why the information cannot be submitted for review. The Health Plan will make a one-time request if clinical information is not sufficient to make a decision. Banner recommends providers label each clinical document when submitted to ensure the required documentation is being submitted and not extraneous information that can delay the review process.

• Certificate of Need (CON), as applicable (not required for Prior Period Coverage)

Retrospective review is available only when:

1. Documentation is provided to substantiate that timely notification of admission and/or concurrent review was not reasonably possible prior to the member’s discharge and/or during the hospitalization. Banner reserves the right to determine what is a reasonable justification to consider a Retrospective Review request.

2. All requested clinical documentation was provided in timely manner in conjunction with concurrent review, but supplemental information subsequently was identified that warrants further consideration.

3. Review is submitted due to Prior Period Coverage

4. Exceptions for BHRFs and SABG Funding - Retrospective reviews can be submitted by contracted substance abuse providers that used Substance Abuse Block Grant funds (aka SABG) for a non-Medicaid member at the time of admission. When the member receives prior period coverage and Medicaid/ BUHP becomes the payer for the Behavioral Health Residential Facility (BHRF) these requests are appropriate to submit in these circumstances only. These retrospective reviews require a medical necessity review.

Upon receipt of a request for retrospective review, the Health Plan will screen the request to determine if it is eligible for Retrospective Review. If it is determined that the request is not eligible for Retrospective Review based on the above criteria, the provider may submit an appeal.
Retrospective reviews and supporting medical records should be directly submitted to the Health Plan claims department via mail:

**Banner – University Family Care / AHCCCS Complete Care (BUFC/ACC)**
P.O. Box 35699
Phoenix, AZ 85069-7169
Electronic ID: 09830

**Banner – University Family Care/Arizona Long Term Care (BUFC/ALTCS)**
P.O. Box 37279
Phoenix, AZ 85069
Electronic ID: 66901

**Banner – University Care Advantage (BUCA)**
P.O. Box 38549
Phoenix, AZ 85069-7169
Electronic ID: 09830 (UCA)

**RESUBMISSIONS**
Be sure to clearly mark “Resubmission” on the claim form or select the appropriate box on the claim form if sending electronically

**APPEALS**
Banner University Health Plans
Attn: Grievance and Appeals Department
2701 E. Elvira
Tucson, AZ 85756
FAX- (866) 465-8340
Email: BUHPGrievances&Appeals@bannerhealth.com

**Adult/Children Behavioral Health Residential Facility (BHRF)**

Care and services provided in a contracted BHRF are based on a per diem rate (24-hour day), require prior authorization based on the circumstances outlined below, and do not include room and board.

All BHRF providers are required to employ staff with the competencies and skills to deliver the required interventions and programmatic services, including developing measurable and achievable treatment goals, ability to clinically document the member’s progress and participate in clinical meetings to support the member’s care, transitions and discharge planning.

All BHRF providers are required to notify the member’s Primary Care Provider and Behavioral Health outpatient provider upon intake and discharge from the BHRF.

For providers that offer comprehensive evaluation processes and intensive behavioral interventions for youth that may have had prior multiple out of home treatment services and/or present with very complex needs, the Health Plan requires a prior authorization and single case agreement request. Cases are reviewed on a case by case basis depending on the member’s needs, the CFT recommendations, the facility treatment services and approaches to the individual member as it relates to medical necessity.
Individuals may be admitted to a BUFC contracted BHRF level of care on an emergent basis or through an Expedited Prior Authorization Request. All BHRF requests are considered expedited. The Health Plan will make a determination of medical necessity within 72 hours of the request, including weekends and legal holidays. If the Health Plan is unable to make a decision within the 72-hour time frame due to lack of clinical documentation to substantiate an approval or denial, a Notice of Extension letter will be sent to the provider and member/guardian.

The Health Plan does not authorize emergent admissions to non-contracted BHRFs. All requests for non-contracted BHRFs must be submitted for a prior authorization. Non-contracted BHRF authorizations will be determined based on medical necessity regarding special circumstances. Non-contracted BHRFs that admit Banner members without a prior authorization approval will be denied.

**Emergent-Admission Criteria for BHRF**

For emergent admissions, a member may be placed in the contracted facility, based on documented information that meets medical necessity criteria. The member requiring an emergent admission to a BHRF may be admitted even if they are not currently enrolled with an outpatient behavioral health provider. For emergent admissions, upon receipt of the required documents, and when medical necessity criteria have been met, an initial authorization will be issued for a brief period only when the notification has been submitted within the two business days of admission. If the notification is received later than the two business days and medical necessity criteria are met, then authorization will be effective the date of receipt of the notification. When admitting a member to a BHRF on an emergent basis, it is the responsibility of the BHRF provider to ensure that there is enough clinical information available to support medical necessity. See the criteria stated below. If member requires a continued stay, the out of home provider must submit a Concurrent Review Form by the last covered day.

**Notification of Emergent Admission to a BHRF** must include the following and be submitted via fax to 520-694-0599 within two business days of admission:

- Behavioral Health Prior Authorization
- Out of Home Admission Notification
- Out of Home Application

Below is a list of Banner contracted Adult BHRF providers accepting Emergent Admissions in the southern region. *This list is not a fully inclusive list.*
Below is a list of Banner contracted Children’s BHRF providers accepting Emergent Admissions in the southern region. This list is not a fully inclusive list.

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Non-Emergent Admissions to BHRF

Prior authorization must occur prior to admission to a BHRF for non-emergent admissions. The Health Plan determines medical necessity for standard decisions within 14 calendar days upon receipt of the request. If appropriate, the Health Plan may issue an extension of an additional 14 calendar days to request additional documentation. The Health Plan requires active involvement of the ART or CFT to facilitate discussion of admission for all levels of care. Expedited authorization may be requested when the provider determines that using the standard timeframe could seriously jeopardize the member’s life and/or health or ability to attain, maintain or regain maximum function. If approved, the Health Plan will issue an authorization for up to 45 days. Upon admission during the 45-day period, another authorization is activated to secure the date range. Providers are required to submit additional clinical documentation if the member does not admit within 45 days of approval.

Request for Prior Authorization for Non-Emergent Admission to a BHRF Level of Care must include the following and submit via fax 520-694-0599:

- Behavioral Health Prior Authorization
- Out of Home Application, with supporting clinical documentation
- If the admission is for substance abuse, include supporting clinical documentation such as American Society of Addiction Medicine (ASAM) Criteria.
Criteria for Admission to a Behavioral Health Residential Facility

Member must have a diagnosed behavioral health condition which reflects the symptoms and behaviors necessary for a request for residential treatment. The behavioral health condition causing the significant functional and/or psychosocial impairment shall be evidenced in the assessment by the following criteria and only used when needs cannot be addressed in a less restrictive level of care or with community-based treatment because of potential danger to self or others:

1. a)  
   i. At least one area of significant risk of harm within the past three months and expectation of continued significant risk of harm as a result of: i. Suicidal/aggressive/self-harm/homicidal thoughts or behaviors resulting in potential risk for danger to self or others without current plan or intent and need for active treatment in this level of care.  
   ii. Impulsivity with poor judgment/insight that are not developmentally appropriate  
   iii. Maladaptive physical or sexual behavior  
   iv. Member’s inability to remain safe within his or her environment, despite environmental supports (i.e. Natural Supports), or community-based services.  
   v. Medication side effects due to toxicity or contraindications which do not require continuous medical or nursing supervision and are appropriate for supervised medication self-administration.  

   AND  

b)  
   i. At least one area of serious functional impairment which cannot be addressed in a less restrictive level of care or community-based treatment because of potential danger to self or others as evidenced by: i. Inability to complete developmentally appropriate self-care or self-regulation due to member’s behavioral health condition(s)  
   ii. Neglect or disruption of ability to attend to majority of basic needs, such as personal safety, hygiene, nutrition or medical care  
   iii. Frequent inpatient psychiatric admissions or legal involvement due to lack of insight or judgment associated with psychotic or affective/mood symptoms or major psychiatric disorders where exclusionary criteria are not met.  
   iv. Inability to independently self-administer medically necessary psychotropic medications despite interventions such as education, regimen simplification, daily outpatient dispensing, and long-acting injectable medications or,  
   v. Impairments persisting in the absence of situational stressors that delay recovery from the presenting problem.  

2. A need for 24-hour behavioral health care and supervision to develop adequate and effective coping skills that will allow the member to live safely in the community.
3. Anticipated stabilization cannot be achieved in a less restrictive setting.
4. Evidence that appropriate treatment in a less restrictive environment has not been successful or is not available, therefore warranting a higher level of care.
5. Member agrees to participate in treatment. In the case of minors, family/guardian/designated representative also agrees to and participates as part of the treatment team.

Admission, Assessment, and Complete Care Plan

Upon admission to a BHRF, the BHRF provider and the outpatient provider will conduct the following assessment and Service Planning/Complete Care planning process:

1. A behavioral health assessment for a member is completed before treatment is initiated and within 48 hours of admission.
2. The CFT/ART is included in the development of the Service Plan within 7 days of admission.
3. A comprehensive discharge plan is created during the development of the initial Treatment Plan and is reviewed and/or updated at each review thereafter. The discharge plan shall document the following:
   a. Anticipated clinical status upon discharge
   b. Member/guardian/designated representative and CFT/ART understands follow-up treatment, crisis and safety plan
   c. Coordination of care and transition planning are in process (e.g. reconciliation of medications, applications for lower level of care submitted, follow-up appointments made).
   d. Comprehensive services and supports to meet the member’s immediate and post-acute needs to support successful transition back to the community
4. The BHRF staff participate in the CFT/ART process and meet to review and modify the Complete Care Plan at least once a month.
5. A Treatment Plan that is completed by a Behavioral Health Professional (BHP) or by a Behavioral Health Technician (BHT) which shall be reviewed and signed off on by a BHP within 24 hours.
6. The provider has a system to document and report on timeliness of BHP signature/review when the Treatment Plan is completed by a BHT.
7. The provider has a process to actively engage family/guardians/designated representative in the treatment planning process as appropriate.
8. The provider’s clinical practices, as applicable to services offered and population served, shall demonstrate adherence to best practices for treating specialized service needs, including but not limited to:
   a. Cognitive/intellectual disability,
   b. Cognitive disability with comorbid behavioral health condition(s),
c. Older adults, and co-occurring disorders (substance use and behavioral health condition(s)), or
d. Comorbid physical and behavioral health condition(s).

9. Services deemed medically necessary through the assessment and/or CFT/ART, which are not offered at the BHRF, shall be accessed to meet the needs of the member. Services which are part of the BHRF cannot be billed separately and must be included under the BHRF per diem.

