2024 Provider Manual

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AHCCCS Complete Care
Arizona Long Term Care System

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Section 1 – Introduction

Banner – University Health Plans (B – UHP) is an Arizona-based, locally-operated Managed Health Care Organization dedicated to ensuring that members receive ready access to high quality and culturally responsive care. B – UHP is committed to bringing the best care possible to our members through a focus on innovative programs and services. B – UHP serves ten Arizona counties—Pima, La Paz, Yuma, Santa Cruz, Cochise, Greenlee, Graham, Pinal, Maricopa and Gila Counties—and recognizes that the needs of each county are unique. B – UHP tailors services to meet the needs of each community and supports community-based efforts to effectively coordinate care.

B – UHP developed this Provider Manual in support of its provider agreements and in conformance with the Arizona Health Care Cost Containment System (AHCCCS) - Contractor Operations Manual (ACOM Manual) and the AHCCCS Medical Policy Manual (AMPM). B – UHP's Provider Manual is applicable to those providers serving members who have both Medicare – and Medicaid-funded health care and are enrolled in B – UHP's Arizona Long Term Care Services (ALTCS) plan or AHCCCS Complete Care (ACC) plan.

Providers are obligated to comply with all terms and conditions of the B – UHP Provider Manual, the provider's agreement with B – UHP, and all applicable federal and state laws and regulations. B – UHP endorses and requires for all subcontracted providers to comply with the Arizona Adult Service System's Nine Guiding Principles.

1. **Respect** is the cornerstone. Meet the person where they are without judgment, with great patience and compassion.
2. **Persons in recovery choose services and are included in program decisions and program development efforts.** A person in recovery has choice and a voice. Their self-determination in driving services, program decisions and program development are made possible, in part, by the ongoing dynamics of education, discussion, and evaluation, thus creating the "informed consumer" and the broadest possible palette from which choice is made. Persons in recovery should be involved at every level of the system, from administration to service delivery.
3. **Focus on individual person, while including and/or developing natural supports.** A person in recovery is held as nothing less than a whole being: capable, competent, and respected for their opinions and choices. As such, focus is given to empowering the greatest possible autonomy and the most natural and well-rounded lifestyle. This includes access to and involvement in the natural supports and social systems customary to an individual's social community.
4. **Empower individuals taking steps towards independence and allowing risk taking without fear of failure.** A person in recovery finds independence through exploration, experimentation, evaluation, contemplation, and action. An atmosphere is maintained whereby steps toward independence are encouraged and reinforced in a setting where both security and risk are valued as ingredients promoting growth.
5. **Integration, collaboration, and participation with the community of one's choice.** Aperson in recovery is a valued, contributing member of society and, as such, is deserving of and beneficial to the community. Such integration and participation underscores one's role as a vital part of the community, the community dynamic being inextricable from the human experience. Community service and volunteerism is valued.
6. **Partnership between individuals, staff, and family members/natural supports for shared decision making with a foundation of trust.** A person in recovery, as with any member of a society, finds strength and support through partnerships. Compassion-based alliances with a focus on recovery optimization bolster self-confidence, expand understanding in all participants, and lead to the creation of optimum protocols and outcomes.
7. **Persons in recovery define their own success.** A person in recovery -- by their own declaration -- discovers success, in part, by quality-of-life outcomes, which may include an improved sense of well-being, advanced integration into the community, and greater self-determination. Persons in recovery are the experts on themselves, defining their own goals and desired outcomes.

8. **Strengths-based, flexible, responsive services reflective of an individual's cultural preferences.** A person in recovery can expect and deserves flexible, timely, and responsive services that are accessible, available, reliable, accountable, and sensitive to cultural values and mores. A person in recovery is the source of his/her own strength and resiliency. Those who serve as supports and facilitators identify, explore, and serve to optimize demonstrated strengths in the individual as tools for generating greater autonomy and effectiveness in life.
9. **Hope is the foundation for the journey towards recovery.** A person in recovery has the capacity for hope and thrives best in associations that foster hope. Through hope, a future of possibility enriches the life experience and creates the environment for uncommon and unexpected positive outcomes to be made real. A person in recovery is held as boundless in potential and possibility.

B – UHP also endorses and requires all contracted providers to comply with the Arizona Vision - 12 Principles for Children's Behavioral Health Service Delivery.

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

The 12 Arizona Principles are:

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

Provider's Responsibilities

B – UHP is proud to have a comprehensive network of valued providers to service our members. To ensure we maintain this valued provider network, our Providers are responsible to adhere to and comply with all terms of the B – UHP plan, provider contract and requirements in the Provider Manual. Responsibilities include but are not limited to:

- Must be registered with AHCCCS
- Must complete Credentialing requirements and be approved through Credentialing Committee
- Adhere to AHCCCS Appointment Availability standards
- Verify member eligibility
- Licensed Level I Facilities and residential facilities must accept all referrals from Banner
- Provide preventive and appropriate routine services
- Meet Quality and Utilization Management standards
- Coordinate Care and refer when applicable for behavioral health and specialty
- Specialist providers to coordinate with the primary care provider
- Educate members on appropriate use of Urgent Care services
- Monitor Controlled and Non-Controlled Medication Utilization
- Maintain member medical records in a legible, detailed, and comprehensive manner, preferably an electronic health record, and be accessible to B – UHP, AHCCCS, CMS or authorized Government entities.
- Comply with Member Rights, review the Member Handbook with all office staff and providers
- Provide healthcare services in a culturally competent manner
- Provide trauma screenings and trauma informed care, interventions, and approaches
- Screen for and document, the presence of SDOH, and connect member to services and supports when indicated
- Notify B – UHP of changes to providers, locations, key contacts, Tax Identification Numbers, or corporate structure within 30 days of change
- Provide a transition plan and 30-day notice when terminating a member from medical practice
- In alignment with AHCCCS Policy AMPM 310-P, B - UHP expects all DME providers to deliver wheelchairs, hospital beds and augmentative communication devices as quickly as possible but no longer than 90 days from date of order.

Registering with AHCCCS

AHCCCS Provider Enrollment Portal (APEP)

Providers must register for a single sign on (SSO) to access the APEP system. All users within a provider's organization who require access to information within APEP must obtain a user ID and password. The APEP system allows providers to easily update their information at any time or submit a new provider enrollment application. Provider data changes include but are not limited to:

- Changes in service address.
- Changes in ownership or managing employees.
- Changes in current population groups set served.

For more information regarding the SSO, such as "Forgot User ID", a Service Ticket is required to complete additional research with the APEP online vendor. A Service Ticket can be opened by emailing

APEPTrainingQuestions@azahcccs.gov or Provider Assistance (602)417-7670 option #5. Please have the email address associated with the SSO available. For more information you may contact Provider Relations at BUHPProviderInquiries@bannerhealth.com.

Notifying B – UHP of Provider Changes

Providers should notify B – UHP immediately when there are changes to an address, contact information, opening or closing panels, adding or removing a practitioner or other demographic information is changed.

Changes should be sent directly to the data department, providers need to email BUHPDataTeam@bannerhealth.com.

Workforce Development

B – UHP's Workforce Development (WFD) department implements, monitors, and regulates Provider WFD activities and requirements. In addition, B – UHP evaluates the impact of the WFD requirements and activities to support Providers in developing a qualified, knowledgeable, and competent workforce. See the Workforce Development section of this Provider Manual for a complete list of trainings.

Electronic Visit Verification (EVV)

EVV is a computer-based system that electronically verifies authorized services to members by capturing the precise time a service delivery visit begins and ends, the member who is receiving the visit and who is providing the service, and the type of service performed. In the event the service does not require an authorization from Banner, the provider must enter the service confirmation via the AHCCCS Service Confirmation Portal. The following services require EVV:

Service	Procedure Code	Auth Required B – UHP	Auth Required UFC/ACC	Line of Business
Attendant Care	S5125	Yes	N/A	ALTCS
Personal Care	T1019	Yes	N/A	ALTCS
Home Maker	S5130	Yes	N/A	ALTCS
Companion Care	S5135	Yes	N/A	ALTCS
Home Health Nursing RN	G0299	Yes	No	ALTCS, ACC
Home Health Nursing LPN	G0300	Yes	No	ALTCS, ACC
Home Health Aide	T1021	Yes	No	ALTCS, ACC
Physical Therapy	G0151, S9131	No	No	ALTCS, ACC
Occupational Therapy	G0152, S9129	No	No	ALTCS, ACC
Speech Therapy	G0153, S9128	No	No	ALTCS, ACC
Respiratory Therapy	S5181	Yes	N/A	ALTCS
Private Duty Nursing RN	S9123	Yes	N/A	ALTCS
Private Duty Nursing LPN	S9124	Yes	N/A	ALTCS
Respite	S5150, S5151	Yes	N/A	ALTCS
Skills Training and Development (Peer Support)	H2014	No	No	ALTCS, ACC
Habilitation	T2017	Yes	No	ALTCS, ACC

Provider Description	Provider Type
Attendant Care Agency	PT 40
Behavioral Outpatient Clinic	PT 77
Community Service Agency	PT A3
Fiscal Intermediary	PT F1
Habilitation Provider	PT 39
Home Health Agency	PT 23
Integrated Clinic	PT IC
Non-Medicare Certified Home Health Agency	PT 95
Private Nurse	PT 46

Place of Service Description	Place of Service Code
Home	12
Assisted Living Facility	13
Other	99
Telehealth	Does not require EVV
In Office	Does not require EVV

EVV Data Entry Process

The provider shall enter the paper timesheet into their EVV System no more than 21 days past the date of service rendered if timeliness filing standards, as found in ACOM Policy 203 or the provider's contract with the Health Plan, are also met. The signature does not have to be recorded in the EVV System, but Agencies shall have the original copy of the signature on file for audit purposes. A faxed copy of the signature is permissible for billing purposes.

Providers shall self-monitor and analyze the following:

1. Performance of the system and employees
    a. Location discrepancies
    b. Visit exceptions
2. Devices
    a. Monitor and maintain devices that have been assigned to the provider from the EVV vendor
3. Service Delivery
    a. Compare the service hours authorized by the health plan compared to the total number of service hours provided to the member

The provider shall:

1. Notify the AHCCCS EVV Vendor whenever:
    a. There is a new user
    b. A use is terminated
    c. A data security incident occurs
2. Maintain records for audit purposes for at least six years from date of payment on the following:
    a. Applicable attestations regarding verification delegation
    b. Paper timesheet allowances

   c. Contingency/back-up plans as specified in AHCCCS policy 540

3. Ensure members or health care decision makers have an understanding on the scheduling flexibility based on the member's service plan or provider plan of care. This should include what tasks can be scheduled and modified depending on the direct care worker's scheduling availability. This should be done at least every 90 days.
4. Ensure all members/health care decision makers understand scheduling flexibility based on the member's Service Plan or the provider plan of care and what tasks can be scheduled and modified depending on the direct care worker's availability. This should be done at least every 90 days.
5. Create a weekly schedule for each EVV service provided to the member. The system will not allow services to be cancelled but they can be rescheduled. Scheduling is not a requirement for members who have a live-in or onsite caregiver.
6. Ensure access and complete training to everyone who is associated with the EVV system.
7. Submit data timely to AHCCCS when an alternate EVV system is used, as a condition of reimbursement as specified in technical requirement documents available on the AHCCCS website.
8. Comply with member responsiveness including answering the phone 24/7 or returning a phone call within 15 minutes for members who are reporting a missed or late visit.
9. Develop and implement policies to account for and ensure the return of devices issues by providers to direct care workers when using the AHCCCS procured EVV system.
10. Have at least two different types of visit verification devices available to accommodate member preferences and services delivery areas with limited/intermittent or no access to landline, cell or internet service.
11. Ensure any device without GPS that are being used to verify start and end of services provided to the member, are fixed to the member's home to ensure the location can be verified.
12. Ensure that any direct care worker using a personal device have an alternate verification method, should their person device become inoperable.
13. Ensure any member devices are not utilized for data collection unless the member has chosen a verification modality that requires use of their device.
14. Contact the member to validate any visit exceptions including instances when the member indicates the service or duration does not accurately reflect the activity performed during the visit.
    a. The documentation of exceptions should be consistent with CMS's Medicare signature and documentation requirements for addendums to records.
    b. Changes as a result of exceptions process are considered an addendum to the record and do not change the original record.
15. Document manual edits to visits within the system and/or maintain hard copies of the documentation.

DUGLess Portal Provider Requirements

Required reporting of social determinants, demographics and outcome data continues to be critical for the monitoring and tracking of elements that support healthcare management practices across the AHCCCS systems. For those social determinant/demographic/outcome elements with no identified alternative data source or Social Determinate diagnosis identifier, AHCCCS created an online portal (DUGless) accessed directly by providers for the collection of applicable identified data elements for members.

Data tracked is utilized to assist in monitoring and tracking of the following:

1. Access and utilization of services
2. Community and stakeholder information
3. Compliance of Federal, State, and grant requirements
4. Health disparities and inequities

5. Member summaries and outcomes
6. Quality and Medical Management activities
7. Social Determinants of Health

Completion of the DUGless is an AHCCCS requirement for any members for whom the data applies to. Providers must submit data for all new members enrolling in services with additional submissions when the member's data changes and/or is updated. B – UFC also requires providers to update DUGless data on an annual basis during the comprehensive assessment update.

For instructions on registering and accessing the portal, as well as the individual data entry fields, please visit:
https://azahcccs.gov/PlansProviders/Downloads/Demographics/DUGlessPortalGuide_V1_0_E10012018.pdf

For technical support, please contact AHCCCS Customer Support at ISDCustomerSupport@azahcccs.gov or (602) 417-4451.

PCP Services

The Primary Care Provider (PCP) is responsible for rendering or ensuring the provision of, covered preventative and primary care services to our members. The primary role and responsibility include but are not limited to:

- Provide initial and primary care services to assigned members
- Initiate, supervise, and coordinate referrals for specialty care and inpatient services and maintain continuity of member care
- Maintain the member's medical record
- Treatment of routine illness
- Maternity services if applicable
- Immunizations
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services for eligible members under age 21
- Adult health screening services and medically necessary treatments for conditions identified in an EPSDT or adult health screening
- Serve as the referral agent for specialty and referral treatments and services to assignedmembers
- Coordination of quality care that is efficient and cost effective, referring members to B – UHP in network providers and hospitals (out of network specialty cases)
- Coordinate with B – UHP Prior Authorization department
- Conduct follow-up for referral services that are rendered to assigned members
- Provide care coordination including the referral to behavioral health care

Care Transformation

Overview

Provider Relations is a support and resource to ensure appropriate, timely education and communication is provided to our B – UHP provider network. We have a dedicated team of representatives who are assigned a neighborhood of providers to support and assist in providing prompt resolution to inquiries, education on important tools found on our website and other helpful information. A comprehensive onboarding education session is conducted for each newly contracted provider/practice. Provider Relations conducts Provider Education Forums, group education sessions, throughout the year to keep providers informed on AHCCCS updates and B – UHP programs.

You may contact Provider Relations by emailing BUHPProviderInquiries@bannerhealth.com or calling (844) 556-7687.

Response Times to Provider Inquiries

A member of our team will acknowledge your Inquiry within 3 days and provide status updates every 30

days until a resolution is provided.

B – UHP Provider Portal, eServices

https://eservices.uph.org

This is a simple self-service tool that allows providers to access member enrollment information, claim status, member roster information, compliance resources, and annual attestations. Providers may register at https://eservices.uph.org

For more information on eServices and to request a demonstration please contact your assigned Provider Relations Associate by sending an email to BUHPProviderInquiries@bannerhealth.com.

Credentialing

Credentialing Application

A credentialing AzAHP application must be submitted for each participating professional practitioner and for each ancillary practitioner location. The credentialing application and supporting documents should be submitted as outlined in the application (AzAHP Form) cover letter.

Practitioners are not authorized to treat B – UHP members and must be contracted and credentialed by the PHSO Credentialing Committee prior to rendering care to members.

The credentialing review process may take up to 90 days. The credentialing approval date is not necessarily your contract effective date, participation is based on the contract terms indicated in your service agreement. In compliance with credentialing accreditation requirements, re-credentialing occurs at least once every 36 months.

The AzAHP applications can be found on our website: https://www.banneruhp.com/join-us/join-our-network

Practitioner Types

PHSO for B – UHP credentials practitioner types, including but not limited to:

- Medical Doctors (MDs)
- Doctors of Osteopathy (DOs)
- Oral and Maxillofacial Surgeons (DMDs)
- Doctors of Podiatric Medicine (DPMs)
- Chiropractors (DCs)
- Optometrists (ODs)
- Advanced Practice Providers (APPs)
- Independent Behavioral Health Professionals

Organization Types:

B – UHP credentials practitioner types, including but not limited to:

- Hospitals
- Home Health Agencies
- Habilitation Providers
- Group Homes
- Skilled Nursing Facilities (SNF)
- Dialysis Centers
- Dental and Medical Schools
- Speech, Physical, and Occupational Therapy Centers
- Urgent Care Clinics

- Freestanding Surgical Centers
- Intermediate Care Facilities
- State or Local Public Health Clinics
- Community/Rural Health Clinics (or Centers) and Federally Qualified Health Centers (FQHC)
- Air Transportation
- Non-Emergency Transportation Vendor
- Transportation Companies
- Clinical Laboratories
- Pharmacies
- Respite Home/Providers
- Assisted Living Facilities
- Hospice
- Durable Medical Equipment (DME)
- Orthotic and Prosthetic Centers
- Radiology Centers
- Sleep Labs
- Mammography Centers
- Free Standing Emergency Centers
- Behavioral Health Facilities, including but not limited to:
    - Independent Clinics
    - Federally Qualified Health Centers (FQHC)
    - Community Mental Health Centers
    - Level 1 Sub-Acute Facility
    - Level 1 Sub-Acute Intermediate Care Facility
    - Level 1 Residential Treatment Center (secure and non-secure)
    - Community Service Agency (CSA)
    - Crisis Services Provider/Agency
    - Behavioral Health Residential Facility
    - Behavioral Health Outpatient Clinic
    - Integrated Health Clinic
    - Rural Substance Abuse Transitional Agency
    - Behavioral Health Foster Care Home
    - Behavioral Health Therapeutic Home
    - Respite Homes/Providers
    - Specialized Assisted Living Centers
    - Specialized Assisted Living Homes

Credentialing Process

B – UHP must complete a thorough review of documentation and qualifications for all practitioners/ organizations requesting participation. This requires the ability to participate in Medicare, Medicaid, and other Federally funded healthcare programs, through the System for Award Management (SAM), Office of

Inspector General (OIG) and Medicare Opt Out, Sanction Check and Medicare Preclusion.

Primary Source Verification (PSV) is also conducted for the following elements, to include but not limited to:

- Education
- Training
- Accreditation
- Certifications
- Licensure status
- Hospital privileges
- Professional liability insurance
- Malpractice history

Collection of Required Documentation and application data

B – UHP partners with CAQH® to collect and store credentialing information including application data and supporting documents. The Universal Provider DataSource (UPD) is the database operated by CAQH that stores provider credentialing information.

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

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

Practitioners/organizations must respond to any and all reasonable requests for additional information from Aperture CVO, PHSO Credentialing or Credentialing staff which supports the Credentialing Committee to prevent the withdrawal or delay in your credentialing.

To inquire about the status of your credentialing, please contact BUHPProviderInquiries@bannerhealth.com.

Re-credentialing

The B – UHP Credentialing Department will initiate a re-credentialing process for each practitioner approximately six (6) months prior to expiration of the credentialing cycle. Practitioners must maintain an active updated CAQH account. Failure to update CAQH information during this period, after appropriate notification, email, or fax, shall be deemed a voluntary termination of participation with B – UHP.

For Organizations requiring re-credentialing an application will be sent to the credentialing contact on file approximately six (6) months prior to expiration of the credentialing cycle. Failure to return a completed application within 60 days after appropriate notification, email, or fax, shall be deemed a voluntary termination of participation in the health plan.

Credentialing Criteria

Practitioners seeking credentialing/re-credentialing must demonstrate the following minimum qualifications:

Licensure
Practitioners must show proof of a current valid, unrestricted license issued by the appropriate state to practice medicine. APPs are required to provide evidence of a current valid, unrestricted license, certification and/or registration by the state in which they practice.

Professional Education and Training
For purposes of this section, an "approved" or "accredited" school or university is one that is fully accredited at the time of the practitioner’s attendance, by one of the agencies, its successor and/or the accrediting agency on file with the U.S. Secretary of Education.

Graduation Requirements
Practitioners must show proof of graduation from an approved medical, osteopathic, dental or podiatric school; satisfactory completion of an approved post-graduate training program; attainment of a PhD degree in a recognized scientific field from an accredited university; certification by the Educational Council for Foreign Medical Graduates; or Fifth Pathway certification and successful completion of the Foreign Medical Graduate Examination in the Medical Sciences.

APPs must show proof of graduation from an approved training program appropriate for the area of practice.

Board Certification
Physicians may be required to maintain board certification. Failure to abide by any certification requirements may result in the voluntary, automatic termination of participation with the health plan. The B – UHP Credentialing Committee may make exceptions to board certification requirements.

Hospital Privileges

Practitioners must have clinical privileges in good standing at a network hospital/facility, unless the applicant is:

- A primary care or specialty practitioner that does not routinely practice at hospitals (e.g., dermatology), and does not have active privileges at an out of network hospital/facility;
- Serving in a coverage area where there is not a contracted network hospital/facility;
- A specialist practicing primarily at ambulatory surgery centers (not hospitals); and does not have active privileges at an out of network hospital/facility; or
- In good standing with clinical privileges at a contracted ambulatory surgery center.

Practitioners who are required, but do not have privileges at a network hospital/facility must apply for and be granted privileges prior to seeing health plan patients or must request and be granted an exemption. Exemption requests must be made in writing at the time of application.

Drug Enforcement Agency (DEA)
Evidence of a current valid, unrestricted DEA registration or pending registration with an agreement by a practitioner in the same specialty to write all prescriptions until the DEA certificate is received. For APPs, evidence of a valid DEA registration is required, if applicable to area of practice.

Professional Liability Insurance
Evidence of professional liability insurance in a type and amount to meet regulatory requirements.

Practitioner Rights
Every practitioner going through initial credentialing and recredentialing process have rights:

1. Review of information submitted to support credentialing application. In the verification process, if any discrepancies are found in the information provided by a practitioner, the credentialing specialist contacts the practitioner by phone or in writing to validate the correct information. The Credentialing Specialist must notify the practitioner if there is a substantial variation in information regarding actions on licenses, malpractice claims history and board certification. The practitioner may not review references or recommendations or other information that is peer review protected, and the credentialing department is not required to reveal the source of information if law prohibits disclosure.
2. Correct any erroneous information in their credentialing application by phone or in writing, prior to the Credentialing Committee meeting date. The practitioner is also notified by email or phone of the deadline for submitting the corrections. The notification includes the following:
    - Erroneous information must be corrected within seven calendar days
    - Submission of corrections must be in the correct format
    - Corrections must be submitted to the credentialing specialist
    - Receipt of the corrections is documented
3. Receives the status of their credentialing or recredentialing application

4. Receives notification of these rights

Appeal Process
The appeal process is not available to applicants whose initial application for participation is denied by the Credentials Committee.

To appeal an adverse action, or if denied during a re-credentialing process, the practitioner must submit a written request to the Banner Health Insurance Division, President within 30 calendar days of receipt of a notice of adverse action. The failure of a practitioner to request an appeal within the required time and in the manner specified shall constitute a waiver of the practitioner's right to appeal.

Credentialing Site Audit
Pre-contractual on-site visits to each PCP office, Pediatric PCP office as well as OB/GYN and behavioral health offices, are conducted. A structural review of the site appearance, adequacy, accessibility, safety, and medical record keeping practices shall be conducted for initial applications.

Ongoing Monitoring
PHSO Credentialing monitors monthly reports from:

- Appropriate state licensing agencies
- Office of the Inspector General (OIG)
- Medicare/Medicaid sanction lists or reports
- Medical staff disciplinary actions
- Member/customer complaints
- Medicare/Medicaid participation

Practitioners/Organizations are required to notify PHSO Credentialing of any licensure changes/loss, privileges changes/loss and changes in Medicare/Medicaid participation.

The Credentialing Committee will be advised of any findings, including disciplinary, possible disciplinary and non-disciplinary action(s) taken against the practitioner/organization.

Reporting
The Credentialing Committee shall comply with reporting requirements of the Boards of Medical/Osteopathic Examiners and other state agencies and the Federal Healthcare Quality Improvement Act as required by law. All reporting will be done by the assigned Chief Medical Officer or appointed designee. The practitioner/organization will be notified of the report and its contents.

Medicare Opt Out
In order to identify Practitioners/Organizations who have opted out of the Medicare program, PHSO Credentialing staff will review monthly updates from the Medicare website. The Credentialing Committee will be notified of any practitioners listed as not participating in Medicare programs and will be removed from participation with the health plan.

Appointment Availability

B – UHP is required by AHCCCS to ensure that our members can see medical professionals in a timely manner. AHCCCS has given B – UHP and our members a list of appointment availability standards that apply to PCPs, Specialists, Dental, Maternity and Behavioral Health providers. The goal of these standards is to reduce unnecessary emergency department utilization and to ensure we have adequate network capacity for our members. B – UHP monitors this with a quarterly provider survey to assess the availability of routine and urgent appointments.

For surveyed providers who do not meet the appointment availability standard, an education letter including the complete list of standards is sent to the provider. A follow up call is made to review survey results and provide education and workflow tips to assist the provider in meeting the standards. Providers that fail the survey are re-surveyed in the next quarter and if fail the second survey a correction action plan is implemented with the office.

Following is a complete list of appointment availability standards.

Appointment Availability

PRIMARY CARE

Urgent care Appointments	Routine Care Appointments
As quickly as the member's health condition requires but no later than two business days of request	Within 21 calendar days of request

SPECIALTY CARE

Urgent Care Appointments	Routine Care Appointments
As quickly as the member's health condition requires but no later than two business days of request	Within 45 calendar days of request

DENTAL CARE

Urgent Care Appointments	Routine Care Appointments
As quickly as the member's health condition requires but no later than three business days of request	Within 45 calendar days of request

Wait Time

Members with an appointment shall not wait more than 45 minutes for treatment. Except when the provider is unavailable due to an emergency. If there is an emergency or delay, you should be given the option to reschedule your appointment within a reasonable period of time. B – UFC/ACC will actively monitor appointment wait times and ensure provider compliance.

MATERNITY CARE

FIRST TRIMESTER	SECOND TRIMESTER	THIRD TRIMESTER	HIGH RISK PREGNANCIES
Within 14 calendar days of request	Within **7 calendar days** of request	Within **3 business days** of request	Within **3 business days** of identification of High Risk

High Risk Pregnancies
As the member's health condition requires and no later than three business days of identification of high risk by the Contractor or maternity care provider, or immediately if an emergency exists.

BEHAVIORAL HEALTH

Urgent Need Appointments	Routine I. Initial Assessment	Routine II. First behavioral health service following the initial assessment	Routine III. All subsequent behavioral health services
As quickly as the member's health condition requires but no later than 24 hours from identification of need	Within 7 calendar days of referral or request for service	As expeditiously as the member's health condition requires but no later than Member age 18 years and older: 23 calendar days after initial assessment Member age under 18 years old: no later than 21 days after initial assessment	As quickly as the member's health condition requires but no later than 45 calendar days from identification of need

PSYCHOTROPIC MEDICATIONS

ASSESS THE URGENCY OF THE NEED IMMEDIATELY

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

ADOPTED CHILDREN

Routine I. Initial Assessment	Routine II. First behavioral health service following the initial assessment	Routine III. All subsequent behavioral health services
Within 7 calendar days after referral or request for service	As quickly as the member's health condition requires but no later than 21 calendar days after the initial assessment	As quickly as the member's health condition requires but no longer than 21 calendar days from the identification of need

If an adopted child does not receive services within these 7 and/or 21 calendar day timeframes, adoptive parent may contact the B – UHP Customer Care at (800) 582-8686 and the AHCCCS Clinical Resolution Unit at (800) 867-5808

Non-emergent Transportation Timeliness:

For medically necessary non-emergent transportation, the member shall arrive on time for an appointment, but no sooner than one hour before the appointment; nor have to wait more than one hour after the conclusion of the treatment for transportation home.

Cultural Competency

Cultural Competency

B – UHP promotes Cultural Competency for its staff, provider network and members. Cultural Competency is an awareness and appreciation of customs, values and beliefs and the ability to incorporate them into the assessment, treatment, and interaction with members. We have a Cultural Competency Committee and Program as well as a Cultural Competency Liaison who creates education programs for the specific audiences of staff, providers, and members. This education comes in the form of provider education sessions and in- services; member and provider newsletter articles, staff in- services and many other forms of communication forums.

The goal of the Cultural Competency Committee is to ensure that members are provided with culturally competent care and services by the health plan staff and the provider network. The purpose is to increase awareness of how our cultural assumptions and language affect interactions with others, including but not limited to, patient care. This does not mean each person will be competent in all cultures, but that each person should be aware that people may have different perceptions of health care based on their respective cultures. The Cultural Competency Plan follows the guidelines set forth by Section 1557 of the Patient Protection and Affordable Care Act, which is the nondiscrimination provision. This law prohibits discrimination based on race, color, national origin, sex, age or disability in certain health program or actives. Section 1557 builds on standing Federal Civil Rights laws.

Additionally, the Cultural Competency Plan addresses the following:

- Ethnicity
- Religion
- Limited English Proficiency (LEP) Area of the country one is from
- Sexual orientation

- Life Experience Age
- Language(s) spoken
- Socioeconomic status Gender
- Family
- Length of residency in the United States

B – UHP will provide member education related to available services offered e.g. translation and interpretation which assist the member with their B – UHP and provider experiences and the results on their health outcome. Providers must maintain compliance with the Cultural Competency Plan (CCP) and Limited English Proficiency requirements.

Civil Rights Act of 1964, Title VI

The Civil Rights act of 1964, Title VI, prohibits discrimination based on race, color, or national origin. B – UHP providers will mainstream all Plan members so that they are provided covered services without regard to payer source, evidence of insurability, race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, genetic information, medical condition, physical or intellectual disability. Restriction of appointment availability standards may not occur. Members must be treated with dignity and respect and have equal access and appointment time availability as other patients in the providers' office. B – UHP will promptly intervene if it is identified that discrimination was involved with a member and will require a corrective action plan from the provider. If you have any questions or are interested in receiving additional information, please contact your Provider Relations Representative.

Interpretation and Translation Services

B – UHP provides interpretive and translation services for its members. If you have a member who needs these services, please contact the Customer Care Center. Interpretive services are not based upon the non-availability of a family member or friend for translation. Members may choose to use family or friends; however, they should not be encouraged to substitute them for the interpretation service.

If you have questions or are interested in receiving additional information, please contact your Provider Relations Representative.

- An interpreter renders SPOKEN word from one language to another.
- A translator renders WRITTEN word from one language to another.

To request interpretation Services for a B – UHP member:

1. Call B – UHP's – Customer Care Center
2. Provide the representative with member's AHCCCS ID number and the nature of the interpretation services required.
3. You will be placed on hold while the representative connects you with the interpretation services.

Important Tips

Working with an Interpreter – Give the interpreter specific questions to relay. Group your thoughts or questions to help conversation flow quickly.

Length of call – Expect interpreted comments to run a bit longer than English phrases. Interpreters convey meaning-for-meaning, not word-for-word. Concepts familiar to English speakers often require explanation or elaboration in other languages and cultures.

Interpreter identification – Interpreters identify themselves by first name only. For reasons of confidentiality, they do not divulge either their full names or phone numbers.

Document translation – University Family Care is responsible for translating written documents for our members. If you have a written document that needs to be translated for a member, call the Customer Care Center.

National Standards for Culturally and Linguistically Appropriate Services (CLAS)

Culturally Competent Care:

- Health care organizations should ensure that patients/consumers receive from all staff member's effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

- Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.
- Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

Language Access Services:

- Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.
- Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
- Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).
- Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Organizational Supports:

1. Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.
2. Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence- related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.
3. Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.
4. Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.
5. Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.
6. Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.
7. Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

Office of Minority Health, U.S. Department of Health and Human Services. (March 2001) National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care. Federal Register, 65(247), 80865-80879. http://www.minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf

Provider Policies

Provider Location and Accessibility Policy

B – UHP has established the highest standards for the delivery of health care for all members. To that end, we require the following commitments from our health care providers:

- Ensure members are treated without discrimination.
- Meet standards for member care.

- Meet Quality and Utilization Management standards.
- Comply with reporting requirements.
- Meet credentialing standards.
- If providing services for AHCCCS members, providers must obtain an AHCCCS provider identification number and register with Arizona Department of Health Services Program Vaccines for Children if providing EPSDT services. This requirement is for both B – UFC and ALTCS.
- Register locations of service with AHCCCS. Link Provider AHCCCS number to Tax Identification Number. This requirement is for both B – UFC and ALTCS.
- Notify plan with changes to providers, locations, key contacts, telephone numbers, Tax Identification Numbers, or corporate structure, etc. This notification should occur within 30 days of the above noted changes.
- Provide care for members via in-network facilities to ensure the most cost effective and quality care.
- Provide transition plan and 30-day notice when terminating a member from medical practice.

B – UHP will ensure that providers are aware that providers have mechanisms to advise or advocate on behalf of the member regarding: the member's health status, medical care or treatment options, including any alternative treatment that may be self-administered; any information the member needs in order to decide among all relevant treatment options; the risks, benefits, and consequences of treatment or non-treatment; and, the members right to participate in decisions regarding his or her health care, including the right to refuse treatment and to express preferences about future treatment decisions.

Provider directories contain provider locations that provide physical access, accessible equipment, and/or reasonable accommodations for members with physical or cognitive disabilities.

Provider directories can be found here: https://www.banneruhp.com/materials-and-services/provider-manuals-and-directories#Provider-Directories

Member Rights

B – UHP is committed to treating members with dignity and respect at all times. Member rights and responsibilities are shared with staff, providers and members and are included in our Member Handbook. A list of member's rights under 42 CFR 438.100 is include below:

- A member's right to be treated with dignity and respect,
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand,
- A member's right to participate in treatment decisions regarding his or her health care, including the right to refuse treatment,
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation,
- Request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR part 164 and applicable State law, and
- Exercise his or her rights and that the exercise of those rights shall not adversely affect service delivery to the member.

Why is Patient Experience Important?

Most of us have high expectations for service and experience across industries, and healthcare consumers are no different. Our patients are the reason we exist and every interaction we have matters. Each of us is responsible for providing a great care experience, whether you are providing care at the bedside or supporting those who do. Ultimately, you are the patient experience. Everything you do impacts patients' perceptions of the care they receive and whether they will choose B – UHP providers to care for them, or their family and friends, in the future.

Capturing the Patient Experience

A patient's healthcare experience is obtained and tracked both internally and externally.

Internally, B – UHP contracts with a vendor to obtain near real-time patient feedback for participating

providers. Shortly after a visit, patients are given the option to share feedback via text, email, or phone (Interactive Voice Response). In addition to sharing comments about their experience, patients are asked to rate the following on a 0-10 scale with 0 being "Not at all likely" and 10 being "Extremely likely" (N/A is also a response option):

1. How likely are you to recommend this Banner Health clinic to friends or family?
2. It was easy to get an appointment in a timely manner.
3. I clearly understood the cost of my visit before my appointment.
4. My interaction with the provider was excellent.
5. The reason for my visit/interaction was addressed.
6. I would recommend the provider (e.g., doctor, physician assistant, nurse practitioner) to my family and friends.
7. The provider showed respect for my time.
8. The provider genuinely cared about helping me.
9. It was easy to receive care from the provider over the phone or by videoconference.
10. The provider helped manage my care among different providers and services.

Externally, for ALTCS members that are enrolled with Banner – University Care Advantage or another Medicare Advantage plan, a Centers for Medicare and Medicaid Services (CMS) approved vendor will field the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, which is a federally required, standardized, publicly reported survey. The CAHPS survey covers a range of topics that are important to healthcare consumers and are used to assess various aspects of healthcare quality such as a provider's communication skills and ease of accessing healthcare services.

CAHPS survey results are used by healthcare consumers, regulators and organizations that monitor quality of care, provider organizations, health plans, community collaboratives, and public and private healthcare purchasers. These individuals and organizations use the survey results to make informed decisions about their care and to improve the overall quality of care.

CAHPS surveys are specific to the type of insurance coverage a patient has. Each type of CAHPS survey is fielded once annually during a specific timeframe.

Type of Insurance	CAHPS Survey	Fielding Time
Medicare Advantage	MA-CAHPS	March - May
Medicaid Fee-For-Service	CAHPS for MIPS	October - January
Medicaid	CAHPS Medicaid ((Adult or Child))	December - March

Here are some of the CAHPS questions specifically tied to a patient's experience with their care provider:

Annual Flu Vaccine	**Care Coordination**
• Have you had a flu shot?	Has your personal doctor or doctor's office... • ...managed your care among different providers and services to your satisfaction? • ...followed up promptly on test results? • ...talked to you about all the medications you take?
Getting Appointments and Care Quickly How often have you ... • ...gotten urgent care as soon as needed? • ...gotten appointments at your doctor's office? • ...been seen within 15 minutes of your appointment time?	**Overall Ratings** On a scale from 0 to 10, how would you rate your... • ...overall health care? • ...personal doctor? • ...specialist seen most often?

Ratings are based on the frequency at which an experience occurred or a scale of 0 to 10. The percent of the best possible response ("Top Box") receives a higher weighting than the other responses. For the CAHPS questions, the possible responses are:

- Never
- Sometimes
- Usually
- Always
- OR 0-10 (9 or 10)

What are Some Ways to Improve Performance?

Below are some tips for improving the overall experience. More tips can be accessed on the Provider Experience page located at https://www.banneruhp.com/materials-and-services/patient-experience.

- Greet patients warmly.
  - Example: "Good morning/afternoon! How may I help you today?"
- Give opportunities to ask questions.
  - Example: "I want to make sure we cover everything you wanted to talk about today. Was there anything else you wanted to discuss or had questions about?"
- Explain the "why" behind a diagnosis, treatment, etc.
- Use common language that patients can understand. Try to stay away from technical medical terminology.
- Provide thorough instructions for what the patient needs to do next, such as setting follow-up appointments, taking medications, etc. Give the patient a printed copy of instructions to take home, if possible.
- Avoid interrupting or rushing a patient.
- Identify patients who have had a fall or problems with balance or walking and talk with themabout how to address these issues.
- Identify patients who experience urinary incontinence and talk with them about how to address the issues.
- Discuss the importance of physical activity with patients and encourage them to maintain or increase physical activity as appropriate
- Offer ideas to improve mental health, such as taking daily walks, staying involved with family, doing crossword puzzles, or meditating.
- Consider a hearing test when appropriate as loss of hearing can feel isolating.

Primary Care

Primary Care Providers (PCP's) perform a critical function for B – UHP. Each PCP is responsible and accountable for the coordination, supervision, delivery, and documentation of health care services to any B – UHP member (except for children's dental services when provided without a PCP referral). PCP's are responsible for maintaining a complete medical record of all services delivered by all providers involved in the members care, including vision, behavioral health, rehabilitative therapy, and medical specialty services, as applicable. The use of the PCP in this model provides for less fragmentation and ensures continuity of care for our members. This model helps to attain effective control over utilization of medical services while maintaining the highest level of care.

The appropriate education of members regarding disease management is not only expected and encouraged, but also required. Providers may discuss medically necessary or appropriate treatment options with members – even if the options are not covered services. Health maintenance education is not only expected and encouraged; it is required for all providers participating with AHCCCS and Special Needs Plans (SNP). B – UHP develops and implements procedures to ensure that our providers have information required for effective and continuous care and quality review. Members should receive counseling regarding disease management, prevention, and the importance of regular health maintenance visits. B – UHP has no policies preventing our providers from advocating on behalf of a member and encourages this dual approach of care and disease management. PCP's are expected to advise the members of their ability to treat behavioral health conditions within the scope of their practice.

Members must be included in the planning and implementation of their care. Providers must recognize that it is the patient's right to choose their final course of action among clinically acceptable choices. Services must be provided in a culturally competent manner to all members, including those with limited English proficiency or limited reading skills. Providers should always consider the ethnic and religious beliefs of their members and their impact on members' participation in care. Providers must maintain compliance with the Cultural Competency Plan (CCP) and Limited English Proficiency (LEP requirements).

PCP's are expected to educate members on the differences between urgent and emergent conditions and instruct members to contact their PCP before visiting an emergency room or calling an ambulance unless a life-threatening emergency exists.

B – UHP shall identify and track members who utilize Emergency Department (ED) services inappropriately four or more times within a six-month period. Interventions shall be implemented to educate the member on the appropriate use of the ED and divert members to the right care in the appropriate place of service.

B – UHP Care Management interventions to educate members should include, but are not limited to:

a. Outreach phone calls/visits
b. Educational Letters
c. Behavioral Health referrals
d. High Need/High-Cost Program referrals
e. Disease Management referrals
f. Exclusive Pharmacy referrals

B – UHP shall submit the ED Diversion Summary to AHCCCS the number of times B – UHP intervenes with members utilizing the ED inappropriately.

The symptoms below are not a complete, specific listing, but rather guidelines for appropriate use of emergency department.

- wheezing, shortness of breath or difficulty breathing
- chest pain
- fainting or dizziness
- sudden numbness or weakness
- bleeding that cannot be stopped
- abdominal pain - especially intense localized pain
- fever with convulsions or rash
- any fever in children under 3 months
- confusion or changes in mental status
- coughing or vomiting blood
- severe headache or head injury, especially if the individual is on aspirin or blood thinners
- blood in the urine, or bloody diarrhea
- sudden inability to speak, see, walk or move
- Slurred speech
- Serious burns
- Eye injury
- Concussion
- Broken bones and dislocated joints
- Seizures Severe cuts that may require stitches
- Severe cold or flu symptoms
- Vaginal bleeding with pregnancy

The symptoms below are not a complete, specific listing, but rather guidelines for appropriate use of a

primary care physician's office, walk in clinic or urgent care facility.

- cough, cold or sore throat
- rashes (without fever) or skin irritations
- fever or flu-like symptoms
- mild injuries
- Earaches
- Vomiting or persistent diarrhea
- Abdominal pain
- Dehydration
- Sprains and strains
- Small cuts that may require stitches
- Painful urination
- Cough and congestion symptoms
- Eye redness, discharge, or itchiness
- Sports physicals (excluding labs)

At a minimum, PCPs are responsible for the following activities:

- Supervision, coordination, and provision of care to each assigned member.
- Initiation of referrals for medically necessary specialty care.
- Maintaining continuity of care for each assigned member.
- Maintaining the member's medical record, including documentation of all services provided to the member by the PCP, as well as any specialty or referral services.

Americans with Disabilities Act (ADA) and Title VI Requirements

B – UHP providers must adhere to the Americans with Disabilities Act (ADA). The Act of 1990 gives civil rights protections to individuals with disabilities similar to those provided to individuals based on race, color, sex, national origin, age and religion. While the ADA is a Federal law, Arizona does have a mirror statute regarding disabilities, giving the Attorney General the authority to enforce this law.

In accordance with the Act, a member will not be discriminated against based on his/her disability. Contracted providers will make reasonable accommodations, without undue hardship, in order to provide quality care for a member with a disability.

PCP Policies

Provider Assignment

The Customer Care Center will ensure every member is assigned to an appropriate PCP. This assignment is based on the geographical location of the member's residence, needs of the member, provider's appointment availability standards, as well as the PCP's participation in Value-Based Purchasing (VBP) initiatives. Members may call and change their PCP at any time although it is recommended that they change no more than 5 times per year and not within 30 days of their last change.

Members receive written notice of their assigned PCP via their "New Member Packet". Members are given the option of selecting another available PCP, as well as information on how to complete this change.

AHCCCS, Medicare and State regulations require a PCP to be licensed in Arizona as an allopathic or osteopathic physician who generally specializes in family practice, internal medicine, pediatrics or are a certified nurse practitioner, or physician's assistant.

Selecting and Changing Primary Care Providers

Members have the right to select their own PCP using the print and/or online directory of participating and available providers. Members also have the right to change a PCP at any time.

1. Changes become effective the first of the month following the day of their request. Please refer members to our Customer Care Center for further assistance.

2. When a member changes PCPs, his or her original or copied medical records MUST be forwarded to the new PCP within 10 business days from receipt of the request for the transfer of medical records.

Primary Care Provider Initiated Changes

A PCP may request member reassignment for a variety of reasons. The PCP must send a written request to the Customer Care Department. The request should include the reason and a copy of the medical record/office notes or other supporting documentation. All requests to reassign members must be reviewed and approved by the B – UHP Medical Director.

PCPs must allow 30 days for a member reassignment and are obligated to continue to treat the member as necessary during this change. Members are offered freedom of choice within our PCP Network.

However, we may restrict this choice when a member has shown an inability to form a relationship with a PCP, as evidenced by frequent changes, or when there is a medically necessary reason. We hope all our patients and providers have satisfactory, productive relationships. If provider staff are having difficulties with a member (not keeping appointments or not complying with their care regime, etc.), please notify our Case Management Department.

PLEASE NOTE: PCPs rendering services for the B – UHP should not advise a member that they have been discharged until the request has been approved and communicated by the B – UHP Chief Medical Officer. Upon final decision by the B – UHP Chief Medical Officer the Administrative Assistant will notify the member of the outcome in writing.

Provider Panel

A PCP who contracts with B – UHP is required to have a panel and accept a minimum of 100 members. If a PCP wishes to close a panel to new members after reaching this minimum, the PCP must send the Data Department written notification at least 60 days in advance. The Data Department will review the request and may agree to close the panel 60 days from the date the written notice is received. The PCP is obligated to accept assignment of any member assigned until the approved date of the panel closure. Members already assigned to a panel at the time of panel closure are considered to be established patients whether or not they have been seen in the office at the time of panel closure.

If a PCP participates in an AHCCCS product line, their AHCCCS member panel should not exceed a ratio of 1:1800. This regulation is to ensure AHCCCS members do not comprise the majority of the PCP's panel of patients.

A PCP's total panel size (all AHCCCS and non-AHCCCS patients) is considered when assessing the PCP's ability to meet appointments and other standards. Provider Panel updates should be sent directly to the data department, providers need to email BUHPDataTeam@bannerhealth.com or submit via the online Provider Update Form at https://www.banneruhp.com/materials-and-services/provider-data-update-form.

Member Roster Requests

B – UHP has a dedicated email address that primary care providers may use to obtain information regarding assigned membership. Please send inquiries related to obtaining information for the provider's assigned membership to our dedicated inbox at BUHPProviderInquiries@bannerhealth.com.Requests will be provided within ten (10) business days of the request.

A Provider self-service option is also available. To access member enrollment information and obtain member rosters, please visit https://eservices.uph.org. For more information about eServices, contact your Provider Relations Representative.

Compliance Program

B – UHP's commitment to compliance includes ensuring that our providers are following applicable state and federal regulations. All contracted providers are responsible for complying with all federal and state laws, regulations, and contractual obligations, including but not limited to: B – UHP's policies and procedures, the Banner Plans and Networks Compliance Program and Fraud, Waste, and Abuse Plan, Compliance Guide for staff and business partners and the Code of Conduct. All of these documents are available at www.BannerUHP.com or through eServices (https://eservices.uph.org), or upon request.

B – UHP has incorporated requirements outlined by Medicaid and other regulatory agencies in these documents. Providers must review the respective guidelines and ensure appropriate protocols are in place to demonstrate compliance.

Medicaid Requirements

For AHCCCS Contracted Providers:

To assist you in understanding your requirements, please refer to the AHCCCS Contractor Operations Manual (ACOM) and the AHCCCS Medical Policy Manual (AMPM):

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

https://www.azahcccs.gov/shared/MedicalPolicyManual/

B – UHP Compliance Program Requirements

Requirements of all B – UHP contracted providers include, but are not limited to:

- Providers are expected to adhere to the B – UFC compliance requirements related to fraud, waste or abuse (FWA), which have been outlined in the Banner Plans and Networks Division Compliance Program and FWA Plan, Compliance Guidance for staff and business partners, and B – UFC's general compliance and FWA trainings.
- Ensure monitoring and oversight is in place for all employees.
- Implement monitoring and oversight of compliance requirements for all relationships with subcontractors.
- Maintain member medical records in a legible, detailed, and comprehensive manner, preferably an electronic health record. Progress notes must be signed after each appointment and/or procedure. Provider signature shall occur as close to the actual entry of treatment notes as possible but must be within 7 calendar days from the date of service.
- Comply with requirements to provide medical records to B-UHP Compliance within 10 business days of receipt of request.
- Comply with Offshore requirements.
- Report all suspected and/or detected FWA to both B – UFC Compliance and to AHCCCS OIG and other applicable law enforcement, or licensing body.
- Establish and maintain policies and procedures for preventing, detecting, correcting, and reporting FWA, in addition to other requirements listed below.
- Ensure employees, managers, officers, and directors responsible for the administration or delivery of Medicaid benefits are free from any conflict of interest and provide B – UFC with full disclosure on any situation that may present as a conflict of interest.
- Complete the B – UHP Compliance Attestation upon request to confirm that your internal processes are compliant with Medicaid and Federal Compliance Program Requirements.
- Establish a compliance program and assign a compliance officer.

Additional information about these requirements is discussed below and can also be found at www.BannerUHP.com.

Written Policies and Procedures and Code of Conduct

B – UHP requires that all providers adopt and abide by the B – UHP Code of Conduct and Policies and Procedures. Providers may also implement a code of conduct and policies and procedures that incorporate requirements consistent with B – UHP's Code of Conduct and Policies and Procedures. The code of conduct states your organization's over-arching principles and values by which your organization operates and defines the underlying framework for the compliance policies and procedures. The code of conduct must provide the standards by which providers and staff will conduct themselves including the responsibility to perform duties in an ethical manner and in compliance with laws, regulations, and policies. Providers and staff are required to comply with all applicable laws, whether the laws are specifically addressed in the code of conduct or not.

As stipulated in the B – UHP Code of Conduct, Providers and staff are required to report issues of non-compliance and potential FWA through the appropriate mechanisms and ensure that all reported issues will be addressed and corrected. Your processes must include detailed and specific guidance for employees regarding how to report potential compliance issues. Confidential and anonymous reports can be made to B – UFC's toll-free hotline (ComplyLine) at 1-888-747-7989 or at bannerhealthcomplylineethicspoint.com.

Policies and Procedures should include provisions and procedures that, at a minimum, outline the following:

- Require that all employees and downstream entities immediately report suspected and/or detected FWA to both B – UHP Compliance and to AHCCCS OIG.
- Ensure all B – UHP confidential and proprietary information is safeguarded.
- Screen all employees and downstream entities/contractors against the federal exclusion lists, upon hire or contract and monthly thereafter. These include the Federal Office of Inspector General "OIG" List of Excluded Individuals and Entities (LEIE) at https://exclusions.oig.hhs.gov/, and the General Services Administration's System for Award Management (SAM) at https://www.sam.gov/SAM/pages/public/searchRecords/search.jsf. Anyone listed on one or both of these lists is not eligible to support B – UHP's Medicaid plans and must be removed immediately from providing services or anything supporting B – UHP. Upon identification of an excluded individual or organization, B – UHP Compliance must be notified immediately.
- Cooperate fully with an investigation of alleged, suspected or detected violation of state or federal laws or regulations.
- Distribute compliance and FWA training to employees and downstream entities
- Implement and publicize disciplinary standards and take actions upon discovery of FWA or actions that could lead to FWA.

The code of conduct and policies and procedures should be distributed to employees within 90 days of hire, when there are updates to the policies, and annually thereafter. You should ensure that employees, as a condition of employment read and agree to comply with all written compliance policies and procedures and code of conduct within 90 days of hire and annually thereafter. Employee statements, attestations, acknowledgements, or certifications should be retained and be available to B – UHP and AHCCCS.

This information must be available upon request by B – UHP or AHCCCS and records should be maintained for 10 years.

Your organization can make B – UHP's Code of Conduct available to all employees. The B – UHP Code of Conduct is available online at www.banneruhp.com

Providers are given access to applicable B – UFC Policies and Procedures via eServices https://eservices.uph.org or on the Provider website www.BannerUHP.com or upon request by contacting the B – UHP Compliance Department at BHPCompliance@bannerhealth.com.

Conflicts of Interest

Your organization's code of conduct should include provisions to ensure employees, managers, officers and directors responsible for the administration or delivery of the Medicaid benefits are free from any conflict of interest in administering or delivering Medicaid benefits. Conflicts of interest are created when an activity or relationship renders a person unable or potentially unable to provide impartial assistance or advice, impairs a person's objectivity, or provides a person with an unfair competitive or monetary advantage.

Disclosure of Ownership and Control

The federal regulations set for in 42 CFR §455. Subpart B; requires B – UHP to identify all persons associated with B – UHP, its subcontracted providers and fiscal agents that have an ownership, control interest or managing employee interest and determine if they have been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program. [42 CFR §455.104 through 106]

B – UHP must obtain the following information regarding ownership, control interest or managing employee interest [42 CFR §455.106]:

1. Business Entity Name, City, State and Zip Code
2. Name of business entity or individual that has Ownership, Control Interest, or is a Managing Employee.
3. Business Address, including all locations and Post Office Box Address. Include Home Addresses of all Managing Employees.
4. The Social Security Number (if Individual), Tax Identification Number (TIN) (if Corporation).
5. The % Ownership or Controlling Interest.

6. The Relationship to Owner (i.e., spouse, parent, child, or sibling).

B – UHP will, on a monthly basis, confirm the identity and determine the exclusion status through routine checks of:

- The List of Excluded Individuals (LEIE)
- The System for Award Management (SAM)
- Any other databases directed by AHCCCS or CMS

Note: B – UHP is required to immediately notify AHCCCS-OIG of any person who has been excluded through these checks in accordance with the 42 CFR §455.106 (2)(b)

Federal Health Care Program Requirement

As a contracted provider, you are obligated under 42 CFR §438.610 and 402.209, to screen employees, contractors, temporary employees, volunteers, consultants, governing board members, and subcontractors, to determine whether any of them have been excluded from participation in Federal health care programs upon hire or contracting and monthly thereafter. The Organization is required to verify their employees (including temporary and volunteer) are not excluded by comparing them against the Department of Health and Human Services (DHHS) Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) and the General Services Administration (GSA) System of Award Management (SAM) and any other databases directed by AHCCCS or CMS. Monthly screening is essential to prevent B – UHP from making inappropriate payment to providers, pharmacies, or other entities that have been added to the exclusions lists since the last time the list was checked. Upon discovery of an excluded individual or entity, the Organization must provide immediate disclosure to B – UHP. No payment will be made by Medicare, Medicaid, or any other Federal or State of Arizona Health Care Programs for any item or service furnished on or after the effective date specified in the notice period, by an excluded individual or entity or at the medical direction or on the prescription of a physician or other authorized individual who is excluded when the person furnishing such item or service knew or had reason to know of the exclusion. Administrative Subcontractors are also required to complete these screenings upon hire or contract and monthly thereafter.

To assist you with the implementation of the OIG/GSA Exclusion process, links to the exclusion websites are below.

- The List of Excluded Individuals (LEIE): https://exclusions.oig.hhs.gov/
- The System of Award Management (SAM): https://www.sam.gov/SAM/pages/public/searchRecords/search.jsf
- Any other databases directed by AHCCCS or CMS

Offshore Requirements

The term "Offshore" refers to any country that is not one of the 50 United States or one of the United States Territories (American Samoa, Guam, Northern Marianas, Puerto Rico, and Virgin Islands). Subcontractors that are considered Offshore can be either American-owned companies with certain portions of their operations performed outside of the United States or foreign-owned companies with their operations performed outside of the United States. Offshore subcontractors provide services that are performed by workers located in offshore countries, regardless of whether the workers are employees of American or foreign companies.

For the State of Arizona's Medicaid Program, AHCCCS, any Organization services that are described in the scope of work that directly serve the State of Arizona, its clients, or AHCCCS members, and involve access to secure or sensitive data or personal client data shall only be performed within the defined territories of the United States. Unless specifically stated otherwise in the specifications, this requirement does not apply to indirect or "overhead" services, redundant back-up services or services that are incidental to the performance of the contract. This provision applies to work performed by the Organization and its subcontractors at all tiers.

Any provider who does not abide by these requirements may be subject to termination of the contract.

Fraud, Waste and Abuse Requirements

In support of the B – UHP Compliance Program, it is the policy of B – UHP to detect, prevent, and control

member and provider related fraud, waste and abuse within the Medicare and Medicaid systems. B – UHP is committed to comply with applicable statutory, regulatory, sub-regulatory guidance, contractual commitments and other requirements related to the delivery of Medicaid and Medicare benefits. B – UFC has a written Fraud, Waste, and Abuse Plan to employ controls to prevent, detect and control potential cases of fraud, waste, and abuse.

Consistent with AHCCCS guidelines as stipulated within the AHCCCS Registration Agreement pertaining to fraud, waste and abuse, B – UHP will reimburse at the AHCCCS By-Report (BR) percentage for covered services billed with a code that does not have an established fee. Such codes payable at the BR percentage could be for unlisted and/or NOC (Not Otherwise Classified) codes. As a payer of Medicare and AHCCCS claims, any BR code found, after pre-payment or retrospective review, to be excessive based on billed charges will be priced by another means than at the BR percentage in order to prevent waste. B – UFC has defined excessive to be any amount that is greater than invoice, greater than similar relative value units of listed codes or in excess of Average Wholesale Price (AWP) + 15% for those codes that have a NDC (National Drug Code). B – UHP will monitor provider billing patterns to avoid excessive reimbursements that contribute to potential fraud, waste and/or abuse.

Our Goal: Eliminating Fraud, Waste and Abuse

B – UHP will strictly enforce fraud, waste, and abuse prevention policies. Specific controls are in place to prevent and/or detect potential cases of fraud, waste, and abuse.

It is our policy to educate providers and their staff on how to prevent, detect, and report potential cases of fraud, waste, and abuse. To eliminate fraud, waste, and abuse successfully, everyone must work together to prevent, identify, and report inappropriate and potentially fraudulent practices. This can be accomplished by:

- Monitoring claims submitted for compliance with billing and coding guidelines
- Adherence by providers and facilities to Treatment Record Standards
- Education of all staff members who have any contact with PHI
- Referring cases of suspected fraud, waste, and abuse

What is a Fraud Violation?

Fraud violations occur when a person deliberately uses a misrepresentation or other deceitful means to obtain something to which he/she is not otherwise entitled. It includes any act that constitutes fraud under applicable State or Federal law. [42 CFR §455.2]

What is an Abuse (of the Program) Violation?

Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the AHCCCS program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care, noncompliance with licensure standards, misuse of billing numbers, or misuse or abuse of billing privileges. It also includes beneficiary practices that result in unnecessary cost to the AHCCCS Program [42 CFR §455.2].

What is a Waste Violation?

Overutilization or inappropriate utilization of services, misuse of resources, or practices that result in unnecessary costs to the Medicaid Program.

Any employee, member, vendor, provider, subcontractor, or community stakeholder has the right to make a Fraud, Waste or Abuse-related or non-compliance issue complaint to B – UHP Compliance if he/she feels that there have been suspicious activities. In addition, this report should be made without fear of retaliation. Reports should also be made directly to AHCCCS OIG.

