## 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. The Health Plan utilizes MCG criteria and licensed behavioral health professionals to determine medical necessity.

### Prior authorization procedures for providers contracted by the Health Plan

Go to www.bannerufc.com for the most current Behavioral Health Prior Authorization Grid.

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

## 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 prior authorization 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 to make a determination. A decision to deny 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

Prior authorization is not required for admission or continued stay at 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 facilities 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 on-going member care for continued stay in the 23-hour observation level of care after the initial 23 hours, facilitate another level of care that the member requires upon assessment and evaluation of the member's status by the facility and to ensure appropriate discharge planning and follow up services are in place upon discharge. Notifications should be sent to: BUHPCareMgmtBHMailbox@bannerhealth.com.

| Level of Care/ Code | Fax Number | Documentation to Submit | Time of Submission |
|---|---|---|---|
| **Level 1 Psychiatric Hospital Admission (excluding BHIF/RTC**) | **520-874-3420 (Banner UM)** | **All** of the following information is required for all inpatient notifications/requests:<br><br>Admission Face Sheet, which includes the following:<br>1. Member's name Member's identification number<br>2. Member's date of birth<br>3. Admission date<br>4. National Provider Identification (NPI) of Facility<br>5. Attending physician name<br>a. Admitting hospital name<br>6. Admitting diagnosis, ICD 10 Code<br>7. Level of care admitted to<br>8. Contact name and phone number/email of in-patient Utilization Reviewer<br>9. Other Insurance<br>10. Certification of Need (CON)<br><br>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 |
| **Emergent BHIF Admission** | **520-694-0599 (Banner BH PA)** | 1. Behavioral Health Prior Authorization Form<br>2. Certificate of Need (CON)<br>3. Request for Out of Home Application<br>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:<br>1. Behavioral Health Prior Authorization Form<br>2. Updated Service Plan/Complete Care Plan<br>3. Recent psychiatric progress notes<br>4. Out of Home Application<br>5. The most recent assessment, or an assessment updated within the past year<br>6. Child and Family Team note indicating team recommendation | |

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| | | 7. Other reports from outpatient providers<br>8. Any psychological reports or other relevant reports from specialty provider<br>9. **Submit a CON within 72 hours of admission**<br><br>If approved, the authorization is valid up to 45 days only. Submit additional clinical documentation if the member does not admit within 45 days of approval. | |
| **Non-Emergent Admission for Behavioral Health Residential Facility (H0018)** | **520-694-0599 (Banner BH PA)** | 1. Behavioral Health Prior Authorization Form<br>2. Out of Home Application with supporting clinical documentation<br>3. If Substance abuse- ASAM and/or clinical documentation<br><br>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<br>2. Out of Home Admission Notification Form<br>3. Out of Home Application Form<br><br>**After 5 Days Admission:**<br>For emergent admissions, authorization will be given for up to 5 days. If member requires a continued stay, the out of home provider **must submit a Concurrent Review Form by the 5th day.** | Submit within 2 days of admission Notification of Admission Form and Behavior Health Prior Authorization Form |
| **Non-emergent Admission to HCTC (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<br>2. Out of Home Application Form with supporting clinical documentation | Up to 45 days prior to admission<br><br>(If approved, the authorization is valid up to 45 days only) |

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| **Emergent Admission to HCTC (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:<br>1. Behavioral Health Prior Authorization Form,<br>2. Out of Home Admission Notification Form, and<br>3. Out of Home Application Form<br><br>**After 5 Days Admission:**<br>For emergent admissions, authorization will be given for up to 5 days. If member requires a continued stay, the out of home provider must **submit a Concurrent Review Form by the 5th day.** | Within 2 business days of admission, Notification of Admission Form and Behavioral Health Prior Authorization Form are submitted. |
| **Concurrent Review Requirements for Inpatient, BHIF, BHRF, HCTC** | **Fax Number** | **Documentation to Submit** | **Time of Submission** |
| **Inpatient Concurrent Review** | **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.** | Submit **all** of the following clinical documentation to support medical necessity:<br><br>1. Attending/Psychiatrist admitting evaluation<br>2. History and Physical (H&P)<br>3. Admission/Intake Assessment<br>4. Medication Administration Record (MAR)<br>5. All physician orders<br>6. Lab results<br>7. RN notes<br>8. Discharge plan/barriers | Submit clinical documentation prior to noon on the last covered day (LCD) of the current authorization; delayed submittals may result in a denial. |
| **Behavioral Health Inpatient Facility Concurrent Review** | **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.** | Submit **all** of the following clinical documentation to support medical necessity:<br><br>1. Psychiatric notes<br>2. Concurrent Review Form<br>3. CFT notes<br>4. Medication Administration Record (MAR)<br>5. Discharge plan<br>6. After 30 days submit a Recertification of Need (RON) | Submit clinical documentation prior to noon on the last covered day (LCD) of the current authorization;<br><br>RON Submitted every 30 days. |