Services to be made available and provided by the BHRF include but are not limited to:

a. Counseling and Therapy (group or individual): Note: Group Behavioral Health Counseling and Therapy may not be billed on the same day as BHRF services unless specialized group behavioral health counseling and therapy have been identified as a specific member need that cannot otherwise be met as required within the BHRF setting. All counseling services not provided directly by the BHRF provider require a prior authorization.

b. Skills Training and Development:
   i. Independent Living Skills (e.g. self-care, household management, budgeting, avoidance of exploitation/safety education and awareness).
   ii. Community Reintegration Skill building (e.g. use of public transportation system, understanding community resources and how to use them).
   iii. Social Communication Skills (e.g. conflict and anger management, same/opposite-sex friendships, development of social support networks, recreation).

c. Behavioral Health Prevention/Promotion Education and Medication Training and Support Services including but not limited to:
   i. Symptom management (e.g. including identification of early warning signs and crisis planning/use of crisis plan),
   ii. Health and wellness education (e.g. benefit of routine medical check-ups, preventive care, communication with the PCP and other health practitioners)
   iii. Medication education and self-administration skills,
   iv. Relapse prevention
   v. Psychoeducation Services and Ongoing Support to Maintain Employment Work/Vocational skills, educational needs assessment and skill building
   vi. Peer and Family Support Services
   vii. Treatment for Substance Use Disorder (e.g. substance use counseling), and Medication Assisted Treatment (MAT)
   viii. Personal Care Services
BHRFs must be licensed to deliver Personal Care Services (see additional licensing requirements in A.A.C. R9-10-702, R9-10-715, R9-10-814) and must provide documentation in the treatment plan if they are going to provide personal care services for a member. Examples of Personal Care Services may include:

i. Blood sugar monitoring, accu check diabetic care

ii. Administration of oxygen

iii. Application and care of orthotic devices

iv. Application and care of prosthetic devices

v. Application of bandages, medical support including high elastic stockings

vi. ACE wraps, arm and leg braces

vii. Application of topical medications

viii. Assistance with ambulation

ix. Assistance with correct use of cane/crutches

x. Bed Baths

xi. Care of hearing aids

xii. Radial pulse monitoring

xiii. Respiration monitoring

xiv. Denture care and brushing teeth

xv. Dressing member

xvi. Supervising self-feeding of members with swallowing deficiencies

xvii. Hair care, including shampooing

xviii. Incontinence support, including assistance with bed pans, bedside commodes, bathroom supports

xix. Measuring and recording blood pressure

xx. Non-Sterile dressing change and wound care

xxi. Passive range of motion exercise

xxii. Use of pad lifts

xxiii. Shaving

xxiv. Shower assistance using shower chair

xxv. Skin maintenance to prevent and treat bruises, injuries, pressure sores. (If stage 3 or 4 pressure sore no BHRF admission permitted)

xxvi. Use of chair lifts

xxvii. Skin and foot care
xxviii. Measuring and giving insulin, glucagon injection
xxix. G-tube care
xxx. Ostomy and surrounding skin care
xxxi. Catheter Care

Expected Treatment Outcomes and SMART Goals

BHRF can only be utilized if there is an expectation that the member will benefit from the treatment provided at this level of care, with anticipated transition to a lower level of care after identified treatment goals have been met.

Treatment outcomes shall align with the Arizona Vision-Twelve Principles for Children’s Behavioral Health Service Delivery or the Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems as outlined in the provider contract, and the member’s individualized basic physical, behavioral and developmentally appropriate needs.

Treatment goals must reflect the behaviors and functioning of the member in a language that the member understands what is required for a successful treatment experience and discharge. These goals should focus on Counseling and Therapy, Skill training and Development and Behavioral Health Prevention/Promotion Education and Medication Training and Support Services. The required treatment goals shall be developed in accordance with the following:

1. Specific to the member’s behavioral health condition(s)
2. Measurable and achievable in a reasonable period of time,
3. Cannot be met in a less restrictive environment
4. Based on the member’s unique needs and tailored to the member and the family’s/guardian’s/designated representative’s choices where possible
5. Support the member’s improved or sustained functioning and integration into the community.

Requests for BHRF level of care that do not include measurable and meaningful goals that support the requirement for this level of care will be denied.

Exclusionary Criteria

Admission to a BHRF shall not be used as a substitute for the following:

1. An alternative to preventative detention or incarceration
2. As a means to ensure community safety in circumstances where a member is exhibiting primarily conduct disordered behavior without the presence of risk or functional impairment
3. A means of providing safe housing, shelter, supervision, or permanency placement
4. A behavioral health intervention when other less restrictive alternatives are available and meet the member’s treatment needs; including situations when the member/guardian/designated representative are unwilling to participate, or
5. An intervention for runaway behaviors unrelated to a behavioral health condition.
Concurrent Review for BHRF

Continued stay must be assessed by the BHRF staff and the ART/CFT during the Treatment Plan review and update. Progress towards the treatment goals and continued display of risk and functional impairment must also be addressed. Treatment intervention, frequency, crisis/safety planning and targeted discharge must be adjusted accordingly to support the need for continued stay. The following criteria will be considered when determining continued stay:

1. The member continues to demonstrate significant risk of harm and/or functional impairment as a result of a behavioral health condition consistent with the criteria for admission.
2. Providers and supports are not available to meet current behavioral and physical health needs at a less restrictive lower level of care.
3. Member is making progress towards identified goals or if there is lack of progress the facility and complete care plan are revised resulting in the expectation of improvement.
4. The member is demonstrating marked improvement toward the one or more identified area of significant risk of harm that was identified during the admission/evaluation period such as:
   A. Suicidal/aggressive/self-harm/homicidal thoughts or behaviors resulting in potential risk for danger to self or others without current plan or intent and need for active treatment in this level of care.
   B. Impulsivity with poor judgment/insight that are not developmentally appropriate
   C. Maladaptive physical or sexual behavior
   D. Member’s inability to remain safe within his or her environment, despite environmental supports (i.e. Natural Supports), or community-based services.
   E. Medication side effects due to toxicity or contraindications which do not require continuous medical or nursing supervision and are appropriate for supervised medication self-administration.

   AND

The member demonstrates marked improvement in one or more in the area of serious functional impairment which could not have been addressed in a less restrictive level of care or community-based treatment because of potential danger to self or others as evidenced by:

i. Inability to complete developmentally appropriate self-care or self-regulation due to member’s behavioral health condition(s)
ii. Neglect or disruption of ability to attend to majority of basic needs, such as personal safety, hygiene, nutrition or medical care
iii. Frequent inpatient psychiatric admissions or legal involvement due to lack of insight or judgment associated with psychotic or affective/mood symptoms or major psychiatric disorders where exclusionary criteria are not met.
iv. Inability to independently self-administer medically necessary psychotropic medications despite interventions such as education, regimen simplification, daily outpatient dispensing, and long-acting injectable medications or,

v. Impairments persisting in the absence of situational stressors that delay recovery from the presenting problem.

F. The member continues to demonstrate a need for 24-hour behavioral health care and supervision to develop adequate and effective coping skills that will allow the member to live safely in the community.

G. Anticipated stabilization cannot be achieved in a less restrictive setting.

H. Evidence that appropriate treatment in a less restrictive environment continues to be assessed as either previously unsuccessful or is not available, therefore justifying this level of care.

I. Member agrees to participate in treatment. In the case of minors, family/guardian/designated representative also agrees to and participates as part of the treatment team.

Health Plan staff will provide technical assistance and/or care management when applicable.

Required Documents from the BHRF/Outpatient Provider

To be submitted within 14 calendar days of the last covered day for concurrent review:

1. Out of Home Concurrent Review Form

2. Adult Recovery Team/Child and Family Team note: Notes should reflect the team’s treatment recommendations, proposed length of stay, changes to proposed discharge plan, if applicable and progress or lack of progress and barriers to progress.

3. Medication and psychiatric progress notes, if applicable

4. Revised Service Plan/Complete Care Plan (as applicable)- The revised Service Plan/Complete Care Plan should include revisions to address identified barriers.

Discharge Readiness

The BHRF provider must submit a completed Discharge Summary no later than 24 hours after discharge to the assigned BUHP Reviewer. Failure to do so may delay claims payment. Discharge readiness will be assessed by the BHRF staff and CFT/ART team who participate in the CFT/ART during each review of the Individual Service Plan/Complete Care Plan (when applicable). The following criteria shall be considered when determining discharge readiness:

1. Symptom or behaviors are reduced, as evidenced by completion of Treatment Plan goals

2. Functional impairment is reduced to manageable levels. Essential functions such as eating or hydrating necessary to sustain life has significantly improved or is able to be cared for in a less restrictive level of care

3. Member can participate in needed monitoring or a caregiver is available to provide monitoring in a less restrictive level of care
4. Providers and supports are available to meet current behavioral and physical health needs at a less restrictive level of care.

Requirements for Discharge Plan/Summary

All BHRF providers are required to submit the Discharge Plan/Summary to the Health Plan and the outpatient behavioral health provider within 24 hours of discharge. BHRF providers may use their own Discharge Form or use the Banner UFC Discharge Form found on our website. Plan/Summary must be submitted to: BUHPUMPAMailbox@bannerhealth.com.

At a minimum the Discharge Plan/Summary must contain the following information:

- Date of discharge
- Discharge diagnosis
- Discharge instructions including follow up services
- Discharge medications including the following: dosage, instructions and number of days of medications provided if applicable (for hospitals and BHIFs)

*Delays in submitting the Discharge Summary to the Health Plan may result in a delay of claims payment. The Health Plan must have accurate documentation to confirm the date of discharge and the discharge information.*

Home Care Training for the Home Care Client (HCTC)

“Also known as Therapeutic Foster Care”

Child/Adolescent and Adults

HCTC services provide treatment for children, adolescents and adults who demonstrate moderate functional impairments, when ambulatory care services in the community do not meet their treatment needs. These services are designed for children and adolescents who have a DSM 5/ICD-10 psychiatric diagnosis. HCTC services are provided by a behavioral health therapeutic home to implement the in-home portion of the Service Plan/Complete care plan (when applicable). HCTC services assist and support a child/adolescent or adult in achieving their complete care plan goals and objectives. It also helps the child/adolescent or adult remain in the community setting, thereby avoiding residential, inpatient or institutional care. These services include supervision and the provision of behavioral health support services such as personal care (especially prescribed behavioral interventions), psychosocial rehabilitation, skills training and development, transportation to therapy or visitations and/or the participation in care and discharge planning. Active treatment focuses on specific targeted goals identified by the Child and Family Team (CFT) or Adult Recovery Team (ART) and are designed to enable the child/adolescent or adult to be discharged at the earliest possible time. A lack of available outpatient services is not in and of itself the sole criterion for admission to a HCTC. Treatment should be at the least restrictive level of care consistent with need and therefore should not be instituted unless there is documentation of a failure to respond to, or professional judgment of an inability to be safely managed in a non-therapeutic community-based placement.
Criteria for Home Care Training to Home Care Client- Adult or Child

Initial Authorization: Initial admission authorization is up to 90 days with initial continued stay/concurrent review to occur within 2 weeks of the last covered day.