Examples of fraud include, but are not limited to:

- Billing for services that were not rendered;
- Misrepresenting as medically necessary non-covered or screening services by reporting them as covered procedure or revenue codes;
- Signing blank records or certification forms, or falsifying information on records orcertification

forms for the sole purpose of obtaining payment;

- Upcoding or consistently using procedure/revenue codes that describe more extensive services than those actually performed;
- Using an incorrect or invalid provider number in order to be paid or to be paid at a higher rate of reimbursement;
- Selling or sharing Medicare/AHCCCS health insurance identification numbers so that false claims can be filed; and
- Falsifying information on applications, medical records, billing statements, cost reports or on any documents filed with the government.

Examples of waste and abuse include, but are not limited to:

- Billing for services or items in excess of those needed by the member;
- Unbundling services that are to be bundled or double billing in order to receive increased payment;
- Adding inappropriate or incorrect information to cost reports;
- Collecting in excess of the deductible or co-insurance amounts; and
- Requiring a deposit or other payment from members as a condition for admission, continued care or other provision of service.

Examples of member fraud include, but are not limited to:

- Misrepresenting or concealing facts that would cause B – UHP to provide coverage to persons who are otherwise not eligible.
- Lending an AHCCCS card to a friend or family member who is not eligible.

Laws that Regulate Fraud, Waste, and Abuse

Deficit Reduction Act of 2005 (DRA):

The Deficit Reduction Act (DRA), Public Law No. 109-171, §6032, passed in 2005, is designed to restrain Federal spending while maintaining the commitment to the Federal program beneficiaries. The Deficit Reduction Act is a law passed by Congress to reconcile the 2006 Federal budget. The Act requires compliance for continued participation in the programs. The development of policies and education relating to false claims, whistleblower protections and procedures for detecting and preventing fraud & abuse is required. This law includes specific provisions aimed at reducing Medicaid fraud and abuse, applies to all health care providers receiving at least $5 million in annual Medicaid payments.

False Claims Act

Under the False Claims Act (FCA), 31 U.S.C. §3729-3733, those who knowing submit, or cause another person or entity to submit, false claims for payment of government funds are liable for three times the government's damages plus civil penalties of $13,508 to $27,018 per False Claim for violations occurring after January 30, 2023. They would also be responsible for the costs of civil actions against the entity that submitted the false claims. A false claim is a claim or written statement that is for services that were not provided, or asserts a material fact that is false, or omits a material fact.

Qui Tam Provision under False Claims Act

The False Claims Act provides a "qui tam" provision, commonly referred to as the "Whistleblower" provision. This allows a private person with knowledge of a false claim to bring a civil action on behalf of the United States Government. The purpose of bringing the qui tam suit is to recover the funds paid by the Government as a result of the false claims. If the United States Government agrees to join the qui tam suit, it shall have the primary responsibility for prosecuting the action. If the suit is successful, the whistleblower who initially brought the suit may be awarded a percentage of the funds recovered. When the Government agrees to join the suit, the percentage is lower as the Government assumes all expenses associated with the suit. If a whistleblower was involved or planned the false claims violation, the court may reduce the share of proceeds. In the whistleblower is convicted of criminal conduct in regard to the false claims case, they will be dismissed from the civil action without receiving any portion of the proceeds.

The False Claims Act also contains a provision 31 U.S.C. §3730(h), that protects a whistleblower from retaliation from their employer. The employer may not discharge, demote, suspend, threaten, harass, or discriminate in any manner against the employee as a result of the false claims action. In the event, these actions occur, the whistleblower may bring an action in the appropriate district court and is entitled to reinstatement with the same seniority status, two times the amount of back pay, interest on the back pay, and compensation for any special damages as a result of the discrimination including litigation costs and reasonable attorneys' fees.

Program Fraud Civil Remedies Act of 1986 (PFCRA):

A similar Federal Law that provides administrative remedies for knowingly submitting False Claims and Statements is the Program Fraud Civil Remedies Act of 1986. A violation of the PFCRA results in a maximum civil penalty of $13,508 up to a maximum of $405,270 (note: civil penalties are adjusted annually for inflation – last amendment was 11/17/2023).

Arizona Revised Statute (ARS) § 36-2918

This statute makes in unlawful for a person to present or cause to be presented to the State of Arizona or to a contractor:

- A claim for a medical or other item or service that the person knows or has reason to know was not provided as claimed;
- A claim for medical or other item or service that the person knows or has reason to know is false or fraudulent; or
- A claim for payment that the person knows or has reason to know may not be made by the system because:
    - The person was terminated or suspended from participation in the program on the date for which the claim is being made,
    - The item or service claimed is substantially in excess of the needs of the individual or of a quality that fails to meet professionally recognized standards of health care, or
    - The patient was not a member on the date for which the claim is being made; or
- A claim for a physician's services or an item of service incidental to a physician's service, by a person who knows or has reason to know that the individual who furnished or supervised the furnishing of the service:
    - Was not licensed as a physician;
    - Obtained the license through a misrepresentation of material fact;
    - Represented to the patient at the time the service was furnished that the physician was certified in a medical specialty by a medical specialty board if the individual was not certified;
    - A request for payment that the person knows or has reason to know is in violation of an agreement between the person and this state or the administration.

Violations of ARS §36-2918 are punishable by civil penalties of up to $2000 per item or service claimed plus an assessment of up to twice the amount claimed for each item or service.

The director of AHCCCS or designee shall investigate potential violations of this statute and shall determine whether to assess civil penalties and/or exclude a person from participation.

This statute requires all contractors, subcontracted providers of care, and non-contracting providers to immediately notify AHCCCS, in a written report, of any cases of suspected fraud or abuse. Any contractor, subcontracted provider of care, or non-contracting provider who fails to report fraud or abuse commits an act of unprofessional conduct and is subject to disciplinary action by the appropriate professional regulatory board or department.

Anti-Kickback Statute

Under the Anti-Kickback Statute, 41 U.S.C, it is a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration for any item or service that is reimbursable by any Federal healthcare program. Penalties may include exclusion from Federal health care programs, criminal penalties, jail, and civil penalties for each violation. Examples of kickbacks include: money, discounts, gratuities, gifts, credits, and commissions.

Violation of this law is a felony. Each violation, therefore, is a felony punishable with a fine of up to $100,000 and up to 10 years in prison.

Persons and entities convicted of violating this law are also subject to mandatory exclusion from participating in Covered Health Care Programs. Finally, health care items or services billed to a Covered Health Care Program as the result of an arrangement that violates that Anti-Kickback Statute may be violations of the health care False Claims Act and may be separately punishable as a felony resulting in criminal fines and/or imprisonment for up to five years or both, or civil fines up to three times the amount improperly received from the government health care programs plus up to $25,076 per improperly filed claims.

Changes to Anti-Kickback Statute

The Final Rule implements seven new safe harbors, modifies four existing safe harbors, and codifies on new exception under the Beneficiary Inducements Civil Monetary Penalty (CMP).

Final Safe Harbor Regulations Protect:

Value-Based Arrangements including the following:

- Care Coordination Arrangements to Improve Quality, Health Outcomes and Efficiency
- Value-Based Arrangements with Substantial Downside Financial Risk; and
- Value-Based Arrangements with Full Financial Risk.

These new safe harbors vary by the type of remuneration protected, level of financial risk assumed by the parties and safeguards:

- Patient Engagement and Support – certain tools and supports furnished to patients
- CMS-Sponsored Models – for certain remuneration provided in connection with a CMS sponsored model
- Cybersecurity Technology and Services – for donations of cybersecurity technology and services.
- Electronic Health Records Items/Services – adds protections for certain related cybersecurity technology, updates for interoperability, and to remove sunset data.
- Outcomes-Based Payments & Part-Time Arrangements – adds flexibility for certain of these payments and arrangements.
- Warranties – revises the definition to provide protection for bundled warranties for one or more items and related services.
- Local Transportation – expands and modifies mileage limits for rural areas for patients discharged from an inpatient facility or released from a hospital after observation for 24 hours.
- Accountable Care Organization (ACO) Beneficiary Incentive Programs – for MSSP codified the statutory exception to definition of "renumeration".
- Under Beneficiary Inducements CMP project:
    - Telehealth for In-Home Dialysis – new statutory exception to the prohibition on beneficiary inducements for "telehealth technologies" furnished to certain patients.

Stark Law

Self-Referral (Stark Law) Statutes, Social Security Act, §1877, pertains to physician referrals under Medicare and Medicaid. Referrals for the provision of health care services, if the referring physician or an immediate family member has a financial relationship with the entity that receives the referral, is not permitted.

This law was modified to evolve the regulation to keep pace with the transition of fee-for-service or a volume-based system to a value-based system. In its previous form, the Stark Law prohibited some arrangements that were designed to enhance care coordination, improve quality, and reduce waste. The final rule creates new, permanent exceptions to Stark Law for value-based arrangements. Exceptions apply to both arrangements that relate to care for individuals with Medicare or other patients.

Compensation provided to a physician by another healthcare provider generally must be at fair market value and the rule provides guidance on how to determine if compensation meets this requirement. The final rule also provides clarity and guidance on a wide range of other technical compliance requirements intended to reduce administrative burden. There is new flexibility for arrangements such as donations of

cybersecurity technology.

HIPAA

The Health Insurance Portability and Accountability Act (HIPAA), 45 CFR, Title II, §201-250, provides clear definition for Fraud & Abuse control programs, establishment of criminal and civil penalties and sanctions for noncompliance. This act protects the privacy of the patient. Under the U.S. Department of Health and Human Services, the Office of Civil Rights (OCR) investigates and enforces HIPAA violations. The OCR reported on September 30, 2023 that since the compliance date of the Privacy Rule in April 2003, OCR has received over 343,032 HIPAA complaints and has initiated over 1,178 compliance reviews. They have resolved ninety-nine percent of these cases (338,401).

The OCR reported that they have investigated and resolved over 30,455 cases, and in these cases, they required changes in privacy practices, corrective actions, or provided technical assistance to both HIPAA Covered Entities and their business associates. The OCR has settled or imposed a civil monetary penalty in 137 cases to date resulting in a total dollar amount collected of $136,918,772.00.

From the compliance date to present, the compliance issues that were most frequently present in complaints in order of frequency included:

- Impermissible uses and disclosures of protected health information;
- Lack of safeguards of protected health information;
- Lack of patient access to their protected health information;
- Lack of administrative safeguards of electronic protected health information; and
- Use or disclosure of more than the minimum necessary protected health information.

The most common types of covered entities that have been alleged to have committed violations are, in order of frequency:

- General Hospitals;
- Private Practices and Physicians;
- Pharmacies;
- Outpatient Facilities; and
- Community Health Centers

The OCR does make referrals to the Department of Justice (DOJ) for criminal investigations regarding cases that involve the knowing disclosure or obtaining of protected health information in violation of the Rules. The OCR has made 1,938 referrals to DOJ to date.

For information on the history of and details about each of the HIPAA Rules, visit https://www.hhs.gov/hipaa/forprofessionals/index.html and click on "Privacy," "Security," or "Breach Notification" from the left-hand toolbar.

Auditing and Monitoring

B – UHP is required to perform effective auditing and monitoring in order to prevent and detect FWA. B – UHP staff and business partners are encouraged to monitor their work and interactions for any suspected FWA.

As a part of the Corporate Compliance Program/Plan, B – UHP has a program integrity audit/review program that is designed to identify fraud, waste, and abuse and to ensure that providers' billing practices are supported by medical record documentation. This process assists B – UHP in tracking inadequate billing practices by providers and identifying trends so that technical assistance and provider education can help avoid future occurrences of problematic billing for contracted providers. Some of the trends that have been identified with the audits include the following:

- Progress notes not signed appropriately by the provider rendering the service or signed weeks, months or even years after the services was provided or in some cases not signed at all or left in a pending status.
- Claims submitted for Medicaid Services under the NPI of one provider when the services rendered as indicated on the medical record progress note are completed by a different provider with a different NPI and oftentimes a mid-level billing under an MD. In some cases, the mid-level (NP, PA) is not credentialed or contracted or not insured with the practices. These are considered false

claims under Medicaid.

- Upcoding of Evaluation and Management (E/M) services as the medical record documentation does not support the level of service selected.
- Copying and pasting of information from one service to the next service when each entry is worded exactly like or similar to the previous entries. It would not be expected that every patient had the exact same problems, symptoms, and required the exact same treatment.
- Inappropriate use of modifiers.

B – UHP contracts with vendors to administer and/or deliver benefits on B – UHP's behalf. These vendors are referred to as delegated First, Tier, Downstream and Related Entities (FDRs) or Subcontractors. B – UHP is responsible for the lawful and compliant administration of Medicaid and Medicare benefits under the contracts with AHCCCS and CMS regardless of delegation.

B – UHP has clearly defined processes and criteria to evaluate and categorize all vendors with whom B – UFC contracts. B – UHP utilizes multiple methods to monitor and audit First Tier Entities or Administrative Contractors to ensure they are compliant with all applicable laws and regulations, and to ensure that the First Tier Entities or Administrative Contractors are monitoring the compliance of the entities with which they contract. Methods include onsite audits, desk reviews and monitoring of self-audit reports.

Training and Documentation

AHCCCS Contracted Provider Requirements:

AHCCCS contracted providers are required to train employees and document training on the following components of the False Claims Act:

- Detailed information about the Federal False Claims Act
- Administrative remedies for false claims and statements
- Any State laws relating to civil or criminal penalties for False Claims and Statements
- Whistleblower protections under such laws

AHCCCS also requires adequate training addressing Fraud, Waste and/or Abuse prevention, recognition, and reporting. In addition, training should encourage employees to report Fraud, Waste and Abuse without fear of retaliation.

In order to assist providers with these trainings, B – UHP has added an applicable training on the B – UHP website for providers at the following link https://www.banneruhp.com/materials-and-services/compliance-program.

Providers and FDRs can take the B – UHP training or a comparable training. Documentation of internal training can be through an individual certificate or a list showing the information for all those who completed it through the internal web-based training.

Provider Responsibilities to Report Suspicious Activity, Non-Compliance or Fraud, Waste, and Abuse

Providers are required to report a suspicious activity, non-compliance, or fraud, waste, and abuse to B – UHP Compliance as well as any appropriate federal or state agency. B – UHP adheres to a policy of non-retaliation and will make every effort to protect the identity of the reporter and will not tolerate any form of retaliation against any person making such a report.

Please report to B – UHP using one of the following methods:

- Confidential and Anonymous 24-hour compliance hotline: (888) 747-7989
- B – UFC Medicaid Compliance Officer: (520) 874-2847 or (520) 548-7862 (cell) or the Medicare Compliance Officer: BMAComplianceOfficer@bannerhealth.com
- U.S. Mail: Banner Health Plans, Compliance Department, 5255 E Williams Circle, Ste 2050, Tucson, AZ 85711
- Email: BHPCompliance@bannerhealth.com
- Secure Fax: (520) 874-7072

Reporting to AHCCCS for Fraud, Waste, or Abuse

Who Can Report Fraud or Abuse?

Absolutely anyone can report fraud, abuse, or member abuse. There are no restrictions.

Providers are required to report all suspected fraud, waste, and abuse to both the B – UFC Compliance Department and to AHCCCS directly immediately. To report to AHCCCS, providers should complete and submit the reporting form entitled, "Report Suspected Fraud or Abuse of the Program," on the AHCCCS-OIG website or contact the OIG directly at the numbers below. All pertinent documentation that would assist AHCCCS in its investigation should be attached to the form at https://www.azahcccs.gov/Fraud/ReportFraud/onlineform.aspx

Contacts:

Provider Fraud

If you want to report suspected fraud by medical provider, please call the numbers below:

In Arizona: (602) 417-4045

Toll Free Outside of Arizona Only: 888-ITS-NOT-OK or (888) 487-6686

Member Fraud

If you want to report suspected fraud by an AHCCCS member, please call the number below:

In Arizona: (602) 417-4193

Toll Free Outside of Arizona Only: 888-ITS-NOT-OK or (888) 487-6686

Questions

If you have questions about AHCCCS fraud, abuse of the program, or abuse of a member, please contact the AHCCCS Office of Inspector General (OIG). Email: AHCCCSFraud@azahcccs.gov.

In addition, if an Administrative Services Subcontractor, or Provider identifies an incident which warrants self-disclosure, the incident shall be reported within 10 calendar days to AHCCCS/OIG by completing and submitting the Provider Self Disclosure form available on the AHCCCS/OIG webpage. All pertinent documentation that could assist AHCCCS in its investigation shall be attached to the form. If a provider identifies a case of fraud, waste, or abuse that requires them to self-disclose, they are to report to AHCCCS by using the "Self-Disclosure Program for Providers" Guidelines and reporting form. The Guidelines are available on the AHCCCS website at: https://www.azahcccs.gov/Fraud/Providers/. Issues appropriate to self-disclosure may include, but are not limited to:

- Substantial routine errors
- Systematic errors
- Patterns of errors
- Potential violation of state and federal laws relating to the AHCCCS program
- Providers must determine whether the repayment of an overpayment warrants a self-disclosure or whether it would be better handled through the administrative billing process.

Disciplinary Guidelines

B – UHP may identify a contracted provider that is conducting Health Plan business in a manner that is not compliant with AHCCCS or Medicare rules, regulations, or requirements; this will be identified as a non-compliant event.

If this occurs, B – UHP may take the following disciplinary action:

- Provide education
- Issue a Corrective Action Plan
- Contract sanction
- Immediate contract suspension or termination

Warn and Duty

Duty to Warn

B – UHP's Providers have duty to warn under A.R.S. § 36-517.02. This statute supplements other immunities of behavioral health providers or mental health treatment agencies that are specified in law. With respect to the legal liability of a behavioral health provider, A.R.S. § 36-517.02 provides that no cause of action or legal liability shall be imposed against a behavioral health provider for breaching a duty

to prevent harm to a person caused by a patient unless both of the following occur:

1. The patient has communicated to the mental health provider an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim or victims, and the patient has the apparent intent and ability to carry out such threat, and
2. The mental health provider fails to take reasonable precautions.

Furthermore, this statute provides that any duty of a behavioral health provider to take reasonable precautions to prevent harm threatened by a patient is discharged when the behavioral health provider:

1. Communicates when possible the threat to all identifiable victims,
2. Notifies a law enforcement agency in the vicinity where the patient or any potential victim resides,
3. Takes reasonable steps to initiate voluntary or involuntary hospitalization, if appropriate, or
4. Takes other precautions that a reasonable, prudent behavioral health provider would take under the circumstances.

This statute also provides immunity from liability when the behavioral health provider discloses confidential communications by or relating to a patient under certain circumstances. The behavioral health provider has no liability resulting from disclosing a confidential communication made by or relating to a patient when a patient has explicitly threatened to cause serious harm to a person or when the behavioral health provider reasonably concludes that a patient is likely to cause harm, and the behavioral health provider discloses a confidential communication made by or relating to the patient to reduce the risk of harm.

All providers, regardless of their specialty or area of practice, have a duty to protect others against a member's potential danger to self and/or danger to others. When a provider determines, or under applicable professional standards, reasonably should have determined, that a patient poses a serious danger to self or others, the provider has a duty to exercise care to protect others against imminent danger of a patient harming him/herself or others. The foreseeable victim need not be specifically identified by the member but may be someone who would be the most likely victim of the member's dangerous conduct.

The responsibility of behavioral health provider to take reasonable precautions to prevent harm threatened by a member may include any of the following:

a. Communicating, when possible, the threat to all identifiable victims,
b. Notifying a law enforcement agency in the vicinity where the member or any potential victim resides,
c. Taking reasonable steps to initiate proceedings for voluntary or involuntary hospitalization, if appropriate, and in accordance with AMPM Policy 320-U, or

Taking any other precautions that a reasonable and prudent provider would take under the circumstances.

Grievance & Appeals

B – UHP's Grievances and Appeals Department is available to members or providers, acting on behalf of a member, and with the member's written consent, to file an appeal. Providers do have the right to immediately appeal a claim decision, but we suggest attempting the resubmission process first. If after resubmission process the claim issue is still not resolved, then the Appeals Department will handle unresolved claim disputes for providers.

The State of Arizona, AHCCCS Administration, CMS and DOI have established laws, rules, policies, and procedures that determine processes and adjudicate Appeals and requests for Fair Hearings and External Independent reviews.

Definitions:

What is a Grievance?

A grievance (complaint) is an expression by a member of dissatisfaction about any aspect of care. Examples of grievances are service issues, transportation issues, quality of care issues and provider office issues. In addition, other possible subjects for grievances include, but are not limited to the quality of care or services provided; aspects of interpersonal relationships; rudeness of a provider or employee or failure to respect the member's rights.

What is an Appeal?

An appeal is a request to reconsider or change a decision, also known as an adverse benefit determination.

What is an Adverse Benefit Determination?

a. The denial or limited authorization of a requested service, including the type or level of service

b. The reduction, suspension, or termination of previously authorized services

c. The denial, in whole or in part, of payment for a service

d. The failure to provide services in a timely manner as set forth in contract

e. The failure of the Health Plan to act within the timeframes specified in contract

b. f. The denial of an enrollee's request to exercise the enrollee's right to obtain services outside of the contractor's network for an enrollee residing in a rural area with only one contractor

Medicaid - Grievances and Appeals Grievances

B – UHP shall acknowledge receipt of each member grievance orally or in writing within five business days. Grievances will be reviewed, and a response will be provided within 90 days of receipt.

Appeals

A standard or expedited appeal must be filed either orally or in writing within 60 days from the Notice of Adverse Benefit Determination. The enrollee, their representative, or a legal representative of a deceased enrollee's estate may file an appeal or a provider acting on behalf of an enrollee may file an appeal. If the provider is filing on behalf of the member, a written consent from the member must accompany the request.

The reasons you may file an appeal are:

- Denial or limited authorization of a requested service, including the type or level of service;
- Reduction, suspension, or termination of a previously authorized service;
- Denial, in whole or in part, of payment for a service;
- Failure to provide services in a timely manner;
- Failure to act within the timeframe required for standard and expedited resolution of appeals and standard disposition of grievances;
- The denial of a rural enrollee's request to obtain services outside the contractor's network under 42 CFR 438.52 (b)(2)(ii), when the contractor is the only contractor in the rural area.

You may also call the Customer Care Center and ask to speak to an Appeals Department representative to file an oral appeal or you may also submit your request by fax or via email. B – UHP may request additional medical information, if necessary, to complete the appeal review. The appeals will be reviewed by healthcare professionals who have the appropriate clinical expertise and who were not involved in the previous level of review.

The member or provider will be given a reasonable opportunity to present evidence and to make legal and factual arguments in person and in writing. B – UHP will inform the member of the limited time available to provide this information sufficiently in advance of the resolution timeframe. The case file is available for review by the member or provider during the appeal process, upon request. B – UHP provides the member and his/her representative the member's case file including medical records, other documents and any new or additional evidence considered, relied upon, or generated by B – UHP regarding the appeal. This information will be provided at no charge to the member and sufficiently in advance of the resolution timeframe. A decision will be rendered by B – UHP within the timeframes outlined below.

Standard Appeal

B – UHP shall resolve standard appeals as expeditiously as the member's health condition requires but no later than 30 calendar days from the date of receipt of the appeal unless an extension is in effect.

Expedited Appeal

An expedited appeal may be filed by the enrollee or on the enrollee's behalf by the provider, with members written consent. If the Provider indicates (when making the request for the member or in support of the member's request) that taking the time for standard resolution could seriously jeopardize

the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. B – UHP shall resolve all expedited appeals as expeditiously as the member's health condition requires but not later than 72 hours from the date B – UHP receives the expedited appeal unless an extension is in effect.

Continuation of Benefits

Members have the right to receive continued benefits pending resolution of their appeal, continuation of benefits must be requested when filing the appeal. The member may be required to pay for the cost of these services if the appeal is denied.

SMI Grievance and Appeal Procedure

It is the philosophy of the AHCCCS to provide state residents with timely access to appropriate and effective health care. Services are provided through the Regional Behavioral Health Authorities (RBHAs) and the Arizona Long Term Care Elderly/ Physically Disabled (ALTCS E/PD) contractors. Should you need to file a SMI grievance/request an investigation, or file an appeal, the following process is followed:

SMI Grievance/Request for Investigation

Any person may file an SMI grievance or request an investigation regarding any act or omission, the Arizona State Hospital, a RBHA or one of its providers, and/or B – UHP or one of its providers alleging that a rights violation or a condition requiring investigation has occurred or currently exists. (Please note: allegations about the need for, or appropriateness of behavioral health services should not be considered an SMI grievance but should be addressed through the appeal process described below.) The request may be verbal or written and must be initiated no later than one year after the date of the alleged rights violation or condition requiring investigation. Forms for filing are available at AHCCCS, the Arizona State Hospital, the RBHAs, B – UHP, case management sites and at all provider sites.

SMI grievances/requests for investigation related to physical or sexual abuse or death will be addressed by AHCCCS. All other SMI grievances/requests for investigation will be addressed by the appropriate RBHA or B – UHP. All SMI grievances/requests for investigations may be filed with the RBHA or B – UHP. The contractor will forward to AHCCCS all SMI grievances/requests for investigation involving abuse or death. SMI Grievances/requests for investigation related to abuse or death may also be filed directly with AHCCCS at 801 East Jefferson, MD-6200, Phoenix, AZ 85034, (602) 364-4575. Within seven days of the date the 134 SMI grievance/request for investigation is received, you will be sent an acknowledgment letter and, if appropriate, an investigator will be assigned to investigate the matter. When a decision is reached, you will receive a written decision.

SMI Appeal

Any person, age 18 or older, or his or her guardian or designated representative, may file an appeal related to services applied for or services currently being received. Matters of appeal are generally related to: a denial of services; disagreement with the findings of an evaluation or assessment; any part of the Individual Service Plan; the Individual Treatment and Discharge Plan; recommended services or actual services provided; barriers or unreasonable delay in accessing services under Title XIX; and fee assessments. Appeals must be filed with B – UHP and must be initiated no later than 60 days after the decision or action being appealed. Appeal forms are available at AHCCCS, B – UHP, case management sites, and at all provider sites.

B – UHP will attempt to resolve all appeals within seven days through an informal process. If the problem cannot be resolved, the matter will be forwarded to AHCCCS for further appeal. If the RBHA or B – UHP will not accept your appeal or dismisses your appeal without consideration, you may request an Administrative Review by AHCCCS of that decision.

For SMI grievances/requests for investigation and appeals, to the greatest extent possible, please include:

1. Name of person filing the SMI grievance/request for investigation or appeal
2. Name of the person receiving services, if different.
3. Mailing address and phone number.
4. Date of issue being appealed or incident requiring investigation.
5. Brief description of issue or incident.
6. Resolution or solution desired.

For either process above, you may represent yourself, designate a representative or use legal counsel.

You may contact the State Protection and Advocacy System, the Arizona Center for Disability Law 1-800-922-1447 in Tucson and 1-800-927-2260 in Phoenix. You may also contact the Office of Human Rights (OHR) at (602) 364- 4585, or 1-800-421-2124, in Phoenix. In Flagstaff, you may contact OHR at (928) 214-8231, or 1-877-744-2250. In Tucson, you may contact OHR at (520) 770-3100, or 1-877-524-6882. If your complaint relates to a licensed behavioral health agency, you may contact the Bureau of Medical Facilities Licensing Office, 150 N. 18th Avenue, Suite 450, Phoenix, Arizona 85007, (602) 364 -3030.

How do I request a State Fair Hearing?

If you are not satisfied with the appeal decision, you may file a request for State Fair Hearing with B – UHP. This request must be made in writing to B – UHP within 90 days of the date of receipt of the Notice of Appeal resolution. B – UHP will send the appeal file to AHCCCS and a hearing date will be scheduled for attendance.

Assistance with filing an Appeal or the State Fair Hearing

If you need assistance filing an appeal or a State Fair Hearing, please contact the Customer Care Center or the Grievance & Appeals Department.

Provider Claim Disputes

A Provider Claim Dispute is a dispute involving the payment or nonpayment of a claim. You may challenge B – UHP's adjudication of a claim by filing a claim dispute, in writing, with the Grievance and Appeals Department. The claim dispute should include the following for faster processing:

1. A cover letter on appropriate letterhead indicating your reason for filing the claim dispute.Please include the following information in your letter:
    a. Date of request;
    b. Claim number(s);
    c. The factual and legal basis for the claim dispute and your expected resolution;
    d. The enrollee's AHCCCS ID number, full name, date of service, and date of birth; and
    e. Writer's name, address, telephone number and/or email address.
2. Supporting documentation, including:
    a. A copy of the EOB or RA from B – ALTCS;
    b. A copy of the original claim(s);
    c. Corrected claim(s), if applicable;
    d. A copy of the Medicare or primary insurer EOB(s), if applicable;
    e. A copy of the authorization, if applicable; and
    f. If you are a contracted provider with specific rates in your contract, a copy of the applicable pages from your contract when challenging the rate of pay.

Please submit the claim dispute letter and supporting documentation to:

Banner – University Family Care/ACC & ALTCS
Attn: Grievance & Appeals Department
5255 E Williams Circle, Ste 2050
Tucson, AZ 85711
Fax: (866) 465-8340

Provider Claim Dispute Submission Timeframes

Unless otherwise stated in your contract, a claim dispute for claims payment issue must be received within 12 months from the date of service, or for a hospital claim within 12 months from the date of discharge, 12 months after the date of eligibility posting, or within 60 days after the date of a timely claim submission, whichever is later. B – UHP ensures that no punitive action will be taken against a provider who requests a claim dispute or supports a member's appeal. All claim disputes are adjudicated in Arizona, including those claim disputes arising from claims processed through an administrative services subcontractor.

Provider Claim Dispute Acknowledgement and Resolution

We will send you an acknowledgement letter within 5 business days of receipt of your claim dispute.

Within 30 calendar days, we will mail you a Notice of Decision. The Notice of Decision will explain our resolution of the dispute, and the factual and legal basis for our resolution. If our decision is to approve your dispute, we will reprocess and pay your claim within 15 days of the Notice of Decision. If our decision is not in your favor, we will explain your right to request a State Fair Hearing.

Provider Requests for Administrative Hearing

If the party filing a claim dispute is dissatisfied with an B – UHP decision, or if a decision is not received within 30 days after the claim dispute is filed, absent an extension of time, a request for administrative hearing may be filed, in writing, with B – UHP. B – UHP will forward the request for hearing to the Office of the General Counsel (OGC).

Timeframes for Requesting an Administrative Hearing

The provider's request for a hearing must be filed in writing and received by B – UHP no later than 30 calendar days of the date of receipt of the B – UHP decision, absent an extension of time, or in the event no decision is rendered, within 30 days of the date of filing the claim dispute, absent an extension.

Scheduling of an Administrative Hearing

Pursuant to A.R.S. § 41-1092.03, upon receipt of a request for an administrative hearing, an administrative hearing will be scheduled pursuant to A.R.S. § 41-1092.05.

Office of the General Counsel (OGC) shall accept a written request for withdrawal from the filing party if the request is received prior to AHCCCS scheduling and mailing of a Notice of Hearing. Otherwise, a filing party who wishes to withdraw must send a written request (motion) for withdrawal to the Office of Administrative Hearings consistent with AAC R2-19-106(A)(3).

If The Health Plan's decision regarding a claim dispute is reversed through the claim dispute or hearing process, The Health Plan will reprocess and pay the claim(s) with interest, when applicable, in a manner consistent with the decision within 15 business days of the date of the decision unless a different timeframe is specified.

Peer and Family Run Organizations

Overview of Peer and Family Support Services

Peer and family support services are a vital part of member- and family-centered care. When you put a member and their family at the center of one's care, the individual's voice is strengthened, and recovery and resiliency can remain the primary focus for all involved in the care of an individual and those loved ones supporting that individual who is experiencing mental health or substance use challenges.

Peer and family support services are a valuable addition to traditional care, and these services are known to contribute to improved outcomes in employment, education, housing stability, satisfaction, engagement and adherence and a sand decrease in the need for more costly services, such as hospitalizations. Peer provided services help to foster recovery, increase treatment and service engagement, reduce acute care use, and improve quality of life.

Peer and family services are available to all Managed Care (MC) Title 19 and Non-Title 19 members and their families within the clinic setting as well as at community-based, Peer and Family-run Organizations (PRO/FRO's). Based on member's choice and/or if peer and/or family support services is not available in the clinic where services are provided, a referral is preferred but not always needed prior to engaging in these community-based, PRO/FRO supportive services.

Families affect and are influenced by the recovery experiences of children, youth, and adults with mental or substance use disorders. As caregivers, navigators, and allies, family members play diverse roles and may require a variety of supports.

Families and family-run organizations are vital components of recovery-oriented service systems. Family members train and support other families—sharing lived experiences and insights that instill hope, increase understanding, and contribute to systems transformation.

Peer Recovery Support Specialists (PRSS) and Family Support Partner (FSP) Training and Credentialing Requirements

Provision of Peer and Family Support Services

AHCCCS has developed training and supervision requirements as well as credentialed standards for the provision of Peer and Family Support Services as described in the AHCCCS Medical Policy Manual

(AMPM), Chapter 900 – Quality Management and Performance Improvement Program Policy 963: Peer and Recovery Support Services Provision Requirements and Policy 964: Credentialed Family Support Partner Requirements:

AMPM 963: https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/900/963.pdf

AMPM 964: https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/900/964.pdf

These apply to all providers delivering peer and/or family support services and/or employment training services for credentialing of individuals as Peer and Recovery Support Specialists (PRSS) or Credentialed Family Support Partners (CFSP) within the AHCCCS public behavioral health system.

Peer and Family Support services include the provision of assistance to utilize the service delivery system more effectively (e.g., assistance in developing plans of care, identifying needs, accessing supports, partnering with professionals, overcoming service barriers); or understanding and coping with the stressors of the individual's disability (e.g., support groups, coaching, role modeling and mentoring).
Individuals with lived experience and family members supporting their loved ones with behavioral health and/or substance use challenges serve an important role in the behavioral health work force. These services may be provided to an individual, group, or family, and are aimed at assisting in the creation of skills to promote long-term, sustainable recovery.

People who have achieved and sustained recovery and parents, caregivers, or individual who care for them can be a powerful influence for individuals seeking their own path to recovery (see Center for Mental Health Services (MHBG) Consumer Affairs E-News October 2, 2007, Vol. 07-158). By sharing personal experiences, peers, parents, caregivers, and other natural supports help build a sense of hope and self-worth, community connectedness, and an improved quality of life to people in recovery.

Peer and family support services are supported on a statewide and national level. The Centers for Medicare and Medicaid Services (CMS) issued a letter to states, recognizing the importance of peer support services as a viable component in the treatment of mental health and substance abuse issues. In the letter, CMS provides guidance to states for establishing criteria for peer support services, including supervision, care coordination, and training/credentialing.

Peer and Recovery Support Specialists (PRSS) and Credentialed Family Support Partners Providers (CFSP) Qualifications

Individuals seeking to be credentialed and employed as PRSS or FSP must:

- Self-identify as a peer with lived experience and in recovery from mental health and or substance use (PRSS) OR a parent, caregiver, or individual with lived experience caring for a child or adult with emotional, behavioral, or substance use needs (FSP); and
- Meet the requirements to function as a behavioral health paraprofessional, behavioral health technician, or behavioral health professional (PRSS only).

Individuals meeting the above criteria may be credentialed as a PRSS or FSP by completing training and passing a competency test through an Office of Individual & Family Affairs (OIFA) Alliance approved Peer Support Employment Training Program (PSETP) or AHCCCS/DCAIR Office of Individual & Family Affairs (OIFA) approved Credentialed Family Support Partner Training Program (CFSTP). AHCCCS/OIFA and/or the OIFA Alliance will oversee the approval of all credentialing material including curriculum and testing tools.

Credentialing through an OIFA Alliance approved Peer Support or AHCCCS/OIFA Credentialed Family Support Partner Training Program is applicable statewide, and these employment trainings are not a billable service for costs associated with training an agency's own employees.

Some agencies may wish to employ individuals prior to the completion of getting credentialed through a Peer Support Employment or Credentialed Family Support Partner Training Program. However, certain trainings must be completed prior to delivering services. An individual must be credentialed as a PRSS or FSP or currently enrolled in an AHCCCS/OIFA or OIFA Alliance approved training program under the supervision of a qualified individual prior to billing Peer Support or Credentialed Family Support Services.

Peer Support Employment (PSETP) and Credentialed Family Support Partner (CFSPTP) Training Competency Exam

Individuals must complete and pass a competency exam with a minimum score of 80% upon completion of required training. Each Peer Support Employment or Credentialed Family Support Partner Training Program has the authority to develop a unique competency exam. However, all exams must include at least one question related to each of the curriculum core elements. If an individual does not pass the competency exam, the Training Program may require the individual to retake the exam or complete additional training prior to taking the competency exam again. Individuals credentialed in another state may obtain credentialing in Arizona if that states credentials and/or training program is following CMS's requirements and can submit their credential for review via email to AHCCCS/OIFA at oifa@azahcccs.gov.

AHCCCS/OIFA asks all agencies training Peer Recovery Support Specialists (PRSS) and/or Family Support Partners (FSP) to complete either Attachment C in AMPM Policy 963 Peer and Recovery Support Service Provision Requirements or Attachment B in AMPM Policy 964: Credentialed Family Support Partner Requirements. These documents are rosters of individuals who have graduated your training and passed your competency exam. These attachments should be completed immediately after each training graduation and emailed to AHCCCS/OIFA at oifa@azahcccs.gov

Peer Support Employment (PSETP) and Credentialed Family Support Partner (CFSPTP) Training Program Approval Process

A Peer Support Employment or Credentialed Family Support Partner Training Program must submit their program curriculum, competency exam, and exam scoring methodology (including an explanation of accommodations or alternative formats of program materials available to individuals who have special needs) to AHCCCS/OIFA or the OIFA Alliance who will issue feedback or approval of the curriculum, competency exam and exam scoring methodology.

For additional information on the Approval Policy, including curriculum standards, please refer to AMPM Policy 963: Peer and Recovery Support Services Provision Requirements (Section III I.) and AMPM Policy 964: Credentialed Parent Peer/Family Support Requirements (Section III. C.).

Peer Support Employment (PSETP) and Credentialed Family Support Partner (CFSPTP) Training Programs Curriculum Monitoring, Development, and Enhancement

B – UFC's Office of Individual and Family Affairs (OIFA) is required to monitor Peer Support Employment (PSETP) and Credentialed Family Support Partner (CFSPTP) Training Program curriculum and at any time may request to do so. This request would come from B – UFC's Office of Individual and Family Affairs (OIFA) Administrator, Colleen McGregor, directly.

Based on the outcomes of the curriculum review, B - UFC OIFA may extend training and/or technical assistance to the state approved PSETP or CFSPTP to ensure compliance with AHCCCS AMPM Policy 963 or 964. If further corrective action is necessary, formal notification will be made to AHCCCS/OIFA and resolution sought in collaboration with B – UFC OIFA and the state-approved PSETP or CFSPTP.

For new or existing PSETP and CFSPTP providers in need of support to establish, further develop or enhance curricula, please contact B – UFC's Office of Individual and Family Affairs (OIFA) Administrator, Colleen McGregor at colleen.mcgregor@bannerhealth.com and the OIFA Team general email box at OIFATeam@bannerhealth.com.

Supervision Requirements for Credentialed Peer and Recovery Support Specialists (PRSS's) and Family Support Partners (CFSP's)

Agencies employing Peer Recovery Support Specialists (PRSS's) and Credentialed Family Support Partners (CFSP's) must provide these individuals supervision performed by a qualified Behavioral Health Technicians (BHT) or Behavioral Health Professionals (BHP) with training/access to continuing education and guidance to ensure current knowledge of best practices in providing this supervision. It must be appropriate to the services being delivered and the PRSS/CFSP qualifications as a Behavioral Health Technician (BHT), Behavioral Health Professional (BHP) or Behavioral Health Paraprofessional (BHPP). Supervision must be documented and inclusive of both clinical and administrative supervision.

Continuing Education and Ongoing Learning Requirements for Credentialed Peer Recovery Support Specialists (PRSS's) and Family Support Partners (CFSP's)

Peer Recovery Support Specialists (PRSS's) and Credentialed Family Support Partners (CFSP) are required to have Continuing Education and/or Ongoing Learning hours every year. For PRSS this is a minimum of four (4) hours relevant to peer support with one (1) hour covering ethics/boundaries.

For CFSP this is a minimum of eight (8) hours relevant to family support with one (1) hour covering ethics/boundaries. Continuing Education and Ongoing Learning opportunities can be accessed through resources such as Relias Learning Management System, the Substance Abuse and Mental Health Services Administration (SAMHSA) Bringing Recovery Supports to Scale (BRSS) Technical Assistance Center Strategy (TACS) https://www.samhsa.gov/brss-tacs/video- trainings. Additionally, advanced, free continuing education resources can also be accessed through the Arizona Peer and Family Career Academy https://www.azpfca.org/. Doors To Well-Being offers another source of continuing education webinars that are free of cost and can be accessed through their website https://www.doorstowellbeing.org. For additional Continuing Education and Ongoing Learning Resources, please outreach B –UFCOIFA through the general email box OIFATeam@bannerhealth.com.

Submitting Evidence of Credentialing

Provider agencies employing, utilizing and billing for Peer Support Services are required to submit, on a quarterly basis on the 5th day of the month in January, April, July, and October, Attachment A of AMPM Policy 963 the Peer Recovery Support Specialist Involvement in Service Delivery deliverable. Provider agencies employing, utilizing and billing for Family Support Services are required to submit, on a bi-annual basis on the 5th day of the month in January and July, Attachment A of AMPM Policy 964 the Credentialed Parent Peer-Family Support Partner Involvement in Service Delivery deliverable. These are submitted to B – UFC OIFA through the general email box OIFATeam@bannerhealth.com.

Links to Attachments:

AMPM 963 Attachment A Peer Recovery Support Specialist Involvement in Service Delivery:
https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/900/963a.xlsx

AMPM 964 Attachment A Credentialed Parent Peer-Family Support Partner Involvement in Service Delivery:
https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/900/964A.xlsx

The BUFC – OIFA Team will send an email reminder each quarter to the agencies we are aware of employing PRSS's and CFSP's to submit Attachment A. If there are questions or any need for technical assistance (TA) with this submission please outreach B – UFC OIFA through our general email box OIFATeam@bannerhealth.com.

It is the responsibility of B - UFC to ensure provider agencies that employee and/or train individuals to become Peer and Recovery Support Specialists (PRSS) and Credentialed Family Support Partners (CFSP) maintain policies & procedures and documentation of required qualifications and credentialing.

To do this:

1. BUFC – OIFA will reference the most current received AMPM 963 & 964 Attachment A and reach out to the provider agency to confirm that this is still the most accurate list of PRSS's and /or CFSP's currently employed.
2. Utilizing the above list BUFC – Quality, with the support of OIFA, will conduct reviews of a sampling of employee files to assure it contains the following:
    - Employee Credential Certification-PRSS and/or CFSP
    - Qualifications meeting the ability to function as one of the following: behavioral health paraprofessional, behavioral health technician, or behavioral health professional (PRSS only).
    - Documentation of supervision with a Behavioral Health Technician (BHT) or Behavioral Health Professional (BHP)
    - Documentation of Continuing Education and Ongoing Learning opportunities (at minimum four (4) hours yearly relevant to peer support with one (1) hour covering ethics/boundaries for PRSS and at minimum eight (8) hours yearly relevant to family support with one (1) hour covering ethics/boundaries for PPFSP).

Partnerships with Families & Family-Run Organizations in the Children's Behavioral Health System

Arizona holds a distinction in the United States for promoting various family roles within the

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

Three categories of roles for families:

- Families are encouraged to participate and are supported as active and respected members of their child's Child and Family Team (CFT). In this capacity, families drive the development and implementation of a service plan that will respond to the unique strengths and needs of the child and family.
- Families participate in various activities that influence the local, regional, and State service system. This type of activity is commonly called "Family Involvement". In Arizona, families have a range of opportunities to offer their unique insight and experience to the development and implementation of programs and policies. This includes various advisory activities on Boards, committees, and policy making groups that work to improve children's services.
- Family members work in a professional capacity in the children's behavioral health system. In this capacity, family members offer a special type of support (peer delivered) to the families and children that they serve. Further, families who work in the service system influence the system by contributing the family perspective.

B – UFC's contracted family-run organizations are expected to serve in a role of helping with the recruitment, training, and support of family members. Procedures outlined in this policy section are aimed at achieving the following outcomes:

- Increased adherence to statewide practice in accordance with the Twelve Principles for Children Service Delivery.
- Improved functional outcomes for children, youth, young adults, and families.
- Improved engagement and collaboration in service planning between children, youth, young adults, families, community providers and other child serving agencies.
- Improved identification and incorporation of strengths and cultural preferences into planning processes.
- Coordinated planning for seamless transitions.
- A stronger partnership with families in the process of supporting their child's/youth's behavioral health needs.

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

Family-run and parent support organizations play a crucial role in supporting families, youth, and young adults involved in the children's behavioral health system. They are key partners in transforming Arizona's behavioral health system and are vital to the process of identifying meaningful roles and opportunities for family members, youth, and young adults to actively contribute to that transformation. Family-run and parent support organizations not only support the current involvement and roles of family, members, youth, and young adults, but also work toward identifying and developing the next generation of community leaders. To demonstrate commitment to the importance and functions of family-run and parent support organizations, providers must:

- Establish partnerships with family-run and parent support organizations.
- Offer family members the opportunity to connect with family-run and parent support organizations as soon as the child is enrolled in the behavioral health system to provide information and parent peer-to-peer support.
- Model an environment that encourages and promotes the value of family-run and parent support.

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

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

- Have Family Advisory Committees that meet regularly that gathers member and family member feedback and ideas regarding services and/or an alternate way to capture this feedback.
- Have a Youth Advisory Committee that meets regularly to solicit youth feedback and ideas regarding services and/or an alternate way to capture this feedback.
- Offer opportunities for youth leadership education and activities regularly.
- Utilize Certified Family Support Partners to provide services they are trained to deliver.

Organizational Commitment to Employment of Family Members

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

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

Effective Member and Family Participation in Service Planning and Service Delivery

Behavioral health services will be done in an effective and recovery-oriented fashion and delivered through a strengths-based assessment and service planning approach. The concept of a "team" is incorporated and established for each member receiving behavioral health services. For children, this team is the Child and Family Team (CFT) and for adults, this team is the Adult Recovery/Resiliency Team (ART). At a minimum, the functions of the CFT and ART include initial and ongoing engagement of the member, family and others who are significant in meeting the behavioral health needs of the member, including their active participation in the decision-making process and involvement in treatment.

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

- Ensure that service planning and delivery is driven by family members, youth, and young adults.
- Approach services and view the enrolled child in the context of the family rather than isolated in the context of treatment.
- Provide culturally and linguistically relevant services that appropriately respond to a family's unique needs.
- Offer family peer to peer support to families and make peer representation available to the CFT when requested.
- Provide information to families on how they can contact staff at all levels of the service system inclusive of the provider agency, B – UFC and AHCCCS at intake and throughout the CFT process; and Work with B – UFC to develop training in family engagement and participation, roles and partnerships for provider staff, parents/caregivers, youth and young adults.

- The Adult Recovery Team (ART) is a key component to the assessment and service planning with focus on engagement and input from the individual, their family and significant others, as well as the clinical team.

B – UFC contracted behavioral health providers must coordinate with members ART to make appropriate referrals in assessing members needs during coordination of care. We remind providers the ART process can be facilitated by telehealth, phone and/or in-person to affectively engaged in members' services and road to recovery.

Through ART, B – UFC endorses and requires all contracted providers to comply with the Arizona Adult Service System's Nine Guiding Principles.

1. Respect
2. Persons in recovery choose services and are included in program decisions and program development efforts.
3. Focus on individual person, while including and/or developing natural supports.
4. Empower individuals taking steps towards independence and allowing risk taking without fear of failure.
5. Integration, collaboration, and participation with the community of one's choice.
6. Partnership between individuals, staff, and family members/natural supports for shared decision making with a foundation of trust.
7. Persons in recovery define their own success.
8. Strengths-based, flexible, responsive services reflective of an individual's cultural preferences.
9. Hope is the foundation for the journey towards recovery.

Responsibilities of B – UFC Integrated Care and Its Providers Regarding Inclusion of Member and Family Member Voice & Choice in Service Delivery and Decision-Making Procedures

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

- Support members, parents/caregivers, youth, and young adults in roles that have influence and authority.
- Establish recruitment, hiring, and retention practices for members, family, youth, and young adults within the agency that reflect the cultures and languages of the communities served.
- Provide training for members, families, youth, and young adults in cultural competency.
- Assign resources to promote member, family, youth, and young adult involvement including committing money, space, time, personnel, and supplies.
- Demonstrate a commitment to regular and ongoing member and/or family member participation in shared decision making, quality improvement, and enhancement of customer service via Advisory Councils or other means of capturing member, family member, youth, and young adult voice. It is the contracted responsibility of B – UFC Office of Individual and Family Affairs (OIFA) to monitor this and will do so in one or more of the following ways: audits, environmental scans, site visits, request for outputs and/or other documents.

Workforce Development

This following information applies to health care providers contracted with Banner – University Health Plans (B – UHP) for the Arizona Health Care Cost Containment System (AHCCCS), Arizona Complete Care (ACC) and Arizona Long Term Care Services (ALTCS) Elderly/Physically Disabled (E/PD). It discusses the requirements, expectations, and recommendations in developing the workforce. The initiatives align with Workforce Development Policy ACOM 407 & ACOM 407 Attachment A.

B – UHP Workforce Development Orientation (WFDO) department implements, monitors, and regulates Provider WFD activities and requirements. In addition, B – UFC evaluates the impact of the WFD requirements and activities to support Providers in developing a qualified, knowledgeable, and competent workforce.

In collaboration with AHCCCS, ACC, ACC/RBHA and ALTCS AWFDA's ensures that all course content is culturally appropriate, has a trauma informed approach and is developed using adult-learning principles and guidelines. Additionally, it is aligned with company guidelines and WFD industry standards, the Substance Abuse and Mental Health Services Administration (SAMHSA) core competencies for WFD, federal and state requirements and the requirements of several agencies, entities and legal agreements.

Workforce Groups

ALTCS Workforce Development Advisory Council is organized by AHCCCS and includes members from: the four ALTCS Manager Care Organizations (MCOs), Community Stakeholders and LTC Advocacy Groups. The purpose of this group is to share resources, develop strategies and support state-wide initiatives in Long-Term Care that are aligned with Arizona's Plan for an Aging Population: Aging 2020 and AHCCCS Policies:

> ACOM 429 and ACOM 407: Direct Care Worker Training and Testing Program. Additionally, this committee will offer advice and recommendations on initiatives set by the MCOs.

ACC, ACC-RBHA Workforce Development Advisory Committee is comprised of leaders, stakeholders, and experts who provide guidance and direction on strategic items important to the ongoing partnership and success around the use of Relias solutions and services, as well as Workforce Development initiatives. This Committee is responsible for maintaining a working relationship and alignment with statewide goals and objectives, as well as providing input to AHCCCS on policies and initiatives related to Workforce Development.

Arizona Association of Health Plans (AzAHP) unites the companies that provide health care services to the almost two million people that are members of the AHCCCS. AzAHP offers valuable training programs through our ACC, ACC-RBHA AzAHP Workforce Development Alliance, and AzAHP supplies assistance and resources to enhance the long-term care workforce through our ALTCS Workforce Development Alliance, and they offer valuable training programs through the ACC/RHBA Workforce Development Alliance.

Arizona Healthcare Workforce Development Coalition (AHWFDC) is organized by the WFD Department at AHCCCS, the AzAHP and includes members from the eight MCOs. This group represents ACC, ALTCS, DCS CHP, DES/DDD and RBHA lines of business. Together, the Coalition ensures initiatives across the state of Arizona align with all lines of business.

AzAHP Workforce Development Alliance (AWFDA) A name given to the WFD Administrators from each Contractor that jointly plan and conduct WFD activities for a particular line of business.

Currently there are two AWFDAs:

- The ACC, ACC-RBHA AWFDA includes the WFD Administrators from ACC, RBHA, and DCS CHP Contractors. In addition to conducting joint WFD planning, the ACC, ACC-RBHA/DCS CHP AWFDA collectively manages the contract between the AzAHP and the Learning Management System (LMS) vendor.
- The ALTCS AWFDA includes WFD Administrators from the DDD and ALTCS E/PD Contractors.

Definitions

Competency is defined as worker's demonstrated ability to perform the basic requirements of a job intentionally, successfully, and efficiently, multiple times, at or near the required standard of performance.

Competency Development is a systematic approach for ensuring that workers are adequately prepared to perform the basic requirements of their jobs. Competency based WFD.

Workforce Capability is the interpersonal, cultural, clinical/medical, and technical competence of the collective workforce or individual worker.

Workforce Capacity is the number of qualified, capable, and culturally representative personnel required to sufficiently deliver services to members.

Workforce Connectivity is the workplace's linkage to sources of potential workers, information required by workers to perform their jobs, and technologies for connecting to workers and/or connecting workers to information

Workforce Development is an approach to improve outcomes by enhancing the knowledge, skills, and competencies of the workforce in order to create, sustain, and retain a viable workforce. It aids in changes to culture, changes to attitudes, and changes to people's potential to influence outcomes.

Training/Compliance Requirements

Prevention of Abuse and Neglect

- The Provider workforce shall have access to, and be in compliance with, all workforce training and/or competency requirements specified in federal and state law, AHCCCS policies, guidance documents, manuals, contracts, plans such as network development, quality improvement, corrective action, etc., and/or special initiatives.
- Providers shall have processes for documenting training, verifying the qualifications, skills, and knowledge of personnel; and retaining required training and competency transcripts and records.

Residential Care (24-Hour Care Facilities) Annual Requirements

- Crisis prevention/de-escalation training for all member-facing staff prior to serving members.
- For facilities where restraints are approved, a nationally approved restraint training for all member-facing staff. This curriculum should include non-verbal, verbal and physical de-escalation techniques.

Division of Licensing Services (DLS) Required Training

- DLS agencies You must be aware of all training requirements to be completed and documented based on all additional licensing or accrediting licensing agencies. This includes the Bureau of Medical Facilities Licensing (BMFL) / Bureau of Residential Facilities Licensing (BRFL), Joint Commission, grant requirements and other entities, as applicable.

Community Service Agencies (CSAs)

- CSAs must submit documentation as part of the first and annual CSA application. The documentation must show that all direct service staff and volunteers have completed CSA training before providing services to members. For a list of all required CSA-specific training, see the AMPM Policy 961-C – Community Service Agencies.

Child and Adolescent Level of Care Utilization System (CALOCUS)

- Employees completing the CALOCUS assessments are required to have training in CALOCUS prior to using the assessment tool with members when assessing for the determination of which children may require high needs case-management. On-going competency assessments are also requiredto evaluate a staff member's knowledge and skills.
- Any other trained provider (PCP, specialty provider, etc.) working with children and adolescents is also able to conduct the CALOCUS assessment and trained providers can coordinate with the health home to share the assessment results for care coordination purposes.
- To ensure the proper identification of children and adolescents with complex needs and appropriate levels of care, AHCCCS has contracted with Deerfield Behavioral Health (Deerfield) to license the Child and Adolescent Level of Care Utilization System (CALOCUS) and Level of Care Utilization System (LOCUS) software, as well as access to online training for those who have familiarity with instruments that measure level of service acuity instruments. The agreement includes the licensing of both CALOCUS/LOCUS online, though AHCCCS is currently only requiring the use of the

CALOCUS. This also includes licensing of the integrated Electronic Health Record (EHR) products, with the intent that providers include the assessment in their data feeds into the Health Information Exchange (HIE).

- Providers can implement LOCUS/CALOCUS in one of two ways.
  - The first is via the web-based version which can be accessed at locus.azahcccs.gov.
  - The second is via an EHR integration.
- Regardless of which option you choose, you must first reach out to Deerfield and sign their end user license agreement as soon as possible. There is no cost associated with this agreement. Matthew Monago will be your contact at Deerfield and his email is mmonago@journeyhealth.org. Please be sure to identify your organization as an AHCCCS provider when emailing.

- Per AHCCCS communication on 10/8/21: "Due to discussions between AHCCCS, B-UHP (WFD) Administrator, members of the American Academy of Child and Adolescent Psychiatry (AACAP) and American Association of Community Psychiatrists, it has been determined that individuals who have previously taken the CASII training, will also need to complete the CALOCUS training. This will ensure consistent alignment with AHCCCS contractual requirements for CALOCUS training, establish a baseline level of CALOCUS understanding for those that administer the tool, and enhance efforts to maintain fidelity to CALOCUS administration."
  - For Children's Providers serving children in the Department of Child Safety Comprehensive Health Plan, B-UHP asks to prioritize the completion of the CALOCUS for youth that are either living in a DCS funded Qualified Residential Treatment Program (QRTP) or are being considered to go into a QRTP.
  - If there are questions regarding CALOCUS training requirements related to the AHCCCS contract, provider agencies should be instructed to please reach out to the Contract Compliance Officer at the contracted Health Plan.
- Monitoring Process
  - All Health Plans will monitor the CALOCUS certification process. Each Health Plan will run Relias reports to monitor those who have completed, as well as have not completed the requirement in the 30-day time frame. These reports will then be compared to the Deerfield completion report, ensuring fidelity to this AHCCCS requirement.

  *It is suggested that those who have completed the Deerfield CALOCUS training prior to July 1, 2022, also be enrolled and marked complete in the training plan for monitoring, tracking, and record transferability.
- Provider Agency Requirements
  - All child and adolescent provider agencies who meet the requirements for the CALOCUS training will need to do the following:
    - Enroll employees who are required to take the Deerfield CALOCUS training in the *AZAHP – CALOCUS Training Requirement (30 Days) training plan in Relias.
    - Once the employee has been enrolled and completes the CALOCUS training through Deerfield the provider agency's supervisor/administrator will mark them complete in the Relias CALOCUS Training Requirement module.
    - Once all steps have been completed, the employee will have met the requirements for CALOCUS certification.

Network Workforce Data Collection

It is the responsibility of the Contractor to produce a Network Workforce Development Plan for each line of business: ACC and ALTCS. A portion of this data will be supported by the Provider Workforce Development Plan (as applicable to LOB), the AZ Healthcare Workforce Goals and Metrics Assessment, and any additional means that are identified.

AZ Healthcare Workforce Goals and Metrics Assessment (AHWGMA)

B – UHP requires that all contracted provider types listed on our website complete the AZ Healthcare Workforce Goals and Metrics Assessment annually to fulfill the requirements from ACOM 407 & ACOM 407 Attachment A. To meet this requirement, all Health Plans and lines of business have collaborated extensively to create a single provider survey that will be disseminated from one source (AZAHP vs. multiple assessments being disseminated and duplicated). Refer to the website for the most up-to-date information, including a list of required Provider Types and a link to the assessment.

AHWGMA Webpage: https://azahp.org/azahp/ahwdfc/az-healthcare-workforce-goals-and-metrics-assessment/

ADHOC Initiatives

B – UHP will promote optional WFD initiatives with **ACC and ALTCS** Providers that support the growth of business practices, improve member outcomes, and increase the competency of the workforce.