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| **Behavioral Health Residential Facility Concurrent Review** | **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.** | 1. Out of Home Concurrent Review Form<br>2. CFT/ART notes<br>3. Medication and psychiatric progress notes, if applicable<br>4. Revised Service Plan/Complete Care Plan (as applicable)- The revised Service Plan/Complete Care Plan should include revisions to address identified barriers | 14 days prior to the expiration of the current authorization |
| **HCTC Concurrent Review** | **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.** | 1. Out of Home Concurrent Review Form<br>2. CFT/ART notes<br>3. Medication and psychiatric progress notes. | 14 days prior to the expiration of the current authorization |
| **Out of State Placements For Children Concurrent Review (varied)** | **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.** | 1. Psychiatric notes<br>2. Concurrent Review Form<br>3. CFT notes<br>4. Medication Administration Record (MAR)<br>5. Discharge plan, and<br>6. After 30 days submit a Recertification of Need (RON) | Submit clinical documentation prior to noon on the last covered day (LCD) of the current authorization;<br><br>RON Submitted every 30 days. |
| **Other Out Patient Services/ Codes** | **Fax Number** | **Documentation to Submit** | **Time of Submission** |
| **Electroconvulsive Therapy (90870)** | **520-694-0599 (Banner BH PA)** | 1. Behavioral Health Prior Authorization Form<br>2. Supporting clinical documentation | Prior to initiation of services |
| **Out of Network Provider** (varied) | **520-594-0599 (Banner BH PA)** | Behavioral Health Prior Authorization Form | Prior to initiation of services. |
| **Transportation-Ground 100+ mileage (A0425)** | **520-594-0599 (Banner BH PA)** | Behavioral Health Prior Authorization Form | Prior to initiation of services. |
| **23 Hour Crisis Observation** | **BUHPCareMgmtBHMailbox@bannerhealth.com** | 1. Member name<br>2. AHCCCS ID<br>3. Date of Birth<br>4. Date of Admission<br>5. Disposition, if applicable | Upon admission to 23 hour crisis observation facility. |
| **Psychotropic Medication (varied)** | **866-349-0338** | Submit the following: Pharmacy Prior Authorization Form | Prior to dispensing |

**Please note, discharge summaries are required within 72 hours of discharge for all levels of care or claims payment may be denied.**

For more information please refer to the Banner Behavioral Health Provider Manual, Medical Management/ Securing Services and Prior Authorization.

https://www.banneruhp.com/materials-and-services/provider-manuals-and-directories#Provider-Manuals

## 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 the 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:
    - Member's name
    - Member's identification number
    - Member's date of birth
    - Admission date
    - National Provider Identification (NPI) of Facility
    - Attending physician name and Admitting hospital name
    - Admitting diagnosis/ICD 10 Code
    - Level of care admitted to
    - Contact name and phone number/email of In-patient Utilization Reviewer
    - Other Insurance
    - Certification of Need (CON)

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, rather it is a federally required attestation by a physician that inpatient services are or were needed at the time of the member's admission. The decision to authorize a service that requires prior authorization is determined through the application of admission and continued stay authorization criteria (See Behavioral Health Comprehensive Provider Manual Form- Certificate of Need.)

The following documentation is needed on a CON:

- Proper treatment of the member's behavioral health condition requires services on an inpatient basis under the direction of a physician
- The service can reasonably be expected to improve the member's condition or prevent further regression so that the service will no longer be needed
- Outpatient resources available in the community do not meet the treatment needs of the member
- CONs must have a dated physician's signature
- Determination of the need/medical necessity for services is based on the federal regulations in 42 CFR: § 441.152. Certification of Need (CON) that demonstrate all of the following in 1-3 below:
    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
- 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 within 14 days of admission. This team is defined in 42 CFR §441.156 as "an interdisciplinary team of physicians and other personnel who are employed by, or provide services to patients in the facility"; and for members who are admitted and then become Title XIX or Title XXI eligible while at the facility, the team responsible for the treatment plan must complete the CON. The CON must cover any period 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 or 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.