The criteria in I-VI below must all be met to meet prior authorization and concurrent review for continued stay:

I. Diagnostic Criteria: There is clinical evidence and documentation that the member has a primary DSM 5/ICD-10 diagnosis that is amenable to active treatment. Any co-occurring diagnosis or diagnoses must be identified and documented prior to admission.

II. Behavior and functioning: As a result of a DSM-5/ICD-10 psychiatric diagnosis, the member has a risk of harm to self or others or disturbance of mood, thought or behavior which renders the child/adolescent incapable of developmentally-appropriate self-care or self-regulation as evidenced by:

The member has demonstrated an inability to function in a typical family setting as evidenced by a history of risk of harm or moderate functional impairment of self-care or self-regulation due to the psychiatric condition that clearly impairs functioning, persists in the absence of stressors, and impairs recovery from the presenting problem.

III. Active Treatment/Intensity of service (must meet all criteria is a-c below): Comprehensive and ongoing assessment and treatment is planned for and being provided for continued stay.

a. Homes providing HCTC services are licensed by the Arizona Department of Economic Security (ADES), Office of Licensing Certification and Regulation (OLCR) as professional foster homes or are licensed by federally recognized Indian Tribes that attest to the Centers for Medicare and Medicaid services via the Arizona Health Care Cost Containment System (AHCCCS), that they meet equivalent requirements. HCTC services assist and support a participant in achieving his/her Individual Service Plan (or Complete Care Plan, when applicable) goals/objectives and help the member remain in the community setting, thereby avoiding residential, inpatient or institutional care.

b. These services in a home setting include supervision and documentation of the provision of behavioral health support services including personal care (especially prescribed behavioral interventions), psychosocial rehabilitation, skills training and development, transportation of the participant when necessary to activities such as therapy and visitations and/or the participation in treatment and discharge planning.

c. Parent/guardian/ caregiver involvement as applicable: For prior authorization there is a plan for active involvement of the parent/guardian/caregiver to successfully discharge the member to the least restrictive community-based setting as quickly as possible. For continued stay there is documentation of active involvement of the parent/guardian/caregiver to successfully discharge the member to the least restrictive community-based setting as quickly as possible.
Non-Emergent Admissions to HCTC
BHIF Non-Emergent Admissions

Prior authorization must occur prior to admission to a HCTC for non-emergent admissions. The Health Plan determines medical necessity for standard decisions within 14 calendar days upon receipt of the request. If appropriate, the Health Plan may issue an extension of an additional 14 calendar days to request additional information. The Health Plan requires active involvement of the CFT to facilitate discussion of admission for all levels of care. Expedited authorization may be requested when the provider determines that using the standard timeframe could seriously jeopardize the member’s life and/or health or ability to attain, maintain or regain maximum function. The Health Plan will look to the CFT to facilitate discussion of admission in consideration of the member when the member is in an inpatient hospital setting- expedited authorization may be granted. If approved, the Health Plan will issue an authorization for up to 45 days. Upon admission during the 45-day period, another authorization is activated to secure the date range. Providers are required to submit additional clinical documentation if the member does not admit within 45 days of approval.

Request for Prior Authorization for Non-Emergent Admission to HCTC must include the following and submitted via fax to: 520-694-0599.

Initial authorization:

- Behavioral Health Prior Authorization
- Out of Home Application, with supporting clinical documentation

Emergent Admissions to HCTC

For emergent admissions, a member may be placed in the facility if the referring provider and accepting agency’s HCTC home have documented information that meets medical necessity criteria. Out of Home Admission Notification, Behavioral Health Authorization and the Out of Home Application, are to be submitted within 2 business days of admission. For emergent admissions, upon receipt of the required documents, an initial authorization will be issued, provided that medical necessity criteria have been met, for a brief period only when the notification has been submitted within the two business days of admission. If the notification is received later than the two business days, then authorization will be effective the date of receipt of the notification, provided that medical necessity criteria have been met.

The Health Plan will look to the ART or CFT to facilitate discussion of placement in consideration of the member when the member is in an inpatient setting- expedited authorization may be granted.

Notification of Emergent Admission to HCTC must include the following and be submitted via fax to: 520-694-0599 within two calendar days of admission:

- Behavioral Health Prior Authorization Form
- Out of Home Admission Notification Form
- Out of Home Application Form
**Concurrent Review for HCTC after Emergent Admission:** For emergent admissions, the Concurrent Review form is due by noon on the last covered day to support additional days after the initial authorization and is faxed to 520-874-3411.

**Concurrent Review for Adult/Child HCTC Level of Care for Non-Emergent Admissions**

Requests for a continued stay at an HCTC level of care require submission of the following documents fourteen (14) days prior to the expiration of the current authorization, to be faxed to 520-874-3411:
- Out of Home Concurrent Review form
- CFT/ART notes
- Medication and psychiatric progress notes

**Expectation of improvement**

For the initial authorization for HCTC there is an expectation that active treatment with the services available at this level of care can reasonably be expected to improve the member’s psychiatric condition to achieve discharge from the HCTC at the earliest possible time and facilitate return to outpatient care. There must be an expectation that the member will participate in treatment.

For continued stay in the HCTC level of care, if the member is not demonstrating improvement the HCTC services and Individual Service Plan (or Complete Care Plan, when applicable) must be revised as part of the ART/CFT process resulting in an expectation of improvement in order to achieve discharge from the HCTC at the earliest possible time and facilitate return to outpatient care. The child/adolescent (and adult if applicable) and the parent/guardian/caregiver must be actively participating in treatment.

**HCTC and Respite**

The AHCCCS Behavioral Health Covered Services Guide explains that respite is available for 600 hours per year (Oct. 1st through Sept. 30th) per member. For a child in the HCTC level of care, respite is available from an eligible provider. The AHCCCS Behavioral Health Covered Services Guide states that HCTC cannot be encountered on the same day respite is provided. If the Child and Family Team believes respite is appropriate, it should be documented on the Individualized Service Plan. A collaborative effort of CFT members should locate an eligible provider through the standard referral process.

It is the responsibility of the HCTC provider to notify the Health Plan prior to the provision of respite services. **Contact the UM Reviewer and submit the following information 3 days before member enters respite care:**
- Name of Member
- Name of HCTC Provider
- Name of Respite Provider
- Date/Time Range of Respite Service
- Confirmation that member Emergency Contact has been given to the Respite Provider.

A “temporary authorization” is not required for a respite provider to bill for respite. A placement change notice would not need to be provided. Respite hours should be billed by the respite provider accordingly. A billing issue should not occur since the HCTC provider does not bill the days during which respite is
provided. It is the responsibility of the HCTC provider to ensure that a claim is not submitted for the time period that the member was in respite. Banner will recoup any claim paid if it is identified that the member was in respite services at the time and not receiving services from the HCTC provider that has been authorized by the Health Plan to provide that level of care for the member.

Discharge plan

There is a written plan for discharge with specific discharge criteria and recommendations for aftercare treatment that includes involvement of the ART or CFT and complies with current standards for medically necessary covered behavioral health services, cost effectiveness, and least restrictive environment and is in conformance with 42 CFR.1. Discharge planning must start at time of admission. Discharge plans must continue to be refined throughout treatment to ensure all needs have been addressed to prepare for a safe and supported transition to lower level services.

Exclusion Criteria

Child/adolescent out of home placements must not meet any of the below exclusionary criteria

- An alternative to preventative detention or as a means to ensure community safety in a member /adolescent exhibiting conduct disordered behavior
- The equivalent of safe housing, permanency placement, or an alternative to parent’s/guardian’s or another agency’s capacity to provide for child/adolescent
- An intervention for runaway behavior.
- An intervention when other less restrictive alternatives are available and not being utilized.

Similarly, adult out of home placements must not meet any of the below exclusionary criteria:

- An alternative to preventative incarceration, or as a means to ensure community safety
- The equivalent of safe housing,
- An intervention for homelessness
- An intervention when other less restrictive alternatives are available and not being utilized.
- Active substance abuse
- History of starting fire
- Registered sex offender.

Prior Authorization for Psychotropic Medications

Submit Pharmacy Prior Authorization Form via fax 866-349-0338

The Health Plan has adopted the drug list developed by AHCCCS for use by all providers. This list denotes the utilization management criteria required for all drugs which includes prior authorization. The prior authorization criteria must be used by contracted providers. Antipsychotics and lithium may be prescribed by any contracted behavioral health provider for members over the age of five years without prior authorization. Non-behavioral health providers will need to refer the member to a behavioral health provider or obtain prior authorization. Ongoing therapy will be provided as a bridge until the
member is able to be seen by a behavioral health provider. For specific information on medications requiring prior authorization, see the Health Plan’s drug list available on the health plan website under the Provider Section.

The approved prior authorization criteria are posted on the Health Plan’s website. The prior authorization requirements for availability, decision timelines and provision of notice will be provided within the AHCCCS required timelines. The Health Plan 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. The Health Plan 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. Please submit a Prior Authorization on the Pharmacy Prior Authorization form and fax to 1-866-349-0338.

Securing Out of Network Provider

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 AFT/CFT’s request. The process for securing services through a non-contracted provider is as follows:

If a needed covered outpatient service is unavailable within the Health Plan’s contracted provider network, the provider submits a Behavioral Health Prior Authorization request to the Health Plan Behavioral Health Department via fax at 520-694-0599.

- All out of network requests must be accompanied by the current individual Service Plan/Complete Care Plan and relevant clinical 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 the Health Plan-approved reimbursement rates. If for any reason the Health Plan Contracts Department is unable to establish a single case agreement with the requested non-contracted provider, the Behavioral Health Department will notify the requesting Clinical Director and/or ART/CFT.
- The ART/CFT then meets to consider alternative services. The ART/CFT is responsible for ensuring that a similar level of equivalent services is in place for the member
- The Health Plan secures services 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 the Health Plan within the AHCCCS required timelines for Notices of Action.