Workforce Development Technical Assistance Needs

The B – UHP Workforce Development Administrator is available to provide technical assistance for various workforce development related needs. Technical Assistance needs could include:

- P-WFDP Guidance
- Recruitment Assistance
- Competency Review
- Workforce Development Goal Review
- Career Path Development
- Training Needs
- Metrics Review
- Relias
- Technology Assistance
- Network Capacity Review
- Cultural Competency
- Diversity/Equity/Inclusion Support
- Community Resources
- Other

For additional information on the P-WFDP requirement, training plans and the provider forums, or to discuss technical assistance needs, please reach out to our WFDO at workforce@bannerhealth.com or via the following contacts:

ACC

ACC Alliance: workforce@azahp.org
ACC AzAHP Website
B – UFC WFD Administrator for ACC:
Selena McDonald,
at selena.mcdonald@bannerhealth.com

ALTCS

ALTCS Alliance: altcswfd@gmail.com
ALTCS AzAHP Website
B – UFC WFD Administrator for ALTCS:
Selena McDonald at
selena.mcdonald@bannerhealth.com

Behavioral Health ACC Providers: *Please refer to the Appendix – Behavioral Health Specific for ACC BH specific Workforce Development information.*

Claim Submission

It is B – UHP's commitment to ensure claims payments are accurate and timely. The guidelines presented on the following pages contain information and instructions that should be followed in order to ensure timely and accurate payment.

Providers must submit claims for all services including those that are capitated. Any provider who renders services to AHCCCS members must be registered with AHCCCS and have an active AHCCCS provider number. If the member is dual eligible, you should be registered with AHCCCS to ensure secondary payment.

Claim Submission Guidelines

The Claims Department will adjudicate all properly submitted, authorized claims that meet "clean claims criteria" within 45 days of receipt unless otherwise stipulated in your contract. A claim is considered a "clean claim" if it is submitted on the appropriate form, contains the correct billing information according to CMS 1500, ADA 2002 and UB-04 requirements and has all the supporting documentation as required for medical and claims review. If any standard information is omitted on the claim, it may be denied or returned for correction. Handwritten claims may be accepted but require pre-approval. Claims with whiteout visible will not be accepted to protect you and us from potential instances of fraud. If the claim form is returned to the provider for correction without being adjudicated (i.e. entered into B – UHP's claim system), the original filing limit still applies from the date of service, not the date of return. These claim forms should be resubmitted with a copy of the original return letter attached. Detailed requirements for CMS 1500, ADA 2002 and UB-04 forms are in this section.

Providers must submit all claims for covered services provided to members within one hundred and twenty (120) days after the Covered Services are rendered, whether fee-for-service or capitation. Unless another timeframe is specified in your contract, claims initially received more than 120 days from the date of service will be denied. Non-contracted providers must submit within six (6) months from the date of service. Secondary claims must include a copy of the primary payer's remittance advice and be received within 60 days of the primary payer's remittance advice. Non-contracted providers have 60 days from date of the primary payer's remittance advice or six months from the date of service, whichever is greater.

Acceptable proof of timely filing requirements must establish that B – UHP or its agent has received a claim or claim related correspondence. Acceptable examples of proof of timely filing include:

- Signed courier routing form documenting specific documents contained
- Certified mail receipt that can be specifically tied to a claim or related correspondence
- Successful fax transmittal confirmation sheet documenting the specific documents faxed
- Acceptable confirmation report from the appropriate clearing house

Unacceptable examples of proof of timely filing include:

- Provider billing history
- Any form or receipt that cannot be specifically tied to a claim or related correspondence Claims initially received outside of the timely filing deadlines will be denied as Past Filing Deadline (PFD). The deadline will be determined by the ending date of service for claims involving hospitalization. If a claim is accepted but denied for a reason which can be corrected and resubmitted, the claim form should be resubmitted following the resubmission guidelines.

Submissions Contact Information

Electronic Data Interchange (EDI)

B – UHP encourages providers to submit their claims electronically. Claims may be submitted electronically through your clearinghouse to one of our EDI partners. Please contact your Provider Relations Representative or Customer Care Center for more information.

Duplicate Claims

Please allow 14 days following the initial submission to validate claims status and allow 60 days prior to resubmitting your claim. This allows B – UHP time to pay the claim and enough time for your staff to post the payment. This practice will decrease the volume of duplicate claims and reduce processing times and administrative costs.

Resubmissions (Replacements)

A resubmission (replacement) is a claim previously denied due to unclean claim status, billing corrections, supporting documentation and/or the need for review due to an error in payment. Resubmitted claims are not considered grievances or appeals and will not be treated as such. The following documentation is required when filing paper claims resubmissions to the Claims Department:

- Clean, corrected claim with "resubmission" clearly marked on the claim and the original claim number being resubmitted (replaced). Must be written on the front of the CMS1500 (box 22), UB-04 (box 84) or ADA 2002 (box 35). Claims corrections with writing, white out or marker cannot be accepted with the exception of handwriting "Resubmission".
- Supporting documentation if needed.
- Brief explanation of the correction needed

When resubmitting a claim previously filed electronically, a paper claim can be resubmitted or resubmissions (replacements may be submitted electronically). Electronic resubmissions must follow the EDI standard and reference the original claim number in the Loop 2300 Element REF02.

Resubmissions must be received within one (1) year from the date of discharge or date of service. Claims not received within the timeline will be denied as Past Filing Deadline.

The claim must be clearly marked as a resubmission. The word "resubmission" and/or the original claim number must be written on the front of the CMS 1500 (box 22), UB-04 (box 84) or ADA 2002 (box 35) claim form. When resubmitting a claim previously filed electronically, a paper claim can be resubmitted. Electronic resubmissions must reference the original claim number in the Loop 2300 Element REF02.

Seeking payment from Members

The AHCCCS plan members cannot be billed for covered services in accordance with A.A.C R9-22- 702. Eligible AHCCCS members cannot be denied covered services if they are unable to pay non- mandatory applicable co-payments.

Providers cannot bill members for covered services regardless of whether the member has signed a release form for assumption of liability.

B – UHP members may receive services from providers that are not covered by AHCCCS or Medicare. Providers must have the member sign a release form stating that he/she understands the service is not a covered benefit and he/she is responsible for payment of the charges.

Claims Customer Care Center Representatives

The Claims Customer Care Center Representatives are available to providers to answer questions regarding claims submissions and to assist in resolving problems and issues regarding the status of a claim. The representatives will explain claim adjudication and assist in tracking the disposition of specific claims. The Claims Customer Care Center Representative will also assist in identifying and correcting claim processing errors.

The Claims Customer Care Center Representatives are not able to correct a provider error in claims preparation and submission. The Provider must resubmit claims requiring corrected information. Corrected claims must be submitted per the resubmission guidelines.

The Claims Customer Care Center Representatives may be contacted Monday through Friday. Your call may be answered by our automated service. Please leave a message and your call will be returned within 48 hours.

Providers should NOT submit the following unless specifically requested to do so:

- Emergency Admission authorization forms
- Patient follow-up care instructions
- Nurses notes
- Blank medical documentation forms
- Consents for treatment forms
- Operative consent forms (exception: BTL & hysterectomy)
- Ultrasound/X-ray films
- Nursing care plans
- DRG/Coding forms
- Medical documentation on prior authorized procedures/Inpatient hospital stays
- Entire medical records

Current and Accurate Provider Information

Physicians, other licensed health professionals, facilities, and ancillary providers contract directly with B – UHP for payment of covered services. It is important that providers ensure B – UHP has accurate billing information on file. Please confirm that the following information is current in our files:

- Provider Name (as noted on his/her current W-9 form)
- Valid, unique AZ Medicaid ID Number for each provider
- Physical location address (as noted on current W-9 form)
- Billing name and address (if different)
- Tax Identification Number
- Provider NPI

Providers must bill with their NPI in box 24J. B – UHP returns claims when billing information does not match the information that is currently in our files. Claims missing the requirements in bold will be returned, and a notice sent to the provider. Such claims are not considered "clean" and therefore cannot be entered into the system.

Update Billing Information

We recommend that providers notify B – UHP in advance of changes pertaining to billing information. Please submit this information on a W-9 form. Changes to a Provider's Tax Identification Number and/or address are NOT acceptable when conveyed via a claim form.

Claims

Claims eligible for payment must meet the following requirements:

- The member is effective on the date of service
- The service provided is a covered benefit on the date of service
- Referral and prior authorization processes were followed

Unless a contract specifies otherwise, B – UHP processes each form- type (Dental/ Professional/Institutional)- to comply with the standard that 95% of all clean claims are adjudicated within 30 days of receipt of the clean claim and 99% are adjudicated within 60 days of receipt of the clean claim.

B – UHP does not pay:

- Claims initially submitted more than 120 days for contracted providers (unless another timeframe is specified in your contract, in which case the contract prevails) or six (6) months for non-contracted providers after date of service or after the date that eligibility is posted, whichever date is later

Regardless of any subcontract with B – UHP, when one AHCCCS plan recoups a claim because the claim is the payment responsibility of another plan; the provider should file a claim for payment with the responsible plan. You should submit a clean claim to the responsible plan no later than:

- 60 days from the date of the recoupment
- 12 months from the date of service

The responsible plan does not deny a claim based on lack of timely filing if the provider submits the claim within the timeframes above. Claim payment requirements pertain to both contracted and non-contracted providers.

Secondary Insurer

B – UHP is the payer of last resort. It is critical that you identify any other available insurance coverage for the patient and bill the other insurance as primary. For example, if Medicare is primary and B – UHP is secondary.

- File an initial claim with B – UHP if you have not received payment or denial from the other insurer before the expiration of your required filing limit. Make sure you are submitting timely in order to preserve your claim dispute rights.
- Upon the receipt of payment or denial by the other insurer, you should then submit your claim to B – UHP, showing the other insurer payment amount or denial reason, and enclosing a complete legible copy of the remittance advice or Explanation of Payment (EOP) from the other insurer.
- When a member has other health insurance, such as Medicare, a Medicare HMO or a commercial carrier, B – UHP coordinates payment of benefits.
- In accordance with requirements of the Balanced Budget Act of 1997,
- B – UHP pays co-payments, deductibles and/or coinsurance for AHCCCS Covered Services up to the lesser of either B – UHP fee schedule or the Medicare/other insurance allowed amount.
- Claims should be submitted within 60 days of the primary insurance remittance advice date for a first submission to retain appeal rights.

Dual Eligibility Cost-Sharing and Coordination of Benefits

When B – UHP members are enrolled in both programs (B – UHP and B – UCA HMO SNP), any cost sharing responsibilities are coordinated between the two payers. In general, providers only need to submit one claim to B – UHP and benefits will be automatically coordinated.

The Provider shall not bill, nor attempt to collect payment directly for through a collection agency from a person claiming to be AHCCCS eligible without first receiving verification from AHCCCS that the person was ineligible for AHCCCS on the date of service, or that the services provided were not AHCCCS covered services. The provider agrees to comply with A.R.S. 36-2903.01 and A.A.C R9-22-702, which prohibits the Provider from charging, collecting or attempting to collect payment from and AHCCCS eligible person of the financially responsible relative or representative. B – UPH retains the right to offset against any amounts due to Provider any amounts collected from AHCCCS eligible persons contrary to this provision. The provider expressly agrees not to accept cash payments from AHCCCS eligible and enrolled persons.

Injuries due to an Accident

In the event the member is being treated for injuries suffered in an accident, the date of the accident should be included on the claim so that B – UHP can investigate the possibility of recovery from any third-party liability source. This is particularly important in cases involving work-related injuries or injuries sustained as the result of a motor vehicle accident.

Electronic Claims Submission

Submissions Contact Information

Paper Claim Original Submissions, tracers, and resubmissions (excluding dental) should be mailed to:

Health Plan	Mailing Information
Banner – University Care Advantage (B – UCA)	P.O. Box 38549, Phoenix, AZ 85069

Banner – University Family Care/ALTCS (B – UFC/ALTCS)	P.O. Box 37279 Phoenix, AZ 85069
Banner – University Family Care/ACC (B – UFC/ACC)	P.O. Box 35699, Phoenix, AZ 85069

Electronic Claim Submissions (excluding dental) Information

Clearinghouse Resources

Banner is currently connected to two additional clearinghouses – listed below. Providers may subscribe to one of these services and Banner will be able to receive your claims.

SSI Healthcare Revenue Cycle Solutions (supporting both 837I and 837P claims submissions)
Website: https://thessigroup.com/

Office Ally Service Center (supporting both 837I and 837P claims submissions for all lines of business)
Website: https://cms.officeally.com/

Health Plan	Electronic Information
Banner – University Family Care/ACC (B – UFC/ACC) and Banner – University Care Advantage (B – UCA)	Payor ID#: 09830 / 9999 Sub ID#0651 SSI
Banner – University Family Care/ALTCS (B – UFC/ALTCS)	Payor ID#: 66901

Imaging Requirements for Paper Claims

B – UHP uses an imaging process for claims retrieval. To ensure accurate and timely claims capture, please observe the following claims submission rules:

Do's

- Do use the correct PO Box number
- Do submit all claims in a 9" x 12", or larger envelope
- Do type all fields completely and correctly
- Do use black or blue font color only
- Do submit on a proper form . . . CMS 1500 or UB 04
- Claim form MUST BE RED AND WHITE

Don'ts

- Don't submit handwritten claim forms
- Don't use red font on claim forms
- Don't circle any data on claim forms
- Don't add extraneous information to any claim form field
- Don't use highlighter on any claim form field
- Don't submit photocopied claim forms
- Don't submit carbon copied claim forms
- Don't submit claim forms via fax
- Don't use "whiteout" or correction tape/fluid
- Don't cross out, cross through, or alter information to avoid fraud

Clean Claims

A clean claim is one that may be processed without obtaining additional information from the provider of service or from a third party but does not include claims under investigation for fraud or abuse or claims under review for medical necessity, as defined by A.R.S. 36-2904.

A clean claim means a claim received by B – UHP for adjudication, in a nationally accepted format in

compliance with standard coding guidelines and which requires no further information, adjustment, or alteration by the provider of the services in order to be processed and paid by B – UHP. The following exceptions apply to this definition: (a) a claim for payment of expenses incurred during a period of time for which premiums are delinquent; (b) a claim for which fraud is suspected; and (c) a claim for which a third-Party Resource should be responsible.

Non-Clean Claim

Non-clean claims are submitted claims that require further investigation or development beyond the information contained therein. Errors or omissions in claim submissions result in the request for additional information from

the provider or other external sources to resolve or correct data omitted from the bill; review of additional medical records; or the need for other information necessary to resolve discrepancies. In addition, non-clean claims may involve issues regarding medical necessity and include claims not submitted within the filing deadlines.

Encounters versus Claims

What is an Encounter Versus a Claim?

You are required to submit an encounter or claim for each service that you render to a B – UHP member.

If you are the PCP for a B – UHP member and receive a monthly capitation amount for services, you must file a “proxy claim” (also referred to as an “encounter”) on a CMS 1500 for each service provided. Since you will have received a pre-payment in the form of capitation, the “proxy claim” or “encounter” is paid at zero-dollar amounts. It is mandatory that your office submits all encounter data.

B – UHP utilizes the encounter reporting to evaluate all aspects of quality and utilization management, and it is required by AHCCCS and by Centers for Medicare and Medicaid Services (CMS).

- A claim is a request for reimbursement submitted either electronically or by paper for any medical service. A claim must be filed on the proper form, such as CMS 1500 or UB 04. A claim will be paid or denied with an explanation for the denial.
- For each claim processed, an Explanation of Payment (EOP) will be mailed to the provider who submitted the original claim

Claim Adjustment

Providers may resubmit a claim(s) to correct a simple billing error or to request an adjustment if it is believed the payment made by the plan is incorrect.

Procedures for Filing a Claim/Encounter Data

B – UHP encourages all providers to file claims/encounters electronically. See “Electronic Claims Submission” in this manual for more information on how to initiate electronic claims/encounters.

Please remember the following when filing your claim/encounter:

- All documentation must be legible.
- PCPs and all participating providers must submit claims or encounter data for every member visit, even though they may receive a monthly capitation payment
- Provider must ensure that all data and documents submitted to B – UHP/ALTCS, to the best of your knowledge, information, and belief, are accurate, complete, and truthful
- All claims and encounter data must be submitted on either form CMS 1500, UB 04, or by electronic media in an approved format
- Review and retain a copy of the error report that is received for claims that have been submitted electronically, then correct any errors and resubmit with your next batch of claims
- All claims must be received by the plan within 120 days for contracted providers or six months for noncontracted providers after date of service in order to be considered for payment
- Claims received after this time frame will be denied for failure to file timely

Common Billing Errors

In order to avoid rejected claims or encounters always remember the following when filing your claim/encounter:

- Use SPECIFIC CPT-4, HCPCS, or ICD codes
- Avoid the use of non-specific or "catch-all" codes (i.e. 99070)
- Use the most current CPT and HCPCS codes. Out-of-date codes will be denied
- Submit all claims/encounters with the proper provider number
- Submit all claims/encounters with the member's complete AHCCCS ID number.
- Verify other insurance information entered on claim

The 11-digit National Drug Code (NDC) must be reported on all qualifying claim forms when injectable drugs are administered in the office/outpatient setting; excluding applicable vaccines/ immunizations. Failure to submit the exact applicable NDC (do not report 99999999999 to bypass edit) administered to the member will result in front-end rejection and/or denial of claims. When reporting a drug, enter identifier N4, the eleven-digit NDC code, Unit Qualifier, and number of units from the package of the dispensed drug for the specified detail line

- Do not enter a space, hyphen, or other separator between N4, the NDC code, Unit Qualifier, and number of units
- If you are given an NDC that is less than 11 digits, add the missing digits as follows:
    - For a 4-4-2 digit number, add a 0 to the beginning
    - For a 5-3-2 digit number, add a 0 as the sixth digit
    - For a 5-4-1 digit number, add a 0 as the tenth digit
        - Example: N412345678901UN2000

Knowledge Base Auditing Rules

B – UHP's code-auditing software audits against both professional claims and outpatient facility claims. The software's "knowledge base" contains auditing logic and rules based on accepted principles regarding the manner by which medical services should be coded for reimbursement. If the software recommends an auditing action (edit) against a claim line, an edit is applied which corresponds to a coding principle. The code auditing software's knowledge base contains coding principles based on coding standards developed by the Center for Medicare and Medicaid Services (CMS); the American Medical Association's Current Procedural Terminology (CPT Manual, CPT Assistant, CPT Insider View); specialty society guidelines such as the American College of Surgeons, American College of Radiology, and the American Academy of Orthopedic Surgeons. Using a comprehensive set of rules, the code auditing software provides consistent and objective claims review by:

- Accurately applying coding criteria for the clinical areas of medicine, surgery, laboratory, pathology, radiology and anesthesiology as outlined by the American Medical Association's (AMA) CPT manual.
- Evaluating the CPT and HCPCS codes submitted by detecting and documenting coding inaccuracies including, but not limited to, unbundling, up coding, fragmentation, duplicate coding, invalid codes, and mutually exclusive procedures.
- Incorporating Historical Claims Auditing (HCA) functionality which links multiple claims found in a patient's claims history to current claims to ensure consistent review across all dates of service.

Billing Codes

It is important that providers bill with codes applicable to the date of service on the claim. Billing with obsolete codes will result in a potential denial of the claim and a consequent denial in payment.

Submit professional claims with current, valid CPT, HCPCS and ICD-10 codes. Submit institutional claims with valid Revenue codes and CPT or HCPCS (when applicable), ICD-10 and DRG codes.

Providers will also improve the efficiency of their reimbursement through proper coding of a patient's diagnosis.

We require the use of valid ICD-10 diagnosis codes, to the ultimate specificity, for all claims. The highest degree of specificity or detail can be determined by using the Tabular list (Volume One) of the ICD-10 code manual in addition to the Alphabetic List (Volume Two) when locating and designating diagnosis codes.

Claim Payment

Non-clean claims will be adjudicated (finalized as paid or denied) within thirty (30), business days from the date of the original submission. B – UHP sends providers written notification via the Website or an Explanation of Payment (EOP) for each claim that is denied, including the reason(s) for the denial, the date contractor received the claim, and a reiteration of the outstanding information required from the provider to adjudicate the claim.

Note: It is the provider's responsibility to check their audit report to verify that B – UHP has accepted their electronically submitted claim.

Providers may discuss questions with B – UHP Provider Services Representatives regarding amount reimbursed or denial of a particular service; Providers may also submit in writing, with all necessary documentation, including the EOP for consideration of additional reimbursement.

Any response to approved adjustments will be provided with accompanying explanation of payment. All disputed claims will be processed in compliance with the claims payment resolution procedure as described herein. For an explanation regarding how to request an informal claim payment adjustment or file a complaint refer to the process described herein.

Overpayments

If the provider identifies any overpayment by the health plan, provider must, as required under section 6402 (a) of the Patient Protection and Affordable Care Act, report and return any and all overpayment to the health plan within 60 days of the providers identification of any all such overpayment along with a written reason for the overpayment. In reporting and returning any such overpayment, provider must follow all applicable CMS and AHCCCS regulations and guidance. Provider should submit their overpayment and written explanation to Banner – University Health Plans, Refunds: Attention Finance, 5255 E Williams Circle, Ste 2050, Tucson, Arizona 85711.

Billing Forms

Providers submit claims using standardized claim forms whether filing on paper or electronically. Submit claims for professional services and durable medical equipment on a CMS 1500. The following areas of information on CMS 1500 claim forms are common submission requirements of a clean claim accepted for processing:

- Full member name
- member's date of birth
- A valid member identification number
- Complete service level information
- Date of Service
- Diagnosis
- Place of Service
- Procedure Code (appropriate CPT, ICD-10 codes)
- Charge Information and units
- Servicing provider's name, address, taxonomy code, and NPI number
- Provider's federal tax identification number
- All mandatory fields must be complete and accurate
- Submit claims for hospital-based inpatient and outpatient services as well as swing bed services on a UB 04.

Completing a CMS 1500 Form

All medical claims are to be submitted on the CMS 1500. The CMS 1500 claim form is required for:

- All professional services "including specialists"
- Individual practitioners

- Non-hospital outpatient clinics
- Transportation providers
- Ancillary Services
- Durable Medical Equipment
- Non-institutional expenses
- Professional and/or technical components of hospital- based physicians and Certified Registered
- Nurse Anesthetists (CRNAs)
- Home Health Services

The CMS 1500 must provide all requested information to receive payment for services rendered. Failure to do so may result in delayed or denied reimbursement. Please refer to the AHCCCS manual for further detail.

B – UHP accepts all nationally approved and recognized coding as defined by CMS national correct coding initiatives and guidelines.

Completing a UB 04 Claim Form

A UB 04 is the only acceptable claim form for submitting inpatient or outpatient hospital (technical services only) charges for reimbursement by B – UHP/ALTCS. Please refer to the AHCCCS manual for specific details.

In addition, a UB 04 is required when billing for nursing home services, swing bed services with revenue and occurrence codes, inpatient hospice services, ambulatory surgery centers (ASC) and dialysis services.

UB 04 Inpatient Documentation

The following information should be submitted along with the UB 04:

- Consent forms for hysterectomies, abortions, and sterilizations UB 04 Hospital Outpatient Claims/Ambulatory Surgery
- The following information applies to outpatient and ambulatory surgery claims:
- Professional fees must be billed on a CMS 1500 claim form
- Include the appropriate CPT-4 code next to each revenue code

Billing the Member

In accordance with State and Federal regulations providers are prohibited from billing members for covered services. Arizona Administrative Code R9-22-702 states in part, "an AHCCCS registered provider shall not do either of the following, unless services are not covered or without first receiving verification from the Administration [AHCCCS] that the person was not an eligible person on the date of service:

- Charge, submit a claim to, or demand or collect payment from a person claiming to be AHCCCS eligible; or
- Refer or report a person claiming to be an eligible person to a collection agency or credit reporting agency"

B – UHP members should not be billed or reported to a collection agency for any covered service your office provides. Claims should be submitted directly to the B – UHP Claims Department. Submission must include the appropriate claim form. Providers must comply with the time submission requirements of Arizona Revised Statute § 36-2904 H. All covered health care providers must have a National provider Identifier (NPI) number and registered with AHCCCS. Claims cannot process for covered health care providers who do not have a NPI or are not registered with AHCCCS. If providers do not have the required NPI necessary forms and instructions may be obtained by contacting the National Plan and Provider Enumeration System (NPPES).

If not registered with AHCCCS, providers can go to the AHCCCS website for instructions on how to apply. Please note, all future billings of B – UHP members for covered services may result in a fraud referral regarding your billing practices to the AHCCCS Office the Inspector General

Encounter Validation Studies

The Centers for Medicare and Medicaid Services (CMS) requires Arizona Health Care Cost Containment System (AHCCCS) to conduct encounter validation studies as a condition for receiving federal Medicaid funding. AHCCCS requires the Contractor to conduct encounter validation studies of their providers.

- The purpose of encounter validation studies is to compare recorded utilization information from a clinical record or other source with submitted encounter data. The review "validates" or confirms that covered services are encountered timely, correctly and completely. The purpose of this section is to:
    - Inform providers that encounter validation studies may be performed by AHCCCS, the Contractor and/or AHCCCS staff
    - Convey the AHCCCS' expectation that providers cooperate fully with any encounter validation review that AHCCCS, the Contractor and/or AHCCCS may conduct.

Criteria Used in Encounter Validation Studies

The criteria used in encounter validation studies include timeliness, correctness, and omission of encounters, in addition to encountering for services not documented in the medical record. These criteria are defined as follows:

- Timeliness -The time elapsed between the date of service and the date that the encounter is received. The Contractor is required to provide specific information for providers on Timeliness standards;
- Correctness - A correct encounter contains a complete and accurate description of a covered behavioral health service provided to a person. Correctness errors frequently identified include, but are not limited to, invalid procedure or revenue codes and ICD-10 diagnoses not reported to the correct level of specificity;
- Omission - Provider documentation shows a service was provided; however, an encounter was not submitted;
- Lack of Documentation

In addition, assessment compliance must be monitored by the Contractor. Providers may be subject to sanctions for failure to meet the criteria used in encounter audits, which may include timeliness, correctness, and omission of encounters.

Payment Responsibilities

General Requirements Regarding Payment for Physical and Behavioral Health Services

1. Regardless of setting, if physical health services are listed on a claim with a Principal Diagnosis of behavioral health, the Behavioral Health Entity is responsible for payment of covered physical health services as well as behavioral health services.
2. Regardless of setting, if behavioral health services are listed on a claim with a Principal Diagnosis of physical health, B – UHP is responsible for payment of covered behavioral health services as well as physical health services.
3. Payment responsibility for professional services associated with an inpatient stay is determined by the Principal Diagnosis on the professional claim. Payment responsibility for the inpatient facility claim and payment responsibility for the associated professional services is not necessarily the same entity. Payment of the professional claim shall not be denied by the responsible entity due to lack of authorization/notification of the inpatient stay regardless of the entity which authorized the inpatient stay.
4. Payment for an emergency department facility claim of an acute care facility including triage and diagnostic tests, when there is no admission to the facility is the responsibility of B – UHP regardless of the Principal Diagnosis on the facility claim. Payment responsibility for professional services associated with the emergency department visit is determined by the Principal Diagnosis on the professional claim. Payment responsibility for the emergency department visit and payment responsibility for the associated professional services is not necessarily the same entity. Payment of the professional claim shall not be denied by the responsible entity due to lack of notification of

the emergency department visit.

In addition to identifying exceptions, Attachment A, also provides detail and clarification regarding payment responsibility in specific scenarios. All AHCCCS services shall be medically necessary, cost effective, and federally and state reimbursable. For specific information on inpatient reimbursement rates refer to A.A.C. R9-22-712.60 et seq. B – UHP may enter into contracts with providers that delineate other payment terms, including responsibility for payment.

Specific Circumstances Regarding Payment for Behavioral Health Services

B – UHP is responsible for reimbursement of services associated with a PCP visit for the diagnosis and treatment of behavioral health conditions within the PCP's scope of practice. Such treatment shall include but not be limited to substance use disorders, depression, anxiety, and/or ADHD. PCPs who treat members with these behavioral health conditions may provide medication management services including prescriptions, laboratory, and other diagnostic tests necessary for diagnosis, and treatment.

B – UHP is responsible for payment of medication management services provided by the PCP while the member may simultaneously be receiving counseling and other medically necessary rehabilitative services from the Behavioral Health Entity. For purposes of medication management, it is not required that the PCP be the member's assigned PCP.

B – UHP is responsible for payment of claims with behavioral health principal diagnoses that are related to communication disorders usually diagnosed in infancy, childhood, or adolescence. These behavioral health conditions require services from non-behavioral health provider types such as speech therapists or other physical health providers and are therefore considered physical health services.

B – UHP shall coordinate with the Behavioral Health Entity when both physical and behavioral health services are rendered during an inpatient stay and B – UHP is notified of the stay. Such coordination shall include, but is not limited to, communication/collaboration of authorizations, determinations of medical necessity, and concurrent reviews.

When the Principal Diagnosis on an inpatient claim is a behavioral health diagnosis, the Behavioral Health Entity shall not deny payment of the inpatient facility claim for lack of authorization or medical necessity when the member's Enrolled Entity authorized and/or determined medical necessity of the stay through concurrent review, such as when the admitting diagnosis is a physical health diagnosis, payment of pre-petition screening and court ordered evaluation services is the fiscal responsibility of a county, refer to ACOM Policy 437. For payment responsibility for other court ordered services such as driving under the influence and domestic violence refer to ACOM Policy 423.

RBHA Contractors are responsible for the payment of crisis stabilization services for all individuals within their assigned GSA(s), including individuals in the Federal Emergency Services Program (FESP). Crisis services include telephone, community based mobile response, and facility-based stabilization (including observation and detox not to exceed 24 hours) along with payment for non-emergent medical transportation (NEMT) to a crisis stabilization provider and any associated covered services delivered by the crisis provider in these settings during the first 24 hours. B – UHP is responsible for the payment of all medically necessary services related to a crisis episode after the initial 24 hours covered by the RBHA Contractor (which may include follow up stabilization services). B – UHP shall ensure timely follow up and care coordination, whether the member received crisis services within or outside of the GSA served by B – UHP.

B – UHP is responsible for payment of all emergent transportation provided during the initial 24 hours of a crisis episode. NEMT from a crisis service provider to another level of care, regardless of the timing within the crisis episode.

Reimbursement

Coordination of Benefits and Third-Party Liability

The AHCCCS plans have members who receive medical and/or behavioral health services, where a third party other than AHCCCS is responsible for payment of services. AHCCCS plans are the payor of last resort unless it is specifically prohibited by applicable state or federal law.

B – UHP applies Coordination of Benefits (COB) and Third Party Liability (TPL) and identifies claims that have a TPL. B – UHP will deny payment for claims when a non-approved entity is identified as primary

payor. B – UHP will require an Evidence of Benefit (EOB) or Remit Advice (RA) from a primary payer to coordinate benefits once the primary payer has adjudicated the claim. B – UHP may further review the claim for medical necessity and decide based on B – UHP criteria to approve or deny claim(s). An exception where B – UHP may pay for services can occur when the primary payer has an exclusion to that service and B – UHP deems the service as medically necessary. If primary payor does not cover the service, B – UHP may waive the need for an EOB or RA.

At times, B – UHP may erroneously pay for services that are the responsibility of a different payer or TPL. During these occurrences, B – UHP will re-adjudicate the claim(s) and notify the provider, through an EOB or RA of a recoupment of a previously paid claim(s). B – UHP may recover payment up to 1 year from the date of payment; the recovery timeframe may extend if known TPL information was withheld.

Permissible payer of last resort after AHCCCS:

- Indian Health Services (IHS/638), contract health, preferred referred care
- Title IV-E
- Arizona Early Intervention Program (AzEIP)
- Local Educational agencies providing services under the Individuals with Disabilities Education Act under 34 CFR Part 300
- Entities and contractors of entities providing services under grants awarded as part of the HIV Health Care Services Program under 42 C.S.C. 300ff et seq.,
- The Arizona Refugee Resettlement Program operated under 45 CFR Part 400, Subpart G
- Substance Abuse Block Grant (SABG)
- Mental Health Services Block Grant (MHBG) and any other grants.

Cost Sharing

B – UHP has members enrolled who are eligible for both Medicaid and Medicare. These members are referred to as “dual eligible”. The AHCCCS plan claims will be paid according to the AHCCCS Medicare Cost Sharing Policy. B – UHP will have no cost sharing responsibility if the Medicare payment matches or exceeds what would have been paid per the provider’s contract. This also applies to members enrolled in other commercial insurance plans.

B – UHP coordinates the payment of both physical and behavioral health claims for members who are not assigned to the RBHA and those assigned to us through the Complete Care model. Payment for AHCCCS covered behavioral health and physical health services is determined by the primary diagnosis appearing on a claim, except in limited circumstance as described in AHCCCS ACOM 432 – Benefit Coordination and Fiscal Responsibility for Behavioral Health Services and Physical Health Services. This Matrix can be used as a tool to identify the responsible payer.

Additional information concerning benefit coordination and fiscal responsibilities for both behavioral health and physical services may be obtained at:
https://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/400/432A.pdf

Medical Claims Review

PharmDs and RN Claims Reviewers work collaboratively with other departments to help manage resolution of claim issues and minimize administrative burden between the provider and the health plan. Reasons for sending a claim for medical review include but are not limited to; authorization date and approval discrepancies, claim codes or units do not match, invalid units, unlisted codes, Plan or CMS exclusions or non-covered services, duplicate charges, duplicate provider, duplicate claims, multiple procedures, overlapping claims, unbundling, and modifier required/invalid modifier issues.

The medical reviewers perform an independent and comprehensive review of a claim issue using clinical and/or coding expertise to assess and resolve the issue using the appropriate application of criteria. The reviewer is responsible to:

- Correctly identify missing or inaccurate information
- Verify accuracy of coding and billing in accordance with national coding guidelines

- Verify claim is compliant with insurance policies, industry standards and regulations
- Review clinical information to evaluate medical necessity and appropriateness of services and procedures listed in claims submissions
- Identify and report quality of care and utilization issues

There may be times an issue cannot be resolved without receiving additional information, in which case the provider may be requested to send a resubmission with the requested information.

Explanation of Benefits (EOBs)

Remittance Advice

Remittance Advice (RA) uses the information from your claim and the information from the claims processing system used by B – UHP to provide you information specific to each claim you submitted. You can access this information electronically, or obtain a paper version with your paper check, to help you reconcile your outstanding accounts receivable to what the health plan determined for each claim. NOTE- if you have access to the Zelis Provider Portal at https://provider.zelispayments.com, you can access copies of your paper RA as well. If you are not already a Zelis customer for ePayments using ACH or Virtual Payment Cards, or electronic remittances (835, Excel, PDF), contact a Zelis Provider Enrollment Advisor today at (855) 496-1571 or visit https://www.zelis.com/provider-solutions/provider-enrollment for more information

The RA contains the following:

1. Date of remittance advice
2. Name of Plan/Program member is enrolled with
3. Internal number assigned to provider
4. Name/address of service provider
5. Member name
6. Member identification number
7. Referral/Authorization number
8. Referral/Authorization type
9. From – To service dates
10. Claim number
11. Service provider account number
12. Procedure code
13. Disposition reason (denial, contract adjustment, prompt pay discounts, etc.)
14. Description of procedure code
15. From – To service dates
16. Total billed amount per service line
17. Amount rejected per service line
18. Member deductible amount per service line
19. Member copay amount per service line
20. Amount approved for payment per service line
21. Amount withheld (for contracts with a withhold provision)
22. Net amount of payment per service line
23. Breakdown of adjudication (total lines for entire claim appear **claims totals**)
24. Total claim for member

25. Total amount billed for all service lines
26. Total amount rejected for all service lines
27. Total amount applied to member deductibles for all service lines

Total amount applied to member copays for all service lines

28. Total amount approved for payment to all service lines
29. Total amount withheld for all service lines
30. Net amount for claims for all service lines

The Remittance Advice also includes appeal rights, instructions, and address for resubmission.

Remittance Notices

Checks and electronic funds transfers (EFT) are processed on a minimum of a bi-weekly basis. Written and electronic notice of claims payment or denial will be reported on your remittance advice or 835 file based on your contract. B – UHP has a partnership with Zelis, where providers are given access to the Provider Portal at https://provider.zelispayments.com. This is a 24/7 accessible website that contains Remittance Advice, EOB, EFT/ ERA Information. If you are not already a Zelis customer for ePayments using ACH or Virtual Payment Cards, or electronic remittances (835, Excel, PDF), contact a Zelis Provider Enrollment Advisor today at (855) 496-1571 or visit https://www.zelis.com/provider-solutions/provider-enrollment for more information .

Payer IDs

Banner – University Family Care/ACC

PO Box 35699
Phoenix, AZ 85069-7169
Electronic ID: 09830

Banner – University Family Care/ALTCS

PO Box 37279
Phoenix, AZ 85069-7169
Electronic ID: 66901

Children's Services

EPSDT

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screening program is a comprehensive visit for the prevention, treatment, correction, and improvement of physical and behavioral health conditions for all eligible members under 21 years of age. EPSDT services include screening services, vision services, dental services, hearing services and other medically necessary mandatory and optional services for eligible members under 21 years of age.

Screenings include:

- A comprehensive documented history of an unclothed physical exam, growth, development, Nutrition and behavioral health assessment will be performed by provider according to the AHCCCS EPSDT Periodicity Schedule.
- Developmental Surveillance: Developmental surveillance shall be performed by the PCP (with anticipatory guidance provided) at each EPSDT / Well-Child visit. Use of the most recent developmental milestones through the "Learn the Signs. Act Early." program (regularly updated and revised by the CDC and AAP).
- Developmental Screenings:
  - Developmental Screening is a separately billable service by PCPs caring for EPSDT-aged (birth through year 20) members.
  - PCPs who bill for developmental screening shall have current training in use and scoring of the Developmental Screening tool being used, as indicated by the American Academy of Pediatrics (AAP). Training resources can be found at www.azdhs.gov/clinicians/training-opportunities/developmental/index.php.
  - Any abnormal developmental screening finding shall result in appropriate referrals and follow-up.
  - A copy of the completed developmental screening tool shall be kept in the medical record.
  - General Developmental Screening shall be completed at the 9-, 18- and 30-month EPSDT visits. Autism Spectrum Disorder (ASD) specific screening should occur at the 18 and 24-month EPSDT visits.
  - Accepted tools are described in the CMS Core Measure Developmental Screening in the First Three Years of Life measure specifications and shall be used for screenings.
- Behavioral Health Screening and Services:
  - PCPs may provide behavioral health (BH) services to eligible EPSDT members, within their scope of practice.
  - The following screenings are separately billable (refer to the Medical Coding page on the AHCCCS website).
    - Adolescent Suicide screening shall be performed at each annual EPSDT / Well-Child visit beginning at 10 years of age, using a standardized, norm-referenced screening tool specific for suicide and depression. Positive screenings require timely and appropriate referrals for further evaluation and services.
    - Postpartum Depression Screening of the birthing parent, using a standard norm-criterion referenced screening tool, shall be performed during the one-, two-, four- and six-month EPSDT / Well-Baby visits. Positive screening results require referral to appropriate case managers and services at the respective maternal health plan
    - Adolescent Substance Use Disorder (SUD) screening consisting of a standard criterion-referenced screening tool specific for substance use shall be performed at annual EPSDT visits beginning at 12 years of age. Positive screening results require

appropriate and timely referral for further evaluation and service provision

  - A copy of all screening documentation shall be kept in the member's medical record.
  - American Indian/Alaska Native members may receive BH services through an Indian Health Service or tribally owned and/or operated 638-facility regardless of health plan enrollment or behavioral health assignment.

- Vision and hearing tests should be completed during EPSDT visits according to the AHCCCS EPSDT Periodicity Schedule.
- Providers will conduct/order Laboratory tests, including blood lead testing and assessment appropriate to EPSDT eligible member's age and risk.
- Oral Health screening conducted by provider is intended to identify oral pathology, including but not limited to tooth decay, oral lesions, and application of fluoride varnish. Provider's may apply fluoride varnish to eligible EPSDT members who are at least six months of age with one or more erupted teeth, with recurrent applications up to once every three months, until up to five years of age.
- Immunizations are covered for all EPSDT eligible members, as specified in the Center for Disease Control and Prevention (CDC) recommended childhood immunization schedule. Providers will be registered as a Vaccines for Children (VFC) provider, use VFC vaccines and shall document immunizations into Arizona State Immunization Information System (ASIIS).

VFC

Through the Vaccine for Children (VFC) program, the Federal and State government purchases and makes vaccines available to all VFC registered providers at no cost for children under the age of nineteen (19) years old. Any provider licensed by the state of Arizona to administer immunizations must register with Arizona Department of Health Services (ADHS) as a VFC provider annually to receive these free vaccines. Any B – UHP provider that fails to enroll or disenrolls from the VFC program and assigned B – UHP members under nineteen (19) years of age, their members will be disenrolled from their care and assigned to a provider enrolled in the VFC program. It is the providers responsibility to coordinate with the Arizona Department of Health Services VFC program for delivery of immunization services.

EPSDT Forms Submission Requirements:

- Providers shall use **AHCCCS EPSDT Clinical Sample Templates** (formerly called *EPSDT Tracking Forms*), or their Electronic Medical Record (EMR) to document EPSDT / Well-Child Visits.
- Providers shall send a signed copy of the EPSDT / Well-Child visit documentation (EPSDT form or EMR equivalent) to the health plan.
- Timely submission of EPSDT visit documents to BUHP supports:
  - Member outreach by the plan, for follow-up and facilitation of referrals made during your care.
  - Identification and addressing of key screenings not yet completed.
  - Resolution of potential barriers to care.
  - Engagement with other health plan teams / resources to support the member and family.
- Submitting EPSDT / Well-Child Visit documents:
  - Secure Email: BUHPEPSDTForms@BannerHealth.com
  - Secure Fax: 520-874-7184
  - US Mail:
    Banner – University Health Plans
    Attn: EPSDT
    5255 E. Williams Circle, Ste 2050
    Tucson, AZ 85711

Nutritional Assessment and Services for EPSDT-Aged Members

Nutritional Assessments

Banner Medicaid Health Plans covers the assessment of nutritional status provided by the member's PCP as part of the EPSDT / Well-Child visit screenings, and on an inter-periodic basis as determined medically necessary by the member's PCP.

Nutritional assessment is a separately billable service by the PCPs who care for EPSDT-aged members.

The Health Plan also covers nutritional assessment of EPSDT-aged members, provided by a registered dietician, when ordered by the member's PCP. This includes EPSDT members who are identified as underweight or overweight. Prior Authorization is not required for nutritional assessments provided by either a PCP, or a Registered Dietician when ordered by a PCP.

Nutritional Therapy

Banner Medicaid Health Plans covers nutritional therapy for EPSDT-aged members on an Enteral Nutrition, Total Parenteral Nutrition (TPN), or oral basis when determined medically necessary to provide either complete daily dietary requirements, or to supplement daily nutritional / caloric intake.

Prior Authorization is required for Commercial Oral Nutritional Supplements, enteral nutrition, or parenteral nutrition unless:

- The member is currently receiving enteral/parenteral nutrition for which PA has already been obtained.
- For the first 30 days with members who require oral supplemental nutritional feedings ona temporary basis due to an emergent hospitalization (i.e., post-hospitalization).

The Health Plan covers nutritional therapy for WIC (Women, Infants and Children)-eligible children who qualify for nutritional therapy due to a medical condition. This includes:

- Formula types which are deemed medically necessary (not based on brand preference) and are not provided through WIC.
- For infants (age birth – 1 year) requiring formulas above the amount provided by WIC. An AHCCCS Certificate of Medical Necessity for Commercial Oral Nutritional Supplements (EPSDT-Aged Members – Initial and Ongoing Requests) form [AMPM 430, Attachment B] must be submitted directly to the health plan's PA department, for the amount of formula that exceeds what is provided by WIC.
- For infants and children under 5 years of age, medically necessary formulas which are not provided by WIC. An AHCCCS Certificate of Medical Necessity for Commercial Oral Nutritional Supplements (EPSDT-Aged Members – Initial and Ongoing Requests) form [AMPM 430, Attachment B] must be submitted directly to the health plan.

Commercial Oral Nutritional Supplements:

- Medical necessity for commercial oral supplements for EPSDT-aged members must be determined on an individual basis by the PCP or Specialist, using the following criteria as specified in [AMPM Policy 430 Early and Periodic Screening, Diagnostic, and Treatment Services].
    A. AMPM 430 Attachment B must indicate which criteria were met when assessing the medical necessity of providing commercial oral nutritional supplements.
        1. The member diagnosed with a chronic disease or condition, is below the recommended Body Mass Index (BMI) percentile (or weight-for-length percentile for members less than two years of age) for the diagnosis per evidence-based guidance as issued by the American Academy of Pediatrics, and there are no alternatives for adequate nutrition.
        2. OR – The member must meet at least two of the following criteria:
            a. Member is at or below the 10th percentile for weight-for-length or BMI, on the appropriate growth chart for their age and gender, as recommended by the Centers for Disease Control (CDC), for 3 months or more.
            b. Member has reached a plateau in growth and / or nutritional status for

more than 6 months, or more than 3 months if member is an infant less than 1 year of age.

c. Member has already demonstrated a medically significant decline in weight within the 3-month period prior to the assessment.

d. Member is able to consume / eat no more than 25% of his/her nutritional requirements from age-appropriate food sources.

3. Additionally - Both of the following requirements must be met:

a. The member has been evaluated and treated for medical conditions that may cause problems with growth (such as feeding problems, behavioral conditions, or psychosocial problems, endocrine or gastrointestinal problems, etc.),

b. AND, the member has had a trial of higher caloric foods, blenderized foods, or commonly available products that may be used as dietary supplements for a period no less than 30 days in duration.

c. If it is determined that a trial of higher caloric foods would be detrimental to the member's overall health, the provider may submit Policy 430, Attachment B, along with supporting documentation demonstrating the risk posed to the member, for the Banner Medicaid Health Plans' Medical Director or designee to consider in approval determination of the provider's prior authorization request.)

B. Supporting documentation
Supporting documentation must accompany the Certificate of Medical Necessity for Commercial Oral Nutritional Supplements. This documentation must demonstrate that the member meets all the required criteria and includes:

a. Documentation demonstrating that nutritional counseling has been provided as a part of the health risk assessment and screening services provided to the member by the PCP or Specialist, or through consultation with a registered dietician.

b. Clinical notes or other supporting documentation dated within three months of the request, providing a detailed history and thorough physical assessment demonstrating evidence of the member meeting all required criteria, as indicated on Attachment B.

c. The physical assessment shall include the member's current & past height/weight percentiles and BMI percentile if the member is two years of age or older.

d. Documentation detailing alternatives that were tried in effort to boost caloric intake and/or change food consistencies to have proven unsuccessful in resolving the nutritional concern identified, as well as member adherence to the prescribed dietary plan/alternatives attempted.

- Ongoing Requests: Subsequent submissions for all nutritional therapies, shall include a clinical note or other supporting documentation dated within three months of the original request, that includes the member's overall response to the supplemental therapy and justification for continued supplement use. This shall include the member's tolerance to formula, recent hospitalizations, current height/weight percentiles, and BMI percentile if member is two years of age or older. Documentation demonstrating encouragement and assistance provided to the parent/guardian in weaning the member from supplemental nutritional feedings should be included, when appropriate.
- Follow-up requirements (all aged members): Members receiving nutritional therapy shall be physically assessed by the member's PCP, specialty provider, or registered dietitian at least annually.
- The PCP or Specialist must submit the Certificate of Medical Necessity for Commercial Oral Nutritional Supplements (EPSDT Aged Members – Initial or Ongoing Requests) [AHCCCS Policy

430, Attachment B], directly to the Banner Medicaid Health Plans, to obtain the required Prior Authorization.

Metabolic Medical Foods: The health plan covers metabolic medical foods used to treat inherited metabolic disorders (rare genetic conditions in which normal metabolic function is inhibited by a deficiency in a critical enzyme), such as metabolic formulas or modified low protein foods which are produced/manufactured specifically for persons with a qualifying metabolic disorder and are not generally used by persons without qualifying disorders. Qualifying conditions, specific requirements and limitations are detailed in the [AMPM Policy 310-GG, Section III., C. Metabolic Medical Foods].

AzEIP

Screening/ Identification

B – UHP strives to remove barriers to developmental screening and evaluation services for our youngest AHCCCS members ages 0-3 years old, to ensure that early developmental opportunities are maximized. During the EPSDT visit the PCP will determine the child's developmental status using appropriate developmental screening tools and discussion with the parent/guardian/designated representative.

Primary Care Providers (PCP) Initiated Service Request

PCPs are required to complete an EPSDT comprehensive unclothed physical exam according to the AHCCCS EPSDT Periodicity Schedule. When concerns about a child's development are identified, the PCP shall provide the member's parents/legal guardian with appropriate anticipatory guidance. The PCP may initiate an evaluation with the Arizona Early Intervention Program (AzEIP) program. A prior authorization is not required for AzEIP evaluation and services from any in network AzEIP provider. All out of network AzEIP providers will require a prior authorization with medical documentation and demonstration of continuity of care, as applicable. All medically necessary services to treat or ameliorate physical and behavioral health disorders, a defect, or a condition will be approved. PCP's may submit a referral to the AzEIP central office for evaluation, support and education, via the online AzEIP portal: https://azeip.azdes.gov/AzEIP/AzeipRef/Forms/Categories.aspx or by calling (888) 592-0140.

- If the PCP identifies potential developmental delays, the PCP can also refer the member to a specialist in the field that the delay was noted.
- The PCP shall document the referral to AzEIP and/or other specialist provider(s) on the EPSDT form (or provider's EMR equivalent) prior to submission to health plan. Once the EPSDT form is received, the Banner University Family Care EPSDT coordinator will review the necessary records to determine if an evaluation by the specialist or AzEIP has been completed. If there are no claims to indicate an evaluation has been performed, the Health Plan's AzEIP Coordinator will contact the AzEIP central referrals coordinator, the member and/or the PCP to determine the referral status and facilitate completion.

Evaluation/ Services

When needed services are identified for an EPSDT eligible child:

- AzEIP screens and conducts an evaluation to determine the child's eligibility for services
- AzEIP will obtain parental/guardian/designated representative consent to request and release records to/from B – UHP and the child's PCP
- If a child is determined to be AzEIP eligible, an AzEIP provider in conjunction with the child's family, will create an Individual Family Service Plan (IFSP) that identifies (a) the child's current level of development, (b) the child's outcomes, (c) the services needed to support the child and his/her family to reach those outcomes, and (d) the start date for each intervention
- The AzEIP provider will fax or Email the AzEIP EPSDT Member Service form and copies of the evaluation/developmental summaries completed as part of the IFSP process to B – UHP, within two (2) business days of completing the IFSP
- B – UHP will enter the prior authorization into our system within one (1) business day of receipt of the request
- B – UHP will fax or Email the AzEIP EPSDT Member Service form and copies of the evaluation/developmental summaries completed as part of the IFSP process to the child's PCP

within two (2) business days

- The PCP will determine which services are medically necessary based on a review of the AzEIP EPSDT Member Service form and copies of the evaluation/developmental summaries completed as part of the IFSP process.
- The PCP will return the signed AzEIP Service Request form with his/her determination of medically necessary services, within ten (10) business days of receipt from B – UHP. The PCP determination will include the medically necessary requested services. B – UHP will fax/email the completed AzEIP EPSDT Request form for services to the AzEIP provider and PCP advising them that of: (a) services approval and (b) identified authorized AzEIP provider, the frequency, duration, and the services start and end dates.

If PCP deems services as Not Medically Necessary, B – UHP will notify AzEIP provider within two (2) business days of receiving the PCP's determination that medical necessity has not been established.

- B – UHP will send a Notice of Adverse Benefit Determination (NOA) to the child's PCP, parent/guardian/ designated representative, notifying them of denied services
- B – UHP will return the AzEIP EPSDT Request form to the AzEIP provider indicating services were deemed not medically necessary by the child's PCP.

When services are determined to be no longer medically necessary, the IFSP will be amended by the IFSP team, which may include:

- Non-medically necessary services covered by AzEIP
- Changes made to IFSP outcomes and IFSP services, including payer, setting, etc.

The IFSP will be reviewed at least every six (6) months by the AzEIP provider, family and other IFSP team members.

- If services are deleted or added during an annual IFSP or IFSP review:
  - The AzEIP provider will notify B – UHP and PCP within two (2) business days of the IFSP review
  - For services added, the AzEIP provider's notification to B – UHP will initiate the medically necessary determination and prior authorization process and authorization of requested services

B – UHP will not delay or postpone the initiation of medically necessary EPSDT services while waiting for AzEIP prior authorization or the IFSP process. AzEIP services are required to be initiated within 45 days of the IFSP origination date.

For members who do not qualify for AzEIP services:

- If the AzEIP evaluation report indicates that the child does not have a 50% developmental delay, or otherwise is not eligible for AzEIP program enrollment, the Banner Medicaid Health Plan will refer all such members to our Maternal Child Health department. The appropriate Coordinator or Care Manager will initiate targeted member outreach to review member/family needs, coordinate care and services, review availability and applicability of other potential resources and community agencies, evaluate for barriers to care and provide any other needed assistance.
- Additional support is also available through other programs such as:
  - Raising Special Kids (RSK)
    RSK, Arizona's Parent and Training Information Center, has identified many different resources for members who don't qualify for AzEIP but may still need additional support. A referral to this program can be made by visiting https://raisingspecialkids.org/refer-a-family/
  - Directory of Resources
    AzEIP's Central Directory of Resources includes the following for infants and toddlers and their families:
    - Public and private early intervention services, resources, and experts available in the state

  - Professional and other groups including parent support, training, and information centers
  - Research and demonstration projects being conducted in the state
  - More information can be found at: https://des.az.gov/services/developmental-disabilities/early-intervention/resources

- For Children Over the Age of 3
  If the PCP is concerned about the member's development and the member is between the ages of 3 (or within 45 days of their third birthday) and 21 years, the PCP can make a referral to the District of Residence by reviewing the AZ Child Find Requirements and Screen Information and submitting the referral form.

More information can be found at https://www.azed.gov/specialeducation/az-find

Dental Services

Oral health screenings are part of an EPSDT visit completed by a Primary Care Provider (PCP), in accordance with the AHCCCS EPSDT Periodicity Schedule (refer to AMPM Policy 430 Attachment A). Oral health screenings are intended to identify gross dental or oral lesions. Oral health screenings do not substitute for a dental examination by a dental provider, which are required in accordance with the AHCCCS Dental Periodicity Schedule (refer to AMPM Policy 431 Attachment A). Members shall be referred for appropriate services based on needs identified through screening processes for routine dental care.

Dental referrals are to be documented on the EPSDT form (EPSDT Clinical Sample Template). Appointments for urgent oral health findings, shall be expedited as the member's health condition requires, but no longer than three (3) business days of the original referral request. Appointments for routine dental care should be within forty-five (45) calendar days of request.

PCPs that have completed the AHCCCS required training can apply fluoride varnish during an EPSDT visit for members as early as six (6) months of age and at least one (1) erupted tooth. Fluoride varnish may be reapplied every three (3) months during an EPSDT visit, until member's fifth (5th) birthday.

Application of fluoride varnish by the PCP does not take the place of an oral health visit.

AHCCCS recommended fluoride varnish application training is located at http://www.smilesforlifeoralhealth.org. The website references training that covers caries- risk assessment, fluoride varnish, and counseling. After completing the required training, providers must submit a copy of their certificate to Banner – University Health Plan (B – UHP), as this is required prior to payment.

Covered Dental Services:

1. Emergency dental services
   a. Treatment for pain, infection, swelling, and/or injury
   b. Extraction of painful, infected, non-restorable primary and permanent teeth, as well as retained primary teeth
   c. General anesthesia, conscious sedation or minimal sedation in which members respond normally to verbal commands, when local anesthesia is not indicated or when management of the member requires.
2. Preventative dental services
   a. Diagnostic Services
      i. Two (2) comprehensive and periodic oral exams per year
      ii. Two (2) oral prophylaxis and fluoride treatments per year for all members up to twenty-one (21) years old.
      iii. For members up to five (5) years of age, fluoride varnish may be applied four (4) times a year (once every three months).
      iv. Additional exams or treatments must be deemed medically necessary and may require prior authorization.

b. Panoramic or full mouth x-rays, supplemental bitewing x-rays, and occlusal or periapical films, as medically necessary and following the recommendations of the American Academy of Pediatric Dentistry (AAPD) for diagnosis of dental abnormalities and/or pathology

c. Panorex films as recommended by the AAPD, up to a maximum times per provider for children ages three (3) to twenty (20) years old. Additional films limited to medical necessity.

d. Preventative services, which include:

   i. Oral prophylactic care by a dental provider or dental hygienist that includes education for self-care oral hygiene instruction to member/ Health Care Decision Maker/ or designated representative

   ii. Application of topical fluoride and fluoride varnish

   Dental sealants for first (1st) and second (2nd) molars twice per first (1st) or second (2nd) molar per provider/ location, allowing for three (3) years between application up to fifteen (15) years old.

   iii. Additional dental sealants for first (1st) and second (2nd) molar must be deemed medically necessary and may require prior authorization.

   iv. Space maintainers when posterior primary teeth are lost and deemed medically necessary and may require prior authorization.

3. Therapeutic dental services are covered when medically necessary but may require prior authorization. Services include, but are not limited to:

   a. Periodontal procedures, scaling, root planning, curettage, gingivectomy, and osseous surgery

   b. Crowns

   c. Endodontic services including pulp therapy for permanent and primary teeth, except third molars (unless a third molar is functioning in place of a missing molar)

   d. Restoration of carious permanent and primary teeth with accepted dental materials other than cast or porcelain restorations unless the member is eighteen (18) to twenty-one (21) years of age and has had endodontic treatment

   e. Restoration of anterior teeth for children under the age of five (5) years old, when medically necessary. Children five (5) years and over with primary anterior tooth decay shall be considered for extraction, if presenting with pain or severely broken-down tooth structure, or be considered for observation until the point of exfoliation as determined by the dental provider

   f. Removable dental prosthetics

   g. Orthodontic services and orthognathic surgery are covered only when medically necessary and determined to be the primary treatment of choice or an essential part of an overall treatment plan developed by both the PCP and the dental provider in consultation with each other. Orthodontic services are not covered when the primary purpose is cosmetic.

Dental services are provided by AHCCCS registered dental providers. Dental providers must advise member/ Health Care Decision Maker of their diagnosis, proposed treatment and alternate treatment methods with associated risks and benefits of each, as well as the associated risks and benefits of not receiving treatment.

Oral Health Treatment Informed Consent include:

4. A written consent for an examination and/or preventative treatment, that does not include an irreversible procedure.

   a. The consent is to be completed at time of initial exam and updated at each six (6) month follow-up appointment.

5. A separate written consent for irreversible, invasive procedure, including but not limited to dental fillings, pulpotomy, etc.

In addition, a written treatment plan must be reviewed and signed by the dental provider and member/ Health Care Decision Maker, and designated representative receiving a copy of both the consent and treatment plan.

Dental Services for Members 21 Years and Over

All members requiring emergency dental service can obtain those services through a contracted dental provider without prior authorization or referral from the primary care provider. All other dental services shall be prior authorized. Covered emergency dental services include a limited problem focused examination of the oral cavity, required radiographs, complex oral surgical procedures such as the treatment of maxillofacial fractures, administration of an appropriate anesthesia and the prescription of pain medication and antibiotics.