The following clinical information/documents should support the medical necessity for an inpatient admission:

- Attending/Psychiatrist admitting evaluation. Initial evaluation is to include:
    - Admitting diagnosis
    - Differential diagnosis, or possible impact of medical conditions/symptoms (UTI, Dehydrated)
    - Mental status examination
    - Medication Administration Record (MAR)
    - CIWA/CINA/COWS protocols, as applicable
    - ELOS (estimated length of stay)
    - Proposed treatment plan (titration of meds, initiating injectable, etc.)
    - Proposed discharge plan (BHRF, med boxes, etc.)
    - Discharge criteria
    - Justification for current level of care and why member is not able to be discharged to lower level of care

## Hospital/Inpatient Admission Criteria

Fax to: 520-874-3420

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

1. Acute dangerousness: Member presents with a level of risk related to harm towards themselves through suicide, self-injury, irritability or mania; or to others through aggression, assaultive, or homicidal behavior. This dimension identifies elements of dangerousness that represent or describe a member's behavior. To evaluate dangerousness, the mental health

practitioner is to assess suicidal intent and homicidal intent; including psychosocial stressors.

2. Functional impairment: Member presents a temporary and reversible reduction in ability to function such as performing personal hygiene and bodily care activities, obtaining adequate nutrition, sleep, functioning in the work place or at school, or becoming socially isolated. This dimension addresses the degree to which psychological problems affect the member's functioning, vary from the member's own typical baseline and contribute to the ability to survive or maintain him/herself in the environment. The assessment of functional impairment must be made each time the member is assessed, to determine whether the member's level of functioning may have changed from the previous baseline level of functioning.
3. Mental status changes or co-occurring conditions: Member presents with disrupted mood, disordered thinking, disorientation, or other mental status changes that need care at the level requested; or there are medical or substance related issues that require care at the level requested.
4. Additional modifiers: The member's history of response to prior treatment, their personal resources such as intellect, characterological issues and history of violence or self-harm. It is preferred that treatment is provided in the least restrictive setting. However, the member's history of response to prior treatment, their personal resources such as intellect, or underlying characterological issues and history of violence or self-harm may influence the decision about which level of care is medically necessary.
5. Primary diagnosis: A valid diagnosis causing the symptoms 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.
6. 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 prior to discharge may result in a referral as a Quality of Care Concern and/or denial.

## 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. 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 occurs:**

1. The Petition for Court Ordered Treatment is filed with the court
2. The individual agrees to voluntary status
3. The individual is released from the 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 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, hematemesis 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)

### 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 a denial. For all requests for inpatient continued stays, clinical information may be submitted via telephonic or email to the assigned Utilization Management (UM) Reviewer or faxed to **520-874-3411 prior to noon on the last day of the current authorization. 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.**

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 will have a specified date and time by which requested clinical documents/ telephonic 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

Administrative denials of reimbursement for weekend days when no clinical coverage is provided is not intended to be punitive or oppositional. 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, when they are

confined to a hospital setting. 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. "Holding" such patients for two days or more (when holidays are involved) with no continuous clinical intervention by a psychiatric provider, is reminiscent of past "warehousing" and should not represent an acceptable standard of care.

**Medical necessity denials will be issued for days when there is no evidence of a BHMP progress note or update.**

**The following clinical documentation should support the medical necessity for concurrent review to occur:**

- Attending Behavioral Health Medical Provider (BHMP) notes for each day of hospitalization. Note must include estimated length of stay
- Labs: may not be needed if meds are not titrated, or levels repeated to ensure therapeutic dose
- Medical Administration Record (MAR): to demonstrate compliance with prescribed meds.
- Orders to provide active medication adjustment

### 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 date of admission. If the member is not enrolled with an outpatient behavioral health provider, the inpatient team is to initiate request to enroll 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 and 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:
    - 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 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
    - 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)
    - Access to prescribed discharge medications
    - Coordination of care with the Health plan including submission of prior authorization, when applicable
    - Post discharge follow up contact to assess the progress of the discharge

## Behavioral Health Inpatient Facility (BHIF)

Fax to 520-694-0599

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.

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

**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.

**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:

        - 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

        - 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**

    ii. 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 is not used primarily, and in a clinically inappropriate manner, 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
- The equivalent of safe housing, permanency placement
- An alternative to parents'/guardian's or another agency's capacity to provide for the child or adolescent
- An intervention when other less restrictive alternatives are available and not being utilized.