Prior Authorization for Non-Medical Transportation Over 100 Miles

Requests for non-medical transportation over 100 miles for a round trip or one way requires a Prior Authorization regardless of the diagnosis code that will be billed on the claim.
Clinical Criteria for Electroconvulsive Therapy-Indications for Procedure

Fax Behavioral Health Prior Authorization Form to 520-694-0599

Electroconvulsive therapy (ECT) may be indicated for **1 or more** of the following:

- **Acute treatment**, as indicated by **ALL** of the following:
  - Diagnosis of a psychiatric condition amenable to ECT treatment, as indicated by **1 or more** of the following:
    - Major depressive disorder
    - Bipolar disorder
    - Schizophrenia and schizoaffective disorders
  - Need for ECT, as indicated by **1 or more** of the following:
    - Catatonia
    - High risk for suicide attempt
    - Inadequate response to pharmacotherapy despite **ALL** of the following:
      - Adequate duration and dosage
      - Documented adherence
      - Trials from 2 or more classes of medications
    - Intractable manic excitement
    - Neuroleptic malignant syndrome
    - Nutritional compromise
    - Pharmacotherapy not preferred due to risk of adverse effects (e.g., pregnant or elderly patients)
    - Unremitting self-injury
  - Patient has undergone medical review and clearance.
  - Pretreatment symptoms rated as severe
- **Extension of acute treatment**, as indicated by **ALL** of the following:
  - Partial positive response to acute treatment
  - Treatment is being re-evaluated and modified (e.g., switch from unilateral to bilateral lead placement, modification of stimulus parameters)
- **Maintenance treatment**, as indicated by **ALL** of the following:
Clinical determination that maintenance treatment is needed to reduce risk of relapse (e.g., previous relapse without ECT)

- Adjunctive pharmacotherapy optimized as indicated
- Sessions tapered to lowest frequency that maintains response (e.g., weekly, biweekly, monthly)

Requests for Prior Authorization for Electroconvulsive Therapy must include the following submitted via fax to: 520-694-0599

1) Behavioral Health Prior Authorization Form
2) Supporting clinical documentation

Medical Necessity Denials for all Levels of Care

A denial based on a lack of documentation of medical necessity for an outpatient service, inpatient admission, or continued stay can only be made by the Health Plan’s Chief Medical Officer or physician designee after review of all clinical information provided. Denials will only be issued when the information provided verbally and/or through documentation does not support medical necessity for the service provided. For denials of admissions or continued stays, the provider may request a peer-to-peer discussion for reconsideration within 24 business hours of the denial. This request will not result in extension of the authorization period unless information is provided to support medical necessity.

For outpatient authorizations and planned admissions to BHRF, BHIF, HCTC - After the Health Plan notifies a provider of the decision to deny a requested authorization the requesting provider or member/guardian can submit an appeal.

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, the Health Plan must provide the member with a Notice of Adverse Benefit Determination following denial of all prior authorizations for outpatient services, including:

- 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
- The denial in whole or in part, of payment for a service (this is the Health Plan’s responsibility).

A copy of the Notice of Adverse Benefit Determination 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.

The Health Plan will ensure 24-hour access to a delegated psychiatrist or other physician designee for any denials of hospital admission. For denials related to a concurrent review stay, a copy of the Notice of Adverse Benefit Determination will be sent to the provider. The Health Plan 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 the Health Plan 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 the Health Plan 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. The Health Plan 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 the Health Plan justifies a need for additional information and the delay is in the member’s best interest.

- When the Health Plan receives an expedited request for a service authorization and the requested service is not of an urgent medical nature, the Health Plan may downgrade the expedited authorization request to a standard request. The Health Plan Behavioral Health Utilization Care Manager notifies the requesting provider of such downgrade and gives the provider an opportunity to disagree with the decision.
Section 9 – Training and Peer Support Supervision Requirements

AHCCCS has developed training and supervision requirements as well as certification standards for Peer Support Specialists/Recovery Support Specialists (PRSS) providing Peer Support Services, as described in the AHCCCS Covered Behavioral Health Services Guide.

Persons with lived experience of recovery from behavioral health and/or substance use disorders serve an important role as behavioral health providers; and AHCCCS expects consistency and quality in Peer Support services statewide.

This applies to all providers delivering training services for certification 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 builds a sense of hope and self-worth, community connectedness, and an improved quality of life to people in recovery.

Peer support 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 PRSS 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 PRSS by completing training and passing a competency test through an AHCCCS/Office of Individual & Family Affairs (OIFA) approved Peer Support Employment Training Program. AHCCCS/OIFA will oversee the approval of all certification materials including curriculum and testing tools. Certification through AHCCCS/OIFA 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/OIFA 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/OIFA, and AHCCCS/OIFA 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/OIFA 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 PRSS 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**

A key element of Peer Support supervision is to create a supportive environment where the job role and work expectations of the CPRSS are open to collaborative discussion. The goal of supervision is to provide the needed support to CPRSSs in meeting treatment needs of members receiving care from CPRSSs, to create a stimulating environment that challenges the CPRSS to find solutions for issues, and to provide information that helps them be successful in their role. This requires using strength-based feedback, setting professional goals, and promoting continuing education. Supervision provides an opportunity for growth within the agency and encouragement of recovery efforts.

Agencies employing CPRSSs 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 CPRSS’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, access to continuing education and guidance to ensure current knowledge of best practices in providing supervision to Certified Peer/Recovery Support Specialists.

**Process for Submitting Evidence of Certification**

Agencies employing CPRSSs who are providing peer support services are responsible for keeping records of required qualifications and certification. Banner University Health Plans (BUHP) will ensure that Peer Support Specialists/Recovery Support Specialists meet qualifications and have certification, as described in this policy.

**Parent/Family Support Training, Certification and Supervision Requirements**

AHCCCS/OIFA has developed training requirements and certification standards for Family Support roles providing Family Support Services, as described in the AHCCCS Covered Behavioral Health Services Guide. AHCCCS and the Health Plan recognizes the importance of the Certified Family Support role as a viable component in the delivery of integrated services and expects statewide support for these roles. AHCCCS and the Health Plan expect consistency and quality in parent/family delivered support of integrated services in both the Children’s and Adult Systems statewide.

**Parent/Family Support Provider and Trainer Qualifications**

**Children’s System**

Individuals seeking certification and employment as a Parent/Family Support Provider or Trainer in the children’s system must:

- Be a parent or primary caregiver with lived experience who has raised or is currently raising a child with emotional, behavioral, mental health or substance abuse needs; and
• Meet the requirements to function as a behavioral health professional, behavioral health technician, or behavioral health paraprofessional

Adult System of Care

Individuals seeking certification and employment as a Parent/Family Support Provider or Trainer in the adult system of care must:

• Have lived experience as a primary natural support for an adult with emotional, behavioral, mental health or substance abuse needs; and
• Meet the requirements to function as a behavioral health professional, behavioral health technician, or behavioral health paraprofessional.

Individuals meeting the above criteria may be certified as a Parent/Family Support Specialist by completing training and passing a competency test through an AHCCCS/OIFA approved Parent/Family Support Training Program. AHCCCS/OIFA will oversee the approval of all certification materials including curriculum and testing tools. Certification through AHCCCS/OIFA approved Parent/Family Support Employment Training Program is applicable statewide.

Parent/Family Support Provider Training Program Approval Process

A Parent/Family Support Provider 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/OIFA. AHCCCS/OIFA 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 content to AHCCCS/OIFA for review and approval no less than 60 days before the changed or updated curriculum is to be utilized.

AHCCCS/OIFA will base approval of the curriculum, competency exam, and exam-scoring methodology only on the elements included in this policy. If a Parent/Family Support Provider Training Program requires regional or culturally specific training exclusive to a GSA or specific population, the specific training cannot prevent employment or transfer of family support certification based on the additional elements or standards.

Competency Exam

Individuals seeking certification and employment as a Parent/Family Support Provider must complete and pass a competency exam with a minimum score of 80% upon completion of required training. Each Parent/Family Support Provider Training Program has the authority to develop a unique competency exam. However, all exams must include questions related to each of the curriculum core elements. Agencies employing Parent/Family Support Providers who are providing family support services are required to ensure that their employees are competently trained to work with their population.

Individuals certified or credentialed in another state must submit their credential to AHCCCS/OIFA. The
individual must demonstrate their state’s credentialing standards meet those of AHCCCS prior to recognition of their credential. If that individual’s credential/certification doesn’t meet Arizona’s standard the individual may obtain certification after passing a competency exam. If an individual does not pass the competency exam, the Parent/Family Support Provider Training Program shall require that the individual complete additional training prior to taking the competency exam again.

**Parent/Family Support Provider Training Curriculum Standards**

A Parent/Family Support Provider Employment Training Program curriculum must include the following core elements for persons working with both children and adults:

- **Communication Techniques:**
  - Person first, strengths-based language; using respectful communication; demonstrating care and commitment;
  - Active listening skills: The ability to demonstrate empathy, provide empathetic responses and differentiate between sympathy and empathy; listening non-judgmentally;
  - Using self-disclosure effectively; sharing one’s story when appropriate.

- **System Knowledge:**
  - Overview and history of the Arizona Behavioral Health System: Jason K., Arizona Vision and 12 Principles and the Child and Family Team (CFT) process; Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems, Adult Recovery Team (ART), and Arnold v. Sarn; Introduction to the Americans with Disabilities Act (ADA); funding sources for behavioral health systems,
  - Overview and history of the family and peer movements; the role of advocacy in systems transformation,
  - Rights of the caregiver/enrolled member
  - Transition Aged Youth: Role changes when bridging the Adult System of Care (ASOC) and Children’s System of Care (CSOC) at transition for an enrolled member, family and Team.

- **Building Collaborative Partnerships and Relationships:**
  - Engagement; Identifies and utilizes strengths;
  - Utilize and model conflict resolution skills, and problem-solving skills,
  - Understanding individual and family culture; biases; perceptions; system’s cultures;
  - The ability to identify, build and connect individuals and families, including families of choice to natural, community and informal supports;

- **Empowerment:**
  - Empower family members and other supports to identify their needs, and promote self-reliance,
Identify and understand stages of change and
Be able to identify unmet needs.

Wellness:
Understanding the stages of grief and loss; and
Understanding self-care and stress management;
Understanding compassion fatigue, burnout, and trauma;
Resiliency and recovery;
Healthy personal and professional boundaries.

Some curriculum elements may include concepts that are part of AHCCCS required training, as described in AHCCCS AMPM Policy 1060 and the Behavioral Health Practice Tool on Unique Needs of Children, Youth and Families Involved with Department of Children’s Services. Credentialed Parent/Family Support Provider training programs must not duplicate training required of individuals for employment with a licensed agency or Community Service Agency (CSA). Training elements in this section must be specific to the Family Support role in the public behavioral health system and instructional for family support interactions.