Limitations: Diagnosis and treatment of temporomandibular joint dysfunction are not covered except for the reduction of trauma.

All emergency dental appointments shall be obtained or granted within 24 hours of the request, or the next business day. If it is determined that this is a life-threatening emergency, no Prior Authorization is necessary.

Medically necessary emergency dental care and extractions are covered for persons age 21 years and older who meet the criteria for a dental emergency. A dental emergency is an acute disorder of oral health resulting in severe pain and/or infection as a result of pathology or trauma.

1. The following services and procedures are covered as emergency dental services:
   a. Emergency oral diagnostic examination (limited oral examination – problem focused),
   b. Radiographs and laboratory services, limited to the symptomatic teeth,
   c. Composite resin due to recent tooth fracture for anterior teeth,
   d. Prefabricated crowns, to eliminate pain due to recent tooth fracture only,
   e. Recementation of clinically sound inlays, onlays, crowns, and fixed bridges,
   f. Pulp cap, direct or indirect plus filling,
   g. Root canals and vital pulpotomies when indicated for the treatment of acute infection or to eliminate pain,
   h. Apicoectomy performed as a separate procedure, for treatment of acute infection or to eliminate pain, with favorable prognosis,
   i. Immediate and palliative procedures, including extractions if medically necessary, for relief of pain associated with an oral or maxillofacial condition,
   j. Tooth reimplantation of accidentally avulsed or displaced anterior tooth, with favorable prognosis,
   k. Temporary restoration which provides palliative/sedative care (limited to the tooth receiving emergency treatment),
   l. Initial treatment for acute infection, including, but not limited to, periapical and periodontal infections and abscesses by appropriate methods,
   m. Preoperative procedures and anesthesia appropriate for optimal patient management, and
   n. Cast crowns limited to the restoration of root canal treated teeth only.

Adult Emergency Dental Services Limitations for Persons Age 21 Years and Older

1. Maxillofacial dental services provided by a Dental Provider are not covered except to the extent prescribed for the reduction of trauma, including reconstruction of regions of the maxilla and mandible.
2. Diagnosis and treatment of temporomandibular joint dysfunction are not covered except for the

reduction of trauma.

3. Routine restorative procedures and routine root canal therapy are not emergency dental services.
4. Treatment for the prevention of pulpal death and imminent tooth loss is limited to non-cast fillings, crowns constructed from pre-formed stainless steel, pulp caps, and pulpotomies only for the tooth causing pain or in the presence of active infection.
5. Fixed bridgework to replace missing teeth is not a covered benefit
6. Dentures are covered for ALTCS members.

Dental Services for Members Eligible for Transplantation Services, Cancer Cases, or Ventilation Cases

B – UHP covers dental diagnosis and elimination of oral infection prior to transplantation of organs or tissues only after the member has been established as an otherwise appropriate candidate for transplantation.

For members who require medically necessary dental services as a pre-requisite to AHCCCS covered organ or tissue transplantation, covered dental services include the elimination of oral infections and the treatment of oral disease, which include dental cleanings, treatment of periodontal disease, medically necessary extractions, and the provision of simple restorations. These services are not subject to the $1,000 adult emergency dental limit.

Prophylactic extraction of teeth in preparation for radiation treatment of cancer of the jaw, neck or head is also a covered benefit. These services are not subject to the $1,000 adult emergency dental limit.

Cleanings for members who are in an inpatient hospital setting and are placed on a ventilator or are physically unable to perform oral hygiene are covered for dental cleanings performed by a hygienist working under the supervision of a physician. If services are billed under the physician, then medical codes will be submitted and are not subject to the $1000 adult emergency dental limit.

Facility and Anesthesia Charges

A member may have an underlying medical condition which necessitates that services provided under the emergency dental benefit be provided in an ambulatory s surgery center or an outpatient hospital and may require anesthesia as part of the emergency service. In those instances, the facility and anesthesia charges are subject to the $1,000 emergency dental limit.

Dentists performing General Anesthesia (GA) on members will bill using dental codes and the cost will count towards the $1,000 emergency dental limit.

Physicians performing GA on members for a dental procedure will bill medical codes and the cost will count towards the $1,000 emergency dental limit.

Informed Consent

Informed consent is a process by which the provider advises the member or the member's Health Care Decision Maker of the diagnosis, proposed treatment and alternate treatment methods with associated risks and benefits of each, as well as the associated risks and benefits of not receiving treatment.

Informed consents for oral health treatment include:

1. A written consent for examination and/or any treatment measure, which does not include an irreversible procedure, as mentioned below. This consent is completed at the time of initial examination and is updated at each subsequent six-month follow-up appointment
2. A separate written consent for any irreversible, invasive procedure, including but not limited to dental fillings, pulpotomies. In addition, a written treatment plan shall be reviewed and signed by both parties, as specified below, with the member or the member's Health Care Decision Maker receiving a copy of the complete treatment plan

All providers shall complete the appropriate informed consents and treatment plans for members as listed above, in order to provide quality and consistent care, in a manner that protects and is easily understood by the member or the member's Health Care Decision Maker. This requirement extends to all

Contractor mobile unit providers. Consents and treatment plans shall be in writing and signed/dated by both the provider and the member, or member's Health Care Decision Maker. Completed consents and treatment plans shall be maintained in the members' chart and are subject to audit.

Well Women's Preventive Care Services

Annual well-woman preventive care visits are a covered benefit for all women enrolled with AHCCCS. These visits provide regular preventive care and screening services to help promote essential healthy lifestyle habits, identify risk factors for disease and address existing medical or behavioral health concerns.

Well-Woman Preventive Care Visits Include (are not limited to):

- Physical (wellness) exam that assesses overall health
- Clinical breast exam
- Pelvic exam (as necessary per current recommendations and best standards of practice)
- Review and administration of immunizations, screenings and testing as appropriate for age and risk factors.
- Screening & counseling as part of the well-woman prev. care visit, focused on maintaining a healthy lifestyle & minimizing risks, addressing at a minimum:
    - Proper Nutrition
    - Physical Activity
    - Elevated BMI indicative of obesity
    - Tobacco/Substance Use, Abuse and/or Dependency
    - Depression Screening
    - Interpersonal & Domestic Violence Screening
      [This screening shall include counseling to elicit information from women and adolescents about current/past violence and abuse, in a culturally sensitive and supportive manner, to address current and future safety and health concerns.]
    - Sexually Transmitted Infections
    - HIV testing, plus available counseling & treatment if positive results are received
    - Family Planning Services & Supplies
    - Preconception Counseling w/ discussion about a healthy lifestyle before & between pregnancies, which includes:
        - Reproductive history & sexual practices
        - Healthy weight, diet, nutrition, supplements & folic acid intake
        - Physical activity or exercise
        - Oral health care
        - Chronic disease management
        - Emotional wellness
        - Tobacco & drug use (prescription drugs, caffeine, alcohol, marijuana, etc.)
        - Recommended intervals between pregnancies
- Immunizations during Well Woman Preventive Care visits:
    - AHCCCS will cover the Human Papilloma Virus (HPV) vaccine for members, as specified in AMPM Policy 310 M.

- Adult immunizations shall be provided in accordance with AHCCCS AMPM Policy 310-M, Immunizations.
- Children (members under 19 years of age) shall be provided immunizations in accordance with AHCCCS AMPM Policy 310-M and Policy 430.
- Providers must coordinate with The Arizona Department of Health Services (ADHS) Vaccines for Children (VFC) Program in the delivery of immunization services if providing vaccinations to Early and Periodic Screening, Diagnostic and Treatment (EPSDT) members less than 19 years of age.

Female members have direct access to preventive and well care services from a PCP or an OB/GYN within the B –UFC/ACC network, without a referral.

Transportation as well as scheduling assistance for Well-Woman Preventive Care services through the B – UFC/ACC Customer Care Center at (800) 582-8686, TTY 711.

*Note: Genetic screening and testing is not covered except as specifically described in (AMPM Policy 310-II, Genetic Testing).

Maternity & Family Planning Services

B – UHP requires that quality family planning, pre-pregnancy and postpartum services are available to every member. The continuum of care is a critical component to achieving optimal outcomes for both mothers and newborns. Primary Care Obstetricians are responsible for the provision of comprehensive care to meet the primary and obstetrical needs of the member. Health Plan members may select or be assigned to a PCP specializing in obstetrics while they are pregnant.

B – UHP covers a full continuum of family planning and maternity care services for all eligible, enrolled members of child-bearing age.

Maternity care services include, but are not limited to:

- Identification of pregnancy
- Medically necessary prenatal services
- The treatment of pregnancy related conditions
- Labor and delivery services and postpartum care

B – UHP benefits provide for a hospital stay of up to 48 hours after vaginal delivery, and up to 96 hours after cesarean section, unless an extended stay is determined to be medical necessary. For payment purposes, inpatient limits will apply. In addition, related services such as outreach, education and family planning services are provided when appropriate.

Family Planning Services

Family planning services, when provided by physicians or practitioners are covered for members regardless of gender, who voluntarily choose to delay or prevent pregnancy. Family Planning Services include covered medical, surgical, pharmacological and laboratory benefits as well as the provision of accurate information and counseling to allow members to make informed decisions about the specific family planning methods available. Covered Family Planning services include:

- Contraceptive counseling, medication and/or supplies including but not limited to:
    - Oral and injectable contraceptives
    - Long-Acting Removable Contraceptives (LARCs) including Sub-dermal Implantable Contraceptives and IUDs (Intrauterine devices)
    - Immediate Postpartum Long-Acting Removable Contraceptives (IPLARC)
    - Diaphragms
    - Condoms
    - Spermicidal foams
    - Suppositories

- Natural family planning education or referral to qualified health professionals
- Post-coital emergency oral contraception within 72 hours after unprotected sexual intercourse. *RU486 is not post-coital emergency contraception*
- Pregnancy screening
- Screening and treatment for sexually transmitted infections
- Medical examinations, laboratory, radiological and ultrasound procedures/studies related to family planning
- Pharmaceuticals when associated with medical conditions related to family planning or other medical conditions
- Treatment of complications resulting from contraceptive use, including emergency treatment
- Sterilization services for both male and female members over 21 years of age, when AHCCCS eligibility requirements are met

The following services are not covered for the purpose of Family Planning:

- Infertility Services (including diagnostic testing, treatment or the reversal of surgically induced infertility)
- Pregnancy termination counseling
- Pregnancy terminations [including the use of Mifepristone (Mifeprez or RU 486)], except as specified in AHCCCS Medical Policy Manual Policy (AMPM) 410
- Hysterectomies for the purpose of sterilization (AMPM 310-L details hysterectomy coverage requirements)

Care Coordination – Maternity Care

B – UHP's specialty Maternal Child Health (MCH) Care Management team is available to assist providers in managing and coordinating pregnancy and family planning care for members with increased risk related to medical conditions, social circumstances, social determinates of health or non-compliant behaviors. The MCH team can help link members with maternity and family planning care needs, to appropriate community resources such as WIC, parenting classes, shelters, substance abuse counseling and other resources. Our specialty Care Managers provide support and promote compliance with prenatal appointments and prescribed medical regimens.

B – UHP places critical importance on early, high quality and regular perinatal health. Our MCH team is available to partner with you in coordinating obstetrical care services for:

- High Risk OB care authorization
- Referrals to perinatology and special services
- Developing effective member outreach
- Direct and ongoing Care Management for identified high-risk members

Maternity Care Program Minimum Requirements

Covered Services (include but are not limited to):

- Preconception counseling (medically necessary)
- Identification of pregnancy
- Medically necessary education and prenatal services for the care of pregnancy
- Treatment of pregnancy-related conditions
- Labor and delivery services
- Intrapartum and postpartum care
- Transportation when needed to access maternity care

In addition, related services such as outreach and family planning services are provided, whenever

appropriate, based on the member's current eligibility and enrollment.

Provider Standards – Maternity Care

All maternity care services must be delivered by qualified physicians and non-physician practitioners and must be provided within American Congress of Obstetricians and Gynecologists (ACOG) standards for obstetrical and gynecological services. Prenatal, labor/delivery and postpartum care services may be provided by licensed midwives within their scope of practice, while adhering to ACOG guidelines. B – UHP providers are required to comply with the following standards in the provision of maternity care services to pregnant members:

- Adhere to the most current standards of care of ACOG, including the use of a standardized risk assessment tool and ongoing risk assessment.
- Submit an NOP (Notification of Pregnancy) form to B – UHP following the first and no later than the second prenatal visit. NOP submissions facilitate the MCH team's timely initiation of maternity care management services. A complete NOP shall include the Estimated Date of Confinement (EDC), Gravida/Para (GP), Risk Status information and planned place of delivery
- Educate members about health behaviors during pregnancy including: Proper nutrition, adverse effects of smoking and smoking cessation, alcohol and illicit drugs on the fetus, and the physiology of pregnancy.
- Provide information regarding the process of labor and delivery, breast-feeding, family planning and preconception counseling, and infant care
- Inform all pregnant women of voluntary prenatal HIV testing and the availability of counseling and treatment if the test is positive
- Refer and facilitate registration of members to childbirth education classes
- Refer members under the age of 21 years for yearly diagnostic, preventive and treatment dental services
- Perform EPSDT screening and referral to dentists on members through the age of 20 years
- Mainstream AHCCCS members into his/her practice
- Notify women that in the event they lose eligibility, they may contact the Arizona Department of Health Services toll free Hot Line at (800) 833-4642 for referrals to low or no cost services, such as family planning and other community resources
- Refer members who lose AHCCCS eligibility to low/no cost agencies for family planning services
- Provide patient data as requested/required by B – UHP.
- Comply with all B – UHP reporting requirements and participate in required audits
- Refer members to other agencies who offer support services such as Women, Infants and Children (WIC)
- Conduct perinatal/postpartum depression screenings at least once during the pregnancy and then again at the postpartum visit, including counseling and making appropriate referrals if a positive screening is obtained
- Conduct screening of all pregnant members through the CSPMP (Controlled Substances Prescription Monitoring Program) system, at least once during each trimester throughout their pregnancy.
- OB Providers shall obtain member consent for coordination of care and information sharing with SUD (substance use disorder) treatment providers, in alignment with ACOG (American College of Obstetricians and Gynecologists) standards
- Conduct screening for Sexually Transmitted Infections (STI), including syphilis at the:
    - First Prenatal Visit
    - Third Trimester, AND

- Time of Delivery

Inductions of Labor and Cesarean Section Deliveries

According to ACOG guidelines, cesarean section deliveries must be medically necessary. Deliveries prior to 39 weeks gestation; inductions of labor and/or cesarean section deliveries must be medically necessary. Per AHCCCS guidelines, inductions and/or cesarean section deliveries performed prior to 39 weeks, not confirmed to be medically necessary based on nationally established criteria, are not eligible for payment.

Maternity Care Appointment Standards

Initial prenatal appointments for pregnant members must be provided as follows:

- First trimester - within 14 days of request
- Second trimester - within 7 days of request
- Third trimester - within 3 days of request
- High risk pregnancy within 3 days of identification of high risk by PCP or maternity care provider or immediately if an emergency exists.

Follow-up prenatal care appointments for pregnant members must be provided as follows:

- First 28 weeks of pregnancy - every 4 weeks.
- 28 - 36 weeks of pregnancy - every 2 to 3 weeks
- After the 36th week - weekly until delivery
- High Risk maternity care members return visit intervals must be scheduled appropriately to their individual needs

Home Uterine Monitoring (HUM)

B – UHP covers home uterine monitoring technology for members with premature labor contractions before 35 weeks, as an alternative to hospitalization. At least one of the following conditions must be present to receive authorization for HUM:

- Multiple gestations, particularly triplets or quadruplets
- One or more births before 35 weeks
- Hospitalization for premature labor before 35 weeks with a documented change in the cervix, controlled by tocolysis and ready to be discharged for bed rest at home.

Loss of Coverage During Pregnancy

Sometimes members lose AHCCCS eligibility during pregnancy. Although members are responsible for their own eligibility, providers are encouraged to notify B – UHP. We will assist in coordinating or resolving eligibility and enrollment issues so pregnancy care may continue without lapse in coverage. To report concerns about eligibility, contact the Maternal Child Health department.

Perinatology Care

B – UHP may approve assignment or transfer of a pregnant woman to a Perinatologist for “Total OB Care” for the following conditions:

- Insulin dependent diabetes in non-pregnant State Chronic renal disease or insufficiency
- Epilepsy requiring medications
- Chronic hypertension requiring medications
- A history of two or more preterm deliveries at 32 weeks or less Malignancy
- Current diagnosis of highly probable IUGR Rupture of Membranes (ROM) before 32 weeks gestation
- Potential need for cerclage
- Diagnosis of Lupus Erythematous
- Twin pregnancy with discordant growth

- Triplets or greater pregnancy
- Positive HIV mother
- Polyhydramnios
- Oligohydramnios

Pregnancy Termination

B – UHP covers pregnancy termination in accordance with AHCCCS guidelines, when it is the result of rape, incest, or in circumstances as determined by the attending provider in collaboration with a B – UHP Medical Director or the AHCCCS Chief Medical Officer or designee, when one of the following conditions is present:

- The member suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused by or arising from the pregnancy itself that would, as certified by a provider, place the member in danger of death unless the pregnancy is terminated
- The pregnancy is a result of rape or incest (this standard applies only to categorically eligible female members)
- The pregnancy termination is medically necessary according to the medical judgment of a licensed physician, who attests that continuation of the pregnancy could reasonably be expected to pose a serious physical or behavioral health problem for the pregnant member by:
    - Creating a serious physical or behavioral health problem for the pregnant member
    - Seriously impairing a bodily function of the pregnant member
    - Causing dysfunction of a bodily organ or part of the pregnant member
    - Exacerbating a health provider of the pregnant member
    - Preventing the pregnant member from obtaining treatment for a health problem

Pregnancy Termination - Conditions, Limitations and Exclusions:

- The attending provider must acknowledge that a pregnancy termination has been determined medically necessary, by submitting the AHCCCS Certificate of Necessity for Pregnancy Termination (AMPM 410 Attachment C). The form must be submitted with a completed Prior Authorization request form to obtain the Health Plan Medical Director's signature. The Certificate of Medical Necessity for Pregnancy Termination must certify that in the provider's professional judgment, one or more of the require criteria have been met.
- A written informed consent must be obtained by the provider and kept in the member's chart for all pregnancy terminations. If the pregnant member is younger than 18 years of age or is 18 years of age or older and considered an incapacitated adult, a dated signature of the pregnant member's parent or legal guardian indicating approval of the pregnancy termination procedure is required
- When the pregnancy is the result of rape or incest, documentation must be obtained that the incident was reported to the proper authorities, including the name of the agency to which it was reported, the report number and the date the report was filed
- If the pregnancy is the result of rape or incest, and the member is less than eighteen years of age, or is older than 18 years of age and considered an incapacitated adult, additional documentation must be included by the provider when submitting the Certificate of Medical Necessity for Pregnancy Termination. Pursuant to Federal and State law, the following information is required:
    - Documentation that the incident was reported to the proper authorities, including the name of the agency to which it was reported, the report number if available, and the date the report was filed
    - The dated signature of the member's parent or legal guardian indicating approval of the pregnancy termination procedure
    - Informed consent from an adult or a minor in the manner prescribed by law. To the extent written consent is required by law, a copy of the consent shall be provided with the

Certificate of Medical Necessity for Pregnancy Termination

Prior Authorization for Pregnancy Termination

Except in cases of medical emergencies, the provider must obtain prior authorization from the B – UHP Medical Director (or his/her designee) for all medically necessary pregnancy terminations. A Completed Certificate of Necessity for Pregnancy Termination (AMPM Policy 410, Attachment C) must be submitted with the completed Prior Authorization request form. B – UHP Medical Director or AHCCCS Chief Medical Officer or designee will review the request and the Certificate, and expeditiously authorize the procedure if the documentation establishes the termination to be medically necessary.

In cases of medical emergencies, the provider must submit a completed Certificate of Necessity for Pregnancy Termination (AMPM Policy 410, Attachment C) with documentation demonstrating emergent medical necessity of the pregnancy termination, to the B-UHP Medical Director within two (2) working days of the date the procedure was performed.

If you wish to discuss how to ensure alignment with AHCCCS policy requirements, authorization and/or documentation requirements related to pregnancy terminations (including emergency pregnancy terminations), please contact:

Michael Riegel RN, BSN
Medical Mgt Director
Maternal & Child Health Services
480-827-5941 (office)
michael.riegel@bannerhealth.com

Covered & Non-Covered Services

Physical & Behavioral Health Covered & Non-Covered Services

B – UHP covers medically necessary services with limitations as outlined in the AHCCCS Medical Policy Manual, Chapters 300 and 400:

Chapter 300: https://www.azahcccs.gov/shared/MedicalPolicyManual/#Ch300

Chapter 400: https://www.azahcccs.gov/shared/MedicalPolicyManual/#Ch400

All services must be provided in-network with the exception of emergent situations or when Prior Authorization has been obtained. Some services, even when provided in-network, require Prior Authorization. Please refer to the PA grid for a list of services that require Prior Authorization. Services that are not covered by AHCCCS may not be on the PA grid. Please refer to the AHCCCS Medical Policy Manual for a full listing of covered services or contact the Plan for further information.

Utilization Management Policies & Procedures

Utilization Management (UM) refers to the process of evaluating medical necessity, appropriateness, and/or efficiency of health services provided by the health plan. It is B – UHP's mission to ensure our members get the right care, at the right level or place, and at the right time to ensure high quality, comprehensive care. UM encompasses Prior Authorization, Initial Inpatient Review, Concurrent Review, and Retrospective Review processes.

Referrals

The provider is responsible for initiating, coordinating and documenting referrals to specialists, including dentists and behavioral health specialists. It may be necessary for a B – UHP member to be referred to another provider for medically necessary services that are beyond the scope of the member's PCP. For those services, providers only need to complete their own Referral Form and refer the member to the appropriate contracted provider. B – UHP's website includes a provider search function for providers.

Referrals can be initiated by a contracted provider or in some instances, a member may self-refer. PCPs and contracted providers may refer members for specific covered services to other practitioners or medical specialists, medical facilities, or ancillary service providers. Member may self-refer to certain medical specialists for specific services. These are:

- Family Planning Services
- OB Services

- GYN Services
- Dental Services for Members Under Age 21
- Vision services for Members Under Age 21
- Behavioral Health Services

When a member self refers for any of the above services, providers rendering services must adhere to the same referral requirements as described below.

All ancillary referrals must use and/or refer to B – UHP contracted providers.

Referrals must meet the following conditions:

- The referral must be requested by a contracted provider and be in accordance with the member's covered benefits.
- The member must be enrolled with B – UHP on the date of service(s) and eligible to receive the service. If there is no contracted provider in B – UHP network to perform the requested services, members may be referred to out of network providers if:
    - The services required are not available within the network
    - B – UHP prior authorizes the service(s)

If out of network services are not prior authorized, the referring and servicing providers may be responsible for the cost of the service. The member may not be billed if the provider fails to follow B – UHP's policies. Both referring and receiving providers must comply with B – UHP policies, documents, and requirements that govern referrals (paper or electronic) including prior authorization. Failure to comply may result in delay in care for the member, a delay or denial of reimbursement or costs associated with the referral being changed to the referring provider. Referrals are a means of communication between two providers servicing the same member. Although B – UHP encourages the use of a Referral Form, it is recognized that some providers use telephone calls and other types of communication to coordinate the member's medical care.

Both the referring and receiving providers have responsibilities. The referring provider's responsibilities include:

- Confirm that the required service is covered under the member's benefit plan prior to referring the member.
- Confirm that the receiving provider is contracted with B – UHP.
- Obtain prior authorization for services that require prior authorization or are performed by a non-contracted provider.
- Complete a Referral Form/communication and mail/fax/call the referral to the receiving provider.

The receiving provider's responsibilities include:

- Schedule and deliver the medically necessary services in compliance with B – UHP's requirements and standards related to appointment availability.
- Verify the member's enrollment and eligibility for the date of service. If the member is not enrolled with B – UHP on the date of service, B – UHP will not render payment regardless of referral or prior authorization status.
- Verify that the service is covered under the member's benefit plan.
- Verify that the prior authorization has been obtained, if applicable, and includes the prior authorization number on the claim when submitted for payment.
- Inform the referring provider of the consultation or service by sending a report and applicable medical records to allow the referring provider to continue the member's care.

Unless otherwise stated in a provider contract or B – UHP policies, a referral is valid for the full extent of the member's care starting from the date it is signed and dated by the referring provider, if the member is enrolled and eligible with B – UHP on the date of service.

Medical Records

Medical Record Review Requirements

1. The provider maintains a legible medical record (including electronic health record or paper medical record) for each enrolled member who has been seen for medical appointments or procedures. The medical record must also contain clinical/behavioral health records from other providers who also provide care/services to the enrolled member.
2. The medical record documents provider's referral to, coordination of care with, and transfer of care to behavioral health and other providers, as appropriate.
3. The medical record is legible, kept up to date, well organized and comprehensive with sufficient detail to promote effective patient care, quality review and identifies the treating or consulting provider. A member may have numerous medical records kept by various health care providers that have rendered services to the member. However, the provider must maintain a comprehensive record that incorporates at least the following components:
    a. Behavioral health information when received from the behavioral health provider about an assigned member even if the provider has not yet seen the assigned member. In lieu of actually establishing a medical record, such information may be kept in an appropriately labeled file but must be associated with the member's medical record as soon as one is established
    b. Member identification information on each page of the medical record (i.e., name or AHCCCS identification number).
    c. Documentation of identifying demographics including the member's name, address, telephone number, AHCCCS identification number, gender, age, date of birth, marital status, next of kin, and, if applicable, guardian or authorized representative
    d. Initial history for the member that includes family medical history, social history, and preventive laboratory screenings (the initial history for members under age 21 should also include prenatal care and birth history of the member's mother while pregnant with the member)
    e. Past medical history for all members that includes disabilities and any previous illnesses or injuries, smoking, alcohol/substance abuse, allergies and adverse reactions to medications, hospitalizations, surgeries, and emergent/urgent care received
    f. Immunization records (required for children; recommended for adult members if available)
    g. Dental history if available, and current dental needs and/or services
    h. Current problem list
    i. Current Medications
    j. Current and complete EPSDT Clinical Sample Template (previously known as EPSDT tracking forms) for members until 20 years of age
    k. General developmental screening tools for children ages nine, 18 and 30 months, with Autism Spectrum Disorder (ASD) specific development screening tools at ages 18 and 24 months
    l. Documentation initialed by the provider to signify review of:
        i. Diagnostic information including laboratory tests and screenings; radiology reports; physical examination notes and other pertinent data
        ii. Reports from referrals, consultations, and specialist
        iii. Emergency/urgent care reports
        iv. Hospital Discharge summaries
        v. Behavioral health referrals and services provided, if applicable, including notification of behavioral health providers, if known, when a member's health status changes or

new medications are prescribed, and

vi. Behavioral health history and behavioral health information received from a Regional Behavioral Health Authority (RBHA) behavioral health provider who is also treating the member.

m. Documentation as to whether or not an adult member has completed advance directives and the location of the document.

Documentation that the provider responds to behavioral health provider information requests pertaining to behavioral health recipient members within ten business days of receiving the request. The response should include all pertinent information, including, but not limited to, current diagnoses, medications, laboratory results, last provider visit, and recent hospitalizations. Documentation must also include the provider's initials signifying review of member behavioral health information received from a behavioral health provider who is also treating the member.

n. Documentation related to requests for release of information and subsequent releases.

o. Documentation that reflects that diagnostic, treatment and disposition information related to a specific member was transmitted to the provider including behavioral health providers, as appropriate to promote continuity of care and quality management of the member's health care.

4. Ensure that obstetric providers complete a standardized, evidence-based risk assessment tool for obstetric members (i.e. Mutual Insurance Company of Arizona [MICA] Obstetric Risk Assessment Tool or American College of Obstetricians and Gynecologists [ACOG]). Also, ensure that lab screenings for members requiring obstetric care conform to ACOG guidelines.

5. Ensure that providers of prenatal and postpartum services provide appropriate counseling and referrals to members if a positive depression screening is obtained in either a prenatal or postpartum follow up visit.

6. Ensure that PCPs utilized AHCCCS approved developmental screening tools

7. Each organizational provider of services (e.g., hospitals, nursing facilities, rehabilitation clinics, etc.) maintains a record of the services provided to a member, including:

   a. Physician or provider orders for the service
   b. Applicable diagnostic or evaluation documentation
   c. A plan of treatment
   d. Periodic summary of the member's progress toward treatment goals
   e. The date and description of service modalities provided
   f. Signature/initials of the provider for each service

8. Ensure that RBHA transportation services that utilize provider employees (e.g. facility vans, drivers, etc.) maintain documentation that supports each transport provided. The follow information shall be documented to verify transportation services:

   a. Complete service provider's name and address,
   b. Signature and credentials of the driver who provided the service,
   c. Vehicle identification (car, van, wheelchair van, etc.),
   d. Members' AHCCCS identification number,
   e. Date of service, including month day and year,
   f. Address of pick up site
   g. Address of drop off destination,
   h. Odometer reading at pick up
   i. Odometer reading at drop off

j. Type of trip – round trip or one way

k. Escort (if any) shall be identified by name and relationship to the member being transported, signature of the member, parent and/or guardian/caregiver, verifying services were rendered including documentation by the driver of refusal by a member to sign. This requirement may be waived during a state or federal public health emergency.

9. Take into consideration professional and community standards and accepted and recognized evidence-based practice guidelines
10. Require documentation in the member's record showing supervision by a licensed professional, who is authorized by the licensing authority to provide the supervision, whenever health care assistants are allowed to provide services

Medical records may be documents on paper or in an electronic format:

a. If records are documented on paper, they must be written legibly in blue or black ink, signed and dated for each entry. Electronic records with electronic signatures must include a time stamp and date of the signature as well as the name of the provider who made the entry.

b. If records are physically altered, the stricken information must be identified as an error and initialed by the person altering the record along with the date when the change was made; correction fluid or tape is not allowed.

c. If kept in an electronic file, the provider shall establish a method of indicating the author, date, and time of added/revised information and a means to assure that information is not altered inadvertently.

d. If revisions to information are made, a system must be in place to track when, and by whom, they are made. In addition, a backup system including initial and revised information must be maintained.

e. Medical record requirements are applicable to both hard copy and electronic medical records. The Health Plan may go on site to review the records electronically or utilize a secure process to review electronic files received from the provider when concerns are identified. Safeguards shall be in place to ensure that only authorized individual are able to access medical records.

B – UHP ensures the appropriate and confidential exchange of member information among providers, including behavioral health providers, and includes verification of:

- A provider making a referral transmits necessary information to provider receiving the referral
- A provider furnishing a referral service reports appropriate information to the referring provider
- Providers request information from other treating providers as necessary to provide appropriate and timely care
- Information about services provided to a member by a non-network provider (i.e., emergency services, etc.) is transmitted to the member's Primary Care Provider (PCP).
- Member records are transferred to the new provider in a timely manner that ensures continuity of care when a member chooses a new PCP
- Member information is shared, when a member subsequently enrolls with a new Contractor, in a manner that maintains confidentiality while promoting continuity of care, and
- Member information is shared within 10 business days behavioral health providers and as appropriate, other providers or entities involved in the member's care for members with ongoing care needs or changes in health status.

Documentation Standards and Electronic Records:

B – UHP providers must have policies and procedures in place which:

1. Identify each provider's original signature
2. Establish a method for indicating the initiator of information
3. Ensure a means that information is not altered

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

PCPs must maintain a comprehensive medical record for each enrolled member who has been seen for a medical appointment. If the PCP has not yet seen the member, any information received about the member will be kept in a temporary appropriately labeled file in lieu of establishing a medical record.

Medical records may be documented on paper or in an electronic format. If records are documented on paper, they must be legible in blue or black ink, signed and dated for each entry. If records are physically altered, the stricken information must be identified as an error and initialed by the person altering the record along with the date when the change was made; correction fluid or tape is not allowed.

Medical record review requirements as described in this section are applied to the review of electronic medical records. B – UHP may go on site to review the records electronically or utilize a secure process to review electronic files received from the provider.

Electronic Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) visit documentation must include all elements of the AHCCCS approved EPSDT Clinical Sample Templates, maintaining confidentiality.

B – UHP follows Health Insurance Portability and Accountability Act (HIPAA) guidelines defining protected heath information (PHI) as any identifiable health information including: names, addresses, date of birth, telephone numbers, fax numbers, email addresses, SSN, medical record numbers, health plan beneficiary numbers, account numbers, certificate /license numbers, vehicle identifiers and serial numbers, license plate numbers, web universal resource locator (URLs) internet protocol (IP) address numbers, biometric identifiers including finger and voice prints, full face photographic images and any comparable images, and any other unique identifying numbers, characteristics or codes.

Information passing between provider and member is privileged and may not be divulged without proper release and member consent or as ordered through proper legal process. All members have a right to privacy in their personal affairs which includes medical care. Neglect in releasing such information either in writing or in conversation may be an invasion of privacy and is prohibited by B – UHP. Release of member medical information without proper consent is strictly prohibited.

Exchange of Member Information

To promote continuity of care, member information must be exchanged as follows:

1. A provider making a referral must transmit necessary information to the provider receiving the referral.
2. A provider furnishing a referral service must report appropriate information back to the referring provider.
3. Providers request information from other treating providers as necessary to provide timely and appropriate care.
4. Information about services provided to a member by a non- network provider (i.e., emergency services) is transmitted to the member’s PCP.
5. Member records are transferred to the new provider in a timely manner that ensures continuity of care when a member chooses a new PCP.
6. Member information is shared with behavioral health providers for members with ongoing care needs or changes in health status.
7. If a member enrolls with a new contractor, sharing of the member record is accomplished ina

confidential manner which promotes continuity of care.

Requests for Member Information

Information involving a member is privileged and is not to be discussed within or outside the workplace unless for a specific medical or work purpose. Any request for member information, whether verbal or written, from an outside agency or person, including relatives, must be accompanied by a signed release from the member. Information may be released, in any form, by the treating provider to another treating provider without written consent, if necessary, for continuity of medical care and/or the safety of a member.

B – UHP and network providers may disclose member information without their authorization as outlined in HIPAA 45 CFR 164.512, which states that it is allowed for the following reasons:

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

Requests made to Billing and Collections regarding balances owed on accounts from spouses or those listed as financially responsible is limited to financial information only and does not include any medical information. Note: these exceptions do not apply to substance abuse records and disclosure of substance abuse records must be released in accordance with 42 CFR. Part 2. All medical information regarding HIV is kept strictly confidential and released only in conformance with the requirements of state law (A.R.S. 36-664).

Requests for Medical Records

Information from, or copies of, records may be released only to authorized individuals. Original and/or copies of medical records are released only in accordance with Federal or State laws and AHCCCS policy, and maintain compliance with HIPAA requirements 42 C.F.R. Part 2, A.R.S. 36-664, and 42 CFR 431.300 et seq.

Information recorded in a member's medical record is privileged information and may not be given to anyone without the member's or guardian's written consent, a valid court order or subpoena, or other specific instances as outlined below.

- All contracted providers who house medical records shall appoint a person who is that facility's "custodian of medical records." Such person is responsible for the safe storage and handling of the medical record, as well as other procedures necessary to maintain the confidentiality and integrity of the record. Such a person is familiar with the basic information concerning the release of medical records.
- Release of member care information in a medical emergency is from a licensed health care professional to a licensed health care professional only.
- The member's medical record shall be maintained by the provider who generates the record. Medical records include those maintained by PCPs or other providers as well as but not limited to those kept in placement settings such as nursing facilities, assisted living facilities and other home and community-based providers.

B – UHP will ensure that each member is guaranteed the right to request and receive one copy of the member's medical record at no cost to the member as specified in Title 45 of the Code of Federal Regulations CFR 164.524. and CFR 164.526.

A subpoena or court order requesting medical records must be complied with in accordance with current Arizona statutes. Requests for medical records of minors, dead persons, and/or incompetent or incapacitated persons must be made by either a custodial parent, legal guardian, or other legal representative. Requests for medical records of members undergoing drug and alcohol abuse treatment and/or psychiatric evaluation or treatment require special handling and consents to release.

B – UHP Authorized Representative Review of Medical Information Practitioners

Practitioners will allow B – UHP or its representative to review and duplicate any data or records maintained on a member that relate to services provided pursuant to practitioner contract language. Practitioners provide B – UHP or its authorized representative with all records necessary to carry out medical management and quality management programs. B – UHP provides authorized agencies access to all member medical records (paper or electronic) within 20 business days from the date of receipt of request.

PCPs must implement appropriate policies and procedures to ensure the organization and its providers have information required for:

1. Effective and continuous patient care through accurate medical record documentation of each member's health status, changes in health status, health care needs, and health care services provided
2. Quality Review
3. An ongoing program to monitor compliance with those policies and procedures. For example, a medical record review of providers with an enrollment of 50 (at the time of recredentialing) or more eligible members, reflective of geographical service area (GSA) and product line must be conducted, at a minimum, every three years. If there is more than one product line, populations must be combined to determine if 50 or more members are in the provider's panel. 10 records will be reviewed per provider unless provider in a group of five or more.
    - For such groups, three records per provider will be reviewed up to a maximum of 30 records.

Each PCP must implement policies and procedures that address medical records and the methodologies to be used by the organization to:

a. Ensure that contracted PCPs, Obstetricians/Gynecologists and high-volume specialists (50 or more referrals per contract year) maintain a legible medical record (including electronic health record/medical record) for each enrolled member who has been seen for medical appointments or procedures and/or

b. Receive medical /behavioral health records from other providers who have seen the enrolled member and confirm that the record is kept up to date, is well organized and comprehensive with sufficient detail to promote effective patient care and quality review. A member may have numerous medical records kept by various health care providers that have rendered services to the member.

c. Implement a process to assess and improve the content, legibility, organization, and completeness of member health records. The Health Plan has written policies and procedures for the maintenance of medical records so that those records are documented accurately and in a timely manner, are readily accessible, and permit prompt and systematic retrieval of information. B – UHP ensures that providers maintain and share a member health record in accordance with professional standards [42 CFR 438(b)(5)], through annual medical record reviews.

B – UHP has written standards for documentation on the medical record for legibility, accuracy, and plan of care, which comply with AMPM Policy 940. Medical records shall be maintained in a detailed and comprehensive manner, which conforms to professional standards, complies with records retention requirements, and permits effective medical review and audit processes, and which facilitates an adequate system for follow up treatment. B – UHP will comply with medical record review requirements as outlined in AMPM Policy 940.

The member's comprehensive record maintained by the PCP must contain the following:

1. Member identification information on each page of the medical record (i.e., name or AHCCCS Identification number)
2. Documentation of identifying demographics including the member's name, address, telephone number, AHCCCS identification number, gender, age, date of birth, marital status, next of kin, and if applicable, guardian or authorized representative.
3. For providers: identifiable signatures, entries legible, entries dated, and co-signatures as appropriate for residents, students, and unlicensed assistive personnel.
4. For patient care team members: identifiable signatures (first initial and last name), title present, entries legible, and entries dated.
5. Initial history for members includes family medical history, social history (smoking, alcohol, substance abuse) and preventive laboratory screenings. The initial history for members under age 21 should also include prenatal care and birth history.
6. Past medical history for all members which includes disabilities, previous illnesses or injuries, smoking, alcohol/substance abuse, allergies and adverse reactions to medications, hospitalizations, surgeries, and emergencies.
7. Annual notice verbally or in writing of the availability of family planning services for women age 15-55 (inclusive) is documented.
8. Pediatric Immunizations: an immunization record is present for children under 21 years, and vaccine name, dose and route are documented.
9. Adult Immunizations: an appropriate immunization history has been made in the medical record for adults 21 years of age and older (Td, influenza, pneumococcal 65 years of age and older).
10. A dental history, if available, is present for all members under 21 years of age. Evidence of dental discussion (e.g. gums checked, dental caries noted, referral given to dentist, etc.) is documented.
11. A completed current medication list with dates of entry, which summarizes all current, chronically prescribed medications.
12. A completed problem list with dates of entry, which summarizes all significant illnesses, medical conditions, past surgical procedures, or chronic health problems. This list is updated as new problems are encountered.
13. Diagnostic information (laboratory tests and screenings, radiology reports, physical examination notes); reports from referrals, consultations and specialists; emergency/urgent care reports; and, hospital discharge summaries are in the medical record and show the provider's initial or indication that the provider has reviewed the results.
14. Behavioral health history and services provided (if applicable) including notification of behavioral health providers, if known, when a member's behavioral health status changes or new medications are prescribed are in the medical record and show the provider's initial or indication that the provider has reviewed the results.
15. The medical record notes whether or not an adult health plan member 21 years of age and older has completed an advance directive.
    a. Provides written information to adult members regarding the provider's policies concerning advance directives
    b. Document whether the adult member has executed an advance directive
    c. Prevent discrimination against a member and not place conditions on the provision of care to the member because of his/her decision to execute or not execute an advance directive.
16. Documentation initialed by the member's PCP, to signify review of:
    a. Diagnostic information including:
        i. Laboratory tests and screenings

        ii. Radiology reports
        iii. Physical examination notes
        iv. Other pertinent data
    b. Reports from referrals, consultations, and specialists
    c. Emergency/urgent care reports
    d. Hospital discharge summaries

17. Signed release of information. This can be in the form of present facility requests to send or receive materials as well as past facility requests. HIPAA consent forms that specifically address release of information can be used in conjunction with materials sent or received for adequate documentation. Notation of follow through is documented.
18. Current problem and exam, plan of treatment, and follow-up visit notation.
19. Behavioral Health History
20. Behavioral health referrals and services provided if applicable, including notification of behavioral health providers. If known when a member's health status changes or new medications are prescribed.
21. Documentation related to requests for release of information and subsequent releases.
22. Documentation that the provider responds to behavioral health provider information requests within ten business days of receiving the request. The response should include all pertinent information, including, but not limited to, current diagnoses, medications, laboratory results, last provider visit, and recent hospitalizations. Documentation must also include the provider's initials signifying review of member behavioral health information received from a behavioral health provider who is also treating the member.
23. Documentation that reflects that diagnostic, treatment and disposition, and other pertinent information related to a specific member was transmitted to the PCP and other providers, including behavioral health providers, as appropriate to promote continuity of care and quality management of the member's health care. (Consider professional and community standards and accepted and recognized practice guidelines.)
24. Confirm that each organizational provider of services (e.g., hospitals, nursing facilities, rehabilitation clinics, etc.) maintains a record of the services provided to a member, including:
    a. Physician or provider orders for the service,
    b. Applicable diagnostic or evaluation documentation,
    c. A plan of treatment,
    d. Periodic summary of the member's progress toward treatment goals,
    e. The date and description of service modalities provided, and
    f. Signature/initials of the provider for each service.
25. Take into consideration professional and community standards and accepted and recognized practice guidelines.
26. Implement a process to assess and improve the content, legibility, organization, and completeness of member health records.
27. Require documentation in the member's record showing supervision by a licensed professional, who is authorized by the licensing authority to provide the supervision, whenever health care assistants are allowed to provide services.
28. Providers must participate/cooperate with the State of Arizona and AHCCCS activities related to the development and implementation of electronic health records and e-prescribing. Electronic EPSDT visit documentation must include all elements of the AHCCCS approved EPSDT Clinical Sample Templates.
29. EPSDT Clinical Sample Templates (or their approved electronic equivalent) are present and

current for children from birth through 21 years of age, which are used by providers to document all age specific, required information related to EPSDT screening services.

30. Monitor use of EPSDT Clinical Sample Templates or electronic equivalent documentation, at each visit, for age appropriate screening and services according to the AHCCCS EPSDT periodicity schedule.
31. Ensure that PCPs utilized AHCCCS approved developmental screening tools and monitoring utilization of the general development screening tools at 9, 18, and 30 months, as well as the Autism Spectrum Disorder (ASD) specific development screening tools at ages 18 and 24 months.
32. Appropriate referrals to low/no cost primary care services are provided to members who are losing AHCCCS or SOBRA FPE eligibility.
33. Obstetric Medical Records
34. A risk assessment tool is completed for obstetric members, i.e. Mutual Insurance Company of Arizona Obstetric Risk Assessment Tool or American College of Obstetrics and Gynecology tool (part of separate OB audit). Laboratory screening for obstetric members conform to ACOG guidelines (part of separate OB audit).

Ambulatory Medical Record Audit

Medical record audits are conducted on all PCPs, OB/GYNs, high volume specialists (50 or more members) in accordance with guidelines outlined above. Passing score is 85% or above. B – UHP will notify providers of the passing score via letter.

The results of the medical record audit on providers who do not receive a passing score will be reviewed with B – UHP's Medical officer and further action will be defined. Results of the medical record review audit, correspondence to providers, including corrective action plans will be stored in a secure confidential manner.

Behavioral Health medical record requirements include, but are not limited, to the following elements:

1. Initial evaluation that includes:
    a. Documentation of the member's receipt of the Member Handbook and receipt of Notice of Privacy Practice,
    b. Contact information for the member's Primary Care Provider; for member receiving substance use treatment services under the Substance Abuse
    c. Prevention & Treatment Block Grant (SABG), documentation that notice was provided regarding the member's right to receive services from a provider to whose religious character the member does not object. See AMPM Policy 320-T, Exhibit 320-9 for Notice requirements
2. For Non-Title XIX/XXI members receiving behavioral health services:
    a. Financial documentation that includes:
    b. Documentation of the results of a completed Title XIX/XXI screening at initial evaluation appointment, when the member has had a significant change in his/her income, and at least annually
    c. Information regarding establishment of any copayments assessed, if applicable
3. Assessment documentation that includes:
    a. Documentation of all information collected in the behavioral health assessment, any applicable addenda and required demographic information (see AMPM Policy 580, AMPM Policy 320-O, and AHCCCS Technical Interface Guidelines),
    b. Diagnostic information including psychiatric, psychological, and medical evaluations,
    c. Copies of 320-Q Attachment B (see AMPM Policy 320-Q) as applicable,
    d. An English version of the assessment and/or service plan if the documents are completed in

any language other than English, and

   e. For members receiving services via telemedicine, copies of electronically recorded information of direct, consultative, or collateral clinical interviews.

4. Treatment and Service Plan documentation that includes:
   a. The member's treatment and service plan,
   b. Child and Family Team (CFT) documentation,
   c. Adult Recovery Team (ART) documentation, and
   d. Progress reports or Service Plans from all other additional service providers.

5. Progress Note documentation that includes:
   a. Documentation of the type of services provided,
   b. The diagnosis, including an indicator that clearly identifies whether the progress note is for a new diagnosis or the continuation of a previous diagnosis. After a principal diagnosis is identified, the member may be determined to have cooccurring diagnoses. The service providing clinician will place the diagnosis code in the progress note to indicate which diagnosis is being addressed during the provider session. The addition of the progress note diagnosis code should be included, if applicable,
   c. The date the service was delivered,
   d. The date and time the progress note was signed,
   e. The signature of the staff that provided the service, including the staff member's credentials,
   f. Duration of the service (time increments),
   g. A description of what occurred during the provision of the service related to the member's treatment plan,
   h. In the event that more than one provider simultaneously provides the same service to a member, documentation of the need for the involvement of multiple providers including the name and roles of each provider involved in the delivery of services,
   i. The member's response to service, and
   j. For members receiving services via telemedicine, electronically recorded information of direct, consultative, or collateral clinical interviews.

6. Paper or electronic correspondence documentation that includes:
   a. Documentation of the provision of diagnostic, treatment, and disposition information to the PCP and other providers to promote continuity of care and quality management for the member, and
   b. Documentation of any requests for and forwarding of behavioral health record information.

7. Legal documentation including:
   a. Documentation related to requests for release of information and subsequent releases,
   b. Copies of any advance directives or mental health care power of attorney:
      i. Documentation that the adult member was provided the information on advance directives and whether an advance directive was executed,
      ii. Documentation of authorization of any health care power of attorney that appoints a designated member to make health care decisions (not including mental health) on behalf of the member if they are found to be incapable of making these decisions,
      iii. Documentation of authorization of any mental health care power of attorney that appoints a designated member to make behavioral health care decisions on behalf of the member if they are found to be incapable of making these decisions,

iv. Documentation of general and informed consent to treatment,

v. Authorization to disclose information,

vi. Any extension granted for the processing of an appeal shall be documented in the case file; including the Notice regarding the extension sent to the member and his/her legal guardian or authorized representative.

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

B – UHP requires the clinical records of the CSA, HCTC Provider, and Habilitation Provider conform to the following standards. CSAs, HCTC Providers and Habilitation Providers shall maintain a record of the services delivered to each behavioral health member. Each record entry shall be:

a. Dated and signed with credentials noted
b. Legible text, written in blue or black ink, or typewritten
c. Factual and correct

The minimum written requirement for each behavioral health member's record shall include:

a. The service provided and the time increment,
b. Signature and the date the service was provided,
c. The name title and credentials of the member providing the service,
d. The member's number and AHCCCS identification number,
e. Services are reflected in the behavioral health member's service plan. CSAs, HCTC Providers and Habilitation Providers shall keep a copy of each behavioral health member's service plan in the member's record, and
f. Monthly summary of progress toward treatment goals. A summary of the information required in this section shall be transmitted from the CSA, HCTC Provider, or Habilitation Provider to the member's clinical team for inclusion in the comprehensive clinical record.
g. Behavioral Health Record reviews are completed annually through the Arizona Association of Health Plans practice. Passing score is 85% or above. The Health Plan will notify providers of the passing score via letter. The results of the Behavioral Health medical record audit on providers who do not receive a passing score will be reviewed with the health plan's Medical Officer and QMPI committee. CAP's will be implemented based on findings. Results of the Behavioral Health medical record review audit, correspondence to providers, including corrective action plans will be stored in a secure confidential manner.

If records are kept in more than one location, the agency/provider shall maintain documentation specifying the location of the records.

Prior Authorization

How to Obtain a PA for Physical Health Services

This section pertains to the processing of prior authorization and utilization review requests. More information can be found in the Forms and Resources section of the secure website at www.BannerUHP.com.

The following guidelines establish minimum standards of evaluation and care that must be met prior to PCP referral. Prior authorization is required for any services that are provided by an out-of-network provider/facility. Prior authorization must be requested through the PCP. For a complete list of services requiring prior authorization, visit www.BannerUHP.com.

Please note that each Plan has a separate prior authorization list.

Behavioral Health prior authorizations and medical necessity requirements by levels of care are located in the BH Appendix of this manual.

Frequently Used Services that Require Prior Authorization

- Behavioral Health Services – out-of-network
- Behavioral Health Inpatient Facility
- Behavioral Health Residential Facility
- Home Care Training to Home Care Clients (HCTC)
- Planned, non-emergency inpatient hospital services
- Electroconvulsive Therapy (ECT)
- Non-emergency out of network services/treatments
- Some medications, check the list of approved medications (formulary)
- Some medical equipment and supplies (DME/electric equipment/prosthetics/orthotics)
- MRI, MRA, PET scans
- Special lab work, genetics
- Surgeries, pre-scheduled
- Dialysis
- Some Outpatient procedures and surgeries
- Some cosmetic surgeries
- Transplants (solid organ)

Augmentative and Alternative Communication (AAC)

Augmentative and Alternative Communication (AAC), or speech generating devices are used to assist when natural speech or communication does not meet a member's needs or goals. AAC evaluations and devices are an AHCCCS covered benefit for members but do require prior authorization. Members, both adult and pediatric, will need a referral from their primary care provider for an evaluation by a contracted provider of these services. A list of in-network, licensed and registered speech language pathologist providers can be found on our website or by calling our Customer Care Department. The evaluation must be completed in a face to face encounter. If a device is indicated, a prior authorization form with clinical documentation supporting the need must be submitted to the health plan for review and approval following our standard prior authorization process.

Prior Authorization Guidelines

The prior authorization submission processes outlined below apply to the following health plans:

- Banner – University Family Care/ACC
- Banner – University Family Care/ALTCS

PCPs are responsible for coordinating the delivery of medical care/services for their patients. Nurses, medical directors, and board-certified specialists conduct medical reviews as needed to ensure services are:

- Included in an individual's benefit plan
- Provided at the most appropriate level of care and site
- Medically necessary

B – UHP uses clinical information sources when making medical necessity determinations. Medical necessity criteria used in clinical decision-making includes, but is not limited to:

- AHCCCS Medical Policies and Guides (AMPM/ACOM)
- Applicable State and Federal Laws
- Plan eligibility and coverage
- Center for Medicare and Medicaid Services – National and Local Coverage Determinations, Local Coverage Articles

- MCG Care Guidelines
- Independent review organizations and consultants (MRIoA)
- Current evidence-based clinical decision resource
- FDA Drug Labeling
- Nationally recognized sources/clinical practice standards
- In the absence of one of these sources, the Medical Directors will make the determination.

A member's case is forwarded to a B – UHP Medical Director for review and determination when the clinical documentation provided does not meet the criteria. A member's case may be discussed with our Medical Director upon an attending physician's request.

To discuss an adverse decision for an AHCCCS member with our B – UHP Medical Director, please call the Utilization Management Department within five (5) business days of the determination.

To request the clinical basis or criteria used when making medical necessity determinations from B – UHP, or to request a peer to peer please fax our Utilization Management Department at (520) 874-3420 or call:

- Banner – University Family Care/ACC: (800) 582-8686, TTY 711
- Banner – University Family Care/ALTCS: (833) 318-4146, TTY 711

Claim payments are not guaranteed when an authorization is submitted and approved; it is based on medical necessity review, proper coding, and covered benefits. Payment is dependent on the member's eligibility at the time of service and/or treatment. To verify a member's eligibility, please call:

- Banner – University Family Care/ACC: (800) 582-8686, TTY 711
- Banner – University Family Care/ALTCS: (833) 318-4146, TTY 711

Prior authorization requests may be made via:

- Phone Provider Experience Center (PEC): (800) 582-8686, TTY 711
- Fax: (520) 874-3418 (local) or (866) 349-0338 or (866) 210-0512 (toll-free)
- Mail:
  Banner – University Health Plans
  Attn: Prior Authorizations Department
  5255 E Williams Circle, Ste 2050
  Tucson, Arizona 85711

Prior Authorization requests should include:

- Name(s) of provider making the request
- Findings of provider – medical records to support the request
- Rationale for service(s) needed
- In-Network Provider to perform service (Rationale for requiring out of network provider if applicable).

Authorization forms are available at www.BannerUHP.com.

For questions about a prior authorization call Provider Experience Center at:

- Banner – University Family Care/ACC: (800) 582-8686, TTY 711
- Banner – University Family Care/ALTCS: (833) 318-4146, TTY 711

Upon receipt, authorization requests will be date and time stamped. Member eligibility will be verified. Medical Records will be reviewed. Failure to provide adequate documentation, including PCP and/or specialist's current notes, relevant labs, X-ray results and/or pre-op clearance, if required, may result in processing delays. The PCP and member will be notified of the request status.

All requests for service should be coordinated through and initiated by the PCP to maximize the continuity of care unless the member is out of the service area. Authorization is not required for Emergency

Department services. Prior authorization services are available 24 hours a day, 365 days per year.

Notice on Missing Prior Authorization Documentation

The Medical Management staff will contact the provider's office to request any missing information to validate the request is medically necessary. Two attempts to obtain records will be made.

If the information is not received at that time, the request is in danger of being denied due to a lack of documentation to support medical necessity. If the request is denied, the member will need to follow the appeals process, which may result in a delay of service for the member.

Urgent/Emergent Care Needs

Treatment at an Emergency Department or Urgent Care does not require prior authorization.

Referrals to Non-Participating (Out-of-Network) Providers

Prior authorization is required for all services not available through a contracted provider, including:

- PCP and specialist procedures included in the current Prior Authorization list
- Out-of-Network (OON) services
- Out-of-Area (OOA) services

Post-Emergency Department and Urgent Care Follow-up

Patients are encouraged to follow up with their PCP after an emergency department or urgent care visit.

If the member was seen by a non-contracted specialist while in the emergency department or was referred to a non-contracted specialist by the emergency department, members will need approval tohave one transition of care visit to complete care with the provider and to prepare for transition to an in Network provider.

If ongoing health concerns necessitate continued care from the non-network specialist, prior authorization is required. The specialist must submit pertinent documentation explaining the need and requesting continuing care.

Post-Hospitalization Follow-up

Patients are encouraged to follow up with their PCP after discharge from the hospital. Prior authorization is needed if the post hospitalization follow-up is with an out-of-network specialist. Subsequent visits to out-of-network specialists can be submitted by the specialist for continuity of care. Documentation demonstrating the need for continuity of care would need to be provided. Patient will be directed to an In Network provider when continuity of care is no longer required.

Self-Referrals

Members/patients may self-refer to contracted specialists for the following:

- Gynecologist – Annual exam
- Optometrist – Annual refraction/vision exam
- Screening mammography at a network facility
- Behavioral health service with a network provider or a network facility

Members must verify health plan benefits for specific services that may be self-referred.

After-Hours Prior Authorization

Authorization is not required for Emergency Department services. Members experiencing a medical emergency should be directed to dial 911.

Requests for after-hours prior authorization of non-emergent services will be processed by the answering service as follows:

1. Answering service operator will record the caller's name, telephone number and affiliation (e.g., Banner Boswell Medical Center requesting member transfer to a skilled nursing facility)
2. Information is promptly forwarded via electronic text message to the after-hours registered nurse

3. The registered nurse will contact the caller to facilitate prior authorization, utilization management, or other member needs
4. When appropriate, a registered nurse will coordinate care through the established ancillary network (e.g., contact home health, arrange transportation, etc.)

Calls forwarded to the after-hours prior authorization nurse will be triaged for urgency.

Emergent or urgent requests will be processed immediately. Non-urgent requests will be deferred until the next business day.

Authorization Timelines

Urgent requests for medications listed on the PA grid will be reviewed within 24 hours. AHCCCS allows an additional 7 days extension if needed.

Medical Standard requests will be reviewed within **14 days**.

Medical Expedited requests will be reviewed within **72 hours of receipt.**

Expedited requests are defined as *the standard review timeframe may seriously jeopardize the life or health of the Member, or the Member's ability to regain maximum function*. Please keep in mind that expedited requests should be reserved for those situations that need urgent decision due to the members health – not as a convenience.

Extensions on expedited and standard requests can be provided if more time is needed to obtain records.

The requesting provider will be notified of the request approval or denial via fax confirmation. The member will receive a written letter notifying him or her of the request determination. If the request is denied, the letter will outline the determination appeal process.

Affirmation of Ethical Decision Making

At B – UHP, utilization management decisions are based solely on medical necessity and appropriateness of care in accordance with the terms of plan coverage. Providers are not compensated for denying coverage, and there are no incentives for inappropriate under-utilization of services. All participants, including physicians, employees, consultants, and management staff responsible for utilization management decisions, must sign an Affirmation of Ethical Decision-Making statement as part of the contracting process and each year thereafter.

Retrospective Review Requests

Retrospective Review is a post-service Utilization Management request for coverage of medical care or services that have already been received. Providers should adhere to all prior authorization requirements prior to initiating a service as described in pages 93– 97 of this manual. See pages 171-173 for Behavioral Health parameters.

A Retrospective Review request will be considered at the plan discretion when good cause is demonstrated why pre-service authorization did not occur prior to services being rendered and/or lack of notification or timely notification for an emergent inpatient admission. Retrospective Reviews are performed by licensed health professionals including Medical Directors, PharmD's and Registered Nurses. These clinicians follow the application of criteria and review for medical necessity as described in pages 94-97 of this manual.