**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 authorization is valid up to 45 days only. 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
- Certificate of Need (CON) (from the facility upon 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
- Any psychological reports or other reports from specialty providers
- **Submit a CON within 72 hours of admission**

If a denial is issued for a non-emergent admission to a BHIF residential facility, the Health Plan will provide recommendations for alternative treatment in the denial. The requesting provider, along with the CFT, including the family, is to develop a clearly outlined alternative Service Plan. It is expected that

the alternative Service Plan/Complete Care Plan (as applicable) will adequately address the behavioral health treatment needs of the member and will provide specific information detailing what services will be provided, where these services will be provided, and when these services will be available and what specific behaviors will be addressed by these services. It is also expected that the alternative complete care plan will include what crisis situations can be anticipated and how the crises will be addressed.

**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 (stated below) are met. For emergent admissions, precertification of admission will take place for up to 5 days 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.

- Behavioral Health Prior Authorization
- Out of Home Admission Notification
- Out of Home Application
- Submit a CON within 72 hours of admission

**Concurrent Review for Emergent BHIF Admissions:** If the member requires a continued stay past the initial 5 days, submit the following via fax to 520-694-0599

Concurrent Review Form by the 5th day

### Concurrent Review for Non-Emergent BHIF Level of Care

Continued stay requests for the BHIF level of care ***must be submitted prior to noon, 7 calendar days prior to the last covered day*** of the current authorization for concurrent review.

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.

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 their 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 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

Provide all of the following clinical documentation to support medical necessity for concurrent review:

1. Psychiatric notes
2. Concurrent Review Form
3. CFT notes
4. Medication Administration Record (MAR)
5. Discharge plan
6. After 30 days submit a Recertification of Need (RON)

### BHIF Discharge planning:

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 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.

### 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/BHIF Discharge Planning

Discharge planning is expected to begin on date of admission. If the member is not enrolled with an outpatient behavioral health agency, inpatient team is to initiate request to enroll 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.

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 health care professional and 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:
    - 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 clinical 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
    - Coordination of care with the Health Plan, when applicable
    - 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

### Administrative Days for Hospital/Inpatient BHIF Level of Care

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

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.

The Health Plan will consider administrative days for an acute hospitalized member who no longer meets medical necessity criteria and is ready for the next level of care. The Health Plan requires the facility to continue to provide medically necessary services as appropriate while the member is awaiting the next level of care and continue to document the care in the medical record.

In addition, it must be clearly documented in the member's medical record that the inpatient facility has attempted to secure the next level of care but has been repeatedly refused by all network available facilities. It is the responsibility of the facility to provide an update to the assigned UM Reviewer, on activities related to securing a safe and appropriate discharge every 48 hours. The Health Plan will issue a denial if the facility cannot provide evidence of actions taken to secure the discharge.

### 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. For purposes of this document, retrospective review refers to 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:

- Entire medical record
- Certificate of Need (CON)
- Copies of legal documents and clinical documentation indicating any activity related to the initiation of Court Ordered Evaluation, date when the petition to the court was filed, member status throughout the process, including date of when member became voluntary, if applicable, and date Court Ordered Treatment started. The Health Plan will not consider the request for a retrospective review when the member was admitted on Court Ordered Evaluation and the documentation is absent to identify the member's status during the hospital stay.

Retrospective review is available only when:

1. Documentation is provided to substantiate that timely notification of admission was not reasonably possible prior to the member's discharge
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. 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 not eligible for retrospective review based on the above criteria, the provider may submit an appeal.

Upon determining a request is eligible for retrospective review, the Health Plan will review the submitted records to ascertain if the Health Plan has received all clinical information necessary to conduct a review. 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.

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)

Fax to 520-694-0599

*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 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 for 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.

**Emergent-Admission Criteria for BHRF** - For emergent admissions, a member may be placed in the contracted facility and based on documented information to suggest medical necessity criteria (stated below) are met. 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, precertification of admission will take place for up to 5 days 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.