Supervision of Certified Parent/Family Support Providers

Agencies employing Parent/Family Support Providers 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 qualifications of the Parent/Family Support Provider as a Behavioral Health Technician, Behavioral Health Professional, or Behavioral Health Paraprofessional. Supervision must be documented and inclusive of both clinical and administrative supervision.

Individuals providing supervision must receive training and guidance to ensure current knowledge of best practices in providing supervision to Parent/Family Support Providers.

Process of Certification

Agencies employing Certified Parent/Family Support Providers who are providing family support services are responsible for keeping records of required qualifications and certification.
Section 10 – Grievance and Appeal System

Notice Requirements and Appeal Process

The Health Plan Grievance & Appeals Department is available to members or providers, acting on behalf of a member with the member’s written consent, to file an appeal. 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, other than an adverse benefit determination. Examples of grievances are: service issues, transportation issues, quality of care issues and provider office issues. These issues are filed with Grievance & Appeals, the Customer Care Center or Network Development departments.

A grievance can be filed in writing and submitted by mail, fax or email to the address listed below. An oral grievance may be filed by calling our Customer Care Center number below.

YOU CAN MAIL GRIEVANCES TO:
Banner University Health Plans
ATTENTION: Grievance & Appeals Department
2701 E. Elvira Road, Tucson, AZ 85756
(Fax) 520-874-3462 or 866-465-8340, TTY/TTD 711
BUHPGrievances@bannerhealth.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 Adverse Benefit Determination (a denial of service by the Health Plan). If we cannot take care of your concern with the adequacy of the Notice of Adverse Benefit Determination, you can also call AHCCCS: Division of Health Care Management – Medical Management Unit (800) 654-8713, (602) 417-400. You can also contact them in writing at 801 E Jefferson St. Phoenix, Arizona 85034.

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 Adverse Benefit Determination. 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 Banner – University Family Care 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:
Banner University Health Plans
ATTENTION: Grievance & Appeals Department
2701 E. Elvira Road, Tucson, AZ 85756
(Fax) 520-874-3462 or 866-465-8340, TTY/TTD 711
BUHPGrievances@bannerhealth.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. The member or provider will be given the opportunity to present information or fact of law to the BUFC reviewer either in person or in writing during the appeal process. The case file is also available for review by the member or provider during the appeal process. A decision will be rendered by Banner – University Family Care within 30 days of receipt of the appeal request, unless a 14-day extension 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 (Fast) Appeal
An expedited appeal may be filed by the enrollee or on the enrollee’s behalf by the provider with consent. An expedited appeal will be approved if Banner – University Family Care determines that the time to process a standard appeal would seriously jeopardize the health, life or ability to attain, maintain or regain maximum function of the enrollee. If an expedited appeal request is not approved, Banner – University Family Care will notify the member and the provider within 24 hours and transition the appeal to the standard appeal timeline of 30 days.

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. This request must be made within 10 days of the receipt of the Notice of Adverse Benefit Determination. However, the member may be required to pay the cost of services if the appeal denial is upheld.
**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 (800) 582-8686, TTY/TTD 711

In addition, 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, 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 EOB)
- 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 may be dismissed. Prior to a claim dispute dismissal, BUFC will attempt to call the provider and a written notification will also be mailed to the provider. In addition, the written notice will state the specific 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. BUFC 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:**

Banner University Health Plans  
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 or a legal or authorized representative may file a Request for State Fair Hearing with BUFC. This request must be made in writing no later than thirty (120) days of the date of receipt of the Notice of Appeal Resolution. BUFC will send the appeal file to AHCCCS and a hearing date will be scheduled for attendance.

REQUESTS FOR HEARING SHOULD BE SUBMITTED TO:
Banner University Health Plans
Attention: Grievance & Appeals Department
2701 E. Elvira Road, Tucson, AZ 85756
(Fax) 520-874-3462 or 866-465-8340 TTY/TTD 711
BUHPGrievances@bannerhealth.com

Grievances and Appeals For Members Determined To Have A Serious Mental Illness

ALTCS members determined to have a Serious Mental Illness (SMI) that feel their rights have been violated, have the right to file a grievance and request an investigation. Members, their legal guardians, or authorized representatives can file a SMI grievance and request an investigation if:

- They are an adult who has been determined to have a SMI.
- If the services received by the member are behavioral health services.
- The member believes their rights have been violated;
- The member believes they have been abused or mistreated by a provider or their staff; or
- The member believes that they have been subjected to illegal, dangerous, or inhumane treatment.

Members, their legal guardians, or authorized representatives have 12 months from the time their rights were violated to file an SMI grievance and request an investigation. SMI Grievances and requests for an investigation can be filed orally or in writing to:

Banner University Health Plans
Attention: Grievance & Appeals Department
2701 E. Elvira Road, Tucson, AZ 85756
(Fax) 520-874-3462 or 866-465-8340, TTY/TTD 711
BUHPGrievances@bannerhealth.com

Forms to file an SMI Grievance and request for an investigation are available at the above address or at any contracted behavioral health provider. Once a member’s SMI Grievance and request for an investigation is received, the Health Plan will respond in writing within five days and will explain how the grievance and request for an investigation will be handled.

Grievances and requests for investigations regarding physical or sexual abuse, or death should be reported directly to AHCCCS at:

Phone: 602-364-4575; Fax: 602-364-4594
In-State Toll Free: (800) 654-8713 (Outside Maricopa County)
Out-of-State Toll Free: (800) 523-0231
For the Hearing Impaired: Arizona Relay 711

Mail requests to:
AHCCCS
Attention: Behavioral Health Grievance and Appeals
701 E Jefferson St. MD 6200
Phoenix, AZ 85034

Serious Mental Illness (SMI) Eligibility Determinations

Serious Mental Illness (SMI) determinations are made by the Crisis Response Network, Inc. (CRN). CRN is responsible for reviewing all applications for SMI services and making these determinations for the state of Arizona.

Appeal Process for Members Who Have Been Determined to Have a Serious Mental Illness (SMI)

If a member disagrees with their SMI determination, they have the right to appeal the decision, including:

- Initial eligibility for SMI services;
- Decisions regarding fees or waivers;
- The assessment report;
- Service plans;
- Treatment plans;
- Discharge plans;
- Decisions regarding services funded through Non-Title 19/21 funds;
- Capacity to make decisions, need for guardianship, or other protective services or needs for special assistance;
- Decisions regarding the loss of eligibility for SMI services; and/or
- A PASRR determination in the context of either a preadmission screening or an annual resident review, which adversely affects the member.

How Do I File an Appeal?

As part of the appeals process, SMI members have the right to give evidence that supports their appeal. They can provide the evidence to the Health Plan or AHCCCS, in person or in writing. The evidence provided to the Health Plan or AHCCCS will be used when deciding the resolution of the appeal. Instructions for appealing a decision issued by AHCCCS, will be contained in the Notice of Appeal Resolution letter.

To Get Help with An Appeal:

Contact the State Protection and Advocacy System, the Arizona Center for Disability Law, at (800) 922-1447 in Tucson and (800) 927-2260 in Phoenix. One may also contact the AHCCCS Office of Human Rights at (602) 364-4585 or (800) 421-2124 in Phoenix, (928) 214-8231 or (877) 524-6882 in Tucson. A Member may also refer to their member handbook for more information about the appeals process or you may contact the Health Plan at (833) 318-4146; (TTY/TDD) 711. They can also submit their appeal in writing to:

Banner University Health Plans
Please include the following information with an appeal:

1. Name of person filing the SMI grievance/request for investigation or appeal
2. Name of the person receiving services, if different.
3. Mailing address and phone number.
4. Date of issue being appealed or incident requiring investigation.
5. Brief description of issue or incident.
6. Resolution or solution desired.

SMI Appeal Timelines:
The Health Plan will send the member a written notice within five business days of when the request for an appeal was received.

The Health Plan will have an informal conference with the member, their legal guardian, or authorized representative within seven business days of when the appeal was received.

The Health Plan will notify the member of the time and location of the conference, in writing, at least two days prior to the date of the conference. If the member cannot come to the conference, they can request that the conference be conducted over the phone.

If the member is satisfied with the resolution of the issue at the informal conference with the Health Plan, they will receive a written notice that summarizes the appeal, the resolution, and the date of when the resolution will be implemented.

If a resolution is not reached at the informal grievance with the Health Plan, and if the appeal is not related to the member’s eligibility for behavioral health services, then an informal conference will be held with AHCCCS within 15 business days of when the appeal was received. The informal conference with AHCCCS is not required and the member can request to skip the second conference.

If a resolution is still not reached at the informal conference with AHCCCS, or if the member chose to skip the informal conference with AHCCCS, then the member will be provided with information on how to request an Administrative Hearing through the AHCCCS office of Behavioral Health Grievance and Appeals.

SMI Expedited Appeal Timelines:
Members who need an appeal to be expedited will receive a written notice from the Health Plan within business day of when the expedited appeal was received.

The Health Plan will have an informal conference with the member, their legal guardian, or authorized representative within two business days of when the expedited appeal was received.
If the member is satisfied with the resolution of the issue at the informal conference with the Health Plan, they will receive a written notice that summarizes the expedited appeal, the resolution, and the date of when the resolution will be implemented.

If a resolution is not reached at the informal conference with the Health Plan, and if the expedited appeal is not related to the member’s eligibility for behavioral health services, then an informal conference will be held with AHCCCS within two business days of when the expedited appeal was received. The informal conference with AHCCCS is not required and the member can request to skip the second conference.

If a resolution is still not reached at the informal conference with AHCCCS, or if the member chose to skip the informal conference with AHCCCS, then the member will be provided with information on how to request an Administrative Hearing through the AHCCCS office of Behavioral Health Grievance and Appeals.

**Continuing Services During the Appeal Process**

Members can continue to receive services they were already receiving unless a qualified clinician decides that reducing or stopping services is best for the member, or if the member agrees, in writing, to reduce or terminate services. If the appeal is not decided in the member’s favor they may be required to pay for the services, they received during the appeal process.

**Medicare Grievance and Appeals**

The Banner – University Care Advantage (BUCA) Grievance & Appeals Department is available to members or providers, acting on behalf of a member, to file an appeal. Unresolved claim reconsiderations and re-openings for contracted providers, are also processed in the Grievance & Appeals Department. 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 Banner – University Care Advantage.

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 standard grievance will be reviewed, and a response will be provided within 30 days of receipt. If an extension is required, the Health Plan will call the member for approval of a 14-day extension. If accepted, the grievance resolution will be provided within 44 days of receipt.