A Medical Director makes all healthcare determinations or decisions to deny a post-service coverage request, or authorize a request in an amount, duration or scope that is less than requested.

A PharmD may make determinations or decisions to deny a post-service medication coverage request, or authorize a medication request in an amount, duration or scope that is less than requested.

Retrospective Review Request Guidelines

- Submit Retrospective Review Request within B – UHP claim submission guidelines.
- Complete the Retrospective Review Request Form with explanation why authorization was not obtained prior to services being rendered and/or lack of notification for emergency inpatient admission.
- Court Ordered screening and evaluations are the responsibility of the county as specified in A.R.S. § 36-545 and cannot be reimbursed by Medicaid.

- Payment for services related to Provider-Preventable Conditions is prohibited, as specified in 42 CFR 447.26 and cannot be reimbursed.
- Submit Retrospective Review Request Form with a claim and appropriate attachments batched together; claim on top followed by the request form and remaining attachments. Send to:

  Banner – University Family Care/AHCCCS Complete Care (B – UFC/ACC)
  P.O. Box 35699
  Phoenix, AZ 85069-7169
  Electronic ID: 09830

  Banner – University Family Care/Arizona Long Term Care (B – UFC/ALTCS)
  P.O. Box 37279
  Phoenix, AZ 85069
  Electronic ID: 66901

Upon receipt of a Retrospective Review Request with the required documentation, B – UHP will make a determination within 30 days of receipt. If it is determined that the request is not eligible for a Retrospective Review based on the above criteria, the provider will be notified and may submit an appeal.

Concurrent Review

B – UHP conducts concurrent utilization review on each member admitted to an inpatient facility, including skilled nursing facilities and freestanding specialty hospitals. Utilization review activities include both admission certification and continued stay review. The review of the member's medical record assesses medical necessity for the admission, and appropriateness of the level of care, using the Milliman Care Guidelines®. Admission certification is conducted within one (1) business day of receiving notification.

It is the responsibility of the facility to notify B – UHP of all member admissions to assure that a service medical necessity review is conducted so that claims are not delayed. Services rendered without notification will result in a claim denial unless a claim is submitted with a Retrospective Review Request as mentioned above. Continued stay reviews are conducted by B – UHP Utilization Review staff before the expiration of the assigned length of stay for Acute, Behavioral Health and Skilled Nursing stays. Providers will be notified of approval or denial of length of stay. The utilization review staff works with the medical directors in reviewing medical record documentation for hospitalized members. B – UHP utilization review staff will notify the facility care management department of days approved.

B – UHP uses Milliman Care Guidelines® to ensure consistency in hospital–based utilization practices. The guidelines span the continuum of patient care and describe best practices for treating common conditions. The Milliman Care Guidelines® are updated regularly as each new version is published. A copy of individual guidelines pertaining to a specific care is available for review upon request.

Effective and timely discharge planning and coordination of care are key factors in the appropriate utilization of services and prevention of readmissions. The hospital staff and the attending physician are responsible for developing a discharge plan for the member and for involving the member and family and assigned outpatient clinical teams in implementing the plan.

B – UHP Utilization review staff works with the hospital discharge team and attending physicians to ensure that cost-effective and quality services are provided at the appropriate level of care. This may include, but is not limited to:

- Assuring early discharge planning. The utilization review staff play a key role in assisting with discharge planning and may facilitate authorization of services required for a safe discharge such as pharmacy, home health and DME.
- Facilitating/attending discharge planning meetings for members with complex and/or multiple discharge needs.
- Providing hospital staff and attending physician with names of contracted providers (i.e., home health agencies, DME/medical supply companies, other outpatient providers).
- Informing hospital staff and attending physician of covered benefits as indicated.

Medical Directors review all admissions that do not meet criteria for the requested level of care or do not meet medical necessity criteria for admission. The Medical Director is the only staff member to deny a request. The utilization reviewer reviews the documentation for evidence of medical necessity according to

established criteria. When the criteria are not met, the case is referred to a medical director. The medical director reviews the documentation, discusses the care with the reviewer and may call the attending physician for more information. Based on the discussion with the physician or additional documentation submitted, the medical director will decide to approve, deny, modify, reduce, suspend or terminate an existing or pending service. Utilization management decisions are based only upon appropriateness of care and service. B – UHP does not reward practitioners, or other individuals involved in utilization review, for issuing denials of coverage or service. The decision to deny a service request will only be made by a physician.

For inpatient denials, hospital staff is verbally notified when B – UHP is denying continued stay. The hospital will receive written notification with the effective date of termination of payment or reduction in level of care. The attending physician may dispute the finding of the medical director informally by phone or formally in writing. If the finding of the medical director is disputed, a formal claim dispute may be filed according to the established B – UHP claim dispute process.

Coordination of Care

PCPs in their care coordination role serve as the referral agent for specialty and referral treatments and services provided to B – UHP members assigned to them and attempt to ensure coordinated quality care that is efficient and cost effective. Coordination responsibilities include, but are not limited to:

- Referring members to providers or hospitals within the B – UHP network, as appropriate, and if necessary, referring members to out-of-network specialty providers
- Coordinating with B – UHP's Prior Authorization Department about prior authorization procedures for members
- Conducting follow-up (including maintaining records of services provided) for referral services that are rendered to their assigned members by other providers, specialty providers and/or hospitals
- Coordinating the medical care of the B – UHP members assigned to them, including at a minimum:
    - Oversight of drug regimens to prevent negative interactive effects
    - Follow-up for all emergency services
    - Coordination of inpatient care
    - Coordination of services provided on a referral basis, and
    - Assurance that care rendered by specialty providers is appropriate and consistent with each member's health care needs.

PCPs are required to, when necessary, provide care coordination which includes the referral and/or transition of members to behavioral health care who:

- Have been admitted to an inpatient hospital for a behavioral health diagnosis.
- Do not respond to treatment and therefore need additional behavioral health services such as counseling and/or more intense medication monitoring.
    - Present with a behavioral health diagnosis other than ADHD, alcohol use disorder, anxiety, depression, or postpartum depression, or opioid use disorder (MAT services).
    - Have experienced a sentinel event (e.g. attempted suicide, danger-to-self, danger-to-others).
    - Require services outside the PCP's scope of expertise.

To facilitate a member's access to behavioral health services in a timely manner, PCP's must call member services for BH provider identification or coordinate with "in network" providers directly for coordination after considering member's clinical presentation, preferred locations, and cultural preferences. They should assist the member with scheduling an intake appointment with the identified BH provider, as necessary.

Additionally, PCPs are responsible for the collecting of basic information about the member to determine the urgency of the situation and assist with the subsequent scheduling of intake session within the required timeframes and with an appropriate provider. Keeping information or documents gathered in the referral process confidential and protected in accordance with applicable federal and state statutes,

regulations, and policies.

Informing, as appropriate, any changes in referrals (refusing services, change in need, etc.) to referred organizations. Including notification to behavioral health providers, if known, when a member's health status changes, medication change, or new medications are prescribed.

Coordination of Care with Other Governmental Entities

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

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

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

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

Children's Services

All B – UHP contracted providers must ensure collaborative and consistent goals established by other governmental agencies serving the child and family. Behavioral health service plans shall be directed by the Child and Family Team (CFT) and the team should seek the inclusion of other involved governmental agencies in the planning process.

B – UHP contracted providers must ensure that service delivery is consistent with AMPM 580 and AMPM 320-O.

Department of Child Safety (DCS)

When a child member receiving services is also receiving services from DCS, B – UHP providers must work toward effective coordination of services with the DCS Specialist and/or Comprehensive Health Plan (CHP) staff, when involved.

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

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

B – UHP Contracted providers who are contracted with AFF are required to:

- Accept referrals for Title XIX/XXI eligible and enrolled members and families referred through AFF
- Accept referrals for Non-Title XIX and Non-Title XXI persons and families referred through AFF and provide services, if eligible
- Ensure that services made available to persons who are Non-Title XIX and Non-Title XXI eligible are provided by maximizing available federal funds before expending State funding as required in the Governor's Executive Order 2008 -01

- Collaborate with ADES/DCS, the ADES Family Assistance Administration (FAA) Jobs Program and Substance Use Treatment providers to minimize duplication of assessments and achieve positive outcomes for families

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

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

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

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

- Working in collaboration with the school and sharing information to the extent permitted by law and authorized by the child's parent or legal guardian
- For children receiving special education services, actively consider information and recommendations contained in the Individual Education Plan (IEP) during the ongoing assessment and service planning process
- For children receiving special education services, ensuring that the provider or designee participates with the school in developing the child's IEP and share the behavior treatment plan interventions, if applicable
- Inviting teachers and other school staff to participate in the CFT process if agreed to by the child and legal guardian
- Having a clear understanding of the Individualized Education Plan (IEP) requirements as described in the Individuals with Disabilities Education Act (IDEA) of 2004
- Ensuring that students with disabilities who qualify for accommodations under 504 of the Rehabilitation Act of 1973 are provided adjustments in the academic requirements and expectations to accommodate their needs and enable them to participate in the general education program
- Ensuring that transitional planning occurs prior to and after discharge of an enrolled child from any out-of-home placement

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

B – UHP contracted providers must ensure the following:

- Children birth to three years of age are referred to AzEIP in a timely manner when information obtained in the child's behavioral health assessment reflects developmental concerns
- Children found to require behavioral health services as part of the AzEIP evaluation process receive appropriate and timely service delivery
- If an AzEIP team has been formed for the child, the behavioral health provider will coordinate team functions so as to avoid duplicative processes between systems

Courts and Corrections

B – UHP and its contracted providers are expected to collaborate and coordinate care for members involved with the justice system including:

- The Arizona Department of Corrections (ADOC)
- Arizona Department of Juvenile Corrections (ADJC)
- Administrative Offices of the Court (AOC)

- County Jails
- Sheriff's Offices
- Correctional Health Services
- Community Supervision and Probation Departments
- Parole Offices

B – UHP contracted providers may also call the Customer Care Center at (800) 582-8686 and ask to speak to court coordinator for assistance.

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

- Working in collaboration with the appropriate staff involved with the member
- Inviting probation or parole representatives to participate in the development of the service plan and all subsequent planning meetings for the Adult Recovery Team (ART) with the member's approval
- Actively considering information and recommendations contained in probation or parole case plans when developing the service plan
- Ensuring that the provider evaluates and participates in transition planning prior to the release of eligible members and arranges and coordinates care upon the member's release

Arizona County Jails

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

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

For members without an identified outpatient provider, the Health Plan's Justice Liaison works directly with the jails for coordination of care. For the following county jails, B – UHP utilizes contracted Jail Liaisons for assisting in coordination of care;

- Pima County: Hope, Inc.
- Yuma, La Paz and Pinal Counties: TLCR

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

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

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

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

Arizona Department of Health Services/Office of Assisted Living Licensing

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

First Responders and Community Agencies

B – UHP expects its providers to proactively collaborate with municipal first responders: police, fire, EMS, Regional Behavioral Health Authority (RBHA) contracted crisis providers and hospital emergency departments and develop strong, effective relationships in the communities they serve.

Veterans Administration

The Veteran's Administration (VA) is a federally funded health system that provides benefits to members who served in the active military, naval, or air service; and who were discharged or released under conditions other than dishonorable (Congressional Research Center, 2012).

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

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

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

1. The interests of the service member, veteran and family should come first
2. Potential conflicts of interests should be disclosed
3. Respect the service member, veteran and/or family member providing accurate information

4. Individuals and organizations should only offer programs, services and resources they are equipped or trained to deliver
5. Organizations that outreach to the military/veteran population have an obligation to equip their personnel and organizations
6. Outreach and messaging to the military and veteran population should be truthful
7. Organizations should be cautious about promising outcomes
8. Coordination of care and follow up is essential

Indian Health Services

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

Coordination of Care with Primary Care Providers

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

Medicare covers limited inpatient services, outpatient services and prescription medications. Medicare covered services are provided on either a fee-for-service basis or a managed care basis (through Medicare Advantage Plans). The term Medicare provider refers to both the fee-for-service Medicare providers and the Medicare Advantage Plans. Coordination of care must occur with Medicare providers to achieve positive health outcomes for Medicare eligible members.

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

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

Coordination of Care Process

The following procedures will assist providers in coordinating care:

- If the identity of the member's primary care provider (PCP) is unknown, a provider must contact B – UHP's Customer Care Center at (800) 582-8686
- B – UHP members who have never contacted their PCP prior to receiving behavioral health services should be encouraged to seek a baseline medical evaluation. B – UHP members should also be prompted to visit their PCP for routine medical examinations annually or more frequently if necessary
- Providers should request medical information from the member's assigned PCP. Examples include current diagnosis, medications, pertinent laboratory results, last PCP visit, Early Periodic Screening, Diagnosis and Treatment (EPSDT) screening results
- Providers are required to document information into the member's Service Plan which provides a

longitudinal single view of care planning of all providers including physical and behavioral health last hospitalization. If the PCP does not respond to the request, contact B – UHP's Customer Care Center for assistance at (800) 582-8686

- Providers must address and attempt to resolve coordination of care issues with PCP's at the lowest possible level. If problems persist contact B – UHP's Customer Care Center at (800) 582-8686

B – UHP Care Management Department

B – UHP Care Management process has a primary purpose of coordinating care needs for members who are medically complex and require intensive physical, and or behavioral health support services.

B – UHP Care Managers identify and manage clinical interventions or alternative treatments for identified members to reduce risk, cost and help achieve improved health outcomes. Care management activities are typically short term and time limited in nature. Care management may include assistance in makingor keeping appointments, following up and explaining hospital discharge instructions, health coaching and referrals related to an individual's immediate needs, Primary Care provider reconnection, and offering other resources or materials related to wellness, lifestyle and prevention.

B – UHP's Care Management Program focuses on ensuring coordination of physical and behavioral health needs across the continuum, based on early identification of health risk factors or special care needs. B – UHP Care managers have direct contact with our members for the purpose of providing information and coordinating care. B – UHP Care management is an administrative function and does not replace any case management at a facility or provider level. B – UHP Care Managers do not perform the day to day duties of the ALTCS Case Manager, the provide Case Manager or TRBHA Care Manager or Tribal ALTCS case manager.

B – UHP Care Management interventions include, but are not limited to, educating individuals and/or their Health Care Decision Maker such as:

1. Outreach phone calls/visits
2. Educational letters
3. Behavioral health referrals
4. High Need/High Cost program referrals
5. Disease/chronic care management referrals
6. Exclusive pharmacy referrals, and
7. Social Determinants of health resources.

Sharing Information with Other Treating Professionals and Involved Stakeholders

To support quality medical management and prevent duplication of services, providers are required to disclose relevant behavioral health information pertaining to eligible members to the assigned PCP, B – UHP, other treating professionals and other involved stakeholders within the following required timeframes:

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

Coordination of Care for Title XIX/XXI Members

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

- Notify the assigned PCP of the results of PCP initiated behavioral health referrals
- Provide a final disposition to B – UHP Behavioral Health Coordinator in response to PCP initiated behavioral health referrals, (for more information on the referral process, see Referral and Intake Process Section)
- Coordinate the placement of persons in out-of-state treatment settings
- Notify, consult with, or disclose information to the assigned PCP regarding persons with Pervasive Developmental Disorders and Developmental Disabilities, such as the initial assessment and treatment plan and care and consultation between specialists

- Provide a copy to the PCP of any executed advance directive, or documentation of refusal to sign an advance directive, for inclusion in the Member's medical record
- Notify, consult with, or disclose other events requiring medical consultation with the person's PCP

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

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

- A header that states "Coordination of Care"
- Be legible
- PCP's name and address
- Reason for the communication
- Diagnoses
- Dose, frequency, and target symptoms of current behavioral health medications
- Summary of critical labs
- Other information as requested by the PCP
- Response to PCP's referral questions
- Additional Behavioral Health Provider Contact Information
- Indicate the date and if the information was either mailed or faxed to the PCP

Pre-Petition Screenings and Court Ordered Evaluations

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

Emergency Behavioral Health Services

When a member presents in an emergency room setting, B – UHP is the payer of last resort after Medicare and any county fiscal responsibilities, for all emergency medical services including triage, physician assessment, and diagnostic tests. Additionally, B – UHP is responsible for psychiatric and/or psychological evaluations in emergency room settings provided to all B – UHP eligible members.

For eligible members, B – UHP is responsible for providing:

- All inpatient emergency services to members with psychiatric or substance abuse diagnoses
- Emergency transportation of an eligible to the emergency room (ER)
- Emergency transportation required to manage an acute medical condition, which includes transportation to the same or higher level of care for immediate medically necessary treatment

If an eligible member is assessed as needing inpatient psychiatric services by B – UHP or subcontracted provider prior to admission to an inpatient psychiatric setting, the entity responsible for primary coverage (Medicare coverage) is responsible for authorization and payment for the full inpatient stay.

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

B – UHP Care Management monitors the length of time adults and children remain in the ED while awaiting behavioral health placement or wrap around services. Immediately upon notification that a

member who requires behavioral health placement or wrap around services is in the ED, Care Management will coordinate care with the ED and the member's treatment team to assist in the discharge to the most appropriate placement and ensure needed behavioral health services are set up.

Emergency Departments and/or outpatient providers should contact the Banner Health Plan 24-hour Customer Care Department to initiate resolution of transitioning the member to the appropriate needed behavioral health services.

Non-emergency Transportation

B – UHP is responsible for:

- Transportation of an eligible member to an initial behavioral health intake appointment
- Long-Term Care members who are unable to provide or secure their own transportation for medically necessary services using the appropriate mode based on the needs of the member

Medical Treatment for Members in Behavioral Health Treatment Facilities

When a member is in a behavioral health residential treatment center and requires medical treatment, the entity responsible for primary coverage (Medicare coverage) is responsible for the provision of covered medical services.

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

PCPs Prescribing Psychotropic Medications

Within their scope of practice and comfort level, a B – UHP PCP may elect to treat select behavioral health disorders:

- Attention-Deficit/Hyperactivity Disorder
- Uncomplicated depressive disorders
- Anxiety disorders
- Opioid Use Disorders

Certain requirements and guiding principles regarding medications for psychiatric disorders have been established for members under the care of both a PCP and behavioral health provider simultaneously. Eligible members must not receive medications for psychiatric disorders from the PCP and behavioral health provider simultaneously. If a member is identified to be simultaneously receiving medications from a PCP and behavioral health provider, the provider must immediately contact the PCP to coordinate care and agree on who will continue to medically manage the member's behavioral health condition.

Transitions of Members with ADHD, Depression, and/or Anxiety to the Care of Their Primary Care Provider

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

- The behavioral health provider must contact the member's PCP to discuss the member's current medication regime and to confirm that the PCP is willing and able to provide treatment for the member's ADHD, depression, and/or anxiety
- If the PCP agrees to transition treatment for the member's diagnosis of ADHD, depression and/or anxiety, the behavioral health provider must provide the PCP with the following information:
    - A written statement indicating that the member is stable on a medication regime
    - A medication sheet or list of medications currently prescribed by a Health Plan Contracted Behavioral Health Medical Practitioner (BHMP)

- A psychiatric evaluation
- Any relevant psychiatric progress notes that may assist in the ongoing treatment of the member
- A discharge summary outlining the member's care and any adverse responses the member has had to treatment or medication

A copy of the packet must be sent to the BUHPCareMgmtBHMailbox@bannerhealth.com.

B – UHP will ensure that the member's transition to the PCP is seamless, and that the member does not go without medications during this transition period. B – UHP Providers must ensure the member is eligible for transition to the care of their PCP by completing the following steps:

- The member's behavioral health provider must confirm the member has a diagnosis of ADHD, depression, and/or anxiety
- The member's behavioral health provider must confirm the member has been stable for at least six months. Indicators for stability are as follows:
    - No medication changes or dosage changes
    - No inpatient admissions
    - No crisis episodes

The behavioral health prescriber who is actively prescribing psychiatric medications for the member must contact the member's assigned PCP telephonically to discuss the member's current prescription regimen. The behavioral health prescriber must confirm that the PCP is willing and able to provide medication management services to the member.

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

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

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

Court Ordered Programs & Processes

Title 36 Court Ordered Evaluation (COE) and Court Ordered Treatment (COT)

At times it may be necessary to initiate civil commitment proceedings to ensure the safety of a member or the safety of others when, due to a member's mental disorder, that member is unable or unwilling to participate in treatment. In accordance with the A.A.C. R9-21-101 and A.R.S. § 36-533 any responsible person may apply for pre-petition screening when another person is alleged to be, as a result of a mental disorder:

- A danger to self (DTS)
- A danger to others (DTO)
- Persistently or acutely disabled (PAD)
- Gravely disabled (GD)
- Unwilling or unable to undergo a Voluntary Evaluation

American Indian members may be subject to COE/COT proceedings or may be subject to a tribal court order, depending on where the behavioral health crisis occurs. If the member is subject to the jurisdiction of a Tribal Nation, the laws of that Tribal Nation will govern the commitment process.

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

Contracted behavioral health providers that receive an application for court ordered evaluation must immediately refer the applicant for pre-petition screening and petitioning for court ordered evaluation to the county designated pre-petition screening agency or county facility. If the pre-petition screening indicates that the member may be DTS, DTO, PAD, or GD, the screening agency will file a Petition for Court Ordered Evaluation along with an application for involuntary evaluation. Based on the immediate safety of the member or others, an emergency admission for evaluation may be necessary. The screening agency, upon receipt of the application, is required to act as prescribed within 48 hours of the submittal of the application, excluding weekends and holidays as described in A.R.S. §36-520.

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

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

If the court orders a combination of inpatient and outpatient treatment, a mental health agency may be identified by the court to supervise the member's outpatient treatment. Before the court can order a mental health agency to supervise the member's outpatient treatment, the agency's medical director must agree and accept responsibility by submitting a written treatment plan and Letter of Intent to Treat (LOI) to the court.

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

Licensing Requirements

Behavioral health providers who are licensed by the Arizona Department of Health Services/Division of Licensing Services as a pre-petition screening, court ordered evaluation or court ordered treatment agency must adhere to ADHS licensing requirements.

Reimbursement of court ordered screening and evaluation services are the responsibility of the County pursuant to A.R.S § 36-545. For additional information regarding behavioral health services refer to 9 A.A.C. 22, 2 & 12. Refer to ACOM Policy 437 for clarification regarding financial responsibility for the provision of medically necessary behavioral health services rendered after the completion of a Court Ordered Evaluation (COE).

Agencies responsible for pre-petition screening and court ordered evaluations must use the following forms prescribed in 9 A.A.C. 21, Article 5:

- Exhibit A - Application for Involuntary Evaluation
- Exhibit B - Petition for Court Ordered Evaluation
- Exhibit C - Application for Emergency Admission for Evaluation
- Exhibit D - Application for Voluntary Evaluation
- Exhibit E – Affidavit
    - Addendum No. 1 - Persistently or Acutely Disabled
    - Addendum No. 2 – Gravely Disabled
- Exhibit F - Petition for Court ordered Treatment
- Exhibit G - Demand for Notice by Relative or Victim
- Exhibit H - Petition for Notice
- Exhibit I – Application for Voluntary Treatment

Pre-Petition Screening

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

The pre-petition screening includes an examination of the member's mental status and/or relevant circumstances by a designated screening agency.

The pre-petition screening agency must follow these procedures:

- Provide pre-petition screening within forty-eight hours excluding weekends and holidays.
- Offer assistance, if needed, to the applicant in the preparation of an application for court ordered evaluation.
- Prepare a report of opinions and conclusions. If pre-petition screening was not possible, the screening agency must report reasons why the screening was not possible, including opinions and conclusions of staff members who attempted to conduct the pre-petition screening.
- Have the Medical Director or designee review the report if it indicates that there is no reasonable cause to believe the allegations of the applicant for court ordered evaluation.
- Prepare a petition for court ordered evaluation and file the petition if the Medical Director or designee determines that the member, due to a mental disorder, including a primary diagnosis of dementia and other cognitive disorders, is DTS, DTO, PAD, or GD. (Exhibit B, Petition for Court Ordered Evaluation).
- Document pertinent information for court ordered evaluation.
- If the screening agency determines that there is reasonable cause to believe that the member is in danger of coming to harm or causing harm without immediate hospitalization, the screening agency must ensure completion of Exhibit C, Application for Emergency Admission for Evaluation, and take all reasonable steps to procure hospitalization on an emergency basis.
- Contact the county attorney prior to filing a petition if it alleges that a member is DTO.

Emergency Admission for Evaluation

An application for emergency admission may be made only when a member, because of a mental disorder, is in such a condition that without immediate hospitalization, is likely to be a DTS, DTO, PAD and/or GD, precluding the use of the pre-petition screening process:

- Applications indicating DTS, DTO, PAD and/or GD can be filed on an emergent basis.
- Applications may be completed by an applicant who has knowledge of the behavior displayed by the member, consistent with the requirements specified in A.R.S. § 36.524.
- The applicant must complete Exhibit C, Application for Emergency Admission for Evaluation. An application by a doctor, nurse or law enforcement officer does not require an original signature, may be a facsimile, and does not have to be notarized.
- The applicant and all witnesses identified in the application as direct observers of the dangerous behavior may be called to testify in court if the application results in a petition for COE.
- A member proposed for emergency admission for evaluation may be apprehended and transported to the facility under the authority of law enforcement or other county contracted transportation using the Application for Emergency Admission for Evaluation as specified in A.R.S. §§ 36-524, 36-524(D) and 36-525(A), and AMPM Policy 320-U (D)(8).
- The member can be held in an inpatient setting up to 24 hours (excluding weekends and holidays) following a written application for emergency evaluation pending the filing of a petition for court ordered evaluation. If no petition for court ordered evaluation is filed within the 24 hours, the member must be released. If a petition is submitted, the hospital may hold the member for an additional seventy-two (72) hours to complete examinations by two (2) physicians.

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

- The member's ability to consent to voluntary treatment will be assessed.

- The member shall be offered and receive treatment to which he/she may consent. Otherwise, the only treatment administered involuntarily will be for the safety of the member or others, i.e. seclusion/restraint or pharmacological restraint in accordance with A.R.S § 36-513
- The psychiatrist will complete the evaluation within 24 hours of determination that the member no longer requires involuntary evaluation.

Petition for Court Ordered Evaluation

If the screening/evaluating agency determines that the member may be DTS, DTO, PAD, and/or GD, the screening/evaluating agency will file a Petition for Court Ordered Evaluation. The procedures for court ordered evaluations are outlined below:

- If, upon review of a Petition for Court Ordered Evaluation, the court agrees that there is significant evidence to warrant an involuntary evaluation, it will issue an Order for Evaluation.
- Evaluations may be conducted on an inpatient or outpatient basis.
- If outpatient, an evaluation must be completed by the fourth day following the first appointment.
- If a member is inpatient, the evaluation must be completed within 72 hours.
- At the conclusion of the 72-hour evaluation period, the inpatient team will determine whether the member requires court ordered treatment for a mental disorder. If the medical director of the inpatient facility does not believe the member requires court ordered treatment, the member must be discharged from the hospital unless the member completes an application for further care and treatment on a voluntary basis.
- If the medical director of the inpatient facility believes the member requires court ordered treatment, a Petition for Court Ordered Treatment is signed and filed by the Evaluation Agency's medical director or physician designee and a hearing is scheduled. (See AMPM Exhibit 320-U-4, Petition for Court Ordered Treatment – Persistently and Acutely Disabled Gravely Disabled Person).
- Title XIX/XXI funds must not be used to reimburse court ordered evaluation services.
- For any Title XIX enrolled member, who has been admitted to an evaluation agency under a Petition for Court Ordered Evaluation, the evaluation period is deemed to end upon the filing of a Petition for Court Ordered Treatment and is not automatically linked to the end of the 72-hour COE period.

Voluntary Evaluation

Any B – UHP provider that receives an application for voluntary evaluation must immediately refer the member to the facility responsible for voluntary evaluations. The B – UHP provider must follow these procedures:

- The evaluating agency must obtain the member's informed consent prior to the evaluation (see Exhibit I, Application for Voluntary Evaluation) and provide evaluation at a scheduled time and place within five days of the notice that the member will voluntarily receive an evaluation.
- For inpatient voluntary evaluations, the evaluating agency must complete evaluations in less than 72 hours (not including weekends and court holidays) of receiving notice that the member will voluntarily receive an evaluation.

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

- A copy of the Application for Voluntary Evaluation
- A completed informed consent form (AMPM Policy 320-Q); and
- A written statement of the member's present medical condition.

Petition for Court Ordered Treatment

Based on the court ordered evaluation, the evaluating agency may petition for court ordered treatment. Behavioral health providers are required to follow these procedures (AMPM 320-U (G)):

- Upon determination that a person is DTS, DTO, GD, or PAD, and if no alternatives to court ordered treatment exist, the Medical Director of the agency that provided the court ordered evaluation must file a petition with the court for court ordered treatment.
- B – UHP must pay for all medically necessary services associated with the period of time between the filing of the Petition for Court Ordered Evaluation and the Hearing set for the purposes of a judicial determination for the need for court ordered treatment.

- Any contracted behavioral health provider filing a Petition for Court Ordered Treatment must do so in consultation with the member's clinical outpatient team prior to filing the petition.
- The petition must be accompanied by the affidavits of the two physicians who conducted the examinations during the evaluation period, and by the affidavit of the applicant for the evaluation.(AAC Title 9, Ch. 21, Article 5: Exhibit E, Affidavit, and corresponding addenda).
- If an investigation for the need of a guardian/HCDM is recommended, a copy of the petition, must be mailed to the public fiduciary in the county of the member's residence, or in which the member was found before evaluation, and to any individual nominated as guardian/HCDM. Additionally, a copy of all petitions shall be mailed to the superintendent of the Arizona State Hospital (ASH).
- During the evaluation period, including and up-to the time of hearing, a member may not be treated psychiatrically unless the member consents. However, seclusion and mechanical or pharmacological restraints may be employed when the member's safety or the safety of others may be jeopardized

Title XIX/XXI Eligible Members and/or Determined to have a Serious Mental Illness (SMI)

When a member referred for court ordered treatment is Title XIX/XXI eligible and/or determined or suspected to meet criteria for SMI designation, the contracted behavioral health provider shall:

a. Submit a referral to a designated contractor for an evaluation to determine if the person has a Serious Mental Illness designation in accordance with AMPM Policy 320-P. The contracted provider is required to conduct a behavioral health assessment to identify the member's service needs in conjunction with the member's clinical team (AMPM Policy 320-O).
b. Provide necessary court ordered treatment and other covered behavioral health services in accordance with the member's needs, as determined by the member's clinical team, the member, family members, and other involved parties.
c. Perform, either directly or by contract, all treatment required by A.R.S. Title 36, Chapter 5, Article 5 and 9 A.A.C. 21, Article 5.

Orders for Treatment/Court Ordered Treatment (COT)

Background

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

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

Every County in Arizona manages this responsibility differently based on their interpretation of the state statutes and the resources in that County. The outpatient behavioral health agency is responsible for following the proper execution of its county's Title 36 procedures.

In serving as regional authority, B – UHP is responsible for treatment of an eligible member* once placed Under a Title 36 civil commitment/court ordered treatment (COT). Per Arizona Administrative Code (R9- 21- 504) the regional authority "shall perform, either directly or by contract all treatment required by A.R.S. Title 36, Chapter 5, Article 5." The B – UHP Court Specialist will serve as the single point of contact for information specific to the court's disposition for eligible members, will assist in coordination of court ordered evaluation and treatment, and will communicate court-related follow-up/requirements to contractor staff. When a member is court ordered for evaluation and/or treatment, they will immediately be entered into the B – UHP Court Ordered Treatment program, and the B – UHP Court Specialist will monitor/track all members placed on court ordered treatment.

Contracted Behavioral Health Provider Responsibilities

Each contracted behavioral health provider is required to designate a staff member to serve as Title 36 Liaison for Court-Ordered services. A contracted behavioral health provider coordinates the provision of clinically appropriate covered services to members requiring court ordered treatment and serves as the

Supervising Agency for court- ordered outpatient treatment plans of B – UHP enrolled members. In all cases, the contracted behavioral health provider's Medical Director, or his/her physician designee, has primary responsibility for oversight of a member's court ordered treatment and is responsible for reviewing and signing all documents filed with the court.

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

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

- Outreach and engagement with these members should be assertive and follow the reengagement processes as outlined in the Reengagement for Members on Court Ordered Treatment section of this manual (pg. 117). The goal is to avoid re- hospitalization and improve the quality of life for the member.
- A solid crisis plan must be developed that includes what works and does not work for this member, supports that can help, and types of outreach that should be attempted if the member has an increase in symptoms or disengages from treatment.
- Contracted behavioral health providers must closely monitor COT expiration dates.

Pursuant to A.R.S 36-540 (D), a court order cannot exceed 365 days, but some counties may order fewer days. Contracted behavioral health providers must ensure they understand the County's interpretation of the COT Expiration date. Contracted behavioral health providers must monitor expiration dates to schedule annual reviews to determine if the member's COT should continue for another year. Additionally, it gives the contracted behavioral health providers enough time to file a Petition for Continued Treatment with court for members who were found Persistently or Acutely Disable or Gravely Disabled. The Health Plan will monitor and audit COT requirements and will issue Corrective Action Letters and/or Sanctions for failure to follow the requirements.

Title 36 Liaisons

B – UHP behavioral health providers that serve as Supervising Agencies for court orders will appoint a Title 36 (T36) Liaison to serve as a central point of contact for all County Mental Health Defenders Office, assigned County Attorney/Office Attorney General, local hospitals and B – UHP. The contracted behavioral health provider's Title 36 Liaison is also responsible for developing and implementing a process for ensuring that contracted provider clinical staff is aware of expectations and changes in procedures as communicated by B – UHP. The T36 Liaison will attend quarterly meetings with the Health Plan Court Coordinator to obtain notification of changes in reporting and/or responsibilities.

Title 36 Liaison responsibilities will include:

Coordinate policies and procedures with B – UHP for enrolled members who have been and/or are in the process of a civil commitment. Reconcile on a monthly basis with B – UHP the roster of members receiving court ordered treatment. Due date of roster will be submitted no later than the 5th of each month to BUHPTitle36@bannerhealth.com. If an agency developed roster is not available, the B – UHP Provider COT Roster template can be utilized. This list will include, but may not be limited to, the following:

- Member's name
- Date of birth
- Health Plan identification number
- Start and End Date of court order
- Standard(s) under which the member was court ordered
- Due dates of Judicial Review, date Judicial Review was completed, indication if Judicial Review was requested by member
- Dates of amendments, type of amendment, dates hospitalized under amendment

- Due date of annual examination, date annual examination completed, recommendation of examination
- Date member was evaluated for potential SMI referral or SMI determination packet was submitted

Provide oversight and technical assistance to contracted provider staff on the Title 36 process, (e.g. testifying, filing of court documents, development of treatment plans), and ensure compliance with statutory requirements, (e.g. Judicial Reviews, Amendments, Annual Examination, etc.).

Development of a current list of members under a Title 36 COT to contracted provider team leaders, supervisors, and on-call staff to ensure communication of current treatment plan recommendations, active suspensions, and other related information.

Compliance with any additional requests by B – UHP which will assist in tracking and monitoring of census data, the implementation of the Title 36 statutes, and delivery of clinical care to members under a Title 36 court order.

Participation in Hearings

Designated process by the County Attorney should be followed. The member's assigned case manager must attend all Title 36 hearings, including the original hearing for court ordered treatment, judicial reviews, annual reviews and petitions for continued treatment of GD or PAD orders. The case manager should be prepared to provide information/clarification to the court regarding facts relevant to the topic of the hearing and the proposed outpatient treatment plan. The case manager must be present to receive orders set forth by the Judge/Commissioner including the dates that Title 36 status reports are to be submitted to the designated county attorney/contracted legal counsel, specific orders regarding submission of the outpatient treatment plan, and the standard of the order (i.e. DTO, DTS, etc.).

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

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

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

If the member is court ordered to treatment, the Judge/Commissioner will request the name of the proposed supervising agency and whether or not a Title 36 Treatment Plan has been prepared. The case manager is to be prepared to submit the original Title 36 Treatment Plan and Letter of Intent to Treat (LOI) to the Judge/Commissioner, with copies given to the County Attorney, the Defense Attorney, the hospital Title 36 Liaison, and the member.

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

Cochise County:

The case manager should not attend any Title 36 hearing unless specifically directed to do so by the County Attorney.

Cochise and Pinal Counties:

Treatment plan and LOI are to be submitted to the County Attorney no later than the day prior to hearing.

Pima County:

Contracted behavioral health providers are responsible for establishing a group generic email box to receive minute entries from the Court. An example is MinuteEntries@[provider name].com. B – UHP has identified a law firm to provide legal representation in filing post-hearing documents and coordinating with the Pima County Superior Court on behalf of providers serving as Supervising Providers. LOI is not required to be submitted for COT hearings in Pima County.

Treatment Plan Development and Filing

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

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

The Court Ordered Treatment Plan must have the member's correct address, zip code and phone number. If the member is to reside with family, friends, etc., provider staff must confirm this arrangement with family, friends, etc. The original Court ordered Treatment Plan is signed by the Judge/Commissioner at the hearing.

Total of 6 treatment plans are to be taken to hearing:

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

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

Subsequent revisions regarding change in provider site, residence, psychiatrist, payee, services, etc. are developed by the member's Adult Recovery Team and included in the ISP. The ISP must be signed by the BHMP, case manager and member.

Upon re-hospitalization following an amendment/revocation of an outpatient treatment plan, the case manager coordinates an ART meeting to develop discharge plans and to ensure that those plans are included in a revised ISP. This plan must be reviewed with the outpatient psychiatrist. The outpatient psychiatrist must discuss the proposed plan and any additional concerns with the inpatient psychiatrist. The member's inpatient team must be involved in, and agree to, discharge decisions. The original ISP is filed in the outpatient chart and a copy of the ISP is filed in the inpatient chart. A member may leave the hospital once this process is complete and if clinically appropriate.

If the member does not agree with the ISP, including revisions to the ISP, he/she may file an appeal with the Health Plan. The case manager must explain the appeal process to the member. If there are changes in the ISP such as residence or covered services, the ISP must be signed by the member, case manager and outpatient psychiatrist. Since all revisions to the ISP are incorporated into and enforced by the original Court Ordered Treatment Plan, a revised Court ordered Treatment Plan does not need to be submitted to the Court.

Amendments/Revocations/Rescissions

If a member fails to comply with the court ordered outpatient treatment plan or needs to be hospitalized and refuses voluntary admission, the Medical Director/physician designee of the contracted agency can amend/rescind the court ordered Outpatient Treatment Plan.

It is important the contracted behavioral health provider track the numbers of days a member has spent in an inpatient setting, because there are a limited number of inpatient days the court may order pursuant to A.R.S. 36-540:

- DTS up to 90 days
- DTO & PAD up to 180 days
- GD up to 365 days

If there are no more inpatient days available, the Medical Director must determine if the member requires continued court-ordered treatment. If the member is in imminent danger and in need of immediate hospitalization, the contracted behavioral health provider can follow the process for an Emergency Application for Evaluation for Admission. If the member does not meet the criteria for the emergent application process, the contracted behavioral health provider can initiate the Annual Review process or follow the Pre-Petition Screening process. Amended outpatient treatment orders do not increase the total period of commitment originally ordered by Court.

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

Emergent Amendments/Revocations/Recessions [A.R.S. 36-540 (E) (5)]

When the member is presenting with DTO/DTS behavior, requires immediate acute hospitalization, and refuses admission, the request to suspend the outpatient treatment plan can be telephonic (emergent). The medical director or physician designee must contact an inpatient psychiatrist, discuss, and agree that the member requires immediate acute inpatient treatment. The medical director or physician designee may authorize a peace officer to transport the member to the inpatient treatment facility.

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

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

Non-Emergent Amendment/Revocation/Recession [A.R. S. 36-540(E)(4)]

If the contracted behavioral health provider determines that the member is not complying with the terms of the order, or that the court ordered outpatient treatment plan is no longer appropriate, the Medical Director or physician designee can petition the court to amend/revoke the outpatient treatment plan to inpatient treatment. The Court, without a hearing and based on the court record, the member's medical record, the affidavits and recommendations of the Medical Director (must be notarized), and the advice of staff and physicians or the psychiatric and mental health nurse practitioner familiar with the treatment of the member, may enter an order amending its original order.

If the member refuses to comply with an amended order for inpatient treatment, the court may authorize and direct a peace officer, on the request of the Medical Director, to take the member into protective custody and transport the member for inpatient treatment. When a member is hospitalized pursuant to an amended order, the contracted behavioral health provider must inform the member of the right to judicial review and the right to consult with counsel pursuant to A.R.S.36-546.

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

The original Request for Amendment of Outpatient Treatment Plan is submitted to the designated county attorney office/law firm and a copy sent to the Health Plan Court Specialist at BUHPTitle36@bannerhealth.com. If the documents are submitted by 10:00 a.m., they will be filed with court that day. If submitted after 10:00 a.m., documents will be filed the following day.

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

Upon admission to the hospital, the contracted behavioral health provider is required to inform the member of the right to judicial review and right to consult with counsel. See Judicial Reviews section.

Quashing an Order to Transport (Amendments/Revocations)

If the member returns to treatment, the Order to Transport on amendment/revocation shall be quashed (voided). The supervising outpatient psychiatrist submits a written statement providing the date when the member returned and reengaged in treatment.

Pima County:

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

Reengagement for Members on Court Ordered Treatment

Providers will reengage the member within 24 hours of a missed appointment and continue frequent reengagement efforts until such a time as the member is reengaged and adherent with treatment, or it has been confirmed that the member is now living in a different geographical area and is reassigned to another health plan, or that the member has permanently moved out of state.

If a member misses a Behavioral Health Medical Practitioner (BHMP) appointment, whether it is because the member canceled, no-showed, or the provider canceled the appointment, the provider should reschedule the member to see the BHMP within two business days.

- BHMP emergency appointment slots should be utilized to accommodate this appointment. Missed appointments and non-adherence to the treatment plan should prompt the treatment team to re-evaluate the treatment plan to ensure that it is meeting the member's needs and goals.

A member's input into the plan, with attention to achieving their goals as much as possible, will help with engagement.

Any barriers to attending appointments should be assertively and creatively addressed, for example a member's difficulty with communication, transportation, competing commitments, childcare, managing schedules, etc. The treatment plan should be as flexible and member centric as possible to facilitate each member's adherence.

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

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

Toll Orders/Notice of Unauthorized Absence

For a member who is noncompliant with the treatment plan and absent without authorization, a Toll Order may be filed. In order to request a Toll Order, the following criteria must be met:

- member is absent from an inpatient treatment facility without authorization;
- member is no longer living in a placement or residence specified by the treatment plan for court ordered treatment and has left without authorization; or
- member left or failed to return to the county or state authorization

The contracted behavioral health provider must adhere to the following process, unless otherwise directed by the local County Attorney:

- Within 5 days of unauthorized absence, the provider may file, through designated legal counsel, a Notice of Patient's Unauthorized Absence and Motion to Toll Treatment Order. The Notice/Motion will include the member's last known address and the date that absence began.
- If there is no open amendment/revocation filed for the current episode of noncompliance, then the provider will also file an amendment/revocation at this time. See Amendments/Revocations.
- The Provider must report all Toll orders on the COT roster and submit documentation to the Health Plan Court Specialist who will track/monitor status.
- The provider must submit a status report while the member is on Toll:
  - Pinal County: every 30 days
  - All other Counties: every 60 days
- Upon member's return from unauthorized absence, the provider will file a Notice of Patient's Return and Request to Revise End Date of Treatment Order. The Notice of Patient's return will include the date member returned and the total number of days member was absent.
- A member whose COT is tolled for a period of at least 60 continuous days may request a judicial review upon voluntary or involuntary return to treatment. The member's case manager is responsible for informing the member of this right.
- If at 180 days the member continues to be absent without authorization, the provider must file a Request to Terminate along with the Report on Efforts to Locate/Return Patient to Treatment.
- A member's COT cannot be tolled for more than 365 days.
- Copies of all documents filed in court relating to the Toll Order must be timely furnished to the Health Plan at BUHPTitle36@bannerhealth.com.

Judicial Reviews A.R.S. 36-546

Every 60 days and upon suspension, the member is to be informed of his/her right to Judicial Review. In cases where the member's outpatient treatment plan has been amended/revoked to an inpatient facility, the member must be offered a Judicial Review within seventy-two (72) hours of admission. This is in addition, and not in place of, the regular Judicial Review schedule. The case manager must inform the member of this right to Judicial Review, member's right to speak to legal counsel, and explain the process. It is the responsibility of the contracted behavioral health Provider to track the Judicial Review dates and ensure a Judicial Review is offered to a member under COT on a timely basis.

If the member requests a Judicial Review, the case manager completes Provider Manual Form - Notification of Individual's Right to Request Judicial Review and Right to Speak to Legal Counsel. The member completes their current address and signs the form. The case manager must schedule an appointment to be evaluated by the supervising BHMP. The Provider Manual Form - Release from COT Worksheet contains the format for, and additional instructions, for completing the evaluation. The Court requires the psychiatric evaluation contains sufficient clinical information to render a decision regarding whether the member needs to remain under court ordered treatment. This evaluation can be in the form of a progress note. The evaluation must be completed and submitted to the designated county attorney/contracted law firm within 72 hours of the request and by the filing deadline of 10:00 a.m. It is best to schedule the appointment no later than 48 hours from request, so that the Judicial Review form is received by the county attorney/contracted law firm the next day, to meet the 72-hour timeframe. Conformed copy of the Judicial Review form is to be submitted to BUHPTitle36@bannerhealth.com.

If the member declines a Judicial Review, the case manager completes the same Provider Manual form Notification of Individual's Right to Request Judicial Review and Right to Speak to Legal Counsel, and the member signs this form. The member provides his/her current address and location. The contracted behavioral health provider maintains this form in the clinical record.

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

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

If the court grants the member's request for release from COT through judicial review, the case manager must immediately notify the member. The provider's Title 36 Liaison must notify the Health Plan and send copy of the court's decision via email to: BUHPTitle36@bannerhealth.com.

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

Cochise, Greenlee, Graham, La Paz, Pinal, Santa Cruz and Yuma Counties:

Designated process directed by County Attorney office should be followed. The following documents are to be submitted to designated County Attorney Office:

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

Status Reports

At the original hearing for COT, the Judge/Commissioner may direct the contracted behavioral health provider to submit status reports to the Court and B – UHP. The Judge/Commissioner will set the dates when the reports are to be submitted. If the contracted behavioral health provider fails to complete the status report to the court, the judge can order the member and/or assigned case manager to appear in court to provide testimony regarding the treatment and status of the member.

- Pinal County Superior Court requires status reports to be submitted to the court at 30, 90, 180, and 270 days.
- Maricopa County Superior Court requires status reports to be submitted to the court at 45 days.
- At this time, no other County Court requires submittal of status reports on a set schedule (unless otherwise Ordered by the Judge).

The status report is completed using the Court Ordered Treatment Status form, or in the format prescribed by the Court. The status report is completed by the case manager and reviewed and signed by the team supervisor and supervising BHMP. Form can be found at https://www.banneruhp.com/materials-and-services/behavioral-health#Behavioral-Health-Materials-and-Forms.

Copy of the report is submitted to B – UHP 7 days prior to due date ordered by the Court. Report is to be submitted to BUHPTitle36@bannerhealth.com. B – UFC/ALTCS members: Assigned ALTCS BHP is responsible for all clinical coordination with BHMP and filing with the B – UHP's contracted law firm.

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

The contracted behavioral health provider shall ensure the supervising BHMP has completed an examination and review of a COT member in an effective and timely manner. This must take place within 90 days but not less than 30 days prior to expiration of any court ordered treatment (see A.R.S. 36-543 and 9 A.A.C. 21-506). To ensure this review has taken place, B – UHP requires the contracted behavioral health provider provide progress notes from the contracted supervising BHMP showing the BHMP met with the member 30-90 days prior to expiration of the COT. This progress note will be collected by B – UHP on a monthly basis, due on the 1st day of the following month, to BUHPTitle36@bannerhealth.com.

Additionally, the member's Adult Recovery Team shall hold a service planning meeting, not less than 30 days prior to the expiration of the COT to determine if the COT should continue (see 9 A.A.C. 21-506). Contracted behavioral health providers can request continuation of COT for members determined to be PAD and/or GD, for another year based on an annual review and examination conducted by the member's supervising BHMP and a petition to the court (Petition for Continued Treatment Pursuant to Annual Review). For members determined only DTS and/or DTO: the contracted behavioral health provider must request a new COE.

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

- The psychiatrist's opinions as to whether the member continues to have a grave disability or persistent or acute disability as a result of a mental disorder, and is in need of continued COT
- A statement as to whether suitable alternatives to COT are available
- A statement as to whether voluntary treatment would be appropriate

- Review of the member's need for a guardian or conservator or both
- Whether the member has a guardian with mental health powers that would not require continued COT
- The result of any physical examination that is relevant to the psychiatric condition of the member.

A written evaluation (annual exam) signed by the contracted supervising BHMP must be submitted to Court for the Judge/Commissioner to review and render a decision. Criteria required by the court to render a decision are contained in the Provider Manual Form Release from COT Worksheet. The original psychiatric evaluation is submitted to the designated county attorney/contracted law firm to be filed with court. For continued treatment examinations for members found to be GD, utilize the Health Plan Behavioral Health Manual Form, Psychiatric Examination for Annual Review of Gravely Disabled Members. For continued treatment examinations for members found to be PAD, utilize Form, Psychiatric Examination for Annual Review of a Persistently or Acutely Disabled. The petition/annual exam must have current contact information for the member. This includes full address, zip code, and telephone number.

The Petition for Continued Treatment must be submitted to the designated county attorney/law firm 45 days prior to expiration of the COT in order to give legal counsel time to review and correct any deficiencies prior to filing with court. If the Petition is filed less than 30 days prior to expiration of COT, the Court on its own motion or by motion of defense may deny request for failure to submit timely.

The designated county attorney/contracted law firm will forward to the contracted behavioral health provider conformed copies of the petition and order that was filed in court. The contracted behavioral health provider is required to provide the paperwork to the member and obtain a signed B – UHP Form Notice of Filing Confirmation of Receipt. This form provides evidence to the court and defense counsel the member is aware of the petition and his/her right to speak to his/her attorney. This original signed form must be submitted to provider's contracted law firm. A copy of this form is to be submitted to BUHPTitle36@bannerhealth.com.

If the member's location and/or other contact information changes at any time, contracted staff must notify the member's defense counsel and B – UHP with the new contact information.

If sufficient criteria are not provided to the court, or the evaluation is illegible, the judge may deny the request or may set a hearing to hear testimony from the supervising BHMP as to why the member should be released from COT.

A hearing may also be set if requested by the member's attorney or otherwise ordered by the court. If set for hearing, the contracted supervising BHMP who completed the Annual Exam must testify at the hearing.

The contracted behavioral health provider's Title 36 Liaison is responsible for informing the assigned staff and the supervising BHMP of the hearing and ensuring coordination for the hearing. The contracted case manager must inform the member of the hearing and arrange for his/her transport to the hearing. The case manager must be familiar with specifics of the case as they may be called to testify at the hearing.

If the member is released from COT, the case manager must notify the member and the Title 36 Liaison must update its systems and the Health Plan at BUHPTitle36@bannerhealth.com to indicate the COT is terminated.

Copies of all documents filed, including minute entries and Orders related to the matter should be furnished to the Health Plan as soon as available. Mailbox: BUHPTitle36@bannerhealth.com.

B – UFC/ALTCS members: Assigned ALTCS BHP is responsible for all clinical coordination with BHMP and filing with B – UHP's contracted law firm. The ALTCS BHP is also responsible for furnishing the names and contact information for witnesses to the member's attorney (via B – UHP's contracted law firm).

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

The Court can order a member to be released from court ordered treatment prior to the expiration of the period originally ordered by the Court upon the written request of the member's supervising BHMP. Before the release or discharge of a member ordered to undergo COT, the Medical Director must notify any relative or victim of the member who has filed a demand for notice with the contracted behavioral health provider, or any member found by Court to have a legitimate reason for receiving notice of the Medical Director's intention to release or discharge the member.

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

- The member has become voluntarily engaged in treatment

- Has developed insight regarding the need for treatment
- Has moved out of state
- Has been appointed a guardian with mental health powers
- Has been sentenced to Department of Corrections
- Has died

Termination/Release for Lack of Contact

For those members who have been absent and the supervising agency has been unable to administer the member's outpatient treatment plan, the Title 36 Liaison must notify the Health Plan Court Specialist at BUHPTitle36@bannerhealth.com to review documentation of re-engagement attempts before the release or discharge of a member ordered to undergo COT (per Outreach, Engagement, Re-engagement and Closure Section of this Provider Manual).

Change of Venue

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

To change venue from one County to another County, the following must be submitted by the outpatient provider:

- Motion for approval of the outpatient Treatment Plan, accompanied by the Treatment Plan
- Motion and Order to Change Venue, accompanied by a LOI
- The documents must be submitted to the County Attorney or contracted law firm to file with court
- If the member is transferring from the Health Plan to a RBHA/Other Health Plan, the contracted behavioral health provider must contact the Health Plan for assistance and coordination at BUHPTitle36@bannerhealth.com.

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

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

Change in Supervising Agencies (Transfers)

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

*Before a member under COT can be transferred from one treating contracted behavioral health provider to another, the relinquishing contracted behavioral health provider must have verification that the Medical Director of the receiving contracted behavioral health provider has accepted the member and accepted the responsibility for overseeing treatment under the court order. This must happen before the transfer is completed.

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

- Name and DOB of the member on COT
- COT start and end date
- The standard(s) under which the member is court ordered (DTO, DTS, PAD, GD)

- Printed name and signature of the receiving Provider's Medical Director
- Effective transfer date (date of intake)
- The letter can read simply: "This letter is to verify that Dr. X and Provider Y has agreed to provide court ordered treatment to member Z"
- The contracted behavioral health provider must keep a copy of the letter and the outpatient treatment plan signed by the psychiatrist, case manager, and the member, in the clinical record.
- The Medical Director of the receiving provider notifies the court in writing that there has been a change in oversight of the member's COT. It is recommended that an official document from the court be requested that reflects the current treatment Provider/Medical Director as the responsible party overseeing the court ordered treatment.
- The transferring contracted behavioral health provider must notify the Health Plan Court Specialist and Behavioral Health Department of all transfers.

Court Ordered Treatment for American Indian Tribal Members in Arizona

Arizona Tribes are sovereign nations, and tribal courts have jurisdiction over their members residing on reservation. American Indian members may be petitioned for COE or COT through the county governed process as specified in A.R.S. § 36-501 et seq. or may be subject to the jurisdiction and laws of the tribal nation, dependent on where the behavioral health crisis occurred. Several Arizona Tribes have adopted procedures in their tribal codes that are similar to Arizona law for COE and COT; however, each Tribe has its own laws which must be followed for the tribal court process. Tribal COT is initiated by tribal behavioral health staff, the tribal prosecutor, or other member authorized under tribal laws. In accordance with tribal codes, tribal members who may be a danger to themselves or others and in need of treatment due to a mental health disorder are evaluated, and recommendations are provided to the tribal judge for a determination of whether COT is necessary. Tribal court orders specify the type of treatment needed. Since many Tribes do not have treatment facilities on reservation to provide the treatment ordered by the tribal court, tribes may need to secure treatment off reservation for tribal members. To secure COT off reservation, the court order must be "recognized" or transferred to the jurisdiction of the State. The process for establishing a tribal court order for treatment under the jurisdiction of the State is a process of recognition, or "domestication" of the tribal court order (see A.R.S. § 12-136). The following process for domestication of a Tribal COT must be followed:

- Within 1 day of member being admitted to a licensed BH Treatment Facility, a copy of the Tribal COT must be filed with the local Superior Court.
- Within 5 days of receipt of filing of Order, the Superior Court will appear/respond. The Superior Court will attempt to resolve any issues raised with the Tribal Court judge.
- If the Tribal COT is found to enforceable, the Superior Court will issue an Order recognizing the Tribal COT and it will be enforceable as though originating in Superior Court. If denied, the member will have to go through the COE process as per the Title 36 statute to place the member under a Title 36 COT.

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

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

Due to the options American Indians have regarding their health care, including behavioral health

services, behavioral health services for AHCCCS eligible American Indians may be covered and/or coordinated through a Contractor, Tribal ALTCS, or IHS/638 provider. Additional information on the history of the tribal court process, legal documents and forms, FFS rates and billing, as well as contact information for the tribes, and tribal court representatives can be found on the AHCCCS website under the Tribal Court Procedures for Involuntary Commitment Digital Toolbox.

For Tribal members transitioning from B – UHP to American Indian Health Plan (AIHP), the Health Plan Court Specialist will reach out to the AIHP COT team and notify their team of the COT status of the member. The Court Specialist will ensure all available COT documents will be provided to the AIHP COT team. The Court Specialist will coordinate with the contracted behavioral health provider and the AIHP COT team to ensure a smooth transition of the COT.

Arizona State Hospital (ASH) Admissions for COT Members

When a need for a referral to the Arizona State Hospital has been identified, the contracted provider must notify the Health Plan Court Specialist. The provider will be responsible for submitting an application for admission directly to ASH via the Admissions Portal (or via email if the portal is down). B – UFC/ALTCS members: Assigned ALTCS BHP is responsible for completing and submitting the application.

Before starting the application process, the provider should reach out to the Health Plan Court Specialist for the most current guidance/process. As a standard rule, ASH will not accept applications for members on COT who have less than 45 inpatient days left on their COT. Prior to submittal of the application to ASH, a copy of the application must be forwarded to the Health Plan for review and approval at BUHPTitle36@bannerhealth.com.

Providers/ALTCS BHP must follow these procedures:

- Create/register an account through the ASH Admission Portal. A Google email account is required (this should be tied to a work email address and not a personal Google account).
- Once registration is complete, AHCCCS will review, approve and send notification to provider that the account is ready to use. This process only needs to happen once.
- Upon approval by the Health Plan, the Provider will submit the application to ASH along with a copy of the current COT.

Acceptance to ASH

If ASH accepts the Application, the provider will need to submit additional documentation, including but not limited to the following:

- T/RBHA Letter of Authorization/Intent to Treat
- RBHA enrollment verification
- Most current history & physical
- Psychiatric Assessment/Evaluation—Most recent
- Recent Psychosocial Assessment/Evaluation
- Current Psychological Assessment
- Current Individual Treatment Plan
- Current Functional Analyses and Behavioral Plans
- Copy of client's Proof of Residency
- Copy of client's Social Security Card
- Completed copy of Payor Financial
- Copy of client's AHCCC/Medicare Card or other insurance cards (if applicable)

(For a complete list of required documents, see the ASH workflows included in the ASH Admission packet found on the BUFC provider website.)

The provider will need to:

- Contact the ASH Admission Office to arrange/schedule an Admission Date and notify all parties involved in the coordination of care for the member (including Health Plan staff).
- Submit the following documentation on the day of admission:
  - Discharge Summary/Assessment from placement
  - Last 2 weeks of progress notes (All Disciplines)
  - Updated Medical Administration (2 weeks only)
  - CON for the day of admission with admission DSM-V diagnosis code

If the Application for Admission to ASH is rejected, the provider should follow the procedures outlined by ASH in the rejection letter. A copy of the rejection letter must be submitted to the Health Plan at: BUHPTitle36@bannerhealth.com.