**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.*

| Facility Name | Program | Accepts SUD (Y/N) | Contact - Phone | Additional Info |
|---|---|---|---|---|
| COPE - Ocotillo Tucson | BHRF | Y | 520 903-1563 | |
| CBI-Tucson | BHRF | Y | 520 327-9863 | Male Only Program |
| CBI-Yuma | BHRF | Y | 928 341-4880 | |
| CBI-Bisbee | BHRF | Y | 520 432-8068 | Female Only Program |
| CBI-Benson | BHRF | Y | 520 586-9543 | |
| CODAC Gila - Tucson | BHRF | Y | 520 327-4505 x 5433 | |
| CODAC Las Amigas - Tucson | BHRF | Y | 520 327-4505 x 4021 | Female Only Program-SUD focus |

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.*

| Facility Name | Program | Accepts SUD (Y/N) | Contact - Phone | Additional Info |
|---|---|---|---|---|
| Summit (ICHD) | BHRF and HCTC | Y | Chris Hileman-520-262-9483 and Lynn Hale-520-609-1645 | Substance abuse program |
| Angel House (ICHD) | BHRF | Y | Lynn Hale-520-721-1887 x 1127 | |
| Devereux BIP/AIC | BHRF | Y | Jazz Garcia-520-332-1385 and Starr Hunter at 520-407-5981 | |

**Non- Emergent Prior Authorization Requests for BHRF:** Care and services provided in a BHRF are based on a per diem rate for a 24-hour day. If the member is not admitted on an emergent basis, the admission requires a prior authorization. Authorization does not include room and board. Contracted providers will ensure appropriate notification is sent to the Primary Care Physician upon intake to and discharge from the BHRF.

**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 ASAM

Admission to a Behavioral Health Residential Facility requires the member to 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:

a. At least one area of significant risk of harm within the past three months as a result of:
    i. Suicidal/aggressive/self-harm/homicidal thoughts or behaviors without current plan or intent
    ii. Impulsivity with poor judgment/insight
    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
    v. Medication side effects due to toxicity or contraindications.

**AND**

b. At least one area of serious functional impairment 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

   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

   v. Impairments persisting in the absence of situational stressors that delay recovery from the presenting problem.

   vi. 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.

   vii. Anticipated stabilization cannot be achieved in a less restrictive setting.

   viii. Evidence that appropriate treatment in a less restrictive environment has not been successful or is not available, therefore warranting a higher level of care.

   ix. Member agrees to and participates 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. Clinical status for 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.
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

### Expected Treatment Outcomes

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 shall be developed in accordance with the following:

1. Member's behavioral health condition(s)
2. Achievable in a reasonable period of time and cannot be met in a less restrictive environment
3. Based on the member's unique needs and tailored to the member and the family's/guardian's/designated representative's choices where possible
4. Support the member's improved or sustained functioning and integration into the community.

### 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
2. Providers and supports are not available to meet current behavioral and physical health needs at a less restrictive lower level of care.

Health Plan staff will provide technical assistance and/or care management when applicable.

**The Out of Home Provider/Outpatient Provider will submit the following 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 Out of Home provider must submit a completed Discharge Summary no later than 3 business days 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 behavior relief is 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

## Criteria for 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:** 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 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.

**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 to suggest medical necessity criteria are met. 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, authorization of admission will take place for up to 5 days.

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.

**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

**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

**After 5 Days Admission:** For emergent admissions, authorization will be given for up to 5 days. If member requires a continued stay, the out of home provider must **submit a Concurrent Review Form by the 5th day.**

**Concurrent Review for Adult/Child HCTC Level of Care**

Documents required to request a continued stay for HCTC level of care requires the following to be submitted 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 when a member is going to receive respite services. **Contact the UM Reviewer and submit the following information:**

- 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 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.

Adults 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

## Denials for all Levels of Care

A denial regarding medical necessity for an outpatient service, admission to 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 made when the information provided verbally and/or through documentation does not support medical necessity for the service provided. For denials of admission to or continued stay 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 for all prior authorizations for outpatient services:

- 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.

## 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

Fax to 520-694-0599

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 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

Fax to 520-694-0599

Prior authorization for all non-medical transportation over 100 miles for a round trip or one way is required regardless of the diagnosis that will be on the code billed on the claim. All requests require submission on the Prior Authorization Form.

## 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 care up to the 24th hour. Providers of 23-hour observation facilities 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 on going member care for continued stay in the 23-hour observation level of care after the initial 23 hours, facilitate another level of care that the member requires upon assessment and evaluation of the member's status by the facility, 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.

Notifications should be sent to: BUHPCareMgmtBHMailbox@bannerhealth.com.

1. Member Name
2. AHCCCS Identification Number
3. Date of Birth
4. Date of Admission
5. Disposition, if applicable

## 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