Banner – University Care Advantage
ATTENTION: Grievance & Appeals
2701 E. Elvira Rd, Tucson, AZ 85756
Phone: (877) 874-3930, TTY/TTD 711
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: (877) 588-1123, TTY: (855) 887-6668
Fax for Appeals: (855) 694-2929
Fax for all other reviews: (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 UCA that the member believes are covered under Medicare, or if not covered under Medicare, should have been furnished arranged for, or reimbursed by UCA:
  - UCA’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 UCA;
  - Reduction, or premature discontinuation of a previously authorized ongoing course of treatment;
  - Failure of UCA 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 UCA 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 UCA’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)**

An enrollee, an enrollee’s representative or a non-contracted physician or provider may request that the determination be reconsidered. If anyone other than the member or the treating physician, other physician or their office staff is appealing on behalf of the member, an Appointment of Representative (AOR) form must be in the file.

When a non-contracted physician or provider seeks a standard reconsideration, for purposes of obtaining payment only, then the non-contracted physician or provider must submit a signed waiver of liability; i.e., the non-contracted physician or provider formally agrees to waive any right to payment from the enrollee for a service.

**YOU CAN MAIL, EMAIL OR FAX AN APPEAL TO:**

Banner University Health Plans
Attention: Grievance & Appeals
2701 E. Elvira Road
Tucson, AZ 85756
(Fax) 866-465-8340

You may also call the Customer Care Center and ask to speak to an Appeals Department representative to file an oral appeal or you may also submit your request by fax or via email. The Health Plan may request additional medical information if necessary to complete the appeal review. The appeals 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 a reasonable opportunity to present evidence and to make legal and factual arguments in person or in writing. The Health Plan will inform the member of the limited time available to provide this information sufficiently in advance of the resolution timeframe. The case file is available for review by the member or provider during the appeal process, upon request.

**Pre-Service Reconsiderations**

Standard appeals for a pre-service request will be resolved as expeditiously as the enrollee’s health condition requires, but no later than 30 calendar days from the date the request is received by the
Health Plan. The time frame may be extended by up to 14 calendar days with the members approval if the enrollee requests the extension or if the Health Plan requires additional information and the delay is in the best interest of the enrollee.

**Expedited Pre-Service Reconsiderations**

An expedited reconsideration request not supported by the physician will be reviewed to determine if the life or health of the enrollee, or the enrollee’s ability to regain maximum function could be seriously jeopardized by applying the standard time frame. If the request is approved, the Health Plan will resolve the request no later than 72 hours after receiving the request, unless an extension is required. If the request is not approved, the Health Plan will promptly notify the enrollee of the denial, their expedited grievance rights and that their expedited appeal was automatically transferred to the standard processing timeframes.

**Claim Payment Reconsiderations**

Will be resolved no later than 60 calendar days from the date the request is received by the Health Plan. The expedited appeal process is not available for payment requests.

All reconsideration requests should include a cover letter indicating your reason for filing the claim dispute and please include the following information in your letter:

- Member name, date of birth, ID number;
- Claim number or pre-service authorization request number;
- Date of Service;
- Denial reason;
- Reason for appeal;
- A copy of the Health Plan’s Remittance Advice or Pre-Service Denial notice;
- Any additional documentation that supports your appeal
- All redeterminations must be submitted individually with all required information and/or documentation.

**Appeals for Part D (Redetermination)**

The Health Plan may re-evaluate an adverse coverage determination, upon request by an enrollee, an enrollee’s representative, or an enrollee’s prescribing physician or other prescriber on behalf of the member with his or her knowledge and approval. If anyone other than the member or the treating physician, other physician or their office staff is appealing on behalf of the member, an Appointment of Representative (AOR) form must be in the file.

**Filing a (Part D) Redetermination**

You may call the Customer Care Center and ask to file an oral appeal. The Health Plan may request additional medical information and the redetermination 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 a reasonable opportunity to present evidence and to make legal
and factual arguments in person and in writing. The Health Plan will inform the member of the limited time available to provide this information sufficiently in advance of the resolution timeframe. The case file is available for review by the member or provider during the appeal process, upon request.

**Standard Redetermination**

Standard redetermination will be resolved as expeditiously as the enrollee’s health condition requires, but no later than 7 calendar days from the date the request is received by the Health Plan.

**Expedited Redetermination**

An expedited redetermination request will be reviewed when submitted by the enrollee or the enrollee’s representative to determine whether the request indicates that the enrollee’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, the Health Plan will promptly notify the enrollee of the denial, their expedited grievance rights and that their expedited appeal will automatically transfer to the standard appeal processing timeframes.

The Health Plan must provide written notice of its decision, whether favorable or adverse, as expeditiously as the enrollee’s health condition requires, but no later than 24 hours from the date the Health Plan receives the request for an expedited redetermination.

**All Part D redetermination requests should include the following for faster processing:**

- Member name, date of birth, ID number;
- Claim number or pre-service authorization request number;
- Date of Service, if applicable;
- Denial reason;
- Reason for appeal, include any additional documentation that supports your appeal;
- All redeterminations must be submitted individually with all required information and/or documentation.

**Redetermination Denials- Next Steps**

If you disagree with the Health Plans decision you have the right to request an independent review. You have 60 days from the date of the Health Plan’s Redetermination Notice to ask for an independent review for MAXIMUS.

**Continuation of Benefits**

Members have the right to receive continued benefits pending resolution of their appeal, continuation of benefits must be requested when filing the appeal. The member may be required to pay for the cost of these services if the appeal is denied.

**You Can Fax or Email Your Request To:**
Banner – University Care Advantage
Attention: Grievance & Appeals
2701 E. Elvira Road
Tucson, AZ 85756
Fax: (866) 465-8340

**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 (877) 874-3930.

**Reopening’s**

Health Plan 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 reopening 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.

**Filing a Reopening**

A request for a reopening must be submitted in writing, to the Grievance and Appeals Department. The reopening request should include the following for faster processing:

- Member name, date of birth, ID number;
- Claim Number;
- Date of Service;
- The specific reason for requesting the reopening;
- Any additional documentation that supports the request;
- All requests must be submitted individually with all required information and/or documentation.

**Reopening Timeframes**

A reopening must be submitted to the Health Plan within:

- 1 year from the date of the determination or reconsideration;
- Within 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;
- At any time to effectuate a decision issued under the coverage (National Coverage Determination) appeals process.

The Health Plan ensures that no punitive action will be taken against a provider who requests a reopening or supports a member’s appeal.
**Note, all incomplete reopening submissions may be returned. A written notice will be mailed to the provider and shall state the reason for the rejection.

Please submit all your reconsideration or reopening requests to:
Banner – University Care Advantage
Attn: Grievance & Appeals Department
2701 E. Elvira Road Tucson, AZ 85756
Phone: (877) 874-3930, TTY/TTD 711
Fax: (866) 465-8340
Email: BUHPGrievances@bannerhealth.com

Independent Review for Reconsiderations (Part C)

If the Health Plan decides to uphold the original adverse decision, either in whole or in part, the Health Plan will automatically forward the entire file to the Independent Review Entity (IRE) for a new and impartial review. In addition, the Health Plan will also forward the entire file to IRE if the notice of decision is not provided within the required timeframe. The Health Plan must send IRE the file within 30 days of the request for services and 60 days of a request for payment. MAXIMUS is CMS’s independent contractor for appeal reviews involving Medicare Advantage plans.

The Health Plan will notify the interested parties that the file has been forwarded for review. For cases submitted for review, IRE will make a reconsideration decision and notify the appellant in writing of their decision. If IRE decides in favor of the appellant, the Health Plan must pay for, provide or authorize the service as expeditiously as the member’s health condition requires, but no later than 14 calendar days from the date it receives notice that the IRE reversed the determination and 72 hours for expedited reviews. If IRE upholds the Health Plan’s decision, their notice will inform the member of rights to a hearing before an Administrative Law Judge (ALJ).

Any initial reconsideration decision made by the Plan, MAXIMUS, the ALJ or the MAC can be reopened by any party (a) within 12 months, (b) within 4 years for good cause in accordance with §120.3.

Get help & more information

Banner – University Care Advantage
Phone: (877) 874-3930 Available 8am to 8pm, 24 hours, 7 days a week or www.BannerUCA.com
1-800-MEDICARE (1-800-633-4227), 24 hours, 7 days a week.
TTY users call: 711 or (877) 486-2048
Medicare Rights Center: (888) HMO-9050
Elder Care Locator: (800) 677-1116 or www.eldercare.gov to find help in your community.
DES Division of Aging and Adult Services
1789 W. Jefferson St. (Site Code 950A), Phoenix, AZ 85007
Local Phone (602) 542-4446, Statewide Hotline 1
Section 11 – Compliance

Telehealth and Telemedicine

Telemedicine shall not replace provider choice and/or member preference for in-person/physical delivery. The Health Plan 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

All providers delivering telemedicine services must ensure staff are trained on the required elements for the use of telemedicine. Prescribing of controlled medications through telemedicine must conform to all federal and state regulations.

**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.

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 Health Plan covered behavioral health benefit.

**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. Tele-presenters may be needed to facilitate the delivery of this service.

**Tele-presenter** 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 tele-presenter must be familiar, but not necessarily a behavioral/medical expert, with the member’s condition in order to present the case accurately. The provider must ensure that staff at the originating or spoke site (where the member is receiving services) are able to support the member’s participation in telemedicine services and respond to
clinical and safety needs if an emergent situation presents.

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:

1. Identifying information,
2. A state of understanding that the participation in telemedicine is voluntary,
3. 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,
4. A description of the purpose(s) for the recording,
5. A statement of the person’s right to rescind the use of the recording at any time,
6. A date upon which permission to use the recording will be void unless otherwise renewed by signature off the person receiving the recorded service,
7. 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,
8. 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
9. A statement of understanding that the informed consent document will become a part of the member’s medical record.

Confidentiality

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.

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 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, the Health Plan’s contracted providers must notify all affected members.

Overview of Confidentiality Information

The Health Plan contracted 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. Providers must verify that all emails being sent by the provider with Protected Health Information (PHI) are sent using a secure email program and must use an individualized secure business domain email, and not use public email entities (such as Google or Yahoo) to conduct business and transmit PHI.

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 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 Health Plan 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, BUHP will redact or de-identify the information to the extent allowed or required by law.

**List of Members Accessing Records**

Health Plan’s contracted 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 or Child/Family 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 Clinical Teams**

Disclosure of information to members of a clinical 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 a clinical team with authorization from the enrolled member. Information not related to drug and alcohol treatment may be disclosed without patient authorization to members of a clinical 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 a clinical 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) 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)(ii). 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. §
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;
- AHCCCS 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

The Health Plan’s contracted 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.