Providers are expected to fully participate in all coordination of care activities during member's admission. The B – UHP Behavioral Health Care Management team, through the AzSH Liaison, maintains contact with ASH, to ensure awareness of members admitted to ASH and of potential discharges, for the purpose of coordination of care. For members with diabetes who are being discharged from ASH, the B – UHP Behavioral Health Care Management AzSH Liaision ensures that the same brand and model of both glucometer and supplies that the member received and were trained to use while admitted to ASH, are supplied upon discharge.

ASH Admissions Resources
Google Account Signup: https://accounts.google.com/signin
ASH Admissions Application Portal: https://ash.azdhs.gov/ASHAdmissionPortal/
For questions related to specific applications, contact admissions.office@azdhs.gov
ASH admission packet (includes list of required documents and portal registration guide) is available on the provider website: www.banneruhp.com/Behavioral Health Materials and Forms

ASH Forensic Admissions (Superior Court Release/Conditional Release Orders)

If a member is being released from ASH after serving a sentence, under the guilty except insane (GEI) standard, the release of this member is generally reviewed by the Superior Court. The Superior Court will make recommendations for the member's release into the community. This will often include a referral to the Health Plan where the member plans to reside upon release and may include a recommendation for court ordered treatment. The Behavioral Health Care Management Dept. will act as the key clinical single point of contact responsible for collaboration with the outpatient treatment team, ASH and the Superior Court.

For members being released from ASH under the above circumstances, the responsibilities of the contracted behavioral health provider must include at minimum the following:

1. Coordination with ASH for discharge planning,
2. Participating in the development and implementation of Conditional Release Plans,
3. Participation in the modification of an existing or the development of a new Service Plan that complies with the Conditional Release Plan (CRP),
4. Member outreach and engagement to assist the Superior Court and ASH in evaluating compliance with the approved CRP,
5. Attendance in outpatient staffing at least once per month, either telephonically or face to face,
6. Care coordination with the member's treatment team, and providers of both physical and behavioral health services to implement the Service Plan and the CRP,
7. Routine delivery of comprehensive status reporting* to the Superior Court and ASH, to include:
    1. Health Reports
    2. Monitoring Reports
    3. Any additional documentation at the request of AHCCCS, ASH, or the Superior Court
8. In the event a member violates any term of their CRP the contracted behavior health provider shall immediately notify the Superior Court and ASH and provide a copy to AHCCCS and,
9. The contracted behavioral health provider further agrees and understands it shall follow all obligations, including those stated above, applicable to it as set forth in A.R.S. §13-3991 and A.R.S. §§ 13-1994 through 13-4000

Any violation of the Conditional Release, psychiatric decompensation or use of alcohol, illegal substances or prescription medications not prescribed to the member shall be reported to the Superior Court and ASH immediately and copy will be provided to AHCCCS (pursuant to AMPM Policy 320-Z).

In the event that a member's mental status renders him/her incapable or unwilling to manage his/her medical condition, and the member has a skilled medical need, the contracted behavioral health providers must arrange ongoing medically necessary nursing services in a timely manner.

*Contracted behavioral health providers must submit a monthly comprehensive status report for members on Conditional Release to the Superior Court and AHCCCS, at BUHPCareMgmtBHMailbox@bannerhealth.com, and to BUHPALTCSBHP@bannerhealth.com for ALTCS members as specified in AMPM Attachment 320-Z. Forms may be found on the AHCCCS Website under "Resources, Oversight of Health Plans – System of Care".

Domestic Violence Offender Treatment

Domestic violence offender treatment may be ordered by a court when a member is convicted of a misdemeanor domestic violence offense. Although the order may indicate that the domestic violence (DV) offender treatment is the financial responsibility of the offender under A.R.S. § 13-3601.01(c), B – UHP will cover DV services with Title XIX/XXI funds when the member is Title XIX/XXI eligible, the service is medically necessary, required prior authorization is obtained if necessary, and/or the service is provided by an in-network provider. The contracted provider will ensure that the member's medical record includes documentation to justify the medical necessity for the services rendered.

Court Ordered Substance Abuse Evaluation and Treatment (DUI)

Substance abuse evaluation and/or treatment (i.e., DUI services) ordered by a court under A.R.S. § 36-2027 is the financial responsibility of the county, city, town or charter city whose court issued the order for evaluation and/or treatment. B-UHP may take into consideration, the medical information and factual findings of the court or administrative agency in making the determination of medical necessity. If B – UHP receives a claim for such services, the claim will be denied with instructions to the contracted provider to bill the responsible county, city, charter city, or town.

Court Ordered Treatment for Individuals Accused of Other Crimes

Pursuant to A.R.S. §36-2027, a court may order evaluation and treatment at an approved treatment facility of an individual who is brought before the court and charged with a crime if it appears that the individual is an alcoholic and the individual chooses the evaluation and treatment procedures. The court cannot order an individual to undergo treatment and evaluation for more than 30 days. When evaluation or treatment is ordered pursuant to this statute, the county, city, town or charter city whose court issued the order for evaluation is responsible for the cost of services to the extent ordered by the court. To the extent those services are also AHCCCS covered services and B-UHP receives a claim for services, B-UHP may direct the provider to bill the appropriate county, city, town or charter city.

Pharmacy

Formulary

Prescription drugs may be prescribed by any authorized provider, such as a PCP, specialist, dentist, etc. Prescriptions should be written to allow generic substitution whenever possible and signatures on prescriptions must be legible in order for the prescription to be dispensed. The Formulary identifies the medications, selected by the Pharmacy and Therapeutics Committee (P&T Committee) that are clinically appropriate to meet the therapeutic needs of members in a cost-effective manner.

The Formulary is developed, monitored, and updated by the Pharmacy and Therapeutics Committee (P&T Committee). The P&T Committee continuously reviews the drug list and medications are added or removed based on objective, clinical and scientific data. Considerations include efficacy, side effect profile, and cost and benefit comparisons to alternative agents, if available.

Key considerations:

- Preferred drugs on the AHCCCS Drug List for specific therapeutic classes.
- Therapeutic advantages of drug as compared to other currently available formulary drugs.
- Products are not added to the list if there are less expensive, similar products on the formulary.
- When a drug is added to the list, other medications may be deleted.

- Participating providers may request additions or deletions for consideration by B – UFC/ALTCS. Requests should include:
  - Basic product information, indications for use, its therapeutic advantage over medications currently on the list.
  - Which drug(s), if any, the recommended medication would replace in the current drug list.
  - Any published supporting literature from peer reviewed medical journals.

To view or to print a hard copy of the AHCCCS Drug List please go to www.azahcccs.gov/Resources/GuidesManualsPolicies/pharmacyupdates.html

Updates are made to the above publication on a quarterly basis by AHCCCS.

All formulary requested additions should be sent to:

B – UFC/ALTCS Pharmacy Department
Attn: Director of Pharmacy
5255 E Williams Circle, Ste 2050
Tucson, AZ 85711
PH: (800) 582-8686
FAX: (866) 349-0338

Notification of Formulary Updates

Providers and affected members will be notified at least 60 days prior to the removal of a drug from the formulary. Affected members will be notified by letter. Providers can refer to the website for upcoming changes to the formulary.

Providers and members can request a printed version of the Formulary by contacting Customer Care Center at (800) 582-8686.

The following limitations shall apply to pharmaceutical services:

- A medication dispensed by a Provider or Dentist is not covered, except in geographically remote areas where there is no participating pharmacy or when pharmacies are closed.
- A prescription in excess of a 30-day supply is not covered unless:
  - The medication is prescribed for chronic illness and the prescription is limited to no more than a 90-day supply,
  - The member will be out of the provider's service area for an extended period of time, not to exceed 90 days,
  - The medication is prescribed for contraception and the prescription is limited to no more than a 90-day supply.
  - Prescriptions for narcotic medications are limited to a 30-day supply
- An over-the-counter medication may be covered for the Health Plan AHCCCS members only as an alternative to a prescription medication only if it is available and less costly than a prescribed medication.
- A prescription is not covered if filled or refilled in excess of the number specified, or if the initial prescription or refill is dispensed more than 1 year from the original prescribed order.
- Approval by the authorized prescriber is required for all changes in, or additions to, an original prescription.
- The date of a prescription change shall be clearly indicated and initialed by the dispensing pharmacist.
- Prescribed medications must be on the drug formulary.
- If generic is available, generic must be dispensed unless otherwise directed by AHCCCS.
- Prior authorization is required for medication not on the drug formulary, see the Pharmacy Prior Authorization Form.
- Pharmacies shall not charge a member the cash price for a prescription, other than an applicable copayment, when the medication is federally and state reimbursable and the prescription is ordered by an AHCCCS Registered Prescribing Clinician.

Prescribing and Monitoring Medications

Prior Authorization Required

Prior authorization may be required:

- If the drug is not included on the Formulary
- The drug has utilization management criteria such as prior authorization, quantity limits, or step therapy

Decisions will be rendered on expedited and standard prior authorization requests within 24 hours. If additional information is needed to make a determination, an extension of up to 7 working (business) days can be added to the turnaround time of expedited and standard prior authorization requests. Please note that an expedited request will be required to meet the AHCCCS criteria which states that following the standard decision timeframe could seriously jeopardize the member's life or health or the ability to attain, maintain, or regain maximum function.

In instances where a prescription is written for drugs not on the Formulary, the pharmacy may contact the prescriber to either request an alternative or to advise the prescriber that prior authorization is required for non-covered drugs.

Prior authorization requests submitted for review must be evaluated for clinical appropriateness based on the strength of the scientific evidence and standards of practice that include, but are not limited, to the following:

- Food and Drug Administration (FDA) approved indications and limits
- Published practice guidelines and treatment protocols
- Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits, and potential member outcomes.
- Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies
- The following references may be used in the evaluation of the request including Drug Facts and Comparisons, American Hospital Formulary Service Drug Information, DRUGDEX Information System, and UpToDate.

Pharmacy Prior Authorization requests may be submitted by fax to the B – UFC/ALTCS Pharmacy Department at (833) 812-0181. To expedite your request, please submit your Prior Authorization via an online ePA portal.

Prescribing of Opioids

- Prior Authorization Requirements for Long-acting Opioids
- Prior authorization is required for all long-acting opioids unless the member has one of the following diagnoses:
  - Active oncology diagnosis with neoplasm related pain
  - Enrolled in hospice care o End of life care (other than hospice)
  - Supply Limits for Short-acting Opioids
  - Members under 18 years of age

Prescriber shall limit the initial and refill prescriptions for short-acting opioids to no more than a 5-day supply.

Exclusions include:

- Active oncology diagnosis
- Hospice care
- End of life care (other than hospice)
- Palliative care
- Children on an opioid wean at time of hospital discharge

- Skilled nursing facility care
- Traumatic injury, excluding post-surgical care
- Chronic conditions for which the prescriber has obtained prior authorization from B – UFC/ACC
- The initial prescription for post-surgical procedures is limited to a supply of no more than 14 days. Refills should be limited to no more than a 5-day supply.
- Members 18 years of age and older
- Prescriber shall limit the initial prescription for short-acting opioids to no more than a 5-day supply
- Post-surgical procedures
- The initial prescription for post-surgical procedures is limited to a supply of no more than 14 days.
- Studies have not shown the benefit of long-term use of opioids in the management of chronic, non-cancer pain. So, it is important to:
    - Limit use and duration of opioids
    - Dosage should be limited to morphine milligram equivalent (MME) of no more than 90
    - Optimize non-opioid medications indicated for the treatment of pain
    - Treat any underlying disorders that may exacerbate pain such as depression, anxiety, or sleep disorders
    - Encourage exercise or physical therapy if indicated
    - Avoid co-prescribing of opioid potentiators especially benzodiazepines
- Prescribe naloxone for members on chronic opioids and educate members on naloxone use

Over the Counter (OTC) Medications

A limited number of OTC medications are covered for members. OTC medications require a written prescription from the provider that must include the quantity to be dispensed and dosing instructions. Members may present the prescription at any contracted pharmacy. OTCs are limited to the package size closest to a 30- day supply. Please refer to the Formulary for more information.

Generic and Biosimilar Drug Substitutions

Contractors must utilize a mandatory generic drug substitution policy that requires the use of a generic equivalent drug whenever one is available. The exceptions to this requirement are:

- A brand name drug can be covered when a generic equivalent is available when the Contractor's negotiated rate for the brand name drug is equal to or less than the cost of the generic drug.
- AHCCCS may require Contractors to provide coverage of a brand name drug when the cost of the generic drug has an overall negative financial impact to the state. The overall financial impact to the state includes consideration of the federal and supplemental rebates.

Prescribing clinicians must clinically justify the use of a brand-name drug over the use of its generic equivalent through the prior authorization process. Generic and biosimilar substitutions shall adhere to Arizona State Board of Pharmacy rules and regulations. AHCCCS Contractors shall not transition to a biosimilar drug until AHCCCS has determined that the biosimilar drug is overall more cost- effective to the state than the continued use of the brand name drug.

Supplies

Diabetes Supplies are limited to a one-month supply (to the nearest package size) with a prescription.

Exclusions

The following categories are excluded from coverage:

- DESI drugs (those considered less than effective by the FDA)
- Any medication limited by federal law to investigational use only
- Medications used for cosmetic purposes
- Non-indicated uses of FDA approved medications without prior authorization
- Drugs being used to treat sexual dysfunction
- Medications used for the treatment of infertility

- Family Planning Medications and Supplies
- The family planning benefit includes:
- Over-the-counter items related to family planning (condoms, foams, suppositories, etc.) are covered and do not require prior authorization
- The member must present a written prescription, to the pharmacy including the quantity to be dispensed. A supply for up to 30-days is covered
- Injectable medications, administered in the provider's office, such as medroxyprogesterone (Depo-Provera) are reimbursed at the Fee Schedule rate, unless otherwise stated in the Provider's contract.
- Oral contraceptives
- IUDs
- Implantable contraceptives

Exclusive Pharmacy and/or Provider Program

To ensure the safe and appropriate use of high-risk medications, members who are on the following medications are monitored on an on-going basis:

- Opioids
- Benzodiazepines
- Muscle relaxants
- Hypnotics
- Stimulants
- Atypical antipsychotics

Members may be limited to one pharmacy and/or one provider for these medications. Criteria include:

- Utilization of four or more different categories of these medications AND
- Four or more providers prescribing these medications AND
- Use of four or more pharmacies to fill these medications within three months
- 12 or more prescriptions for one of these medications within three months
- A forged or altered prescription presented at the pharmacy.

Assignment to a specific provider or pharmacy is in place for 12 months. It will then be reviewed to see if the restriction is still indicated. Members and providers will be notified in writing before this assignment occurs. Members will have the right to appeal this decision. In an emergency, members may contact B – UFC/ALTCS for assistance in a one-time exception to the restriction.

Medication Management Services

Primary Care Provider Medication Management Services: In addition to treating physical health conditions, the Contractor shall allow Primary Care Provider (PCPs) to treat behavioral health conditions within their scope of practice. For purposes of medication management, it is not required that the PCP be the member's assigned PCP. PCPs who treat members with behavioral health conditions may provide medication management services including prescriptions, laboratory and other diagnostic tests necessary for diagnosis, and treatment. For the antipsychotic class of medications, prior authorization may be required. For PCPs prescribing medications to treat substance use disorders (SUDs), the PCP must refer the member to a behavioral health provider for the psychological and/or behavioral therapy component of the Medication Assisted Treatment (MAT) model and coordinate care with the behavioral health provider. The Contractor is responsible for these services both in the prospective and prior period coverage timeframes.

Dosing Procedures

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

Opioid Treatment Program (OTP)/ Office Base Opioid Treatment (OBOT) Provider Guest Dosing

In compliance with AHCCCS regulatory AMPM 320-0 and AMPM 660 members seeking guest dosing outside their GSA Home OTP/OBOT Provider to a Guest OTP/OBOT Provider.

A member may qualify for guest dosing when:

1. The member is receiving administration of Medication Assisted Treatment (MAT) services from SAMHSA-Certified Opioid Treatment Program (OTP).
2. The member needs to travel outside their Home OTP/OBOT provider.
3. The member is not eligible for take home medication.
4. The Home OTP/OBOT provider and Guest OTP/OBOT Provider have agreed to transition the member to the Guest OTP/OBOT provider for a scheduled period of time.

OTP/OBOT Providers are required to comply with the following process when coordinating member guest dosing of methadone or Buprenorphine administration when the BUHP member is traveling outside GSA Home OTP/OBOT provider due to member not being a recipient of take-home medication:

OTP/OBOT Role and Responsibilities for Guest Dosing

1. Banner Medicaid and Medicare members shall not be charged for guest dosing except as permitted by A.A.C. R9-22-702 Charges to Members and A.A.C. R9-22-711 Copayments.
2. The Home OTP/OBOT Provider shall:
    a. Forward information to the Guest OTP/OBOT Provider prior to the member's arrival, information shall include at a minimum:
        i. A valid release of information signed by the patient.
        ii. Current medications
        iii. Date and amount of last dose administered or dispensed.
        iv. Physician order for guest dosing, including first and last dates of guest dosing.
        v. Description of clinical stability including recent alcohol or illicitly drug abuse.
        vi. Any other pertinent information.
    b. Provide a copy of the information to the member in a sealed, signed envelope for the member to present to the Guest OTP-OBOT Provider.
    c. Submit notification to the BUHP heal plan of the guest dosing arrangement.
    d. Accept the member upon return from the Guest OTP-OBOT Provider unless other arrangements have been made.
3. The Guest OTP/OBOT Provider shall:
    a. Respond to the Home MAT provider in a timely fashion, verifying receipt of information and acceptance of the member for guest medication as quickly as possible.
    b. Provide the same dosage that the patient is receiving at the member's Home MAT provider and change only after consultation with Home MAT provider.
    c. Submit claims for reimbursement utilizing the appropriate coding and modifier.
    d. Provide address of Guest OTP/OBOT Provider and dispensing hours.
    e. Determine appropriateness for dosing prior to administering a dose to the member. The Guest OTP/OBOT Provider has the right to deny medication to a patient if he/she presents inebriated or under the influence, acting in a bizarre manner, threatening violence, loitering, or inappropriately interacting with patients.
    f. Communicate any concerns about a guest-dosing the member to the home OTP/OBOT Provider including termination of guest-dosing if indicated and communicate last dose date and amount back to the home OTP/OBOT Provider.

Reporting

Incidents, Accidents and Deaths Reporting

B – UHP requires its providers to report all incidents of abuse, neglect, exploitation, suicide attempts, unexpected deaths, human rights violations, healthcare acquired conditions (HCAC) and other provider preventable conditions (OPPC) to B – UHP and to the AHCCCS Quality Management Unit as outlined in AMPM Chapters 900. All incidents for the Behavioral Health System must be reported via the AHCCCS QM Portal.

B – UHP providers are required to report to B – UHP and proper authorities all cases of abuse and neglect incidents, injuries (e.g. falls and fractures), allegations of exploitation, HCACs, OPPCs, and/ or unexpected deaths as soon as the providers are aware of such incidents.

B – UHP's Quality Management (QM) Department is the Plan's central repository for all member incidents. These are inclusive of the following:

1. Deaths;
2. Medication error(s)/Adverse Drug Events;
3. Abuse or neglect allegation made about staff member(s);
4. Suicide attempt;
5. Self-inflicted injury;
6. Injury requiring emergency treatment;
7. Physical injury that occurs as the result of personal, chemical, or mechanical restraint;
8. Unauthorized absence from a licensed behavioral health facility, group home of children or recipients under court order for treatment;
9. Suspected or alleged criminal activity;
10. Discovery that a client, staff member, or employee has a communicable disease as listed in R9-6-202 or (B);
11. Incidents or allegations of violations of the rights as described in A.A.C. R9- Patient Rights. and A.A.C. R9-21, Article 2; these are summarized below:
    a. Abuse;
    b. Neglect;
    c. Exploitation; Coercion; or Manipulation;
    d. Sexual abuse or Sexual assault;
    e. Seclusion, except as allowed under R9-10-217 or
    f. Retaliation for submitting a complaint to authorities,
    g. Misappropriation of personal and private property by agency staff.
    h. Threats of discharge/transfer for punishment;
    i. Use of restraint or seclusion as retaliation
    j. Mistreatment (e.g., Treatment involving denial of food; opportunity to sleep; opportunity to use toilet).
        i. HCACs
        ii. OPPCs
12. B – UHP requires all its providers to report these incidents to B – UHP as soon as the provider is aware of such incidents but no longer than 48 hours of the occurrence/becoming aware of the

occurrence of the incident.

13. In cases of abuse of a child or an incapacitated adult, providers must report these to the police and/or Adult or Child Protective Services as required by statute.
14. ALTCS and Complete Care providers providing behavioral health services must submit these to the AHCCCS Quality team and B – UHP via the QM Portal AHCCCS QM Portal within 48 hours of becoming aware of the incident.
15. Incomplete forms will be noted, and the Quality Team will follow up with provider to ensure re-submission.
16. B – UHP requires all providers to answer questions that may arise after B – UHP Quality Team reviews.
17. B – UHP requires all providers to attend to and respond to improvement/corrective actions arising from its review of Incidents that may warrant improvement/corrective action.

Reporting Quality of Care Concerns

Quality of Care Concerns

It is Banner – University Health Plans policy to investigate and resolve potential quality of care concerns, or allegations of abuse raised by enrolled members (and/or their guardian or representative), contracted providers, and others in a timely manner. Potential quality of care concerns may also include quality of service concerns that have the potential to impact care.

Referral of Potential Quality of Care Concerns:

Potential quality of care concerns may be received or identified throughout the organization, delegated entities as well as from external organizations through AHCCCS QM Portal in the form of an IAD (Incident, Accident or Death) or an IRF (Internal Referral form) created by from AHCCCS CQM or B – UHP QOC analysts.

Any potential quality of care concerns, which are reported through the above various avenues are then routed to the Health Plan's QM Department by internal email/referral through Care Management Module and the AHCCCS QM Portal IAD and IRF, through Grievance department, or other appropriate avenue in compliance with HIPAA.

Quality of Care Investigation Process:

1. Immediate jeopardy:
    a. If the event of immediate jeopardy where the member's health and safety is at risk, or has the potential to cause the member serious injury, harm or impairment, the Director Quality of Management will be notified immediately and is responsible for coordinating the health plan's response;
    b. Health and Safety and Immediate Jeopardy On-site visits are unannounced and QM staff is to be present and leading on-site visits. Providers are to welcome these staff and grant access to the Health Plans members, their medical records and to a staff person who can answer any of the questions posed by the Quality of Care Staff.
    c. Immediate jeopardy affecting multiple members could provoke the implementation of the business continuity plan, and involve a multi-department coordinated effort to minimize the risk of jeopardizing the health and safety of members;
    d. Immediate jeopardy of an individual member will result in immediate action by the health plan to minimize the risk of the health and safety of members, e.g. if the quality of care delivered by a facility places member in immediate jeopardy the health plan will coordinate alternative placements.

Severity of quality of care issues are categorized as follows:

1. Not a potential quality of care issue. Track and Trend Level 0: No Quality Issue Finding
2. Level 1: Quality issue exists with minimal potential for significant adverse effects to the patient/

recipient

3. Level II: Quality issue exists with significant potential for adverse effects to the patient / recipient if not resolved timely.
4. Level III: Quality issue exists with significant adverse effects on the patient / recipient, is dangerous and / or life threatening
5. Level IV: Quality issue exists with the most severe adverse effects on the patient/recipient, no longer impacts the patient/recipient with the potential to cause harm to others.

Substantiation

1. Any case leveled "1" or greater is considered substantiated.
2. All Substantiated case receive a Determination of the recommended Interventions to resolve the issue.

Corrective Action Plans

Providers are required to submit a Corrective Action when needed, this may include all or any of the following:

1. Corrective action plan(s) or action(s) taken to resolve the concern and/or to reduce/eliminate the likelihood of the issue reoccurring
2. Documentation that education/training was completed.
3. Assigning new interventions/approaches when necessary. These may include, but are not limited to:
4. In-service attendance sheets and training objectives,
5. New policies and/or procedures, and
6. Follow-up with the member that includes, but is not limited to:
7. Providing assistance as needed to ensure that the immediate health care needs are met,
8. Determining, implementing and documenting appropriate interventions,
9. Monitoring and documenting the success of the interventions,
10. Incorporating interventions into the organization's Quality Management (QM) program if successful.

ED Utilization

Prior authorization is not required for emergency services. In an emergency, members should go to the nearest emergency department. Emergency medical services are provided for the treatment of an emergent physical or behavioral health condition. BUHP educates its members regarding the appropriate use of Emergency Services.

An emergency is a medical or behavioral health condition, including labor and delivery, which manifests itself by acute symptoms of enough severity, including severe pain, 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:

- Placing the health of the person, including mental health, in serious jeopardy
- Serious impairment of bodily functions
- Serious dysfunction of any bodily organ or part
- Serious physical harm to another person. Examples of this may include:
  - Poisoning
  - Sudden chest pains - heart attack
  - Car accident
  - Convulsions
  - Very bad bleeding, especially if you are pregnant
  - Broken bones
  - Serious burns
  - Trouble breathing
  - Overdose

While providers serve as the medical home to members and are required to adhere to the AHCCCS and BUHP appointment availability standards, in some cases, it may be necessary to refer members to one of BUHPs contracted urgent care centers (after hours in most cases).

BUHP educates its members regarding the appropriate use of Urgent Care Services. Urgent Care Services are to be used when a member needs care right away but is not in danger of lasting harm or of loss of life. Examples of this may include medical care for:

- Flu, colds, sore throats, earaches
- Urinary tract infections
- Prescription refills or requests
- Health conditions that you have had for a long time
- Back strain
- Migraine headaches

PHI Disclosure

Release and Confidentiality of Medical Information

It is the policy of BUHP to ensure the appropriate and confidential exchange of member information among providers to ensure continuity of care. All contracted providers who house medical records shall appoint a "custodian of medical records." This person is responsible for the safe storage and handling of the medical record as well as procedures to maintain confidentiality and integrity of each record.

HIPAA (Health Insurance Portability requires covered entities, including, but not limited to, health plans and providers, to safeguard protected health information (PHI) and use or disclose it only as permitted under Federal and State law. The confidentiality of member PHI must be protected and outlined in policy and/or procedure as required by Federal and State law. B – UFC has policy CP 5007 Protected Health Information. Documentation must exist that both the BUHP and provider office staff are informed of, understand, and agree to required confidentiality standards.

Consistent with 9 A.A.C. 22, Article 5, BUHP, and providers, including noncontracted providers, shall safeguard the privacy of Medical Records and information about members who request or receive services from AHCCCS or BUHP.

The content of any Medical Record may be disclosed in accordance with the prior written consent of the member with respect to whom such record is maintained, but only to such extent, under such circumstances, and for such purposes as may be allowed under regulations prescribed pursuant to 42 U.S.C. §290 dd-2 (confidentiality of records), 42 CFR Part 2, 2.1 – 2.67.

Original and/or copies of Medical Records shall be released only in accordance with Federal or State laws, and AHCCCS Policy and Contracts. B – UFC and providers shall comply with the Health Insurance Portability and Accountability Act (HIPAA) requirements and 42 CFR 431.300 et seq.

Certain PHI may be disclosed without member authorization as outlined in HIPAA 45 CFR §164.512, including, but not limited to the following reasons:

- Requirement by law
- Regarding victims of abuse, neglect, or domestic violence
- Health oversight
- Judicial and Administrative proceedings

Medical Records or copies of Medical Record information related to a member shall be forwarded by any AHCCCS-registered provider to the member’s PCP within 10 business days from receipt of a request from the member or the member’s PCP. When a member chooses a new Primary Care Provider, medical records must be transferred to the new provider within 10 days of the request to assure and promote continuity of care. Any provider sending member records, upon member written request to a new or referring provider must ensure the medical records are forwarded in such a way that unauthorized individuals are not able to access or alter PHI.

AHCCCS is not required to obtain written approval from a member before requesting the member's Designated Record Set (DRS) from a healthcare provider or any agency. For purposes relating to treatment, payment, or health care operations, AHCCCS may request sufficient copies of records necessary for administrative purposes, free of charge.

AHCCCS shall have access to all Medical Records, whether electronic or hard copy, within at least 20 business days of receipt of a request.

Written approval from the member is not required by the PCP when:

- Transmitting Medical Records to a provider when services are rendered to the member through referral to a BUHP subcontracted provide
- Sharing treatment or diagnostic information with the entity or entities responsible for or directly providing behavioral health services
- Sharing Medical Records with BUHP

The following applies to the member’s Designated Record Set (DRS). The DRS is the property of the provider who generates the DRS. The DRS is a group of records maintained by the provider and may include the following:

- Medical and billing records maintained by a provider. According to Arizona Revised Statute 12-2291, Medical records" means all communications related to a patient's physical or mental health or condition that are recorded in any form or medium and that are maintained for purposes of patient diagnosis or treatment, including medical records that are prepared by a health care provider or by other providers.”

- Case/medical management records,
- Any other records used by the provider to make behavioral and/or medical decisions about the member.

A member may:

- Review, request, and annually receive a copy, free of charge, of those portions of the DRS that were generated by the provider
- Request that specific provider information is amended or corrected
- Not review, request, amend, correct, or receive a copy of the portions of the DRS that are prohibited from view under HIPAA

HIPAA also provides the member the right to obtain a copy of their records. Any BUHP member is entitled to receive one copy of his/her medical records from the provider office at no cost, annually as specified in Title 45 of the Code of Federal Regulations CFR 164.524. The records maintained in the designated record set must be provided within 30 days.

unless the provider requests a 30-day extension from the member and the member agrees. The records much be provided in the form and format requested by the member if it is readily producible in such form and format, or if not in a readable hard copy form or a form agreed upon by both parties. If a member requests an amendment of their medical

record, providers must review the request including the reason that supports the request and inform the member of the decision regarding their request. Providers may require members to make this request in writing.

Providers must act on the member's request no later than 60 days of the receipt of such request. Providers may deny the request for an amendment if the information was not created by the provider, is not part of the record used to make decisions about the member, is not part of the information that the member is permitted to inspect or copy or if the information is accurate and complete.

If the request is denied, the provider must provide a written denial with the basis for the denial and information on the member's right to submit a written statement disagreeing with denial and how to file the statement. The provider, must, as appropriate, identify the record or protected health information in the designated record set that is the subject of the request for amendment and either amend or attach the statement of disagreement to the designated record set.

Additional information on the amendment of protected health information can be located at Title 45 of the Code of Federal Regulations CFR 164.526.

Availability and Retention of Medical Records

It is the policy of BUHP to make available at all reasonable times during the term of the contract, all BUHP member records for inspection, audit, or reproduction for quality review purpose by an authorized representative of BUHP, State or Federal regulatory agencies.

For retention of patient medical records, BUHP shall ensure compliance with A.R.S. §12-2297 which provides, in part, that a health care provider shall retain patient medical records according to the following:

- If the patient is an adult, the provider shall retain the patient medical records for at least six years after the last date the adult patient received medical or health care services from that provider.
- If the patient is under 18 years of age, the provider shall retain the patient medical records either for at least three years after the child's eighteenth birthday or for at least six years after the last date the child received medical or health care services from that provider, whichever date occurs later.

In addition, the providers shall comply with the record retention periods specified in HIPAA laws and regulations, including, but not limited to, 45 CFR §164.530(j)(2).

BUHP will retain member records as required by specific State and Federal agencies. BUHP may obtain a copy of the member's medical records, without written approval of the member, if the reason for such

request is directly related to the administration of the health plan.

Providers are required to comply with requests for medical records from B – UFC and submit within 10 business days of the request.

Eligibility

BUHP issues an identification card for members when they become eligible for benefits. This card includes the following information:

- Member's name,
- Identification number
- Health Plan name
- Pharmacy Information
- Claims Mailing Address

To verify a member's eligibility, Providers can use the plastic identification card with the Medifax system, the eServices website, or contacting the Customer Care Center.

Please remember it is the provider's responsibility to verify eligibility and benefits prior to providing services.

Providers can verify a member's PCP assignment by calling the Provider Experience Center Representatives or by visiting the eServices website.

Providers can also verify eligibility on the AHCCCS website at www.azahcccs.gov. Choose the Plan/Providers tab and then AHCCCS Online. AHCCCS obtains photos from the Arizona Department of Transportation Motor Vehicle Division (MVD) of all AHCCCS members who have an Arizona driver's license, or a State issued Identification Card.

Providers who are electronically linked to the BUHP computer system will have access to daily membership updates. Providers must register for this service. This service is provided at no charge.

BUHP's eServices website provides access to member enrollment information and the availability to obtain member rosters. https://eservices.uph.org/ For more information about eServices, contact the Provider Experience Center.

Member's Rights

BUHP is committed to listening, respecting, and understanding member's needs. Members have rights and responsibilities. These rights are shared with staff, providers and members and are included in our Member Handbook.

A list of member's rights under 42 CFR 438.100 is included below:

- Right to be treated with dignity and respect
- Right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand
- Right to participate in treatment decisions regarding his or her health care, including the right to refuse treatment
- Right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- Right to request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR part 164 and applicable State law
- Exercise his or her rights and that the exercise of those rights shall not adversely affect service delivery to the member

Member Advocate

BUHP does not prohibit, or otherwise restrict a provider, acting within the lawful scope of practice, from

advising or advocating on behalf of a member who is his or her patient, for the following:

- The member's health care, medical needs, or treatment options, including alternative treatment that may be self-administered, even if needed services are not covered by BUHP
- Any information the member needs to decide among all relevant treatment options
- The risks, benefits and consequences of treatment or non-treatment
- The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment and to express preferences about future treatment decisions. (42 CFR 438.102)

Providers must provide information regarding treatment options in a culturally competent manner, including the option of refusing treatment, and must ensure that members with disabilities have effective communication in making decisions regarding treatment options.

Informed Consent

Every member has the right to participate in decisions regarding their own health care. Members should be made aware of any and all options or alternatives available to them as well as specific risks or benefits associated with care or services. There are two types of consent, general consent and informed consent.

- General consent shall be obtained prior to any services or treatment provided. In emergency situations general consent is not required.
- Informed consent is a higher level of consent and is presented with all facts necessary to formthe basis of an intelligent consent with no minimization of known dangers or risks.
- All evidence of general or informed consent should be documented in the member's medical records. If the member is unable to provide written or signed consent, then a verbal consent is acceptable and should be documented. It is also acceptable for the member's designated health care decision maker to provide consent in the event that the member is unable to do so.
- For complete information on informed consent please refer to AHCCCS Chapter 300, section 320. www.azahcccs.gov › shared › Downloads › MedicalPolicyManual

Advanced Directives

The law requires doctor and health care facilities to inform patients, in writing, of the patients' right to create "Advance Directives" relating to their medical care. Advanced Directives are used to allow patients to make medical decisions about themselves should they no longer be able to do so. The two most common Advanced Directives are the Living Will and the Durable Power of Attorney.

The Living Will gives information about whether patients want or don't want life sustaining procedures if they have a condition that cannot be cured or improved.

A Medical Power of Attorney allows a patient to name a person they trust to decide what type of treatment you will receive if you are unable to decide for yourself.

These forms can be found at two state approved websites:

- Arizona Attorney General's Office – Life Care Planning - www.azag.gov
- Arizona Secretary of State - www.azsos.gov/services/advance-directives

Even though a patient has made Advanced Directives, a PCP may still choose whether to follow a patient's wishes. A patient cannot be denied care without these documents, but without written instructions, a judge may have to make a personal and medical decision for a patient. A patient may ask a PCP to make the Advance Directive a part of their medical record.

Health Plan members have the right to make decisions about their health care, including the right to accept or refuse medical care and the right to execute an advanced directive. Members can exercise his or her rights, and the exercising those rights shall not have an adverse effect on service delivery to the member.

PCPs are required to:

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

- Document in the member's medical record whether the adult member has been provided with the above information and whether or not an advanced directive has been executed.
- Not discriminate against a member because of his or her decision to execute or not execute an advanced directive and not make it a condition of or the provision of health care.
- Provide education to staff on issues concerning advanced directives, including notification of direct care providers of services, such as home health care and personal care providers, of any advanced directives executed by the member to whom they are assigned to provide services.

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

Information concerning advanced directives may be obtained from your Care Transformation Representative.

Changing Medicaid Health Plan

There may be times outside of the AHCCCS Annual Enrollment Choice period that AHCCCS allows members to change plans. There are two types of health plan change requests, those that can be made by the member for specific reasons and those that must go through a review process at the health plan.

1. Members may request a health plan change for the following reasons either through the HEAplus system (healthearizonaplus.gov) or by contacting AHCCCS at (602) 417-7100 or 1-(800)-334-5283:
    a. Annual enrollment
    b. Member was auto assigned and within the first 90 days may request a change in health plan
    c. Family members are in different health plans and wish to all be in the same plan
    d. Member moves to a location where their current plan is not available
        i. If you need help choosing a health plan or want to know if a doctor accepts your current health plan, you may speak to a Beneficiary Support Specialist by calling (602) 417-7100 from area codes (480), (602), and (623) or 1-(800)-334-5283 from area codes (520) and (928) or 1-(800)-334-5283.
2. Health plan review request for health plan change
    a. Members should contact their health plan for resolution to the following concerns. In the event a concern cannot be resolved by your health plan, you will receive a response informing you of this. If your concern can be handled by another health plan, you will receive a response informing you of an approval to change health plans. The following are examples of concerns to take to your health plan for resolution. This list is not all-inclusive:
3. Quality of care issues
        i. Case management responsiveness
        ii. Transportation issues
        iii. Physician or provider preference
        iv. Physician or provider recommendations
        v. Timing of appointments or services
        vi. Medical continuity of care
    b. Requests should be directed to your health plan or you may submit your request in writing, and it will be forwarded to your health plan.
        i. AHCCCS
PO Box 25520
Phoenix, AZ 85002
4. The written request to change health plans must include the following information:
        i. The current health plan the customer is enrolled in;
        ii. The name of the plan that the customer would like to be enrolled in instead; and

iii. A detailed statement about the reason that the customer wants to change health plan

Member Transition

BUHP shall identify and facilitate coordination of care for members during transitions between MCOs, as well as changes in service areas, subcontractors, and/or health care providers. Members with special circumstances may require additional or distinctive assistance during a period of transition.

Special circumstances include but are not limited to the following:

1. Pregnancy (especially women who are high risk or in their third trimester).
2. Major organ or tissue transplantation services which are in process.
3. Chronic illness, which has placed the member in a high-risk category and/or resulted in emergency department utilization, hospitalization, or placement in nursing, or other facilities, and/or
4. Significant medical or behavioral health conditions (e.g., diabetes, asthma, hypertension, depression, or serious mental illness) that require ongoing specialist care and appointments.
5. Chemotherapy and/or radiation therapy.
6. Dialysis, or
7. Hospitalization at the time of transition.
8. Members with ongoing needs such as:
    a. Medical equipment including ventilators and other respiratory assistance equipment,
    b. Home care services, such as Attendant Care or Home Health,
    c. Medically necessary transportation on a scheduled and/or ongoing basis,
    d. Prescription medications (including those that have been stabilized through a step therapy process), and/or
    e. Pain management services.
9. Members who frequently contact AHCCCS, State and local officials, the Governor's Office and/or the media.
10. Members with qualifying Children's Rehabilitative Services (CRS) conditions,
11. Members with qualifying CRS conditions transitioning to adulthood.
12. Members diagnosed with HIV/AIDS.
13. Members who are being considered for or are actively engaged in a transplant process and for up to one-year post-transplant.
14. Members enrolled in the ALTCS program who are elderly and/or have a physical disability.
15. Members enrolled in the ALTCS program who have a developmental disability.
16. Members who are engaged in care or services through the Arizona Early Intervention Program (AzEIP).
17. Members who are diagnosed with a Serious Mental Illness (SMI).
18. Any child who has been determined as high needs.
19. Members who have a Seriously Emotionally Disturbed (SED) diagnosis flag in the system.
20. Substance exposed newborns and infants diagnosed with neonatal abstinence syndrome (NAS).
21. Members diagnosed with Severe Combined Immunodeficiency (SCID).
22. Members with a diagnosis of autism or who are at risk for autism.
23. Members diagnosed with opioid use disorder, separately tracking pregnant members and members with co-occurring pain and opioid use disorder.
24. Members enrolled with Division of Child Safety/Comprehensive Medical and Dental Program (CMDP).
25. Members who transition out of the CMDP up to one-year post-transition.

26. Members identified as a High Need/High Cost member.
27. Members on conditional release from Arizona State Hospital.
28. Other services not indicated in the State Plan for eligible members but covered by Title XIX and Title XXI for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) eligible members, including members whose conditions require ongoing monitoring or screening.
29. Members who at the time of their transition have received prior authorization or approval for:
    a. Scheduled elective surgery(ies),
    b. Procedures and/or therapies to be provided on dates after their transition, including post-surgical follow-up visits,
    c. Sterilization and have a signed sterilization consent form, but are waiting for expiration of the 30-day period,
    d. Behavioral health services,
    e. Appointments with a specialist located out of the Contractor service area, and
    f. Nursing facility admissions.

Appendix – Behavioral Health Specific

Please note, this section of the provider manual is for helpful information that is for behavioral health providers and groups only. Any information that is helpful for all types of providers is covered in the main sections of the Provider Manual.

Clinical Services

Practice Guidelines and Coverage Criteria

Utilization Management Review Process and Medical Necessity Criteria for Behavioral Health

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 process, it is the clinical team's responsibility to identify available resources and the most appropriate provider(s) for services using B – UHP'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. For considerations when working with children in out-of-home services reference AHCCCS Policy AMPM 270 – Children's Out-of-Home Services.

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

B – UHP Evidence-Based Care Guidelines

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

Prior Authorization Procedures for Behavioral Health Providers

Visit www.BannerUFC.com for the most current Behavioral Health Prior Authorization Grid.

Requires Prior Authorization Before Receipt of Services	Authorization Upon Notification
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	Emergent admission to and continued stay in

Behavioral Health Inpatient Facility (BHIF)	Behavioral Health Inpatient Facility (BHIF)
Admission to and continued stay in Behavioral Health Residential Facility (BHRF) (adult/child); (Effective January 18, 2019, per AHCCCS, all non-emergent BHRF requests are to be expedited)	Emergent Admission to and continued stay in Behavioral Health Residential Facility (BHRF) (adult/child)
Admission to and continued stay in Therapeutic Foster Care (Child) and Adult Behavioral Health Therapeutic Home (ABHTH)	Emergent Admission to and continued stay in Therapeutic Foster Care (Child) and Adult Behavioral Health Therapeutic Home (ABHTH)
Psychotropic medications (per formulary)	
Initiation and continuation of Out of Network outpatient services	
Electroconvulsive Therapy (includes necessary monitoring)	
Transfer from hospital facility to hospital facility	
Transcranial Magnetic Stimulation	

B – UHP utilizes a telephonic utilization management review process once the notification of admission has been received and an initial reference number has been assigned to the request. The reference number is a not a guarantee of payment. Health Plan Utilization Management (UM) Reviewers are assigned to each case and will contact the facility/provider upon receipt of notification to introduce themselves and initiate the process of telephonic utilization reviews to establish medical necessity for the admission and concurrent reviews. Telephonic reviews provide a timely and efficient way to determine medical necessity and decrease the administrative burden of exchanging paper or electronic documents. At any time, an UM Reviewer may request a document for submittal to support the evidence of medical necessity. A facility /provider is also permitted to submit clinically supportive documents via fax for all reviews upon the approval of the UM Reviewer.

The following grid outlines the processes and timelines of all notifications and requests for authorizations including concurrent reviews and discharge planning in order for the Health Plan to approve the care for reimbursement.

All forms referenced in this chapter can be found at www.bannerufc.com

- Transfer Request Form
- Recertification of Need (RON)
- Pharmacy Prior Authorization Request Form
- Out of Home Admission Application
- Out of Home Admission Notification
- Out of Home Discharge Summary Form
- Initial Facility Inpatient Review Form
- Inpatient Transfer Request Form
- Behavioral Health Prior Authorization Form
- Behavioral Health - Utilization Management Grid
- Certification of Need (CON)
- Concurrent Review Guide - Adult
- Concurrent Review Guide – Children

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)	**For Admission Notification: All** of the following information is required for all inpatient **notifications/requests:** 1. Admission Face Sheet, which includes the following: a. Member's name and member's identification number, and b. Member's date of birth, and c. Admission date, and d. National Provider Identifications (NPI) of Facility, and e. Attending physician name and admitting hospital name, and f. Admitting diagnosis and ICD 10 Code, and g. Level of care admitted to, and h. Contact name and phone number/e-mail of in-patient Utilization Reviewer, and i. Other insurance. 2. Certificate of Need (CON) Clinical documentation submitted **prior** to the submittal of Notification of admission will not be saved and considered for the medical necessity review.	Within 72 hours of admission
Level 1 Psychiatric Hospital Initial Authorization	(520) 874-3411 (BH UM)	Admission/Intake Assessment or telephonic review with UM Reviewer	As requested by UM Reviewer
Emergent BHIF Admission	(520) 694-0599 (Banner BH PA)	1. Behavioral Health Prior Authorization Form, 2. Certificate of Need (CON), 3. Request for Out of Home Application, and 4. Out of Home Admission Notification Form	Within 2 business days of admission
Admission for BHIF	(520) 694-0599 (Banner BH PA)	**Prior to Admission:** Submit **all** of the following: 1. Behavioral Health Prior Authorization Form, 2. Updated Service Plan/Service Plan, 3. Recent psychiatric progress notes, 4. Out of Home Application, 5. The most recent assessment, or an assessment updated within the past year,	Prior to Admission to BHIF

		6. Child and Family Team note indicating team recommendation, 7. Other reports from outpatient providers, 8. Any psychological reports or other relevant reports from specialty provider, and **9. Submit a CON within 72 hours of admission.** If approved, the authorization is valid up to 45 days only. Submit additional clinical 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, and 2. Out of Home Application with supporting clinical documentation 3. If Substance abuse- ASAM and/or related clinical documentation If approved, authorization is valid up to 45 days only. Submit additional clinical documentation or contact the reviewer to provide a verbal update if the member does not admit within 45 days of approval.	Submit Up to 45 days Prior to Admission
Emergent Admission For Behavioral Health Residential Facility **(H0018)**	(520) 694-0599 (Banner BH PA)	1. Behavioral Health Prior Authorization Form, 2. Out of Home Admission Notification Form, and 3. Out of Home Application Form If member requires a continued stay, the out of home provider **must submit a Concurrent Review Form by the last covered day.**	Submit within 2 days
Non-emergent Admission to (TFC/ ABHTH) **(S5109-HB, ages 18-64)** **(S5109-HC, over 65)** **(S5109-HA, age 0-17)**	(520) 694-0599 (Banner BH PA)	1. Behavioral Health Prior Authorization Form, and 2. Out of Home Application Form with supporting clinical documentation	Up to 45 days Prior to Admission (If approved, the authorization is valid up to 45 days only)
Emergent Admission to (TFC/ ABHTH) (S5109-HB, ages 18-64) **(S5109-HC, over 65)** **(S5109-HA, age 0-17)**	(520) 694-0599 (Banner BH PA)	Submit **all** of the following: 1. Behavioral Health Prior Authorization Form, 2. Out of Home Admission Notification Form, and 3. Out of Home Application Form If member requires a continued stay,	Within 2 days of admission

		the out of home provider must **submit a Concurrent Review Form by the last covered day.**	
Concurrent Review Requirements for Inpatient, BHIF, BHRF, TFC/ABHTH	**Fax Number/**	**Documentation to Submit**	**Time of Submission**
Inpatient Concurrent Review	Banner Behavioral Health UM Reviewer will contact facility and provide e mail address. Facility must send documentation securely to UM reviewer e mail address when requested if not completing telephonic review	Provide the following information via telephonic review. 1. Attending Behavioral Health Medical Practitioner (BHMP) notes for each day of hospitalization and subacute detox level of care. 2. For subacute facilities not providing detox, BHMP notes must be provided at a minimum for 5 days (M-F) out of the week • Estimated length of stay • Medication Administration Record (MARS) • CIWA/CINA/COWS protocols as applicable • All physician orders • RN notes • Lab results, if indicated • Discharge plan/barriers, including updates every 24 hours if barriers are resulting in avoidable days.	Provide clinical documentation during the scheduled telephonic review time. on the last covered day (LCD) of the current authorization.
Behavioral Health Inpatient Facility Concurrent Review	(520) 874-3411 or Banner Behavioral Health UM Reviewer will contact facility and provide e mail address. Facility must send documentation securely to UM reviewer email address when requested.	Provide the UM Reviewer via telephonic review to support medical necessity: 1. Psychiatric notes, 2. Concurrent Review Form, 3. CFT notes, 4. Medication Administration Record (MARS), 5. Discharge plan, and 6. After 30 days, **submit** a Recertification of Need (RON)	Provide the clinical documentation prior to scheduled telephonic review RON Submitted every 30 days.
Behavioral Health Residential Facility (BHRF) **Concurrent Review**	Banner Behavioral Health UM Reviewer will contact facility and provide e mail address. Facility must send documentation securely to UM reviewer e mail	Utilize the Concurrent Review Guide/Children or Adult located at www.BannerUFC.com	During the scheduled telephonic review time.

	address when requested.		
TFC/ ABHTH Non-Emergent Concurrent Review	Banner Behavioral Health UM Reviewer will contact facility and provide e mail address. Facility must send documentation securely to UM reviewer e mail address when requested.	Utilize the Concurrent Review Guide/Children or Adult located at www.BannerUFC.com	During the scheduled telephonic review
TFC/ABHTH Emergent Concurrent Review	Banner Behavioral Health UM Reviewer will contact facility and provide e mail address. Facility must send documentation securely to UM reviewer e mail address when requested.	Utilize the concurrent review form found on the website. Out of Home Concurrent Review Guide	During the scheduled telephonic review.
Other Outpatient 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, and 2. Supporting clinical documentation	Prior to initiation of services
Transcranial Magnetic Stimulation	(520) 694-0599 (Banner BH PA)	1. Behavioral Health Prior Authorization Form, and 2. Supporting clinical documentation	Prior to initiation of services
Out of Network Provider (varied)	(520) 594-0599 (Banner BH PA)	1. Behavioral Health Prior Authorization Form 2. Provide clinical documentation to support the need for an out of network provider services.	Prior to initiation of services.
23 Hour Crisis Observation	BUHPCareMgmtBHMailbox@bannerhealth.com	1. Member name 2. AHCCCS ID 3. Date of Birth 4. Diagnosis/Reason for admission 5. Date of Admission 6. Disposition, if applicable	Per the B – UHP template.
Psychotropic Medication (varied)	(866) 349-0338	Submit the following: Pharmacy Prior Authorization Form	Prior to dispensing

Hospital/Inpatient Level of Care

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

Notification of Inpatient Admission

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

- By fax: 520-874-3420
- Notifications can be faxed 24 hours a day, 7 days a week.
- The following information is required for all inpatient notification requests:
    - 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/e mail of in-patient Utilization Reviewer
    - Other Insurance, and
    - Certification of Need (CON) For Medicaid (B – UFC) members
- Please note, clinical information submitted prior to the notification or prior to the Health Plan issuing an authorization will not be acknowledged. Facilities must send the clinical documentation upon request of the Utilization Management (UM) reviewer.

Certification of Need (CON)

A CON is a certification made by a physician that inpatient services are or were needed at the time of the member's admission. Although a CON must be submitted prior to a member's admission (except in an emergency), a CON is not an authorization tool designed to approve or deny an inpatient service. It is a federally required attestation by a physician that inpatient services are or were needed at the time of the member's admission. The decision to authorize a service that requires prior authorization is determined through the application of admission and continued stay authorization criteria. The Certificate of Need can be found https://www.banneruhp.com/materials-and-services/behavioral-health#Behavioral-Health-Materials-and-Forms.

The following documentation is needed on a CON:

- CONS must have a dated physician's signature, and must include documentation of the elements of medical necessity contained in 42 CFR 441.152, including the following:
    1. Ambulatory care resources available in the community do not meet the treatment needs of the recipient
    2. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician
    3. The services can reasonably be expected to improve the recipient's condition or prevent
    4. further regression so that the services will no longer be needed.

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

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

When a member has exhausted their Medicare inpatient lifetime limit of 190 days in a psychiatric facility, a CON must be submitted to initiate the member's Medicaid benefit.

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

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

Hospital /Inpatient Admission Criteria

B – UHP utilizes MCG criteria for all inpatient admission criteria to determine medical necessity. 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:

- 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.
- 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 workplace 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.
- Mental status changes or co-occurring conditions: Member presents with disrupted mood, disordered thinking, disorientation, or other mental status changes that need care at the level requested; or there are medical or substance related issues that require care at the level requested.
- Additional modifiers: The member's history of response to prior treatment, their personal resources such as intellect, characterological issues, and history of violence or self-harm may influence the decision about which level of care is medically necessary. However, the preferred treatment is provided in the least restrictive setting.
- Primary diagnosis: A valid diagnosis causing the symptoms that require professional intervention and the intensity of services needed. At least one valid DSM-5 diagnosis/ICD 10 code and the member's condition must be directly attributable to the designated mental disorder and not to an antisocial personality or be a part of a pervasive pattern of antisocial conduct. Professional intervention is considered likely to be effective and is essential to contain risks presented and provide for improvement.

Detoxification Admissions

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

Hospital Inpatient Admission Criteria for Eating Disorders

An inpatient admission for the treatment of an eating disorder requires a prior authorization and is not considered an emergent admission. The CFT/ARTshould 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.
    d. 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:
    e. There has been substantial inability to achieve or maintain clinically appropriate weight goals.
    f. There has been continued or renewed compensatory weight-loss behavior (e.g., food refusal, self-induced vomiting, or excessive exercise).
    g. 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).
3. 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.
4. 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).

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. B – UHP has no current financial agreements with counties or RBHAs for blended payments for Court Ordered Evaluations.

B – UHP will reimburse for court ordered treatment when services are medically necessary. However, for members undergoing Court Ordered Evaluation, medical necessity is not established until the required Psychiatric Evaluations have been completed, since the initial admission of the member is based on statutory processes, rather than a clinical determination. It is the responsibility of the facility to notify the Health Plan when there is a change of payer related to the end of Court Ordered Evaluation. The issue of voluntarily participating in treatment is not, in and of itself, a factor in the determination of medical necessity. Furthermore, the refusal of a Title XIX/XXI member to accept medication is not, in and of itself, a factor in determining the medical necessity of the service, responding to a prior authorization request, or adjudicating the claim.

Per AHCCCS Contractors Operations Manual Policy 437, B – UHP reimburses for medically necessary services when the Court Ordered Evaluation ends and when one of the following occur:

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

B – UHP must have legal documentation submitted to evidence one of the three items above has taken place to initiate the authorization of services.

Hospital/Inpatient Concurrent Review

It is always the responsibility of the provider to request authorization for specific days. Failure to request further authorization and timely submittal of clinical documentation will result in an Administrative Denial. Any additional requests for documentation from the UM Reviewer must be submitted within 24 hours or will be considered untimely and subject to an Administrative Denial.

Hospital staff must be available to conduct the telephonic reviews during their scheduled review time and be prepared to provide clinical information that supports medical necessity. Below is an example of the type of clinical information that may be requested from the UM reviewer:

- Attending Behavioral Health Medical Practitioner (BHMP) notes for each day of hospitalization and subacute detox level of care, including a specific description of the member's residual symptoms and level of risk/impairment, as well as a detailed plan, specific to the individual member, that describes the medication changes or other treatment interventions that are to be employed to address remaining clinical needs.
- For sub-acute facilities not providing detox, BHMP notes must be provided at a minimum for M-F
- Estimated length of stay
- Medication Administration Record (MARS)
- CIWA/CINA/COWS protocols, as applicable
- All physician orders
- Lab results, if clinically indicated
- Discharge barriers (including updates every 24 hours if barriers are resulting in avoidable days)

To facilitate effective collaboration, the appropriate and efficient utilization of health care resources, and optimal care management, all inpatient psychiatric providers are required to participate in timely submittal of clinical information to support the concurrent review of the services provided for which reimbursement is sought.

To justify remaining in an inpatient level of care, submission of all required clinical information/documentation must be evident to show that the condition or its symptoms are treatment responsive. The member must continue to manifest symptoms justifying the principal DSM-5 diagnosis/ICD 10 code, and the following:

- The intensity of service being delivered should be appropriate to the risk level that justified the admission
- 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.
- Need for continued observation
- Persistence of symptoms such that continued observation or treatment is required
- Increased risk of complications as a result of intervention or as a product of newly discovered conditions
- 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.

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

additional member condition updates are required.

Psychiatric inpatient admissions now are characterized as acute care hospitalizations, rather than long term hospital stays. The associated expectation is that the care of psychiatric patients who are admitted to these acute care facilities will be managed in a manner that is consistent with short-term hospitalization, including **daily clinical assessments by an attending provider**, accompanied by any clinically appropriate modifications to the patient's treatment regimen and care plan. If a patient is admitted to an inpatient psychiatric unit on a Friday afternoon (typically with only standard admission orders, and at best, perhaps the continuation of outpatient medication orders that have not been effective in treating or controlling the patient's mental health symptoms in the community), but with no follow-up by a psychiatric clinician or assigned treatment team until the following Monday, the stay of that patient inevitably will be prolonged, secondary to this 2-day delay in initiating meaningful care. With a median length of stay of just 4.5 days, the lack of weekend coverage by a psychiatric clinician could potentially extend the patient's hospitalization (which frequently has occurred on an involuntary basis) in a locked and highly restricted environment to 6.5 days or more (with continued decompensation of the patient, even in an inpatient setting, while awaiting the initiation of treatment that presumably cannot be provided at a lower level of care). In addition, the more symptomatic a patient becomes while awaiting additional clinical assessment and treatment, the more difficult (and time-consuming) his/her symptoms ultimately will be to control, potentially requiring an even lengthier period of hospitalization.

Administrative Denials During Inpatient Hospitalization

An Administrative Denial is based on the following:

- Failure of the facility to provide ALL of the required documentation/clinical information to conduct comprehensive utilization review activities to determine medical necessity for admission and/or concurrent review/continued stay within the required time frame **and/or**
- Failure to provide the services required and/or
- Failure to provide telephonic review during the scheduled review time

Administrative denials are based on the lack of information timely submitted and/or deficiency in provision of services required and not based on medical necessity criteria. As a result, they do not require physician review or involvement in the denial decision. These denials will result in the termination of the authorization where there is a deficiency in documentation/information or services for the entire remaining length of stay or denial of specified days where required documentation/information or services, for example a BHMP note is not provided during specified days.

After an Administrative Denial has been issued, the facility can submit the claim/request as a Retrospective Review through the Claims Department. However, Retrospective Review cannot be utilized in lieu of good faith participation in the Concurrent Review process. The request for reimbursement through a Retrospective Review must include the following to be considered for reimbursement:

1. The facility **must** provide an explanation as to why the facility was unable to submit timely and comprehensive clinical documentation required to determine medical necessity at the time of admission, concurrent review or the UM reviewer's request.
2. The facility **must** also include information related to the member being admitted on Court Ordered Evaluation and provide legal documentation to support the end of the Court Ordered Evaluation. Requests for Retrospective Reviews that include the days the member was under a Court Ordered Evaluation will be denied as the county is the payer.