The Health Plan’s contracted 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.

The Health Plan’s contracted providers may require enrolled members to carry identification cards while the member is on the premises of an agency. Health Plan’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. The Health Plan’s contracted 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.

The Health Plan’s contracted 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.

The Health Plan’s contracted 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;
• Payment and Health Care Operations: The Final Rule allows lawful holders of patient records to re-disclose the minimum amount of information necessary to contractors, subcontractors, and legal representatives for purposes of payment and health care operations. Disclosures to contractors, subcontractors, and legal representatives are not permitted to carry out other purposes, such as activities related to patient diagnosis, treatment, or referral for treatment. The list of the proposed payment and health care operations activities include the following:

  o Billing, claims management, collections activities, obtaining payment under a contract for reinsurance, claims filing and related health care data processing;
  o Clinical professional support services (e.g., quality assessment and improvement initiatives; utilization review and management services);
  o Patient safety activities;
  o Activities pertaining to:
    ▪ The training of student trainees and health care professionals,
    ▪ The assessment of practitioner competencies,
    ▪ The assessment of provider and/or health plan performance, and
    ▪ Training of non-health care professionals;
  o Accreditation, certification, licensing, or credentialing activities;
  o Underwriting, enrollment, premium rating, and other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care;
  o Third-party liability coverage;
  o Activities related to addressing fraud, waste and abuse;
  o Conducting or arranging for medical review, legal services, and auditing functions;
  o Business planning and development, such as conducting cost-management and planning related analyses related to managing and operating, including formulary development and administration, development or improvement of methods of payment or coverage policies;
  o Business management and general administrative activities, including management activities relating to implementation of and compliance with the requirements of this or other statutes or regulations;
  o Customer services, including the provision of data analyses for policy holders, plan sponsors, or other customers;
  o Resolution of internal grievances;
  o The sale, transfer, merger, consolidation, or dissolution of an organization;
Determinations of eligibility or coverage (e.g., coordination of benefit services or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;

- Risk adjusting amounts due based on enrollee health status and demographic characteristics; and
- Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges.

- 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.
A general medical release form or any authorization form that does not contain all of the elements listed above is not acceptable.

**Telemedicine**

See Telemedicine section.

**Security Breach Notification**

The Health Plan and its contracted 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.

**Pledge to Protect Confidential Information**

If requested by the AHCCCS Procurement Office, Health Plan contracted providers must sign a “Pledge to Protect Confidential Information” and abide by the statements addressing the creation, use and disclosure of confidential information, including information designated as protected health information and all other confidential or sensitive information as defined in policy. In addition, if requested, Health Plan contracted providers must attend or participate in HIPAA training offered by AHCCCS or provide written verification that the provider has attended or participated in job-related HIPAA training that is: (1) intended to make the provider proficient in HIPAA for purposes of performing the services required and (2) presented by a HIPAA Privacy Officer or other person or program knowledgeable and experienced in HIPAA and who has been approved by the ADOA-ASET Arizona State Chief Information Security Officer.
Section 12 – Deliverable Requirements

Deliverable Naming Convention: For all deliverables submitted to the Health Plan, please utilize the following naming convention “deliverable name_due date_provider name”.

For example: RehabProgressReport_010519_CBI

Due Dates: If the due date of a deliverable falls on a weekend or holiday, please submit on the following next business day.

For example: 1/5/19 due date falls on a Saturday, the deliverable would be submitted on Monday 1/7/19

Deliverable Submissions: For deliverables that list multiple options for submission (i.e. email, fax, mail). Our preferences is email, but you are not required to submit by all methods.

For example: The “Seclusions and Restraints” deliverable may be submitted either by mailbox: BHQOCReferral@bannerhealth.com or by Fax: (520) 874-3567.

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<td>At the time referral is made.</td>
<td>[<a href="https://azahcccs.gov/shared/downloads/medical-policy-manual/400/Exhibit">https://azahcccs.gov/shared/downloads/medical-policy-manual/400/Exhibit</a> 430-4.docx](<a href="https://azahcccs.gov/shared/downloads/medical-policy-manual/400/Exhibit">https://azahcccs.gov/shared/downloads/medical-policy-manual/400/Exhibit</a> 430-4.docx)</td>
<td>AzEIP AHCCCS AMPM 430 Exhibit 430-4</td>
<td><a href="BUHPAzEIP@bannerhealth.com">BUHPAzEIP@bannerhealth.com</a></td>
<td>RightFax: 520-874-3415 Email: <a href="mailto:BUHPAzEIP@bannerhealth.com">BUHPAzEIP@bannerhealth.com</a></td>
</tr>
<tr>
<td>BH department</td>
<td>Monthly</td>
<td>Outpatient commitment COT monitoring</td>
<td>15th of each month</td>
<td>COT roster</td>
<td>COT process</td>
<td>BUHPCare MgmtBH <a href="mailto:Mailbox@bannerhealth.com">Mailbox@bannerhealth.com</a></td>
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</tr>
<tr>
<td>Employmen</td>
<td>Quarterly</td>
<td>VR Member Referral Tracking Grid</td>
<td>5th of the month following the end of the quarter</td>
<td>VR Member Referral Tracking Grid</td>
<td></td>
<td><a href="HealthPlanEmployment@bannerhealth.com">HealthPlanEmployment@bannerhealth.com</a></td>
<td>Email</td>
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</tbody>
</table>
Section 13 – Forms and Attachments

Below is a list of the forms and attachments that can be found on our Provider Website at the following link: [https://www.banneruhp.com/materials-and-services/behavioral-health#Behavioral-Health-Materials-and-Forms](https://www.banneruhp.com/materials-and-services/behavioral-health#Behavioral-Health-Materials-and-Forms)

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<th>File Name</th>
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<td>File Name - AMPM Exhibit 320-U-1, Application for Involuntary Evaluation</td>
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<tr>
<td>3. AMPM Exhibit 320-U-3, Petition for Court-Ordered Evaluation</td>
<td>File Name - AMPM Exhibit 320-U-3, Petition for Court-Ordered Evaluation</td>
</tr>
<tr>
<td>4. AMPM Exhibit 320-U-4, Petition for Court-Ordered Treatment Gravely Disabled Person</td>
<td>File Name - AMPM Exhibit 320-U-4, Petition for Court-Ordered Treatment Gravely Disabled Person</td>
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<tr>
<td>5. AMPM Exhibit 320-U-5, Affidavit</td>
<td>File Name - AMPM Exhibit 320-U-5, Affidavit</td>
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<tr>
<td>7. Court Ordered Treatment Plan - Individual</td>
<td>File Name - Court Ordered Treatment Plan - Individual</td>
</tr>
<tr>
<td>8. Court Order Treatment Plan Generic Template</td>
<td>File Name - Court Order Treatment Plan Generic Template</td>
</tr>
<tr>
<td>9. Law Enforcement Committal Information</td>
<td>File Name - Law Enforcement Committal Information</td>
</tr>
<tr>
<td>10. Request for Suspension of Outpatient Treatment Plan</td>
<td>File Name - Request for Suspension of Outpatient Treatment Plan</td>
</tr>
<tr>
<td>11. Notification of Individual’s Right to Request Judicial Review and Right to Speak to Legal Counsel</td>
<td>File Name - Notification of Individual’s Right to Request Judicial Review and Right to Speak to Legal Counsel</td>
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<td>12. Release from Court Order Treatment Worksheet</td>
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<td>Court Ordered Treatment Status</td>
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<td>15.</td>
<td>Psychiatric Examination for Annual Review of a Persistently or Acutely Disabled</td>
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<td>Notice of Filing Confirmation of Receipt</td>
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<td>Discharge Referral Tracking Log</td>
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<td>Discharge Plan</td>
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<td>Discharge Referral Tracking Log</td>
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<td>Request for Out of Home Admission</td>
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<td>30.</td>
<td>Deliverable – VR Member Referral Tracking Grid</td>
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<tr>
<td>33. Behavioral Health UM Grid</td>
<td><strong>File Name</strong> – BH UM Grid 12062018</td>
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</tbody>
</table>
Section 14 – Definitions


- **Adult Recovery Team ("ART")** means a defined group of individuals that includes, at a minimum, the member, their family, a behavioral health representative, and any individuals important in the member’s life that are identified and invited to participate by the member. This may include system partners such as extended family members, friends, family support partners, healthcare providers, community resource providers, representatives from churches, synagogues or mosques, agents from other service systems like the Department of Developmental Disabilities (DDD), Probation, or the Administrative Office of the Courts (AOC). The size, scope and intensity of involvement of the team members are determined by the objectives established for the adult, the needs of the family in providing for the adult, and by which individuals are needed to develop an effective service plan and can therefore expand and contract as necessary to be successful on behalf of the adult should this be needed or required.

- **AHCCCS Health Plan** means an organization or entity that has a contract with AHCCCS to provide specified health-related goods and services in conformance with the stated requirements, Arizona statute and rules, and federal law and regulations.

- **AHCCCS Registered Provider** means a provider that enters into an agreement with AHCCCS under A.A.C. R9-22-703(A) and meets licensing or certification requirements to provide covered services.

- **Amendment** means a written document that is issued for the purpose of making changes to a document.

- **Arizona Department of Economic Security ("ADES")** means the State agency that has the powers and duties set forth in A.R.S. § 41-1951, et seq.

- **Behavioral Health** – Mental health and substance use collectively.

- **Behavioral Health Disorder** means any behavioral, mental health, and/or substance use diagnoses found in the most current version of the Diagnostic and Statistical Manual of International Classification of Disorders excluding those diagnoses such as intellectual disability, learning disorders and dementia, which are not typically responsive to mental health or substance abuse treatment.

- **Behavioral Health Provider** means an individual or facility that delivers behavioral health services as a subcontractor in the Health Plan’s provider network.

- **Best Practices** means evidence-based practices, promising practices, or emerging practices.

- **Board Eligible for Psychiatry** means a physician with documentation of completion of an accredited psychiatry residency program approved by the American College of Graduate Medical Education, or the American Osteopathic Association. Documentation would include either a certificate of residency training including exact dates, or a letter of verification of residency training from the training director including the exact dates of training.
• **Claim** means a service billed under a fee-for-service arrangement.

• **Community Service Agency ("CSA")** means an agency that is contracted directly by the Health Plan and registered with AHCCCS to provide rehabilitation and support services consistent with the staff qualifications and training. Refer to the AHCCCS Covered Behavioral Health Services Guide for details. **Complex Needs** means the presence of significant behavioral challenges that impact the safety of a member, facility personnel, and/or other members for which additional staff support is needed to address and successfully treat the member’s behavioral challenges in the facility.