For concurrent review/continued stay Administrative Denials will be issued in the following situations:

- **For Psychiatric hospitalization and sub-acute detox:** Administrative Denials will be issued when there is lack of documentation/information to demonstrate appropriate BHMP services daily for each day, including weekends and holidays. This includes documentation of a Psychiatric Evaluation and History & Physical within 24 hours of the member's admission. All psychiatric hospitals and sub-acute facilities providing detoxification services are required to submit BHMP progress notes for each day.
- **For sub-acute facilities that do not conduct detox:** Administrative Denials will be issued when there is lack of documentation/information to demonstrate BHMP services for any weekday or if a psychiatric assessment has not been conducted within 24 hours of admission. All sub-acute facilities that are providing services that exclude detoxification services must submit BHMP

progress notes at a minimum of all weekdays and a psychiatric assessment within 24 hours of admission.

- Administrative Denials of reimbursement for weekend days when no clinical coverage is provided is not intended to be punitive. Such denials rather represent advocacy on behalf of our members with mental health disorders. These members are entitled to receive appropriate care and treatment, on par with the services received by patients on other medical units. They are entitled to remain on locked and highly restricted units for the minimum amount of time necessary to safely and adequately treat their symptoms, and to allow for a transition to a lower level of care.

Hospital/Inpatient Avoidable Days

At times, potentially avoidable delays may occur in discharging members from an acute level of behavioral health care to a less restrictive treatment setting. Such delays typically occur because the less restrictive, community-based treatment and supports that are necessary for a safe and successful discharge are not yet fully arranged or available. Potentially avoidable inpatient days are periods of continued hospitalization on a Level I or subacute behavioral health unit that are authorized by the health plan when medical necessity no longer is demonstrated, but services at a lower level of care are not yet available, despite active, comprehensive, and timely discharge planning efforts by the facility or provider.

Potentially avoidable inpatient days will be authorized only when discharge planning activities are documented appropriately by the facility or provider from the time of the member's initial admission, and when evidence of continued, comprehensive discharge planning efforts is submitted daily to the health plan for review, until discharge of the member occurs.

Potentially avoidable inpatient days must be preceded by at least one acute inpatient day (24 hours in duration) that meets medical necessity criteria. Authorization will not be provided for direct admission from an outpatient or residential treatment setting to a more acute level of care for which medical necessity has not been demonstrated, or for which prior authorization has not been obtained. Potentially avoidable inpatient days also will not be authorized solely for convenience, or when appropriate services in an alternative setting are available, but refused or declined by the member, the member's family, or the inpatient treatment team.

When potentially avoidable inpatient days are authorized, the facility or provider must continue to assure that appropriate behavioral health treatment and services are provided to the member until the time of discharge to a lower level of care. Types of potentially avoidable inpatient days include: (1) lack of an available residential treatment bed in a BHRF, BHIF, or TFC/ ABHTH level of care; (2) lack of available specialty services (such as those that are medically necessary for members with an autism spectrum diagnosis, sexually maladaptive behaviors, cognitive limitations, a significant history of aggression toward others, accompanying medical disorders, or other similar conditions), and (3) lack of access to other community-based treatment and supports that are necessary to sustain adequate functioning in the community.

Required Reporting of Avoidable Days

To justify avoidable/administrative bed days the following must be provided to the UM Reviewer during concurrent review. Failure to provide this information may result in an Administrative or Medical Necessity Denial:

- Clinical documentation must support that alternative discharge arrangements available are not adequate to safely meet the needs of the member.
- If a required service is not currently available, the Discharge Plan must clearly state this and identify the steps to be able to access needed services. Entries such as "deferred until patient stabilizes," "to be determined," or "placement pending," are not acceptable.
- Evidence of active attempts to effectuate discharge to a specified placement/level of care or community-based service must be provided and resubmitted/updated and reviewed by staff every 24 hours. If there are insufficient discharge planning activities a denial may be issued.

Hospital/Inpatient Discharge Criteria

The member is ready for discharge when any of the following criteria have been satisfied:

- The planned course of treatment has been completed
- The member's symptom intensity or impairment in functioning no longer requires the level of observation or intensity of service at the requested level of care

- Further professional intervention is not expected to result in significant improvement in the member's condition
- The member leaves against medical advice (AMA)

Hospital/Inpatient Discharge Planning

The intent of the discharge planning process is to improve the management of inpatient admissions and the coordination of post-discharge services, reduce unnecessary institutional and hospital stays, ensure discharge needs are met, and decrease readmissions within 30 days of discharge. Discharge planning is expected to begin on the date of admission. If the member is not enrolled with an outpatient behavioral health provider, the inpatient team must initiate a request to enroll the member with an outpatient agency chosen by the member or by zip code. Facilities should coordinate with the health plan UM Reviewer when an urgent enrollment is needed for the member to ensure discharge and follow up care can be established. 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. Discharge planning must be performed by a qualified health care professional and is initiated on the initial concurrent review, updated periodically during the inpatient stay and continued post discharge to ensure a timely, effective, safe, and appropriate discharge. The following must be included as part of this process:

- The qualified health professional participating in the discharge planning process shall ensure the member/Health Care Decision Maker/ designated representative is a) involved and participates in the discharge planning process, b) understands the written discharge plan, instructions and recommendations provided by the facility and c) is provided resources, referrals and possible interventions to meet the member's assessed and anticipated needs after discharge.
- Coordination and management of the care shall include the following but are not limited to:
    a. Follow up appointment with the BHMP/Specialist within 7 business days
    b. Coordination and communication with the Health Plan to ensure a safe and clinically appropriate discharge placement, and community support services
    c. Communication of the member's treatment plan and medical history across the various outpatient providers, including the member's outpatient clinical team and other natural supports as applicable.
    d. Access to prescription medications
    e. Nursing Services or Medical equipment as applicable,
    f. Referral to appropriate community resources
    g. Referral to the Health Plan Care Management Programs as applicable
    h. Coordination with the Health Plan even when the Health Plan is not the primary payer.
    i. Coordination of care with the Health Plan including submission of Prior Authorizations for transfers before a is discharged to another Level I inpatient psychiatric facility or to an alternative level of care (including a BHRF).

Requirements for Hospital/Inpatient Discharge Plan/Summary

All facilities are required to submit the Discharge Plan/Summary to the Health Plan and the outpatient behavioral health provider within 24 hours of discharge. Discharge Plan/Summary must be submitted to: BUHPUMPAMailbox@bannerhealth.com.

At a minimum the Discharge Plan/Summary must contain the following information:

a. Date of discharge
b. Discharge diagnosis
c. Discharge instructions, including follow up services and discharge appointments (required to have an appointment with prescriber or BHMP within 7 days)
d. Discharge medications including the following: dosage, instructions, and number of days of

medications provided if applicable (for hospitals and BHIFs)

e. The Discharge Plan/Summary must include the follow up appointment with a BHMP even if the member is discharging to a BHRF.

Delays in submitting the Discharge Summary to B – UHP may result in a delay of claims payment. The Health Plan must have accurate documentation to confirm the date of discharge and the discharge information.

Hospital Transfers to Other Hospital Level of Care

All transfers from one hospital level of care to the same level of care require a prior authorization. All transfers must be reviewed with the UM Reviewer. When a member has been in the hospital level of care and requires a transfer to the same level of care it is not considered an emergent admission. This is considered a planned admission and requires a prior authorization. Prior authorization must be obtained by submitting the Behavioral Health Prior Authorization Form and faxing to 520-694-0599.

If a provider determines that a member is better served in a different location that is an equal level of care, they may request a facility transfer. Transfers can occur based on either administrative or clinical reasons. Transfers must be requested from and approved by the Health Plan prior to member transferring. The transferring facility must obtain approval from a receiving facility for the transfer. Transfer decisions will be made within 3 business days of receipt. Complete the Inpatient Transfer Request Form in its entirety explaining the reason for the transfer. Email the Inpatient Transfer Request Form to: BUHPBHUMPAMailbox@Bannerhealth.com.

The transferring provider must not transfer the member until they receive an authorization from the Health Plan. The transferring facility must submit the discharge form to the Health Plan within 48 hours of the completed transfer.

The transferring and receiving facilities are responsible for arranging transportation.

Facilities that accept an inpatient transfer from another inpatient facility without ensuring the health plan has approved it may be subject to a denial as this is considered a planned admission and requires a prior authorization.

Institutions for Mental Disease (IMD)

When a member is receiving services in an IMD facility and the length of the member's stay is anticipated to exceed 15 days, further care of the member must be coordinated with and authorized by B – UHP as part of the concurrent review process. B – UHP does not require an automatic transfer/discharge based on the member's length of stay in an IMD facility. Transfer of the member to another facility or toanother level of care does not constitute an emergent admission, nor are such transfers automatically authorized, but rather are considered individually, based on a review of clinical documentation, a determination of medical necessity, and continuity of care considerations.

Behavioral Health Inpatient Facility (BHIF)

BHIF services provide treatment for children and adolescents who demonstrate severe and persistent psychiatric disorders, when ambulatory care services in the community or services in a less restrictive therapeutic level of care do not meet their treatment needs and they require services under the direction of a Behavioral Health Medical Professional (BHMP). These services are designed for children and adolescents who have a DSM 5/ICD-10 psychiatric diagnosis, significant deficits in functioning, and who require active treatment in a controlled environment with a high degree of psychiatric oversight, 24-hour nursing services, comprehensive programming and treatment. Active treatment focuses on specific targeted goals identified by the Child and Family Team (CFT) and are designed to enable the child/adolescent to be discharged at the earliest possible time. A lack of available outpatient services or services in a less restrictive therapeutic level of care is not, in and of itself, the sole criterion for admission to a BHIF.

Admissions to a **Non-Emergent** BHIF level of care. All admissions must meet medical necessity criteria.

There are two types of BHIFs:

1. **Secure** - A BHIF which may employ security guards and/or uses monitoring equipment and alarms
2. **Non-secure** – A BHIF that is unlocked, and continuous supervision is provided by professional behavioral health staff.

Prior Authorization for BHIF Level of Care for Non-Emergent Admissions

Prior authorization must occur prior to admission to a BHIF for non-emergent admissions. The Health Plan determines medical necessity for standard decisions within 14 calendar days upon receipt of the request. If appropriate, the Health Plan may issue an extension of an additional 14 calendar days to request additional information. The Health Plan requires active involvement of the CFT to facilitate discussion of admission for all levels of care. Expedited authorization may be requested when the provider determines that using the standard timeframe could seriously jeopardize the member's life and/or health or ability to attain, maintain or regain maximum function. The Health Plan will look to the CFT to facilitate discussion of admission in consideration of the member when the member is in an inpatient hospital setting-expedited authorization may be granted. If approved, the Health Plan will issue an authorization for up to 45 days. Upon admission during the 45-day period, another authorization is activated to secure the date range. Providers are required to submit additional clinical documentation if the member does not admit within 45 days of approval.

Request for Prior Authorization for Admission to a BHIF must include the following, submitted via fax to (520) 694-0599:

- The Behavioral Health Prior Authorization Form,
- An updated Individual Service Plan indicating the goal for the admission to the BHIF,
- A recent psychiatric evaluation or psychiatric progress note that reflects current behaviors and functioning and diagnoses, and
- Certificate of Need (CON) (from the facility upon admission/ no later than 72 hours after admission)
- Out of Home Application,
- The most recent assessment or an assessment that has been updated in the past year,
- The Child Family Team (CFT) note indicating the team's recommendations,
- Any other reports from outpatient providers or other treatment providers, and
- Any psychological reports or other reports from specialty providers.

Criteria for BHIF Admissions

- **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, c, and d 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. 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 unsuccessful treatment within the last month while the member received services in intensive community based treatment or TFC services or Behavioral Health Residential Facility, or a psychiatric hospital or the professional judgement that the youth's clinical needs cannot safely and comprehensively be met in a lower level of care and,
    d. The support system is unable to manage the intensity of child/adolescent symptoms to ensure safety and, the child/adolescent does not require a level of medical or professional supervision that surpasses that which is available at the BHIF and the child/adolescent's Service Plan must be aligned with the facility care plan. Additionally, the provider must ensure comprehensive and ongoing assessment and treatment is planned for prior authorization and being provided for concurrent review authorization.

BHIF Exclusion Criteria

The admission cannot be used as an intervention for any of the following:

- An alternative to incarceration, preventative detention, or to ensure community safety in a

child/adolescent exhibiting primarily delinquent/antisocial behavior including runaway behavior; or

- The equivalent of safe housing, permanency placement, or
- An alternative to parents'/guardian's or another agency's capacity to provide for the child or adolescent; or
- An intervention when other less restrictive alternatives are available and not being utilized.

Concurrent Review for BHIF

If the member requires a continued stay past the initial authorized days, provide clinical documentation to the UM Reviewer during the scheduled telephonic review.

Documents that must be submitted to support medical necessity for concurrent review:

a. Psychiatric notes,
b. concurrent Review Form,
c. CFT notes,
d. Medication List,
e. Discharge plan, and
f. After 30 days submit a Recertification of Need (RON).

For concurrent review authorization, if the youth is not demonstrating improvement, the facility care plan must be revised as part of the CFT process resulting in an expectation of improvement to achieve discharge from the BHIF at the earliest possible time and facilitate return to outpatient care or less restrictive therapeutic level of care. The child/adolescent must be actively participating in treatment.

B – UHP bases concurrent review determinations solely on the medical information obtained by the reviewer at the time of the review determination. Frequency of the reviews are based on the severity or complexity of the member's condition or on necessary treatment and discharge planning activity but will also meet the prescribed review timelines according to MCG criteria. Authorization for BHIF will have a specified date and time by which requested clinical information/ documents will be required for review. This information will be provided to the requesting provider to ensure coordination and understanding of when additional member condition updates are required. Please note section on issuance of Administrative Denials when clinical information is not submitted timely or fully.

To justify remaining in a BHIF level of care, progress must be evident to show that the condition or its symptoms are treatment responsive, the member must ***continue*** to manifest symptoms justifying the principal DSM-5 diagnosis/ICD 10 code, and one or more of the following:

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

Concurrent review documentation should include a description of the active treatment and interventions that are being provided (and documented in the clinical record) that is assisting the member in achieving identified service plan goals for a successful discharge. Active treatment services should include the following:

1. Psychiatric services at a minimum of every other week, or more as indicated, to provide active psychiatric treatment including a focus on psychosocial interventions and pharmacotherapy to meet individualized needs
2. Clinical assessment at a minimum on a daily basis that includes close, continuous, 24 hour skilled medical/nursing supervision
3. Individual and family therapy each a minimum of once a week or more to meet individualized needs. If family therapy is not being provided rationale must be documented in the clinical record
4. Group therapy and/or an individualized or family therapy service on a daily basis

5. Active and individualized ongoing positive behavioral management
6. School or vocational programming

Re-certification Of Need (RON)

A RON is a re-certification made by a physician, a nurse practitioner or physician assistant. The RON must recertify for each applicant or beneficiary that continued inpatient services in a BHIF are needed. A RON must be completed at least **every 30 days for a member under the age of 18 who is receiving services in a Behavioral Health Inpatient Facility**. The completion and review of the Service Plan in this circumstance meets the requirement for the re-certification of need. For a sample RON form go to Recertificate of Need.

The following documentation is needed on a RON:

- Fax RONS to (520) 874-3411
- Proper treatment of the member's behavioral health condition requires services on an inpatient basis under the direction of a physician
- The service can reasonably be expected to improve the member's condition or prevent further regression so that the service will no longer be needed
- Outpatient resources available in the community do not meet the treatment needs of the member
- RONs must have a dated signature by a physician, nurse practitioner or physician assistant.

Administrative Denials During BHIF Hospitalization

An Administrative Denial is based on the following:

- Failure of the facility to submit ALL of the required documentation/clinical information to conduct comprehensive utilization review activities to determine medical necessity for admission and/or concurrent review/continued stay, and/or
- Failure to provide the services required, and /or
- Failure to provide telephonic review during the scheduled time

Administrative Denials are based on the lack of information timely submitted and/or deficiency in provision of services required and not based on medical necessity criteria. As a result, they do not require physician review or involvement in the denial decision. These denials will result in the termination of the authorization where there is a deficiency in documentation/information or services for the entire or remaining length of stay or denial of specified days where required documentation/information or services, for example a BHMP note is not provided during specified days.

Administrative denials will be issued for concurrent review/continued stay of BHIFs when there is lack of documentation/information to demonstrate required services have been provided consistent with the required interventions including the following:

1. Psychiatric services at a minimum of every other week, or more as indicated, to provide active psychiatric treatment including a focus on psychosocial interventions and pharmacotherapy to meet individualized needs
2. Clinical assessment at a minimum on a daily basis that includes close, continuous, 24 hour skilled medical/nursing supervision
3. Individual and family therapy each a minimum of once a week or more to meet individualized needs. If family therapy is not being provided rationale must be documented in the clinical record
4. Group therapy and/or an individualized or family therapy service on a daily basis
5. Active and individualized ongoing positive behavioral management
6. School or vocational programming

After an Administrative Denial has been issued, the facility can submit the claim/request as a Retrospective Review through the Claims Department. The request for reimbursement through a Retrospective Review must include an explanation as to why the facility was unable to submit timely and comprehensive clinical documentation required to determine medical necessity at the time of admission, concurrent review or the UM reviewer's request.

BHIF Discharge Criteria

The member is ready for discharge when any of the following criteria have been satisfied:

- The planned course of treatment has been completed.
- The member's symptom intensity or impairment in functioning no longer requires the level of observation or intensity of service at the requested level of care. Including, when a member presented with a danger to self or others, there is absence of thoughts of suicide, homicide or serious harm to another, or the thoughts of suicide/homicide, or serious harm to self or to another are present but are manageable/treatable at available lower level of care.
- Further professional intervention is not expected to result in significant improvement in the patient's condition
- The member leaves against medical advice (AMA)

BHIF Discharge Planning

The intent of the discharge planning process is to improve the management of inpatient admissions and the coordination of post-discharge services, reduce unnecessary institutional and hospital stays, ensure discharge needs are met, and decrease readmissions within 30 days of discharge. Discharge planning is expected to begin on the date of admission. If the member is not enrolled with an outpatient behavioral health provider, the inpatient team must initiate a request to enroll the member with an outpatient agency chosen by the member or by zip code. Facilities should coordinate with the health plan UM reviewer when an urgent enrollment is needed for the member to ensure discharge and follow up care can be established. Timely identification and documentation of the member's outpatient behavioral health provider must also include active engagement of such providers in the discharge process. B – UHP 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. Discharge planning must be performed by a qualified health care professional and is initiated on the initial concurrent review, updated periodically during the inpatient stay and continued post discharge to ensure a timely, effective, safe and appropriate discharge. The following must be included as part of this process:

- The qualified health professional participating in the discharge planning process shall ensure the member/Health Care Decision Maker/ designated representative is a) involved and participates in the discharge planning process, b) understands the written discharge plan, instructions and recommendations provided by the facility and c) is provided resources, referrals and possible interventions to meet the member's assessed and anticipated needs after discharge.
- Coordination and management of the care shall include the following but are not limited to:
    - Follow up appointment with the BHMP/Specialist within 7 business days
    - Coordination and communication with the Health Plan to ensure a safe and clinically appropriate discharge placement, and community support services
    - Communication of the member's treatment plan and medical history across the various outpatient providers, including the member's outpatient clinical team and other natural supports as applicable.
    - Access to prescription medications
    - Nursing Services or Medical equipment as applicable,
    - Referral to appropriate community resources
    - Referral to the Health Plan Care Management Programs as applicable
    - Coordination with the Health Plan even when the Health Plan is not the primary payer.
    - Coordination of care with the Health Plan including submission of Prior Authorizations for transfers before a is discharged to another Level I inpatient psychiatric facility or to an alternative level of care (including a BHRF).

Requirements for BHIF Discharge Plan/Summary

All facilities are required to submit the Discharge Plan/Summary to the Health Plan and the outpatient behavioral health provider within 24 hours of discharge. Discharge Plan/Summary must be submitted to: BUHPUMPAMailbox@bannerhealth.com.

At a minimum the Discharge Plan/Summary must contain the following information:

- Date of discharge
- Discharge diagnosis
- Discharge instructions, including follow up services and discharge appointments (required to have an appointment with prescriber or BHMP within 7 days)
- Discharge medications including the following: dosage, instructions, and number of days of medications provided if applicable (for hospitals and BHIFs)
- The Discharge Plan/Summary must include the follow up appointment with a BHMP even if the member is discharging to a BHRF.

Delays in submitting the Discharge Summary to the Health Plan may result in a delay of claims payment. B – UHP must have accurate documentation to confirm the date of discharge and the discharge information.

Delays in submitting the Discharge Summary to B – UHP may result in a delay of claims payment. B – UHP must have accurate documentation to confirm the date of discharge and the discharge information.

BHIF Avoidable Days

At times, potentially avoidable delays may occur in discharging members from an acute level of behavioral health care to a less restrictive treatment setting. Such delays typically occur because the less restrictive, community-based treatment and supports that are necessary for a safe and successful discharge are not yet fully arranged or available. Potentially avoidable inpatient days are periods of continued hospitalization on a BHIF level of care are authorized by the health plan when medical necessity no longer is demonstrated, but services at a lower level of care are not yet available, despite active, comprehensive, and timely discharge planning efforts by the facility or provider. Potentially avoidable inpatient days will be authorized only when discharge planning activities are documented appropriately by the facility or provider from the time of the member’s initial admission, and when evidence of continued, comprehensive discharge planning efforts is submitted daily to the health plan for review, until discharge of the member occurs.

Potentially avoidable inpatient days must be preceded by at least one acute inpatient day (24 hours in duration) that meets medical necessity criteria. Authorization will not be provided for direct admission from an outpatient or residential treatment setting to a more acute level of care for which medical necessity has not been demonstrated, or for which prior authorization has not been obtained. Potentially avoidable inpatient days also will not be authorized solely for convenience, or when appropriate services in an alternative setting are available, but refused or declined by the member, the member’s family, or the inpatient treatment team.

When potentially avoidable inpatient days are authorized, the facility or provider must continue to assure that appropriate BH treatment and services are provided to the member until the time of discharge to a lower level of care. Types of potentially avoidable inpatient days include: (1) lack of an available residential treatment bed in a BHRF, or TFC/ ABHTH level of care; (2) lack of available specialty services (such as those that are medically necessary for members with an autism spectrum diagnosis, sexually maladaptive behaviors, cognitive limitations, a significant history of aggression toward others, accompanying medical disorders, or other similar conditions), and (3) lack of access to other community based treatment and supports that are necessary to sustain adequate functioning in the community.

BHIF Required Reporting of Avoidable Days

To justify avoidable/administrative bed days the following must be provided during the UM Reviewer during concurrent review, failure to provide this information may result in an Administrative or Medical Necessity Denial:

- Clinical documentation must support that alternative discharge arrangements available are not adequate to safely meet the needs of the member
- If a required service is not currently available, the discharge plan must clearly state this and identify the steps to be able to access needed services. Entries such as "deferred until patient

stabilizes," "to be determined," or "placement pending," are not acceptable.

- Evidence of active attempts to effectuate discharge to a specified placement/level of care or community-based service must be provided and resubmitted/updated and reviewed by staff every 24 hours. If there are insufficient discharge planning activities a denial should be issued.

B – UHP 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.

Adult/Children Behavioral Health Residential Facility (BHRF)

Care and services provided in a contracted BHRF are based on a per diem rate (24-hour day), require prior authorization based on the circumstances outlined below, and do not include room and board.

All BHRF providers are required to employ staff with the competencies and skills to deliver the required interventions and programmatic services, including developing measurable and achievable treatment goals, ability to clinically document the member's progress and participate in clinical meetings to support the member's care, transitions and discharge planning. External contractors of the BHRF must be credentialed and receive prior authorization for any on site services being rendered to a member.

BHRF providers that serve juveniles must comply with all relevant provisions in A.R.S. 36-1201.

All BHRF providers are required to notify the member's PCP and Behavioral Health outpatient provider upon intake and discharge from the BHRF.

Individuals may be admitted to a B – UHP contracted BHRF level of care through an Emergent Admission (through September 30, 2021) or through an Expedited Prior Authorization Request. All BHRF prior authorization requests are considered expedited. B – UHP will make a determination of medical necessity within 72 hours of the request, including weekends and legal holidays. If B – UHP 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.

B – UHP will only authorize non-contracted BHRF providers when a member is currently receiving services from the BHRF and the member transitions from a current Health Plan to B – UHP. Disruption of services should not occur due to this transition. The relinquishing Health Plan is required to notify Banner of the transition. B – UHP will contact the BHRF for the authorization and continued stay. If a non-contracted BHRF admits a Banner member with Medicare as the primary payor, or the member has other commercial insurance, the non-contracted BHRF must notify the Health Plan and follow the process outlined below. All requests for non-contracted BHRFs must be submitted for a prior authorization. Non contracted BHRF authorizations will be determined based on medical necessity regarding special circumstances.

BHRF providers, including providers that are frequently described in the community as Brief Intervention Programs or BIPs, are still required to adhere the prior authorization requirements set forth in this chapter. BIPs are specialized programs rendered at the BHRF level of care and members must meet medical necessity for these services. Emergent admissions to these BHRF providers should only be used when a member's needs require placement immediately or within a timeframe that cannot be accommodated by the prior authorization process. The emergent admission process is typically meant to be used as a step down from a higher level of care such as hospitalization.

All BHRFs that provide substance abuse treatment are required to have Narcan available for emergency use in case of an opioid overdose in the facility. All BHRFs providing substance abuse treatment must train all staff to administer Narcan in an emergency overdose occurrence. This is not a substitute for medical care but rather an intervention until emergency services are able to be provided. Narcan doesnot require a prescription. Providers may contact Sonoran Prevention Works for Narcan training and assistance

BHRF and Medication Assisted Treatment (MAT)

BHRF providers must ensure that members on Medication Assisted Treatment (MAT) are not excluded from admission and are able to receive their MAT services to ensure compliance with the Arizona Opioid Epidemic Act SB 1001, Laws 2018. Providers must have policies that specifically ensure that members have access to their MAT services and must train all staff on this requirement. Providers are required to

collaborate this care with the member's outpatient behavioral health provider. MAT services do not require a prior authorization however, any associated counseling or treatment services do require a prior authorization. All services provided outside of the per diem BHRF rate without a prior authorization will be denied

Emergent-Admission Criteria for BHRF

For emergent admissions, a member may be placed in the contracted facility, based on documented information that meets medical necessity criteria. The member requiring an admission to a BHRF may be admitted even if they are not currently enrolled with an outpatient behavioral health provider.

- Admission in a higher behavioral health therapeutic level of care
- Admission in a psychiatric hospital
- Development of behaviors resulting in risk of admission to a higher level of care
- Extending the length of stay beyond what is medically necessary in a level 1 psychiatric facility, crisis observation or another higher level of behavioral health services while waiting for prior authorization.

For emergent admissions, upon receipt of the required documents, and when medical necessity criteria have been met, an initial authorization will be issued for a brief period only when the notification has been submitted within the two business days of admission. If the notification is received later than the two business days and medical necessity criteria are met, then authorization will be effective the date of receipt of the notification. See the criteria stated below. If member requires a continued stay, the out of home provider must provide updated clinical information demonstrating the continued need during the scheduled telephonic review.

- Behavioral Health Prior Authorization
- Out of Home Admission Notification
- Out of Home Application

Non-Emergent Admissions to BHRF/Expedited Prior Authorizations

Prior authorization must occur prior to admission to a BHRF for non-emergent admissions. B – UHP determines medical necessity for prior authorizations within 72 hours including weekends and holidays. If appropriate, B – UHP may issue an extension of an additional 14 calendar days to request additional documentation. B – UHP requires active involvement of the ART or CFT to facilitate discussion of admission for all levels of care. Expedited authorization may be requested when the provider determines that using the standard timeframe could seriously jeopardize the member's life and/or health or ability to attain, maintain or regain maximum function. If approved, B – UHP will issue an authorization for up to 45 days. Upon admission during the 45-day period, another authorization is activated to secure the date range. Providers are required to submit additional clinical documentation if the member does not admit within 45 days of approval.

Request for Prior Authorization for Admission to a BHRF Level of Care must include the following and submit via fax (520) 694-0599:

- Behavioral Health Prior Authorization
- Out of Home Application, with supporting clinical documentation
- If the admission is for substance abuse, include supporting clinical documentation such as American Society of Addiction Medicine (ASAM) Criteria.

Medical Necessity Criteria for Admission to a Behavioral Health Residential Facility

If a member does not have an outpatient provider, they must obtain one within 7 days. Providers should consult with the UM Reviewer if assistance is needed in obtaining an outpatient provider for the member. Delay in obtaining an outpatient provider for the member may result in an Administrative Denial.

Member must have a diagnosed behavioral health condition which reflects the symptoms and behaviors necessary for a request for residential treatment. The behavioral health condition causing the significant functional and/or psychosocial impairment shall be evidenced in the assessment by the following criteria and only used when needs cannot be addressed in a less restrictive level of care or with community-based treatment because of potential danger to self or others:

At least one area of significant risk of harm within the past three months and expectation of continued

significant risk of harm as a result of:

- Suicidal/aggressive/self-harm/homicidal thoughts or behaviors resulting in potential risk for danger to self or others without current plan or intent and need for active treatment in this level of care.
- Impulsivity with poor judgment/insight that are not developmentally appropriate
- Maladaptive physical or sexual behavior
- Member's inability to remain safe within his or her environment, despite environmental supports (i.e. Natural Supports), or community-based services.
- Medication side effects due to toxicity or contraindications which do not require continuous medical or nursing supervision and are appropriate for supervised medication self-administration.

AND

At least one area of serious functional impairment which cannot be addressed in a less restrictive level of care or community-based treatment because of potential danger to self or others as evidenced by:

- Inability to complete developmentally appropriate self-care or self-regulation due to member's behavioral health condition(s)
- Neglect or disruption of ability to attend to majority of basic needs, such as personal safety, hygiene, nutrition or medical care
- Frequent inpatient psychiatric admissions or legal involvement due to lack of insight or judgment associated with psychotic or affective/mood symptoms or major psychiatric disorders where exclusionary criteria are not met.
- Frequent withdrawal management services, which can include but are not limited to, detox facilities, MAT and ambulatory detoxification.
- Inability to independently self-administer medically necessary psychotropic medications despite interventions such as education, regimen simplification, daily outpatient dispensing, and long acting injectable medications or,
- Impairments persisting in the absence of situational stressors that delay recovery from the presenting problem.
- 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.
- Anticipated stabilization cannot be achieved in a less restrictive setting.
- Evidence that appropriate treatment in a less restrictive environment has not been successful or is not available, therefore warranting a higher level of care.
- Member agrees to participate in treatment. In the case of minors, family/guardian/designated representative also agrees to and participates as part of the treatment team.

Admission, Assessment, and Service Plan Coordinated with Outpatient Providers

Upon admission to a BHRF, the BHRF provider and the outpatient provider will conduct the following assessment and service planning process:

- A behavioral health assessment for a member is completed before treatment is initiated and within 48 hours of admission.
- The CFT/ART is included in the development of the Service Plan within 7 days of admission.
- A comprehensive discharge plan is created during the development of the initial service plan and is reviewed and/or updated at each review thereafter. The discharge plan shall document the following:
    - Anticipated clinical status upon discharge
    - Member/guardian/designated representative and CFT/ART understands follow-up treatment, crisis and safety plan. CFT/ARTs must include the member's assigned outpatient provider in order to promote the transition of care from the BHRF to the outpatient provider upon discharge, including the transition of medication management.
    - 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).

- Comprehensive services and supports to meet the member’s immediate and post-acute needs to support successful transition back to the community.

- The BHRF staff participate in the CFT/ART process and meet to review and modify the service plan at least once a month.
- A service 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.
- The provider has a system to document and report on timeliness of BHP signature/review when the service plan is completed by a BHT.
- The provider has a process to actively engage family/guardians/designated representative in the service planning process as appropriate.
- 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:
  - Cognitive/intellectual disability, (see exclusionary criteria below)
  - Cognitive disability with comorbid behavioral health condition(s),
  - Older adults, and co-occurring disorders (substance use and behavioral health condition(s)), or
  - Comorbid physical and behavioral health condition(s).
- 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.
- Medication management services typically are not provided by the BHRF, but rather by an established outpatient BH provider, and are not included in the BHRF per diem rate.
- BHRF’s that choose to make on-site medication management services available through a designated/contracted provider that bills separately for such services must assure that:
  - Members are not required or unduly pressured to receive on-site medication management services in conjunction with BHRF admission. The BHRF must continue to facilitate medication management visits with off-site BH providers and must report to the health plan any information that suggests that a member is receiving psychotropic medications from multiple prescribers simultaneously.
  - Medication prescribers that provide on-site services are appropriately credentialed through the health plan as in-network providers unless Prior Authorization for the use of an out of network prescriber first has been approved.
  - In order to maintain continuity of care, transitions in a member’s medication management services, regardless of duration, are coordinated with previous inpatient and outpatient providers who were providing behavioral health services to the member, or who had an open episode of enrollment, just prior to the member’s BHRF admission, including providers of Medication Assisted Treatment services.
- Appropriate records from these previous providers must be requested and reviewed prior to initiating on-site medication management services, consistent with established standards of medical practice. The requested records must include (but are not necessarily limited to) a current, comprehensive medication list, including the most recent date, quantity, and dosing regimen of each active medication prescribed to the member; the member’s most recent psychiatric evaluation (which must be dated within the past year), as well as documentation of any interim updates (unless a comprehensive psychiatric evaluation is completed at the time of the initial on-site medication management visit with the member); and relevant labs, including therapeutic drug levels, as appropriate.
- Initial on-site medication management visits must occur in a timely manner, as warranted by the member’s clinical symptoms, presentation, and available medication supply, but in no event later than 7 days after admission if a member is admitted to the BHRF from a higher level of care (including a Level I inpatient or subacute facility, or a crisis observation/stabilization unit).
  a. Documentation of on-site medication management visits must reasonably incorporate all clinically relevant information and must conform to current standards of care.
  b. On-site medication prescribers must have access to clinical services and supports that

typically are available to outpatient behavioral health providers, including vital sign monitoring, laboratory studies, and the administration of long-acting injections.

c. Informed consent must be documented for all psychiatric medications prescribed on-site, in accordance with health plan and AHCCCS requirements.

d. Prescriptions for all non-formulary medications must be accompanied by the timely submission of Prior Authorization requests, with alternative formulary prescriptions issued in a timely manner if Prior Authorization is declined.

e. Upon discharge from the BHRF, the member's care is appropriately transitioned to a designated outpatient behavioral health provider who has agreed to assume care of the member and to continue medication management services. The date and time of the member's initial follow up visit with the accepting medication provider must be documented in the member's record and must be scheduled to occur within 30 days of discharge from the BHRF. An adequate supply of prescribed psychiatric medications must be provided to the member to sustain treatment until the time of follow up, and copies of all medication management records during the member's BHRF admission, including an up-to-date and comprehensive medication list, must be provided at the time of discharge.

- Members on Court Ordered Treatment must continue to receive all medication management services through the behavioral health provider approved by the court and cannot receive on-site services from an alternative prescriber at the BHRF.
- Failure of a medication prescriber to assure continuity of a member's medication management services upon discharge from the BHRF may constitute abandonment and unprofessional conduct and may result in a Quality of Care investigation or referral to the appropriate professional/facility licensing entity.
- According to the guidelines of AHCCCS Policy 320-V, the member's Adult Recovery Team (ART) is to consist of, at a minimum, the member, the member's guardian (if applicable), advocates, and an assigned qualified behavioral health representative. The team may also include other entities such as the member's family, physical health providers, and representatives from agencies providing services to the member. Because the members who receive treatment in BHRF are expected to step down and continue their care in the community from providers within the community, the Health Plan expects members to be connected to community provider agencies within the first 30 days of admission to BHRF so that representatives from the community provider agency can participate in the Adult Recovery Team/Child Family Team, assist with the development of the discharge plan, and help to ensure continuity of care when the member discharges from BHRF treatment. Member voice and choice are important; however, it is not acceptable for members to decline care from all providers external to the BHRF as the BHRF is expected to assist in fostering a therapeutic relationship between members and other outpatient providers for care collaboration and continuity.

Services to be made available and provided by the BHRF include but are not limited to:

- Counseling and Therapy (group or individual):
  - Note: Group Behavioral Health Counseling and Therapy may not be billed on the same day as BHRF services unless specialized group behavioral health counseling and therapy have been identified as a specific member need that cannot otherwise be met as required within the BHRF setting. **All counseling services not provided directly by the BHRF provider require a prior authorization**. The BHRF provider should ensure that providers delivering counseling services provided outside of the BHRF per diem rate obtain a prior authorization or subcontract with the BHRF for their rates. All services provided outside of the per diem BHRF rate without a prior authorization will be denied. Services not prior authorized and rendered outside of the BHRF per diem rate will be considered as Fraud, Waste and Abuse by both the outpatient provider and the BHRF provider and reported to the AHCCCS Office of Inspector General.
- Family therapy shall be provided at a minimum weekly, by the BHRF provider for members under 18 years of age. If family therapy has not been provided weekly, there must be documentation of efforts to engage family members in therapy, or there must be documentation of the clinical rationale for not providing family therapy.
- Skills Training and Development:
  - Independent Living Skills (e.g. self-care, household management, budgeting, avoidance of

exploitation/safety education and awareness).

    - Community Reintegration Skill building (e.g. use of public transportation system, understanding community resources and how to use them).
    - Social Communication Skills (e.g. conflict and anger management, same/opposite-sex friendships, development of social support networks, recreation).

- Behavioral Health Prevention/Promotion Education and Medication Training and Support Services including but not limited to:
    - Symptom management (e.g. including identification of early warning signs and crisis and safety planning/use of crisis and safety plan),
    - Health and wellness education (e.g. benefit of routine medical check-ups, preventive care, communication with the PCP and other health practitioners)
    - Medication education and self-administration skills,
    - Relapse prevention
    - Psychoeducation Services and Ongoing Support to Maintain Employment Work/Vocational skills, educational needs assessment and skill building
    - Peer and Family Support Services
    - Treatment for Substance Use Disorder (e.g. substance use counseling), and Medication Assisted Treatment (MAT)
    - Personal Care Services

BHRFs must be specifically licensed to deliver Personal Care Services (see additional licensing requirements in A.A.C. R9-10-702, R9-10-715, R9-10-814) and must provide documentation in the service plan if they are going to provide personal care services for a member. Examples of Personal Care Services may include:

- Blood sugar monitoring, accu-check diabetic care
- Administration of oxygen
- Application and care of orthotic devices
- Application and care of prosthetic devices
- Application of bandages, medical support including high elastic
- stockings
- ACE wraps, arm and leg braces
- Application of topical medications
- Assistance with ambulation
- Assistance with correct use of cane/crutches
- Bed Baths
- Care of hearing aids
- Radial pulse monitoring
- Respiration monitoring
- Denture care and brushing teeth
- Dressing member
- Supervising self-feeding of members with swallowing deficiencies
- Hair care, including shampooing
- Incontinence support, including assistance with bed pans, bedside commodes, bathroom supports
- Measuring and recording blood pressure
- Non-Sterile dressing change and wound care
- Passive range of motion exercise
- Use of pad lifts

- Shaving
- Shower assistance using shower chair
- Skin maintenance to prevent and treat bruises, injuries, pressure sores. (If stage 3 or 4 pressure sore no BHRF admission permitted)
- Use of chair lifts
- Skin and foot care
- Measuring and giving insulin, glucagon injection
- G-tube care
- Ostomy and surrounding skin care
- Catheter Care

Expected Treatment Outcomes and SMART Goals

(SMART goals assistance can be found at: https://www.banneruhp.com/-/media/files/project/uahp/behavioral-health-forms)

BHRF can only be utilized if there is an expectation that the member will benefit from the treatment provided at this level of care, with anticipated transition to a lower level of care after identified treatment goals have been met.

Treatment outcomes shall align with the Arizona Vision-Twelve Principles for Children's Behavioral Health Service Delivery or the Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems as outlined in the provider contract, and the member's individualized basic physical, behavioral and developmentally appropriate needs.

Treatment goals must reflect the behaviors and functioning of the member in a language that the member understands what is required for a successful treatment experience and discharge. These goals should focus on Counseling and Therapy, Skill training and Development and Behavioral Health Prevention/Promotion Education and Medication Training and Support Services.

The required treatment goals shall be developed in accordance with the following:

- Specific to the member's behavioral health condition(s)
- Measurable and achievable in a reasonable period of time,
- Cannot be met in a less restrictive environment
- Based on the member's unique needs and tailored to the member and the family's/guardian's/designated representative's choices where possible
- Support the member's improved or sustained functioning and integration into the community.

Requests for BHRF level of care that do not include measurable and meaningful goals that support the requirement for this level of care will be denied.

BHRF Exclusionary Criteria

Admission to a BHRF shall not be used as a substitute for the following:

- An alternative to preventative detention or incarceration
- 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
- A means of providing safe housing, shelter, supervision, or permanency placement
- 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
- An intervention for runaway behaviors unrelated to a behavioral health condition.
- Members with cognitive limitations that are unable to meaningfully engage in services provided by the BHRF with or without an established evidence-based approach. The member must be able to demonstrate improvement and engagement in all services provided by the BHRF.

Concurrent Review for BHRF

Continued stay must be assessed by the BHRF staff and the CFT/ARTduring the service 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:

- The member continues to demonstrate significant risk of harm and/or functional impairment as a result of a behavioral health condition consistent with the criteria for admission.
- Providers and supports are not available to meet current behavioral and physical health needs at a less restrictive lower level of care.
- Member is making progress towards identified goals or if there is lack of progress the facility and service plan are revised resulting in the expectation of improvement.
- The member is demonstrating marked improvement toward the one or more identified area of significant risk of harm that was identified during the admission/evaluation period such as:
    a. Suicidal /aggressive/self-harm/homicidal thoughts or behaviors resulting in potential risk for danger to self or others without current plan or intent and need for active treatment in this level of care.
    b. Impulsivity with poor judgment/insight that are not developmentally appropriate
    c. Maladaptive physical or sexual behavior
    d. Member's inability to remain safe within his or her environment, despite environmental supports (i.e. Natural Supports), or community-based services.
    e. Medication side effects due to toxicity or contraindications which do not require continuous medical or nursing supervision and are appropriate for supervised medication self-administration.

AND

- The member demonstrates marked improvement in one or more in the area of serious functional impairment which could not have been addressed in a less restrictive level of care or community- based treatment because of potential danger to self or others as evidenced by:
    - Inability to complete developmentally appropriate self-care or self-regulation due to member's behavioral health condition(s)
    - Neglect or disruption of ability to attend to majority of basic needs, such as personal safety, hygiene, nutrition or medical care
    - Frequent inpatient psychiatric admissions or legal involvement due to lack of insightor judgment associated with psychotic or affective/mood symptoms or major psychiatric disorders where exclusionary criteria are not met.
    - Inability to independently self-administer medically necessary psychotropic medications despite interventions such as education, regimen simplification, daily outpatient dispensing, and long-acting injectable medications or,
    - Impairments persisting in the absence of situational stressors that delay recovery from the presenting problem.
    - The member continues to demonstrate a need for 24-hour behavioral health care and supervision to develop adequate and effective coping skills that will allow the member to live safely in the community.
    - Anticipated stabilization cannot be achieved in a less restrictive setting
    - Evidence that appropriate treatment in a less restrictive environment continues to be assessed as either previously unsuccessful or is not available, therefore justifying this level of care.

- Member agrees to participate in treatment. In the case of minors, family/guardian/designated representative also agrees to and participates as part of the treatment team.

B – UHP staff will provide technical assistance and/or care management when applicable.

Required Documents from the BHRF/Outpatient Provider

The BHRF provider must schedule telephonic reviews with B – UHP UM Reviewer and be prepared to provide clinical information based on the Concurrent Review Guide.

Based on the timely submitted clinical documentation, the Health Plan will review for medical necessity for the continued stay within 72 hours of receipt of the submittal. If the Health Plan issues a denial based on medical necessity, the BHRF has 10 calendar days to transition the member to the appropriate care and services.

BHRF Discharge Readiness

The BHRF provider must submit a completed Discharge Summary no later than 24 hours after discharge to the assigned B – UHP 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 service plan. The following criteria shall be considered when determining discharge readiness:

- Symptoms or behaviors are reduced, as evidenced by completion of service plan goals.
- Functional impairment is reduced to manageable levels. Essential functions such as eating or hydrating necessary to sustain life have significantly improved or is able to be cared for in a less restrictive level of care.
- Member can participate in needed monitoring or a caregiver is available to provide monitoring in a less restrictive level of care.
- Providers and supports are available to meet current behavioral and physical health needs at a less restrictive level of care.

BHRF Requirements for Discharge Plan/Summary

All BHRF providers are required to submit the Discharge Plan/Summary to the Health Plan and the outpatient behavioral health provider within 24 hours of discharge. BHRF providers may use their own Discharge Form or use the Banner UFC Discharge Form found on our website.

PYX Application for Adult BHRFs - All Adult BHRF providers are required to introduce the Health Plan PYX application to adult members during discharge planning. The discharge plan must have documentation that the member was offered instructions on downloading the PYX application and whether the member accepted or declined or was without the phone technology to obtain the PYX application. Instructional flyers for the PYX Application are in English and Spanish and can be found at www.BannerUFC.com.

The Discharge Plan/Summary must be submitted to: BUHPUMPAMailbox@bannerhealth.com.

At a minimum the Discharge Plan/Summary must contain the following information:

- Date of Discharge
- Discharge instructions including follow up services
- Discharge Diagnosis
- Discharge medications including the following: dosage, instructions and number of days of medications provided if applicable (for hospitals and BHIFs)

Delays in submitting the Discharge Summary to the Health Plan may result in a delay of claims payment. The Health Plan must have accurate documentation to confirm the date of discharge and the discharge information.

Retrospective Review for Behavioral Health Inpatient Hospitalizations

Retrospective Review is a process that occurs after a treatment has been completed and discharge from the service has occurred. The review of services encompasses appropriateness, coverage, efficiency and verification for medical necessity. The retrospective review process may be initiated upon receipt of delayed notification and/or service and/or admission and must be received within 30 days from

completion of the service. Administrative Denials are issued when the Retrospective Review Request exceeds timely filing, with exception of Prior Period Coverage.

For purposes of this document, retrospective review refers to a claims submission that occurs following an inpatient psychiatric admission, after treatment has been completed and the member has discharged. Retrospective review will not serve as an alternative to or a substitute for mandatory concurrent review.

B – UHP conducts retrospective reviews for inpatient psychiatric hospitalizations level of care only.

Delayed notification of admission to a psychiatric facility while the member is still hospitalized and receiving active treatment must be submitted through the Notification of Admission process for consideration of admission and concurrent review. The Health Plan reserves the right to determine when a delayed notification of admission should be considered a retrospective review and submitted through the Claims department.

Requests for retrospective reviews must include ALL of the following:

1. Submit Retrospective Review Request within B – UHP claim submission guidelines. Admin denials will be administered for requests submitted past timely filing.
2. Complete the Retrospective Review Request Form with dates of service and explanation why authorization was not obtained prior to services being rendered and/or lack of notification for emergency inpatient admission.
3. Request must include a reasonable explanation of why the provider was not able to notify B – UHP of the admission or was not able to provide timely clinical documentation to participate in the utilization management concurrent review process at the time of the hospitalization. If the provider indicates that attempts were made to contact B – UHP upon admission and no response was received, the provider must submit evidence of the attempts to contact B – UHP during the hospitalization.
4. Submit legal documentation if the member was admitted under a Court Ordered Evaluation with the dates of the initiation and completion of the Court Ordered Evaluation period. This must include why the Court Ordered Evaluation was ended (time expired, discharged, voluntary etc.) All requests for Retrospective Review that include the Court Ordered Evaluation period time frame for reimbursement will be denied. All Court Ordered Evaluations are funded by the county. Medicaid is the payer of last resort and does not reimburse for Court Ordered Evaluation.

All requests for Retrospective Reviews or Appeals must include the required clinical documentation as follows:

For initial admission

1. The Attending/Psychiatrist admission evaluation must include: admitting diagnosis, differential diagnosis or possible impact of medication conditions/symptoms (e.g. UTI, dehydration), mental status exam, Medication Reconciliation Record (MARS), mental status exam, estimated length of stay, proposed treatment plan (titration of meds, initiating injectable), proposed discharge plan, discharge criteria, justification for current level of care and why member is not able to be discharged at a lower level of care.
2. History and Physical
3. Admission/Intake Assessment
4. Medication Administration Record
5. CIWA/CINA/COWS protocols, as applicable

For concurrent review

1. Attending Behavioral Health Medical Provider (BHMP) notes for each day of hospitalization and sub-acute level of care.
2. For subacute facilities not providing detox, BHMP notes must be provided at a minimum for 5 days (M-F) out of the week.
3. Estimated length of stay
4. Medication Administration Record (MARS)
5. CIWA/CINA/COWS protocols, as applicable

6. All physicians orders
7. RN notes
8. Lab results, if indicated
9. Discharge plan, barriers including updates every 24 hours if barriers are resulting in avoidable days

The entire medical record is not required for Retrospective Reviews. Submittal of entire medical record may result in delays of reviews and reimbursement. Providers are to only send the required documents. Records submitted in entirety will be denied. If the provider fails to submit sufficient information to render an authorization determination, B – UHP 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 B – UHP why the information cannot be submitted for review.

B – UHP will make a one-time request if clinical information is not sufficient to make a decision. Banner recommends providers label each clinical document when submitted to ensure the required documentation is being submitted and not extraneous information that can delay the review process.

Retrospective review is available only when:

- Documentation is provided to substantiate that timely notification of admission and/or concurrent review was not reasonably possible prior to the member's discharge and/or during the hospitalization. B – UHP reserves the right to determine what is a reasonable justification to consider a Retrospective Review request.
- All requested clinical documentation was provided in a timely manner in conjunction with concurrent review, but supplemental information subsequently was identified that warrants further consideration.
- Review is submitted due to Prior Period Coverage
- Exceptions for BHRFs and SABG Funding- Retrospective reviews can be submitted by contracted substance abuse providers that used Substance Abuse Block Grant funds (aka SABG) for a non-Medicaid member at the time of admission. When the member receives prior period coverage and B – UHP 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, B – UHP will screen the request to determine if it is eligible for Retrospective Review and make a determination within 30 days of receipt. If it is determined that the request is not eligible for Retrospective Review based on the above criteria, the provider may submit an appeal.

To ensure the accurate and timely submittal of a retrospective review that will result in a prompt and successful reimbursement consideration, refer to the Medical Record Requirements for Retrospective Review for Covered Services and the Provider Retrospective Review Request documents found on our website at https://www.banneruhp.com/-/media/files/project/uahp/prior-authorization-forms/buhp_retrospective-review-request-letter_feb2020.ashx?la=en

Complete and follow the instructions in the Retrospective Review Request form located at Banner – University Health Plans | Health Care Made Easier in Arizona (banneruhp.com) to ensure an accurate and timely retrospective review results in a prompt and successful reimbursement consideration.

Retrospective Review Requests and supporting clinical information should be submitted to B – UHP claims department via mail in the following order: claim form → retrospective review request form → medical necessity documents:

Banner – University Family Care/AHCCCS Complete Care (B – UFC/ACC)
P.O. Box 35699
Phoenix, AZ 85069-7169
Electronic ID: 09830

Banner – University Family Care/Arizona Long Term Care System (B – UFC/ALTCS)
P.O. Box 37279
Phoenix, AZ 85069
Electronic ID: 66901

Therapeutic Foster Care (TFC) and Adult Behavioral Health Therapeutic Home (ABHTH)

Child/Adolescent and Adults

ABHTH and TFC are covered behavioral health services when medically necessary, that provide daily therapeutic interventions within a licensed family setting. These services are designed to maximize the member's ability to live and participate in the community and to function independently, including assistance in the self-administration of medication and any ancillary services (such as living skills and health promotion) indicated by the member's Treatment Plan as appropriate (Arizona State Plan for Medicaid).

Programmatic support is available to the ABHTH providers and TFC Family Providers 24 hours per day, seven days per week. Care and services provided in an ABHTH or TFC are based on a per diem rate (24-hour day), require prior and continued authorization, and do not include room and board. All authorization requests for TFC and ABHTH services shall be treated as expedited requests.

ABHTH services can only be provided for up to three adults [no more than three] in an Adult Therapeutic Foster Home and TFC services can only be provided for no more than three children in a Professional Foster Home (Arizona State Plan for Medicaid).

ABHTH, and TFC Agency Providers shall ensure appropriate notification is sent to the Primary Care Provider (PCP) and Behavioral Health Home/Agency/TRBHA/ Tribal ALTCS program upon intake/admission to, and discharge from, an ABHTH or TFC. ABHTH providers shall adhere to this requirement as well as procedure requirements outlined in A.A.C. R9-10-1801.

Medical Necessity Criteria for Admission to TFC

Therapeutic Foster Care (TFC) is a covered behavioral health service when medically necessary, that provides daily therapeutic interventions within a licensed family setting. These services are designed to maximize the member's ability to live and participate in the community and to function independently, including assistance in the self-administration of medication and any ancillary services (such as living skills and health promotion) indicated by the member's Treatment Plan as appropriate (Arizona State Plan for Medicaid).

Programmatic support is available to the TFC Family Providers 24 hours per day, seven days per week. Care and services provided in a TFC are based on a per diem rate (24-hour day), require prior and continued authorization, and do not include room and board. All authorization requests for TFC services shall be treated as expedited requests.

TFC services can only be provided for no more than three children in a Professional Foster Home (Arizona State Plan for Medicaid). TFC Agency Providers shall ensure appropriate notification is sent to the Primary Care Provider (PCP) and Behavioral Health Home/Agency/TRBHA/ Tribal ALTCS program upon intake/admission to, and discharge from, a TFC.

When submitting a prior authorization request for therapeutic foster care, the goals developed by the Child and Family Team (CFT) that are on the request must be written as SMART goals. That is, they must be specific, measurable, achievable, relevant and time bound.

Admission Criteria for TFC

a. The recommendation for TFC shall come through the CFT process,

b. Following an assessment by a licensed Behavioral Health Professional (BHP), the member has been diagnosed with a behavioral health condition which reflects the symptoms and behaviors necessary for a request for TFC, and

c. As a result of the behavioral health condition, there is evidence that the member has recently (within the past 90 days) had a disturbance of mood, thought or behavior which renders the member incapable of independent or age-appropriate self-care or self-regulation. This moderate functional and/or psychosocial impairment:

    i. Per assessment by a Behavioral Health Professional (BHP), cannot be reasonably expected to improve in response to a less intensive level of care, and

    ii. Does not require or meet clinical criteria for a higher level of care, or

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

d. At time of admission to a TFC, there is a documented plan for discharge which includes:
    i. Tentative disposition/living arrangement identified,
    ii. Recommendations for aftercare treatment based upon above treatment goals.

Concurrent Review for TFC

All of the following shall be met:

a. The member continues to meet diagnostic threshold for the behavioral health condition that warranted admission to TFC,
b. There is an expectation that continued treatment at the TFC shall improve the member's condition so that this type of service shall no longer be needed,
c. The CFT is meeting at least monthly to review progress, and have revised the Treatment Plan and Service Plan to respond to any lack of progress, and for members, the biological family, kinship family, adoptive family, and/or transition foster family to whom the member shall be transitioned after discharge from a TFC has been identified and is actively involved in the member's care/treatment, if applicable.
d. Evidence that the CFT has reviewed the goals and that progress is being made toward those goals. If there is a lack of progress, evidence that interventions are being adjusted.
e. Evidence that the member and the member's guardian are actively engaged in treatment activities, including weekly family therapy to work toward reunification and reintegration to the home. If there is a lack of engagement, there is evidence of the provider's efforts to engage the member and the guardian.
f. For tribal members in the custody of tribal social services or Department of Child Safety (DCS) who have no identified guardian or family, evidence of active efforts to engage other family members.
g. **At least one of the following is met:**
    1. The member continues to demonstrate (within the last 90 days) moderate functional or psychosocial impairment as a result of the behavioral health condition, as identified through disturbances of mood, thought or behavior, which substantially impairs independent or age appropriate self-care or self-regulation, or
    2. Active treatment is reducing the severity of disturbances of mood, thought, or behaviors, which were identified as reasons for admission to TFC, and treatment at the TFC is empowering the member to gain skills to successfully function in the community.

Expected Treatment Outcomes

Treatment outcomes shall align with:

- The Arizona Vision-12 Principles for Children's Behavioral Health Service Delivery as specified in AMPM Policy 100
- The member's individualized physical, behavioral, and developmentally appropriate needs.

Treatment goals for the member's time in TFC shall be developed and be:

- Specific to the member's behavioral health condition that warranted treatment
- Measurable and achievable,
- Cannot be met in a less restrictive environment,
- Based on the member's unique needs,
- Include input from the member's family/healthcare decision-maker and designatedrepresentative's choices where applicable, and
- Support the member's improved or sustained functioning and integration into the community.

Active treatment with the services available at this level of care can reasonably be expected to:

- Improve the member's condition in order to achieve discharge from the TFC at the earliest possible time, and
- Facilitate the member's return to primarily outpatient care in a non-therapeutic/non-licensed setting.

TFC Exclusionary Criteria

Admission to a TFC shall not be used as a substitute for the following:

- An alternative to detention or incarceration,
- As a means to ensure community safety in an individual exhibiting primarily conduct disordered behaviors,
- As a means of providing safe housing, shelter, supervision or permanency placement,
- As an alternative to parents'/guardians' or other agencies' capacity to provide for the member,
- A behavioral health intervention when other less restrictive alternatives are available and meet the member's treatment needs, including situations when the member/health care decision maker is unwilling to participate in the less restrictive alternative, or an intervention for member runaway behaviors unrelated to a behavioral health condition.

TFC Criteria for Discharge

- Sufficient symptom or behavior relief is achieved as evidenced by completion of the TFC treatment goals.
- The member's functional capacity is improved, and the member can be safely cared for in a less restrictive level of care.
- The member can participate in needed monitoring and follow-up services or a caregiver is available to provide monitoring in a less restrictive level of care.
- Appropriate services, providers, and supports are available to meet the member's current behavioral health needs at a less restrictive level of care.
- There is no evidence to indicate that continued treatment in TFC would improve member's clinical outcome.
- There is potential risk that continued stay in a TFC may precipitate regression or decompensation of member's condition.

Adult Behavioral Health Therapeutic Home (ABHTH)

ABHTH provides care and services for adults who demonstrate moderate functional impairments, when ambulatory care services in the community do not meet their treatment needs. These services are designed for adults who have a DSM 5/ICD-10 psychiatric diagnosis. ABHTH home is a licensed residence that provides behavioral health treatment, maximizing the ability of an individual experiencing behavioral health symptoms to live and participate in the community, functioning independently.

ABHTH services assist and support an adult in achieving their service plan goals and objectives. It also helps the adult remain in the community setting, thereby avoiding residential, inpatient or institutional care. ABHTH services provides daily behavioral interventions within a licensed family setting.

The Adult Recovery Team (ART) is required to work collaboratively with the ABHTH family including being actively involved in the member's assessment, service planning, and service delivery. The member's treatment plan guides scope, goals, and delivery of services for the member while in ABHTH.

ABHTH services include but are not limited to supervision and the provision of behavioral health support services such as assistance with self-administration of medication, psychosocial rehabilitation, skills training and development, assistance with arranging or providing transportation to therapy, and participation in care and discharge planning. Active treatment is required to focus on the specific targeted goals identified by ART and is designed to enable the member 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 an ABHTH. 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.