• **Conflict of Interest ("COI")** means any situation in which the Subcontractor or an individual employed or retained by the Subcontractor is in a position to exploit a contractual, professional, or official capacity in some way for personal or organizational benefit that otherwise would not exist.

• **Credentialing** means the process of obtaining, verifying and evaluating information regarding applicable licensure, accreditation, certification, and educational and practice requirements to determine whether a provider has the required credentials to deliver specific covered services to members.

• **Cultural Competence** means a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals which enables that system, agency, or those professionals to work effectively in cross-cultural situations. Culture refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. Competence implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors and needs presented by consumers and their communities.

• **Deliverables** means the reports and other deliverables the Subcontractor is required to provide to the Health Plan pursuant to the Health Plan Provider Manual.

• **Direct Care Staff** means, in the case where a Subcontractor is a health care entity, a person or entity who is employed by or otherwise engaged by Subcontractor to provide Covered Services to Members.

• **Disenrollment** means the discontinuance of a Member’s eligibility to receive Covered Services.

• **Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)** - A comprehensive child health program of prevention, treatment, correction, and improvement of physical and behavioral health problems for AHCCCS members under the age of 21. The purpose of EPSDT is to ensure the availability and accessibility of health care resources as well as to assist Medicaid recipients in effectively utilizing these resources. EPSDT services provide comprehensive health care through primary prevention, early intervention, diagnosis, medically necessary treatment, and follow-up care of physical and behavioral health problems for AHCCCS members less than 21 years of age. EPSDT services include screening services, vision services, dental services, hearing services and all other medically necessary mandatory and optional services listed in Federal Law 42 U.S.C. 1396d(a) to correct or ameliorate defects and physical and mental
illnesses and conditions identified in an EPSDT screening whether or not the services are covered under the AHCCCS State Plan. Limitations and exclusions, other than the requirement for medical necessity and cost effectiveness, do not apply to EPSDT services.

- **Exhibit** means any item labeled as an Exhibit to the RBHA/MCO/Health Plan Attachment or placed in the Exhibits section of the RBHA/MCO/Health Plan Attachment.

- **Federal CLAS Standards** means the US Office of Minority Health standards for Culturally and Linguistically Appropriate Services ("CLAS"), which may be amended or supplemented from time to time and is included as *Exhibit F*.

- **Formulary** means a list of covered medications available for treatment of Members.

- **Geographic Service Area ("GSA")** means a specific region or regions in Arizona (defined by zip code) in which the Health Plan provides, directly or through subcontract, covered services to Members of that region.

- **General Mental Health/Substance Use Disorder (GMH/SU)** - Behavioral health services provided to adult members age 18 and older who have not been determined to have a serious mental illness.

- **Grievance** means a member’s expression of dissatisfaction with any aspect of their care, other than dissatisfaction with respect to an Action, which is managed as an appeal.

- **High Need Case Management** is an intensive level of case management services provided to high need Members.

- **Interagency Service Agreement ("ISA")** means an agreement between two or more agencies of the State wherein an agency is reimbursed for services provided to another agency or is advanced funds for services provided to another agency. (A.R.S. § 35-148(A))

- **Level I Behavioral Health Facility** means an inpatient treatment program or behavioral health treatment facility that is licensed under A.A.C. Title 9, Chapter 10 and includes a psychiatric acute hospital, a residential treatment center for individuals under the age of twenty-one (21), or a sub-acute facility.

- **Level IV Behavioral Health Facility** means a behavioral health agency as defined in A.A.C. Title 9, Chapter 10.

- **Material Gap** means a temporary change in a provider network that may reasonably be foreseen to jeopardize the delivery of covered health services to an identifiable segment of the Member population.

- **Medical Institution** means an acute care hospital, psychiatric hospital—Non IMD, psychiatric hospital – IMD—, Residential Treatment Center—Non IMD, psychiatric hospital – IMD—, Skilled Nursing Facility, or Intermediate Care Facility for persons with intellectual disabilities.

- **Medicare Modernization Improvement Act of 2003 ("MMA")** means the federal law that created a prescription drug benefit called Medicare Part D for individuals who are eligible for Medicare Part A and/or enrolled in Medicare Part B.
**Medicare Part D Excluded Drugs** means the prescription drug coverage option available to Medicare beneficiaries, including Dual Eligible Members. Medications that are available under this benefit are not covered by AHCCCS for dual eligible Members. Certain drugs that are excluded from coverage by Medicare continue to be covered by AHCCCS. Those medications are barbiturates, benzodiazepines, and over the counter medication as defined in the AMPM. Prescription medications that are covered under Medicare, but are not on a Part D health plan’s formulary are not considered excluded drugs, and are not covered by AHCCCS.

**Medications List** has the same meaning as "Formulary.

**Mental Health Block Grant ("MHBG")** means an annual formula grant from The Substance Abuse and Mental Health Services Administration (SAMSHA) that provides funds to establish or expand an organized community-based system of care for providing non-Title XIX mental health services to children with serious emotional disturbances (SED) and adults with serious mental illness (SMI). These funds are used to: (1) carry out the State plan contained in the application; (2) evaluate programs and services, and; (3) conduct planning, administration, and educational activities related to the provision of services.

**Must** denotes the imperative.

**Non-Title XIX/XXI Funding** means fixed, non-capitated funds, including funds from MHBG and SABG, County, and other funds, and State appropriations (excluding State appropriations for state match to support the Title XIX and Title XXI program), which are used for services to Non-Title XIX/XXI eligible persons and for medically necessary services not covered by Title XIX or Title XXI programs.

**Non-Title XIX/XXI Member** or **Non-Title XIX/XXI Person** means an individual who needs or may be at risk of needing covered health-related services but does not meet federal and state requirements for Title XIX or Title XXI eligibility.

**Non-Title XIX/XXI SMI Member** means a Non-Title XIX/XXI Member who has met the criteria to be designated as Seriously Mentally Ill.

**Office of Individual and Family Affairs (OIFA)** is an AHCCCS bureau that builds partnerships with individuals, families of choice, youth, communities, organizations to promote recovery, resiliency and wellness. OIFA collaborates with key leadership and community members in the decision-making process at all levels of the behavioral health system. In partnership with the community, OIFA advocates for the development of culturally inclusive environments that are welcoming to individuals and families. establishes structures to promote diverse youth, family and individual voices in leadership positions throughout Arizona, delivers training, technical assistance and instructional materials for individuals and their families, ensure peers support and family support are available to all persons receiving services and their families, and monitors contractor performance and measure outcomes.

**Outreach** means activities to identify and encourage Members or potential Members, who may be in need of, but not yet receiving physical or behavioral health services.

**Payor** means the Health Plan or another entity that is responsible for funding Covered Services to Members.
• **Primary Care** - All health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, or other licensed practitioner as authorized by the State Medicaid program, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them. [42 CFR 438.2]

• **Provider Network** means the agencies, facilities, professional groups, and professionals or other persons under subcontract to the Health Plan to provide Covered Services to Members, including the Subcontractor to the extent the Subcontractor directly provides Covered Services to Members.

• **Psychiatrist** means a person who is a licensed physician as defined in A.R.S. Title 32, Chapter 13 or Chapter 17 and who holds psychiatric board certification from the American Board of Psychiatry and Neurology, the American College of Osteopathic Neurologists and Psychiatrists, or the American Osteopathic Board of Neurology and Psychiatry; or is board eligible.

• **Regional Behavioral Health Authority/Managed Care Organization** - A Managed Care Organization that has a Contract with the administration, the primary purpose of which is to coordinate the delivery of comprehensive behavioral health services to all eligible persons assigned by the administration to the managed care organization. Additionally, the Managed Care Organization shall coordinate the delivery of comprehensive physical health services to all eligible persons with a serious mental illness enrolled by the administration to the managed care organization.

• **Rehabilitation Services Administration ("RSA")** means the Division within Arizona Department of Economic Security.

• **SAMHSA** means the Substance Abuse and Mental Health Services Administration, which is a part of the U.S. Public Health Service that provides funding through block grants for direct substance abuse and mental health services including substance abuse prevention and addiction treatment.

• **Shall** means something is mandatory.

• **Should** denotes a preference.

• **SMI Grievance Investigation** means a grievance or request for investigation that is filed by or on behalf of a person with Serious Mental Illness alleging a violation of the member’s rights or asserting that a condition requiring investigation exists.

• **SMI Member** means a person who meets the criteria for Serious Mental Illness.

• **State** means the State of Arizona and AHCCCS.

• **Step Therapy** means the practice of initiating drug therapy for a medical condition with the most cost-effective and safest drug and stepping up through a sequence of alternative drug therapies as a preceding treatment option fails.

• **Substance Abuse Block Grant ("SABG")** an annual formula grant from The Substance Abuse and Mental Health Services Administration (SAMHSA) that supports primary prevention services
and treatment services for persons with substance use disorders. It is used to plan, implement and evaluate activities to prevent and treat substance abuse. Grant funds are also used to provide early intervention services for HIV and tuberculosis disease in high-risk substance abusers.

- **Support Services** means Covered Services as defined in the AHCCCS Covered Behavioral Health Services Guide.

- **Temporary Assistance to Needy Families ("TANF")** means the federal cash assistance program under Title IV of the Social Security Act established by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193).

- **Third Party** means an individual, entity or program that is or may be liable to pay all or part of the medical cost of injury, disease, or disability of an AHCCCS applicant or Member as defined in R9-22-1001.

- **Title XIX** - Known as Medicaid, Title XIX of the Social Security Act provides for Federal grants to the States for medical assistance programs. Title XIX enables States to furnish medical assistance to those who have insufficient income and resources to meet the costs of necessary medical services, rehabilitation and other services, to help those families and individuals become or remain independent and able to care for themselves. Title XIX members include but are not limited to those eligible under Section 1931 of the Social Security Act, Supplemental Security Income (SSI), SSI-related groups, Medicare cost sharing groups, Breast and Cervical Cancer Treatment Program and Freedom to Work Program. Which includes those populations described in 42 U.S.C. 1396 a(a)(10)(A).

- **Title XIX Covered Services** means the covered services identified in the AHCCCS Covered Behavioral Health Services Guide and the physical health care covered services described in Solicitation No. ADHS 15-00004276, Scope of Work Section 4.7, Physical Health Care Covered Services.

- **Title XXI Eligible Person** or **Title XXI Eligible Member**, means an individual who meets federal and state requirements for Title XXI eligibility.

- **Young Adult Transitional Insurance ("YATI")** means individuals age 18 through age 25 who were enrolled in the foster care program under jurisdiction of the Department of Child Safety in Arizona on their 18th birthday.