Programmatic support for the member and family is available to the ABHTH Providers 24 hours per day, seven days per week by the Collaborating Healthcare Institution (CHI). Care and services provided in an ABHTH are based on a per diem rate (24-hour day), require prior and continued authorization, and do not include room and board.

Homes providing ABHTH services are licensed and regulated by the Bureau of Residential Facilities

Licensing (BRFL) under the Arizona Department of Health Services (ADHS). The BRFL licenses and regulates Residential Healthcare Facilities, including Assisted Living Centers/Homes and Behavioral Health Residential Facilities, along with Adult Day Health Care Facilities, Adult Foster Care Homes, Behavioral Health Respite Homes, and Behavioral Health Therapeutic Homes.

Medical Necessity Criteria for ABHTH

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 below must all be met to meet prior authorization and concurrent review for continued stay:

1. The recommendation for ABHTH shall come through the ART process,
2. Following an Assessment by a licensed BHP, the member has been diagnosed with a behavioral health condition which reflects the symptoms and behaviors necessary for a request for ABHTH,
3. As a result of the behavioral health condition, there is evidence that the member has recently (within the past 90 days) had a disturbance of mood, thought, or behavior which renders the member incapable of independent or age-appropriate self-care or self-regulation. This moderate functional and/or psychosocial impairment per Assessment by a BHP:
    a. Cannot be reasonably expected to improve in response to a less intensive level of care, and
    b. Does not require or meet clinical criteria for a higher level of care, or
    c. Demonstrates that appropriate treatment in a less restrictive environment has not been successful or is not available, therefore warranting a higher level of care.
4. 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.
5. Member is in agreement with treatment in ABHTH.
6. At time of admission to an ABHTH, in participation with the Health Care Decision Maker and all relevant stakeholders, there is a documented plan for discharge which includes:
    a. Tentative disposition/living arrangement identified, and
    b. Recommendations for aftercare treatment based upon treatment goals.

For the initial authorization for ABHTH 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 ABHTH at the earliest possible time and facilitate return to outpatient care. There must be an expectation that the member will participate in treatment.

Concurrent Review for ABHTH

For continued stay in the ABHTH level of care, if the member is not demonstrating improvement the ABHTH services and treatment plan must be revised as part of the ART process resulting in an expectation of improvement in order to achieve discharge from the ABHTH at the earliest possible time and facilitate return to outpatient care. The member must be actively participating in treatment.

All of the following shall be met:

1. The member continues to meet diagnostic threshold for the behavioral health condition that warranted admission to ABHTH,
2. The member continues to demonstrate (within the last 90 days) moderate functional or psychosocial impairment as a result of the behavioral health condition, as identified through disturbances of mood, thought, or behavior, which substantially impairs independent or appropriate self-care or self-regulation,
3. Active treatment is reducing the severity of disturbances of mood, thought, or behaviors, which were identified as reasons for admission to ABHTH, and treatment at the ABHTH is empowering the member to gain skills to successfully function in the community,
4. There is an expectation that continued treatment at the ABHTH shall improve the member's condition so that this type of service shall no longer be needed, and
5. If appropriate, supports and providers who will be involved with the member upon discharge from ABHTH should be identified and involved in the member's care.

6. The ART is meeting at least monthly to review progress and have revised the Treatment Plan and/or Service Plan to respond to any lack of progress including
    a. addressing lack of member's engagement and evidence of the ABHTH family and provider to engage the member.
    b. Evidence of the goals and progress toward the goals has been reviewed and adjusted interventions to address a lack of progress.

Expected Treatment Outcomes

1. Treatment outcomes shall align with:
    - The Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems as specified in AMPM Policy 100, and
    - The member's individualized physical, behavioral, and developmentally appropriate needs.
2. Treatment goals for members placed in an ABHTH shall be:
    - Specific to the member's behavioral health condition that warranted treatment,
    - Measurable and achievable,
    - Unable to be met in a less restrictive environment,
    - Based on the member's unique needs,
    - Inclusive of input from the member's family/Health Care Decision-Maker and Designated Representative's choices where applicable, and
    - Supportive of the member's improved or sustained functioning and integration into the community.
3. Active treatment with the services available at this level of care can reasonably be expected to:
    - Improve the member's condition in order to achieve discharge from the ABHTH at the earliest possible time, and
    - Facilitate the member's return to primarily outpatient care in a non-therapeutic/non-licensed setting.

ABHTH Exclusionary Criteria

Admission to an ABHTH shall not be used as a substitute for the following:

- An alternative to detention or incarceration
- As a means to ensure community safety in an individual exhibiting primarily conductdisordered behaviors,
- As a means of providing safe housing, shelter, supervision, permanency placement, or otherwise alleviate or prevent homelessness.
- As an alternative to member/guardians' or other agencies' capacity to provide for the member,
- A behavioral health intervention when other less restrictive alternatives are available and meet the member's treatment needs, including situations when the member/health care decision maker is unwilling to participate in the less restrictive alternative.

Additionally, members cannot be safely accommodated in ABHTH family setting if they:

- Are in active substance abuse
- Have a history of starting fires
- Are a registered sex offender

A member meeting VI-VIII exclusion criteria because they cannot be safely accommodated in ABHTH, will be reviewed for Behavioral Health Residential Facility (BHRF) if they are meeting all other ABHTH admission criteria and none of the exclusion criteria I-V in this section is met.

ABHTH Discharge Planning

There is a written plan for discharge with specific discharge criteria and recommendations for aftercare

treatment that includes involvement of the ART 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. A discharge plan must be documented on the treatment plan prior to 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.

A comprehensive discharge plan shall be created during the development of the initial Treatment Plan and shall be reviewed and/or updated at each review thereafter. The discharge plan shall document the following:

1. Clinical status for discharge.
2. Follow-up treatment, crisis, and safety plan.
3. Coordination of care and transition planning are in process when appropriate.
4. Notation of dates it was reviewed when it is reviewed by the ART but not updated.

ABHTH Criteria for Discharge

- Sufficient symptom or behavior relief is achieved as evidenced by completion of the ABHTH treatment goals.
- The member's functional capacity is improved, and the member can be safely cared for in a less restrictive level of care
- There are appropriate services, providers, and supports are available to meet the member's current behavioral health needs at a less restrictive level of care.
- There is no evidence to indicate that continued treatment in ABHTH would improve member's clinical outcome.
- There is potential risk that continued stay in an ABHTH may precipitate regression or decompensation of member's condition.
- The member has left the ABHTH unscheduled/unplanned and not returned within 24 hours.

TFC/ ABHTH 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 TFC level of care, respite is available from an eligible provider. AHCCCS states that TFC cannot be encountered on the same day respite is provided. If the CFT believes respite is appropriate, it should be documented on the service plan. A collaborative effort of CFT members should locate an eligible provider through the standard referral process.

It is the responsibility of the TFC provider to notify the Health Plan prior to the provision of respite services. **Contact the UM Reviewer and submit the following information 3 days before member enters respite care:**

- Name of Member
- Name of TFC 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 TFC provider does not bill the days during which respite is provided. It is the responsibility of the TFC 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 TFC provider that has been authorized by the Health Plan to provide that level of care for the member.

Out of Home Services (OOH), Between Facility Transfers

A prior authorization is required when an Out of Home (BHRF, BHRF or TFC/ABHTH) is requested initially. If a provider determines that a member is better served in a different location that is an equal level of

care, they may request a facility transfer. Transfers can occur based on either administrative or clinical reasons. Transfers must be requested from and approved by the Health Plan prior to member transferring. Transfers are not considered an emergency service as OOH facilities are not acute/emergency providers. The transferring facility must obtain approval from a receiving facility for the transfer. Transfer decisions will be made within 3 business days of receipt.

After a member has been authorized for treatment for behavioral health out of home services (BHRF, BHIF, TFC/ ABHTH) and the facility determines that the member requires a transfer to an equal type, but different out of home location, the OOH facility provider must do the following:

1. Complete the OOH Between Facility Transfer form in its entirety explaining the reason for the transfer.
2. Email the OOH Between Facility Transfer form to: BUHPBHUMPAMailbox@Bannerhealth.com

The transferring provider must not transfer the member until they receive an authorization from the Health Plan. The transferring facility must submit the discharge form to the Health Plan within 48 hours of the completed transfer.

The transferring and receiving facilities are responsible for arranging transportation.

The receiving facility must send the OOH Notice of Admission within 2 business days of the member's arrival.

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 which drugs require prior authorization. Contracted providers must ensure members meet the prior authorization criteria. 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 or refer to the AHCCCS drug list for medications requiring a prior authorization.**

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 an Out of Network Provider

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

If a needed covered outpatient service is unavailable within the Health Plan's contracted provider network, the provider submits a Behavioral Health Prior Authorization request to the Health Plan Behavioral Health Department via fax at **(520) 694-0599**.

- All out of network requests must be accompanied by the current individual service plan 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 Contract 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 CFT/ART.
- The CFT/ART then meets to consider alternative services. The CFT/ART is responsible for ensuring that a similar level of equivalent services is in place for the member
- B – UHP secures services and provides payment to non-contracted providers through single case

agreements.

If a request to secure covered services through a non-contracted provider is denied, notice of the decision will be provided by B – UHP within the AHCCCS required timelines for Notices of Action.

NOTE: Federal Law enacted in both the Patient Protection and Affordable Care Act (ACA) and the 21st Century Cures Act (Cures) requires that all health care providers who provide services to, order (refer), prescribe, or certify health care services for AHCCCS members must be enrolled as an AHCCCS provider. After June 1, 2021 claims which include referring, ordering, prescribing, or attending providers who are not enrolled with AHCCCS will not be reimbursed. For additional information please refer to https://www.azahcccs.gov/PlansProviders/NewProviders/ROPA.html

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

Criteria for Transcranial Magnetic Stimulation

Fax Behavioral Health Prior Authorization Form to (520) 694-0599

Transcranial Magnetic Stimulation (TMS) may be indicated when **ALL** of the following are present:

- Age 18 years or older (25)
- Major depressive disorder (severe) and 1 or more of the following:
    - Need for treatment, as indicated by 1 or more of the following:
        - Inadequate response to pharmacotherapy despite ALL of the following:
            - Adequate duration and dosage
            - Documented adherence
            - Trials from 2 or more classes of medications
    - Inability to tolerate pharmacotherapy as evidenced by 4 trials of agents with documented side effects
- Continuation of index (acute) course of treatment, as indicated by ALL of the following:
    - Continuation of symptoms after index (acute) course of treatment
    - Previous positive response to index (acute) course of treatment
- No acute or chronic psychotic symptoms or disorders (e.g., schizophrenia, schizophreniform, or schizoaffective disorder)
- No cochlear implant, deep brain stimulator, or vagus nerve stimulator
- No epilepsy or history of seizure or presence of other neurologic disease that may lower seizure threshold (e.g., cerebrovascular accident, severe head trauma, increased intracranial pressure)
- No metallic hardware or implanted magnetic-sensitive medical device (e.g., implanted cardioverter defibrillator, pacemaker, metal aneurysm clips or coils) at a distance within the electromagnetic field of the discharging coil (e.g., less than or equal to 30 cm to the discharging coil)

Requests for Prior Authorization for Transcranial Magnetic Stimulation must include the following submitted via fax to (520) 694-0599.

1. Behavioral Health Prior Authorization Form
2. Supporting clinical documentation

Medical Necessity Denials for all Levels of Care

A denial based on a lack of documentation of medical necessity for an outpatient service, inpatient admission, or continued stay can only be made by the Health Plan's Chief Medical Officer or physician designee after review of all clinical information provided. Denials will only be issued when the information provided verbally and/or through documentation does not support medical necessity for the service provided. For denials of admissions or continued stays, the provider may request a peer-to-peer discussion for reconsideration within one business day of the denial. The peer to peer discussion must be requested and conducted within one business day of the denial and the provider must be able to participate in the peer to peer during this time frame. This request will not result in extension of the authorization period unless information is provided to support medical necessity. No peer to peer is conducted for an administrative denial.

When requesting a peer to peer for an out of home level of care such as BHRF or TFC/ ABHTH, the requesting provider must have the highest level of clinical staff familiar with the member's care request and discuss the peer to peer review with Health Plan medical staff. The peer to peer review is based on a review of medical necessity and staff should be prepared to have this clinical discussion with the medical staff.

For outpatient authorizations and planned admissions to BHRF, BHIF, TFC/ ABHTH. After B – UHP notifies a provider of the decision to deny a requested authorization the requesting provider or member/guardian can submit an appeal.

For Title XIX/XXI covered services requested by members who are Title XIX/XXI eligible or who have been

determined to have a serious mental illness, the Health Plan must provide the member with a Notice of Adverse Benefit Determination following denial of all prior authorizations for outpatient services, including:

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

A copy of the Notice of Adverse Benefit Determination will also be sent to the provider submitting the request. Before a final decision to deny is made, the member's attending psychiatrist can ask for reconsideration and present additional information. All other levels of care must have the highest-level clinician request and discuss the peer to peer review with the Health Plan medical staff.

B – UHP 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. B – UHP 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 B – UHP 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. B – UHP Behavioral Health Utilization Care Manager notifies the requesting provider of such downgrade and gives the provider an opportunity to disagree with the decision.

General Consents and Informed Consents

All members have the right to participate in decisions regarding his or her physical and/or behavioral health care, including the right to refuse treatment. It is important for members seeking physical or behavioral health services to be made aware of the service options and alternatives available to them, as well as specific risks and benefits associated with these services in order to be able to agree to these services. There are two primary types of consent for physical and behavioral health services:

1. General Consent and
2. Informed Consent.

Unless otherwise provided by law, General Consent shall be obtained before any services and/or treatment are provided. Verification of member's enrollment does not require consent.

Providers treating members in an emergency are not required to obtain General Consent prior to the provision of emergency services. Providers treating members pursuant to court order shall obtain consent, as specified in A.R.S. Title 36, Chapter 5.

Documenting Consent:

1. All evidence of Informed Consent and General Consent to treatment shall be documented in the member's medical record as specified in AMPM Policy 940,
2. If the member, or when applicable, the member's Health Care Decision Maker, refuses to sign a written acknowledgment and gives verbal Informed Consent or General Consent instead, the provider shall document in the member's medical record that the information was given, the member or the member's Health Care Decision HEALTH CARE POWER OF ATTORNEY a written document that designates an individual who is allowed to make health care decisions for someone.

3. The document shall specify if there are any health care decisions the Power of Attorney is not allowed to make, otherwise it is assumed all decisions are permissible.
4. The document shall include:
    a. The name and signature of the individual and the name of the Power of Attorney.
    b. It shall be dated and explain whether it is in operation always, or only if the individual is incapacitated. As specified in A.R.S. §§8-514.05, 36-3221. Mental Healthcare Power of Attorney can be found in A.R.S. §§8-514.05, 36-3281.
    c. Examples of forms for a durable power of attorney can be found on the Arizona Attorney General's website.

General Consent for Adults

1. Adults are considered individuals ages 18 years and older or emancipated minors as specified in A.R.S. §12-2451 et seq. a. The following specifications apply to both general and informed consent. Unless otherwise provided by law:
    a. Any member in need of physical or behavioral health services shall give voluntary General Consent to treatment and/or services, as demonstrated by the member, or when applicable, the member's Health Care Decision Maker's signature on a General Consent form, before receiving treatment and/or services,
    b. Any member, or when applicable, the member's Health Care Decision Maker after being fully informed of the consequences, benefits and risks of treatment, has the right to not consent to receive physical or behavioral health services,
    c. Any member or, when applicable, the member's Health Care Decision Maker has the right to refuse medications unless specifically required by a court order or in an emergency situation, and
    d. A member, or when applicable, the member's Health Care Decision Maker, may revoke Informed Consent or General Consent at any time orally or by submitting a written statement withdrawing the consent. b. To meet the requirements of consent for members with an SMI designation, the consent shall comply with the specifications found in A.A.C. R9-21-206.

Universal Requirements for Informed Consent

A higher level of consent may be required for provision of specific behavioral or physical health services or for services provided to vulnerable members. This is not an exhaustive list of those instances but a guide of some situations in which informed consent may be necessary.

1. Providers of behavioral health services shall gain Informed Consent in a variety of specific circumstances for members with an SMI designation. These requirements can be found in A.A.C. R9-21-206.01. AHCCCS MEDICAL POLICY MANUAL CHAPTER 300, SECTION 320 – SERVICES WITH SPECIAL CIRCUMSTANCES 320-Q, Page 4 of 7
2. At times, involuntary treatment, including medications, can be necessary to protect safety and meet needs when a member, due to mental disorder, is unwilling or unable to consent to necessary treatment. In this case, a court order may serve as the legal basis to proceed with treatment. However, capacity to give Informed Consent is situational, not global, as a member may be willing and able to give Informed Consent for aspects of treatment even when not able to give General Consent. Members should be assessed for capacity to give Informed Consent for specific treatment and such consent obtained if the member is willing and able, even though the member remains under court order.
3. At a minimum, the following treatments and services require Informed Consent:
    a. Surgical or other procedures requiring anesthesia services,
    b. Sterilization as specified in all requirements in 42 CFR 441, Subpart F and AMPM Policy 420,
    c. Procedures or services with known substantial risks or side effects, or
    d. As required by Arizona or Federal law. 4. Telehealth In addition to the requirements set forth in section of Universal Requirements for Informed Consent of this Policy, before a provider delivers health care via telehealth, verbal or written Informed Consent from the

member, or when applicable, the member's Health Care Decision Maker, shall be obtained as specified in AMPM Policy 320-I, A.R.S. §36-3602, and A.A.C. R9-21-206.01.

4. Exceptions to this Consent requirement include:
    a. If the telehealth interaction does not take place in the physical presence of the member,
    b. In an emergency situation in which the member, or when applicable, the member's Health Care Decision Maker is unable to give Informed Consent, or
    c. Transmission of diagnostic images to a health care provider serving as a consultant or the reporting of diagnostic test results by that consultant.

General and Informed Consent for Children

1. Unless otherwise provided by law:
    a. To the extent legally authorized to do so, the member's Health Care Decision Maker, shall give General Consent to treatment, demonstrated by the authorized Health Care Decision Maker's signature on a General Consent form prior to the delivery of physical or behavioral health services, or refuse treatment.
        i. Under A.R.S. §8-514.05, in situations where the Department of Child Safety (DCS) and/or Foster Caregiver are temporarily operating as the Health Care Decision Maker of a child member, consent may only be granted for some services.
        ii. In cases where the member's Health Care Decision Maker is unavailable to provide General or Informed Consent and the child is being supervised by a caregiver who is not the child's Health Care Decision Maker (e.g. grandparent), a Health Care Power of Attorney (or a document with similar provisions) is necessary to provide General and Informed Consent. AHCCCS MEDICAL POLICY MANUAL CHAPTER 300, SECTION 320 – SERVICES WITH SPECIAL CIRCUMSTANCES 320-Q, Page 5 of 7 2.
    b. Emergency Situations
        i. In emergencies involving a child in need of immediate hospitalization or medical attention, general and, when applicable, Informed Consent to treatment is not required, and
        ii. Any child, 12 years of age or older, who is determined upon diagnosis by a licensed physician, to be under the influence of a dangerous drug or narcotic, may be considered an emergency situation and can receive behavioral health care as needed for the treatment of the condition without general and when applicable, Informed Consent to treat.
    c. Emancipated Minor
        i. In the event the child is an emancipated minor, evidence of an emancipation shall be required, except in emergency situations under A.R.S. §12-2453, and
        ii. Any minor who has entered into a lawful contract of marriage, whether or not that marriage has been dissolved subsequently, any emancipated youth or any homeless minor may provide General and, when applicable, Informed Consent to treatment without parental consent (A.R.S. §44-132).
    d. Foster Children
        i. For any child who has been removed from the home by DCS the Foster Caregiver, may give General Consent for the following:
            1. Routine physical, behavioral health, and dental treatment and procedures, including but not limited to, early periodic screening, diagnosis and treatment services, and services by health care providers to relieve pain or treat symptoms of common childhood illnesses or conditions (including behavioral health services and psychotropic medications) (A.R.S. §8-514.05(C-D), and
            2. Evaluation and treatment for emergency conditions that are not life threatening.
            3. A Foster Caregiver (except for a DCS case manager) shall not consent to:
                a. General Anesthesia,

b. Surgery,

c. Testing for the presence of the Human Immunodeficiency Virus (HIV),

d. Termination of behavioral health treatment,

e. Blood transfusions, or

f. Abortions. AHCCCS MEDICAL POLICY MANUAL CHAPTER 300, SECTION 320 – SERVICES WITH SPECIAL CIRCUMSTANCES 320-Q, Page 6 of 7

e. If someone other than the member's Health Care Decision Maker intends to provide General and, when applicable, Informed Consent to treatment, the following documentation shall be obtained and filed in the member's medical record:

INDIVIDUAL/ENTITY	DOCUMENTATION NEEDED
1. Legal guardian	1. Copy of court order assigning custody
2. Relatives	2. Copy of Health Care Power of Attorney
3. Other individual/agency Copy of court order assigning custody or a Health Care Power of Attorney	3. Copy of court order assigning custody or a Health Care Power of Attorney
4. DCS Placements (for children removed from the home by DCS), such as: • Foster parents • Group home staff • Foster home staff • Relatives • Other individual/agency in whose care DCS has placed the child	4. Foster Caregiver Resources is available on the AHCCCS website: www.azahcccs.gov Look under the "Members/Applicants tab: "Already Covered" "Member Resources"
Note: If behavioral health providers doubt whether the individual bringing the child in for services is an individual/agency representative in whose care DCS has placed the child, the provider may ask to review verification, such as documentation given to the individual by DCS indicating that the individual is an authorized DCS representative. If the individual does not have this documentation, then the provider may also contact the child's DCS caseworker to verify the individual's identity.	

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

Written consent shall be obtained from a child's Health Care Decision Maker for any behavioral health survey, analysis, or evaluation conducted in reference to a school-based prevention program administered by AHCCCS. A.R.S. §15-104 requires written consent from a child's Health Care Decision Maker for any behavioral health survey.

Attachment B shall be used to gain the Health Care Decision Maker's consent for evaluation of school-based prevention programs. Providers may use an alternative consent form only with the prior written approval of AHCCCS. The consent shall satisfy all of the following requirements:

- Contain language that clearly explains the nature of the screening program and when and where the screening will take place,
- Be signed by the child's Health Care Decision Maker, and AHCCCS MEDICAL POLICY MANUAL CHAPTER 300, SECTION 320 – SERVICES WITH SPECIAL CIRCUMSTANCES 320-Q, Page 7 of 7
- Provide notice that a copy of the actual survey, analysis, or evaluation questions to be asked of the student is available for inspection upon request by Health Care Decision Maker.

Completion of Attachment B applies solely to consent for a survey, analysis, or evaluation only, and does not constitute consent for participation in the program itself.

BH Services

Behavioral Health Provider Responsibilities of all Behavioral Health Provider Types 77, IC, 22, 29:

All Behavioral Health Providers are responsible for ensuring members receive medically necessary covered behavioral health services and for coordination of care with behavioral health providers and physical health providers.

Behavioral Health Providers are required to be in compliances with AMPM 320-O, Behavioral Health Assessments, Service and Treatment Planning and AMPM 580 Child and Family Team. All behavioral health providers are required to ensure the following:

- Documentation of intake including hospital based when indicated
- Evidence that enrollment and demographic requirements are met
- Behavioral Health Assessment and reassessment in accordance with AMPM 320-O and the requirements below:
    - Behavioral Health Assessment conducted by an assessor that meets the minimum AHCCCS qualifications
    - Includes all the Health Plan required elements of the Behavioral Health Assessment
    - Developmental Screening for youth birth through 5 consistent with AHCCCS Policy AMPM 210 – Working with the Birth through Five population
    - Evaluation of appropriate level of care and referrals as indicated for youth birth through five as directed by AHCCCS
    - Child and Adolescent Level of Care Utilization System (CALOCUS) or other assessment as directed by AHCCCS for youth 6 to 18
    - Strength Needs and Cultural Discovery (SNCD) for youth who meet criteria for high needs
    - Screening for substance use disorders with standardized screens for youths and adults
- Evidence of trauma screenings and referral to trauma treatment services when indicated
- Evidence of screening for the presence of SDOH and connection of member to services and supports when indicated
- Utilize social determinant diagnosis codes in compliance with AHCCCS billing requirement
- Completed documentation and referral for Serious Emotional Disturbance (SED) determinations for all youth under the age of 18 who present with a diagnosis, impairment and history that may meet eligibility criteria
    - Members with a SED determination are required to be connected to a health home for care coordination
- Completed documentation and referral for SMI determinations for all adults and youth no later than age 17.5 who present with a diagnosis, impairment and history that may meet eligibility criteria
- Evidence of support for all youth for successful transition to adulthood consistent with AHCCCS Policy AMPM 280 – Transition to Adulthood
- Evidence of participation in Child and Family Team (CFT) and Adult Recovery Team (ART) process with fidelity to system of care polices with fidelity to the Arizona Vision and Twelve Principles for Children's Behavioral Health Services and the Adult Services Delivery System Nine Guiding Principles
- Evidence of case management for adult members when medically necessary
- Evidence of medically indicated case management for youth members and referral to high needs or other indicated level of case management as necessary.
- Evidence of individualized Service Planning to meet the comprehensive behavioral health needs

of members with collaboration from behavioral health and physical health providers.

- Evidence of coordination of care including medically necessary referrals for services and transportation.
- Evidence of crisis and safety planning, including access to 24/7 telephonic response to meet member's emergent needs
- Evidence of diversion planning when necessary
- Evidence of discharge planning
- Documentation of provision of trauma informed care, interventions, and approaches
- Evidence of implementation of the out- of -state protocol when necessary
- Provide 24/7 telephonic response to meet the member's emergent needs and coordinate with crisis providers

Behavioral Health Providers are responsible for the following:

- Attend all meetings as required by the Health Plan
- Submit all deliverables as required by the Health Plan
- Submit requests for authorization for all services on the prior authorization grid as required
- Participate in designated Quality Management audits, investigations and the Quality-of-Care Concern (QOC) process
- Conduct Outreach, Engagement, Re-Engagement and Closure Activities as required
- Designate an assigned point of contact for Health Plan staff for clinical and administrative functions and a medical director if psychiatric services are provided

Provider Case Manager Role and Responsibilities

Provider case management is a supportive service provided to monitor the needs of the individual, coordinate support and treatment services, and improve treatment outcomes. Case management is conducted at the interval and intensity appropriate to meet the unique needs of the individual and in compliance with AHCCCS standards. The case manager coordinates care on the behalf of the individual to ensure they receive treatment and support that will meet their identified needs.

Case management activities include but are not limited to:

1. Coordination with the individual/Health Care Decision Maker (HCDM)/Designated Representative (DR).
2. Coordination and collaboration with contracted behavioral health and physical health service providers as applicable, (specialty providers, rehabilitation, vocational/employment, hospital, housing, residential, crisis, primary care, etc.),
3. Coordination and collaboration with community supports, state agencies, stakeholders
4. Promote the integration of natural and informal supports.
5. Coordination of care with the health plan care managers and discharge coordinators.
6. Monitoring the needs, goals, and progress of the individual and updating the treatment plan.
7. Facilitating the referral process for treatment services and supports.
8. Assisting with the identification of community resources.
9. Coordination activities related to continuity of care between levels of care (e.g., inpatient to outpatient care) and across multiple services (e.g., personal care services, nursing services, and family counseling) and providers.
10. Assisting individuals in applying for social security benefits.

11. Collection and dissemination of treatment plan specific information to identified team members.
    a. Provide a copy of the service plan to the other service providers.
    b. Provide medication and laboratory information to residential and independent livingservice providers or other caregivers involve with the individual/HCDM consent.
12. Participation in provider staffing and treatment planning meetings.
13. Provide education and support to family members, HCDM, DR, and significant others regarding the individual's diagnosis and treatment with the individual/HCDM's consent.
14. Conduct crisis and safety planning and coordination with crisis providers as specified in

AMPM 320-O.

In crisis situations, provider case managers shall:

1. Identify, intervene, and/or follow-up with a potential or active crisis in a timely manner.
2. Provide information, backup, and direct assistance to crisis and emergency personnel, including "on-call" availability of case manager or case management team to the crisis system.
3. Provide follow-up with the individual/HCDM, DR, after crisis situations, including contact with the individual within 24hrs of discharge a crisis setting.
4. Immediately assess for, provide, and coordinate additional supports and services as needed to accommodate the individual's needs.

AHCCCS Behavioral Health Practice Tools

The AHCCCS Behavioral Health Practice Tools (BHPT) were previously housed under the Resources section of the AHCCCS Website have now been incorporated into Chapter 200 of the AHCCCS Medical Policy Manual (AMPM). BHPTs are designed to strengthen the capacity of Arizona's Behavioral Health System in response to the unique needs of children and their families. Refer to the policies below for guidance when working with children and families:

- AMPM 210 –Working with the Birth through Five Population
- AMPM 211 –Psychiatric and Psychotherapeutic Best Practices for Children Birth through Five Years of Age
- AMPM 230 –Support and Rehabilitation Services for Children, Adolescent, and Young Adults
- AMPM 240 –Family Involvement in the Children's Behavioral Health System
- AMPM 250 –Youth Involvement in the Children's Behavioral Health System
- AMPM 260 –The Unique Behavioral Health Services –Needs of Children, Youth, and Families Involved with DCS
- AMPM 270 –Children's Out-of-Home Services
- AMPM 280 –Transition to Adulthood
- AMPM 580 – Child and Family Team

Referral and Intake Process

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

Members are not required to be enrolled with an "intake agency" or "behavioral health home" in order to receive behavioral health services, however the provider must be contracted and follow all guidelines to

serving AHCCCS members:

- ART or CFT practices
- Provide an assessment of needs
- Include a service plan in the clinical record
- Health Plan contracted providers must provide or refer members for high needs case management when:
    - Children birth through five years of age present with two or more of the following:
        - Other agency involvement; specifically: AzEIP, DCS, and/or DDD, and/or
        - Out of home placement for behavioral health treatment (within past six months), and/or
        - Psychotropic medication utilization (two or more medications), and/or
        - Evidence of severe psycho-social stressors (e.g., family member serious illness, disability, death, job loss, eviction), and
    - Children six through 17 years of age have a CALOCUS score of 4, 5, or 6; or otherwise determined to meet criteria for high needs
- Provider must refer for additional covered services when clinically indicated
- Coordinate with other providers including PCP and physical health providers

Contracted Behavioral Health Provider Appointments:

- Urgent appointments are scheduled expeditiously no later than 24 hours from identification of need
- Routine care appointments:
    - Initial assessment within seven calendar days of referral or request for service,
    - The first behavioral health service following the initial assessment for members aged 18 years or older, is provided as expeditiously as the member's health condition requires but no later than 23 calendar days after the initial assessment.
    - The first behavioral health service following the initial assessment for members under the age of 18 years old, is provided as expeditiously as the member's health condition requires but no later than 21 days.
    - All subsequent behavioral health services, as expeditiously as the member's health condition requires but no later than 45 calendar days from identification of need.
    - The first behavioral health service following the initial assessment for members aged 18 years or older, is provided as expeditiously as the member's health condition requires but no later than 23 calendar days after the initial assessment.
    - The first behavioral health service following the initial assessment for members under the age of 18 years old, is provided as expeditiously as the member's health condition requires but no later than 21 days.

Psychotropic Medications:

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

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

Providers must not arbitrarily or prematurely reject or eject a member from services/referrals without

prior authorization of the Health Plan. Health Plan contracted providers must resolve referral disputes promptly. The Health Plan will promptly intervene and resolve any dispute between a provider and a referring source when those parties cannot informally resolve disputes regarding the need for emergency, urgent, or routine appointments.

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

To facilitate a member's access to services in a timely manner, the Health Plan Contracted Providers will maintain an effective process for the referral, intake and initiation of services which includes:

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

Resources for Special Populations

Birth through Five

The early social and emotional development of children is impacted by various factors including access to necessary resources and supportive adults. Access to preventative and treatment services can be critical to the wellbeing of infants and toddlers. A list of both community and behavioral health resources that specialize in supporting the birth through five population can be located at B–UHP website: https://www.banneruhp.com/resources/child-and-family-support.

For considerations and best practices when working with the birth through five population refer to AHCCCS Policy AMPM 210 –Working with the Birth Through Five Population and AHCCCS Policy AMPM 211 – Psychiatric and Psychotherapeutic Best Practices for Children Birth through Five Years of Age.

School-Based Services (SBS)

B –UHP is committed to supporting the needs of students and families by increasing the accessibility of behavioral health services in schools. B –UHP has developed regional School-Based Behavioral Health Provider documents to serve as helpful resources to connect schools with local providers that offer school-based services (SBS). Regional documents can be located at: https://www.banneruhp.com/resources/child-and-family-support.

For considerations and best practices when working with the birth through five population refer to AHCCCS Policy AMPM 210 – Working with the Birth Through Five Population and AHCCCS Policy AMPM 211 –

Psychiatric and Psychotherapeutic Best Practices for Children Birth through Five Years of Age.

Diagnosed or at Risk of Autism Spectrum Disorder

When the primary care physician (PCP) or a behavioral health contracted provider identifies a member under the age of 18 as being diagnosed with or at risk of Autism Spectrum Disorder (ASD), he/she/they may arrange an evaluation with an in-network provider and prior authorization is not required. Should an evaluation with an out of network provider be needed, prior authorization is required. A list of comprehensive network providers that are able to assess, diagnose and provide specialty services can be located at B–UHP website: https://www.banneruhp.com/resources/autism-spectrum-disorder.

Members in need of an assessment through the Division of Developmental Disabilities (DDD) can refer to: https://des.az.gov/services/disabilities/developmental-disabilities/determine-eligibility.

Support and Rehabilitation Services

Support and Rehabilitation Services are an essential part of community-based practice and

culturally competent care. These services help members live successfully in the community. The CFT/ART is responsible for assessing the underlying needs of the member and identifying the various options presented through Support and Rehabilitation Services for meeting those needs. Support and Rehabilitation Services include but are not limited to; un-skilled respite, skills training, peer and family support, and supported employment.

Refer to the Children's Specialty Behavioral Health Provider Directory for a comprehensive list of Support and Rehabilitation Services for children. www.banneruhp.com/resources/child-and-family-support

Refer to the Adult Specialty Behavioral Health Provider Directory for a comprehensive list of Support and Rehabilitation Services for adults. www.banneruhp.com/resources/mental-health-substance-use

Transition Age Youth (TAY)

Planning for transition into adulthood begins for any child involved in behavioral health care when the child reaches the age of 16. Transition planning focuses on the needs of the youth and how those needs can be met through resources and services as they approach adulthood. An assessment of self-care and independent living skills, social skills, work and education, earning potential, and psychiatric stability should be conducted to identify areas of need. Additional areas that require advance planning include living arrangements, financial, and legal considerations. A list of both community and behavioral health resources and evidence based practices that specialize in providing support to TAY members, the TAY Tool and the Transition to Adulthood Checklist can be located at B–UHP website: https://www.banneruhp.com/resources/child-and-family-support.

For considerations when working with the TAY population refer to AHCCCS Policy AMPM280 –Transition to Adulthood.

First Episode Psychosis (FEP)

First Episode Psychosis (FEP) refers to adolescents and young adults who are experiencing psychotic symptoms or a psychotic episode for the first time. Members ranging in ages from 15-25 (ranges may vary by program) that have recently (typically within the past 2 years) experienced their first episode of psychosis may qualify for FEP services. FEP programs are designed to reduce hospitalization, relapse, incarceration, and vocational difficulties associated with the onset of psychosis and psychosis-related illnesses over a long period of time. FEP providers throughout the state utilize practices including: psychotherapy, medication management, nursing services, intensive case management, family education & support, cognitive behavioral therapies, individual and group therapies, cognitive remediation therapy utilizing software programs aimed at improving memory, decision making, and attention, as well as other specialized services. Additional practices include support for employment and education. Families and providers can contact their respective Regional Behavioral Health Authority (RBHA) to find out more about the FEP programs in their area.

Children in Out-of-Home Services

When community-based services are not effective in maintaining the child in his/her/their home setting, or

safety concerns become critical, the use of out of home treatment services can provide essential behavioral health interventions to stabilize the situation. The primary goal of out-of-home treatment interventions is to prepare the child and family, as quickly as possible, for the child's safe return to his/her/their home and community setting. Service programming, therapeutic strategies, and discharge planning must reflect this goal and be focused on assisting the child/youth to successfully function in the community setting to which he/she/they will return. Every child receiving out-of-home treatment services must be treated within the context of their family or support system and a strengths-based, culturally competent approach must be used in all aspects of care.

Every child receiving treatment services in an out-of-home setting must be served through a CFT. Outpatient behavioral health providers must incorporate members from the out-of-home service provider team and should encourage and support the family to be an active partner involved in all aspects of the child's out-of-home treatment. For considerations when working with children in out-of-home services reference AHCCCS Policy AMPM 270 –Children's Out-of-Home Services.

Human Trafficking

Members who have been victims of human trafficking and/or sex trafficking may have experienced force, fraud, or coercion to lure them into labor or commercial sex act(s). It is important to note that certain populations are more vulnerable than others. Among these populations are children and young adults who are experiencing homelessness and may not be linked to appropriate community and natural supports. Helping connect vulnerable populations can decrease safety risks by ensuring basic needs are met, putting proper supports in place, and providing education on the signs and risks of human trafficking.

For a comprehensive list of community, behavioral health and prevention services refer to https://www.banneruhp.com/resources/child-and-family-support.

LGBTQIA+

The health needs of LGBTQIA+ youth and adults can differ from those of their peers. Supports and services tailored to help the LGBTQIA+ population are critical in order to promote safety, increase access to care, and improve health outcomes. For a list of services and resources compiled with the unique needs of LGBTQIA+ members in mind, refer to https://www.banneruhp.com/resources/child-and-family-support.

Behavioral Health Medicaid and Medicare Covered Services

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

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

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

Eligibility status is essential for identification of the types of behavioral health services a member may be

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

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

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

General Mental Health/Substance Use (GMH/SU)

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

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

Medicare Behavioral Health Covered Services (UCA)	Medicaid Behavioral Health Covered Services (Complete Care & Long Term Care)
Inpatient Psychiatric Care (190-day lifetime limit for days in a psychiatric hospital. Inpatient psychiatric days in a general hospital are not counted toward the lifetime maximum.)	Inpatient Hospital Services Non-Hospital Inpatient Psychiatric Facilities Services (Level I residential treatment centers and sub-acute facilities)
Psychiatric diagnostic interviews	Assessment, Evaluation and Screening Services
Individual/ Group/Family Psychotherapy	Individual, Group and Family Therapy and Counseling
Interactive psychotherapy	
Pharmacologic management	Psychotropic Medication Adjustment and Monitoring
	Laboratory and Radiology Services for Psychotropic Medication Regulation and Diagnosis
Part B Prescription Drugs	Psychotropic Medication
Out Patient Substance Abuse Services	Opioid Agonist Treatment (Covered under Counseling Services)
Electroconvulsive Therapy	Electroconvulsive Therapy
Diagnostic psychological and neuropsychological tests	(Covered under Assessment, Evaluation and Screening Services)

Hypnotherapy	(Covered under Counseling Services)
Narcosynthesis	
Biofeedback Therapy	
Individualized activity therapy (as part of a Partial Hospitalization Program that is not primarily recreational or diversionary)	Partial Care (supervised day program, therapeutic day program and medical day program)
Depression Screening with PCP (one per year)	
Screening and Counseling to reduce alcohol misuse. If positive screen, up to 4 brief face to face sessions per year with a qualified primary doctor in a primary care setting.	
Smoking and Tobacco use Cessation (counseling to stop smoking or tobacco use) (2 counseling quit attempts per year. Each counseling attempt includes up to four face to face visits.)	
	Therapeutic Foster Care (TFC)
	Respite Care (limited to 600 hours per contract year-October 1 through September 30)

	Emergency and Non-Emergency Transportation
	Behavioral Health Nursing Services
	Behavioral Health Care Management Services (Complete Care Only)
	Emergency Behavioral Health Care
	Psychosocial Rehabilitation (generalist direct support and rehabilitation; living skills training; health promotion; supportive employment services)
	Behavioral Health Substance Abuse Transitional Facilities
	Behavior Management (member care, family support/home care training, peer support)
	Out of Home Behavioral Health Admission
	Behavioral Health Crisis Services covered by the RBHA
	Behavior Analysis Services

Medicare Part D Prescription Drug Coverage

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

- Benzodiazepines;

- Barbiturates; and
- Certain over the counter drugs
- Medicaid Only Behavioral Health Benefits - Not covered by Medicare
- Behavior Management (personal care, family support/home care training, peer support)
- Behavioral Health Case Management Services
- Behavioral Health Nursing Services
- Emergency Behavioral Health Care
- Emergency and Non-Emergency Transportation
- Non-Hospital Inpatient Psychiatric Facilities Services (Level I residential treatment centers and sub-acute facilities)
- Behavioral Health Residential Facility
- Partial Care (supervised day program, therapeutic day program and medical day program)
- Respite Care (limited to 600 hours per contract year - October 1 through September 30)
- Behavioral Health Substance Abuse Transitional Facilities
- Therapeutic Foster Care (TFC)

Complete Care

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

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

Long Term Care

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

Covered Physical Health Services for Title XIX/XXI Adults with SMI Opt-Out

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

Physical Health Care Services	Title XIX/XXI Adults with SMI	
	Age 18-20	Age 21 and Over
Audiology	X	X
Breast Reconstruction after Mastectomy	X	X
Chiropractic Services	X	

Cochlear Implants	X	
Emergency Dental Services	X	
Preventative & Therapeutic Dental Services	X	
Limited Medical and Surgical Services by a Dentist (for Members Age 21 and older)	X	
Supplemental Dental Coverage Based on Criteria Established by the Health Plan	X	X
Dialysis	X	X
Emergency Services – Medical	X	X
Emergency Eye Exam	X	X
Vision Exam/Prescriptive Lenses	X	
Lens Post Cataract Surgery	X	X
Treatment for Medical Condition of the Eye	X	X
Health Risk Assessment & Screening Tests (for Members age 21 and older)	X	
Preventive Examinations in the Absence of any Known Disease or Symptom	X	
HIV/AIDS Antiretroviral Therapy	X	X
Home Health Services	X	X
Hospice	X	X
Hospital Inpatient Medical	X	X
Hospital Observation	X	X
Hospital Outpatient Medical	X	X
Hysterectomy (medically necessary)	X	X
Immunizations	X	X
Laboratory	X	X
Maternity Services	X	X
Family Planning	X	X
Early and Periodic Screening, Diagnosis and Treatment (Medical Services)	X	
Other Early and Periodic Screening, Diagnosis and Treatment Services Covered by Title XIX/XXI	X	
Medical Foods	X	X
Durable Medical Equipment	X	X
Medical Supplies	X	X
Prosthetic	X	X
Orthotic Devices	X	
Nursing Facilities (up to 90 days)	X	X

Non-Physician First Surgical Assistant	X	X
Physician Services	X	X
Foot and Ankle Services	X	X
Prescription Drugs	X	X
Primary Care Provider Services	X	X
Private Duty Nursing	X	X
Radiology and Medical Imaging	X	X
Occupational Therapy – Inpatient	X	X
Occupational Therapy – Outpatient	X	
Physical Therapy – Inpatient	X	X
Physical Therapy – Outpatient	X	X
Speech Therapy – Inpatient	X	X
Speech Therapy – Outpatient	X	
Respiratory Therapy	X	X
Total Outpatient Parenteral Nutrition	X	X
Non-Experimental Transplants Approved for Title XIX/XXI Reimbursement*		
Transplant Related Immunosuppressant Drugs	X	X
Transportation – Emergency	X	X
Transportation – Non-emergency	X	X
Triage	X	X
Well Exams	X	

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

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

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

An individual who is not eligible for Title XIX/XXI covered services may still be eligible for Non-Title XIX/XXI services including services through the Substance Abuse Block Grant (SABG), the Mental Health Block Grant (MHBG), or the Projects for Assistance in Transition from Homelessness (PATH) Program. See

this manual section on accessing Non TXIX nondiscretionary federal grants and the delivery of behavioral health services. An individual may also be covered under another health insurance plan, including Medicare. Individuals who do not have any insurance or entitlement status may be asked to pay a percentage of the cost of services. Refer to ACOM Policy 406, Attachment A regarding copayments for Non-Title XIX/XXI individuals.

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

Title XIX/XXI Eligibility Verification and Screening/Application Process

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

1. AHCCCS web-based verification (Customer Support 602-417-4451) This web site allows the providers to verify eligibility and enrollment. To use the web site, providers shall create an account before using the applications. To create an account, go to: https://azweb.statemedicaid.us/Home.asp and follow the prompts. Once the providers have an account they can view eligibility and claim information (claim information is limited to FFS). Batch transactions are also available. There is no charge to providers to create an account or view transactions. For technical Web-based issues, contact AHCCCS Customer Support at 602-417-4451, Monday – Friday 7:00 a.m. to 5:00 p.m.

   When providers use the web-based member verification system and enter a member's social security number, the member's photo, if available from the Arizona Department of Motor Vehicles (DMV), will be displayed on the AHCCCS eligibility verification screen along with other AHCCCS coverage information. The photo image assists providers to quickly validate the identity of a member.

2. Interactive Voice Response (IVR) system IVR allows unlimited verification information by entering the AHCCCS member's identification number on a touch-tone telephone. This allows providers access to the AHCCCS Prepaid Medical Management Information System (PMMIS) for up-to-date eligibility and enrollment. Providers may also request a faxed copy of eligibility for their records. There is no charge for this service. Providers may call IVR within Maricopa County at (602) 417-7200 and all other counties at (800) 331-5090,
3. Medifax -Medifax allows providers to use a PC or terminal to access PMMIS for up-to date eligibility and enrollment information. For information on Eligibility Verification Screening (EVS), contact Emdeon at (800) 444-4336,
4. If an individual's Title XIX/XXI eligibility status cannot be determined using one of the above methods the provider shall:
   a. Call the B – UHP Customer Care Center for assistance during normal business hours (8:00 am through 5:00 pm, Monday-Friday), or
   b. Call the AHCCCS Verification Unit, which is open Monday through Friday, from 8:00 a.m. to 5:00 p.m. The Unit is closed Saturdays and Sundays and on state holidays. Callers from outside Maricopa County can call (800) 962- 6690 or call (602) 417-7000 in Maricopa County. When calling the AHCCCS Verification Unit, the provider shall be prepared to provide the verification unit operator the following information:
      i. Provider identification number,
      ii. The individual's name, date of birth, AHCCCS identification number and social security number (if known), and
      iii. Dates of service(s).

Interpret Eligibility Information

1. A provider will access the AHCCCS Codes and Values (CV) 13 Reference System when using the eligibility verification methods described above. This includes a key code index that may be used by providers to interpret AHCCCS' eligibility key codes and/or AHCCCS rate codes,
2. For information on the eligibility key codes and AHCCCS rate codes refer to the AHCCCS Reference Subsystem Codes and Values on the AHCCCS website, and
3. If Title XIX/XXI eligibility status and provider responsibility is confirmed, the provider shall provide any needed covered behavioral health services in accordance with the AMPM and AHCCCS Covered Behavioral Health Services Guide.
4. For individuals who are not identified as Title XIX/XXI eligible, providers shall assist individuals with the AHCCCS screening/application process for Title XIX/XXI or other Public Program eligibility through HEAPlus at the following times:
    a. Upon initial request for behavioral health services,
    b. At least annually, if still receiving behavioral health services, and
    c. When significant changes occur in the individual's financial status.
5. To conduct the AHCCCS screening/application for Title XIX/XXI or other Public Program eligibility through HEAPlus, behavioral health providers shall meet with the individual and complete the AHCCCS HEAPlus online application. Once completed, HEAPlus will indicate if the individual is potentially Title XXI/XXI eligible.
6. To the extent that it is practicable, the provider is expected to assist applicants in obtaining the required documentation of identification and U.S. citizenship/lawful presence within the timeframes indicated by HEAPlus,
7. For information regarding what documents are required in order to verify proof of U.S. citizenship/lawful presence refer to Arizona's Eligibility Policy Manual for Medical, Nutrition, and Cash Assistance Manual Chapter 500, Policy 507 and Policy 524,
8. Documentation of Title XIX/XXI and other Public Program eligibility screening/application shall be included in the individual's medical record including the Application Summary and final Determination of eligibility status notification printed from HEAPlus,
9. Pending the outcome of the Title XIX/XXI or other Public Program eligibility determination via HEAPlus the individual is eligible for covered Non-Title XIX/XXI services in accordance with the AHCCCS Covered Behavioral Health Services Guide and the AHCCCS Medical Policy 320-T.
10. Upon the final processing of a Title XIX/XXI and other Public Program screening/application, if the individual is determined ineligible for Title XIX/XXI or other Public Program benefits, regardless of verification of US Citizenship/Lawful Presence, the individual is eligible for covered Non-Title XIX/XXI services in accordance with the AHCCCS Covered Behavioral Health Services Guide and AMPM Policy 320 T,
11. An individual found not to be eligible for Title XIX/XXI or other Public Program benefits may submit the application for review by AHCCCS and/or DES. Additional information requested and verified by AHCCCS and/or DES may result in the individual subsequently receiving Title XIX/XXI or other Public Program.

Outreach Engagement Re-Engagement and Closure

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

This section addresses critical activities that the Health Plan contracted providers must incorporate when delivering services:

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

Community Outreach

Outreach activities conducted by the Health Plan and the Health Plan contracted providers may include, but are not limited to:

- Participation in community events, local health fairs or health promotion activities;
- Involvement with local schools;
- Involvement with outreach activities for military veterans, such as Arizona Veterans StandDown Coalition Events,
- Outreach programs and activities for first responders (i.e. police, fire, EMT)
- Routine contact with the Health Plan's behavioral health care management and/or primary care providers;
- Development of outreach programs to members experiencing homelessness;
- Development of outreach programs to members who are at risk, are identified as a group with high incidence or prevalence of behavioral health issues or are underserved;
- Publication and distribution of informational materials;
- Liaison activities with local, county and tribal jails, county detention facilities, and local and county Department of Child Safety Offices and programs
- Regular interaction with agencies that have contact with pregnant women/teenagers who have a substance use disorder,
- Development and implementation of outreach programs that identify members with co- morbid medical and behavioral health disorders, including those who could be determined or have been determined to have a Serious Mental Illness within the Health Plan's geographic service area, including members who reside in jails, homeless shelters, county detention facilities or other settings;
- Provision of information to mental health advocacy organizations; and
- Development of information of outreach programs to American Indian tribes in Arizona to provide services for tribal members.

Engagement

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

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

Re- Engagement

The Health Plan contracted providers are required to ensure re-engagement attempts are made with members who have withdrawn from participation in the treatment process prior to the successful

completion of treatment, refused services or failed to appear for a scheduled service based on a clinical assessment of need. All attempts to re-engage members must be documented in the comprehensive clinical record. The Health Plan contracted provider must attempt to re-engage the member by:

- Communicating in the member's preferred language.
- Contacting the member or the member's legal guardian by telephone at times when the member may reasonably be expected to be available (e.g., after work or school)
- When possible, contacting the member or the member's legal guardian face to face if telephone contact insufficient to locate the member or determine acuity and risk.
- Sending a letter to the current or most recent address requesting contact. If all attempts at personal contact are unsuccessful, except when a letter is contraindicated due to safety concerns (e.g. domestic violence) or confidentiality issues. The Health Plan provider will note safety or confidentiality concerns in the progress notes section of the clinical record and include a copy of the letter sent in the comprehensive clinical record, and
- For members determined to have a SMI who are receiving Special Assistance, contacting the person designated to provide Special Assistance for his/her involvement in re-engagement efforts.

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

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

Follow-Up after Significant and/or Critical Events

B – UHP providers are required to ensure activities are documented in the clinical record and follow-up activities are conducted to maintain engagement within the following timeframes:

- Discharged from inpatient services, in accordance with the discharge plan and within seven days of the member's release to ensure member stabilization, medication adherence and to avoid re-hospitalization,
- Involved in a behavioral health crisis within timeframes based upon the member's clinical needs, but no later than seven days,
- Refusing prescribed psychotropic medications within timeframes based upon the member's clinical needs and individual history, and
- Changes in the level of care.

Determining Serious Mental Illness

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

In order to ensure that B – UHP members who are eligible for SMI services are promptly identified and enrolled for services, AHCCCS requires that all SMI determinations to be determined by a statewide contractor, referred to as the Determining Entity. The Determining Entity for the service areas covered by the Health Plan is Solari Crisis and Human Services. Solari Crisis and Human Services has adopted the

process that Regional Behavioral Health Authorities (RBHAs) use for referral, evaluation and determination for SMI eligibility.

Health Plan Behavioral Health Contracted Provider Responsibilities

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

All SMI evaluations must be completed by a qualified assessor. If the qualified assessor is a Behavioral

Health Technician then the evaluation must be reviewed, approved, and signed by a Behavioral Health Professional. If a B – UHP contracted provider does not have the staff capacity to conduct an SMI evaluation please contact the Health Plan for a referral to a Health Plan contracted provider that can perform this evaluation.

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

- Requests a SMI determination; or
- Has a qualifying SMI diagnosis as indicated by the following (Also see AMPM 320- P-attachment B, Serious Mental Illness Qualifying Diagnosis):
- To begin the process the provider should complete the SMI Determination form found on the AHCCCS website under the AHCCCS Medical Policy Manual - AMPM 320- P-attachment A. Upon completion of the initial evaluation, submit all information to the Determining Entity within one business day.
    - Once the SMI Evaluation has been completed, the behavioral health provider must submit the SMI evaluation and accompanying documents to the Solari Crisis and Human Services via the Provider Submission Portal (PSP) located at https://community.solari-inc.org/eligibility-and-care-services/
    - Solari Crisis and Human Services can be contacted at (855) 832-2866 or (TTY) (800) 327-9254. Current versions of all needed forms can be found at https://community.solari-inc.org/eligibility-and-care-services/

Workforce Development

Training/Compliance Requirements

Relias Learning Management System (LMS)

The ACC, ACC-RBHA A-WFDA Providers, under the provider types listed at the link below, ensure that all employees who work in programs that support, oversee, or are paid by the Health Plan contract have access to Relias and are enrolled in the AzAHP Training Plans listed in this addendum. This includes, but is not limited to, full time/part time/on-call, direct care, clinical, medical, administrative, leadership, executive and support staff.

Provider types:
https://azahp.org/azahp/azahp-accrhba-awfda/resources-2/

Exceptions:

- Any employee(s) hired for temporary services working less than 90 days is required to complete applicable training at the discretion of the Provider.
- Any employee(s) hired as an intern is required to complete applicable training at the discretion of the Provider.
- Any Independent Contractor (IC) is required to complete applicable training at the discretion of the Provider.
- Behavioral Health Hospitals

- Federally Qualified Healthcare providers (FQHCs), may request exemption from their contracted Health Plan(s). Exemptions may be granted on a case-by-case basis and will take into account the following: Portion of AHCCCS Members enrolled in the network and served by that provider, geographic area serviced, and number of other service providers in the surrounding area.
- Housing Providers
- Individually Contracted Practitioners
- Prevention Providers
- Transportation Providers

Agencies must manage and maintain their Relias Learning portal. This includes activating and deactivating users as well as enrollment and disenrollment of courses/events.

To request access to Relias, please contact your B – UFC Workforce Development Administrator for further assistance. The request should include the following information:

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

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

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

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

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

AzAHP Core Training Plans

AzAHP–Core Training Plan (90 Days)

The Training Plan below is set to auto-enroll all NEW Relias users in your system who have been assigned one (or more) of the 7 Health Plans under the "Plan" field in their user profile. If the employee hired has a previous account under another agency, please ensure that you have their transcripts transferred (there is a job aid available at www.azahp.org).

1. Welcome to Relias (Due within 7 days of hire date)
2. *AHCCCS –Health Plan Fraud (0.75hrs)
3. *AHCCCS –NEO –Rehabilitation Employment (0.5hrs)

4. *AzAHP –AHCCCS 101 (2.0hrs)
5. *AzAHP –Client Rights, Grievances and Appeals (1.25hrs)
6. *AzAHP –Cultural Competency in Health Care (1.0hrs)
7. *AzAHP –Quality of Care Concern (1.0hr)
8. Corporate Compliance: The Basics (0.5hrs)
9. HIPAA: The Basics (0.5hrs)
10. Integrating Primary Care with Behavioral Healthcare (1.25hrs)

AzAHP –Core Training Plan (Annual)

The Training Plan below is set to auto-enroll all Relias users in your system who have been assigned one (or more) of the 7 Health Plans under the "Plan" field in their user profile.

1. HIPAA: The Basics (0.5hrs) Due: January 31st
2. Abuse and Neglect: Preventing, Identifying and Responding to Abuse and Neglect (1.0hrs) Due: April 30th
3. Corporate Compliance: The Basics (0.5hrs) Due: May 31st
4. *AzAHP –Cultural Competency in Health Care (1.0hrs) Due: July 31st
5. *AHCCCS –Health Plan Fraud (0.75hrs) Due: October 31st
6. *AzAHP –Quality of Care Concern (1.0hr) Due: December 31st

Quarterly Reports

The ACC, ACC-RBHA AWFDA will run Quarterly Learner/Course Status Reports on the two AzAHP Training Plans: *AzAHP – Core Training Plan (90 Days) & *AzAHP – Core Training Plan (Annual). The goal for Providers is to hold a 90% (or higher) completion rate for this group of courses, within the specified reporting period. Reporting time frames for this initiative are listed below:

- **01/01-03/31 – AWFDA will run this report on 4/30**
- **04/01-06/30 – AWFDA will run this report on 7/31**
- **07/01- 09/30 – AWFDA will run this report on 10/31**
- **10/01-12/31 – AWFDA will run this report on 1/31**

If either of those dates falls on a weekend or holiday, the ACC, ACC-RBHA reserves the right to run the report on the following business day.

Provider agencies falling at 75% or below on the above completion reports will be required to have at least 1 Relias Administrator/Supervisor from their agency complete the course titled: *AzAHP – Navigating & Managing Your Relias Portal

Provider agencies falling below 90% on the above completion reports may be subject to corrective action and/or sanctions (including suspension, fines or termination of contract) by their contracting Health Plan(s).

Child and Family Team (CFT) Initiatives

The statewide Child and Family Team (CFT) Facilitator Course initiative and the two associated Train-the-Trainer (TtT) courses are for Providers who serve children and adolescents in the Children's System of Care (CSOC) and have employees who facilitate CFT's.

- **Initiative 1: CFT Facilitators Course**
    - The CFT Facilitator Course is 2 days in length, is intended for in-person delivery, and meets all AHCCCS and Health Plan training requirements for individuals who will be leading/facilitating CFT sessions.

- It is expected that provider agencies be prepared to train this course in-house, which enables providing complimentary agency-specific processes, procedures, and protocols, thus creating a robust learner-centric experience for attendees and future CFT facilitators.
- Once an agency has an employee who has become a CFT Champion, by successfully completing the TtT session (noted below), the requirement is for the CFT Champion to train the 2-day course to newly hired employees at a provider agency. Employees who already meet the existing CFT Facilitator training requirement need not attend the new course; however, each provider agency may make their own determination otherwise.
- All provider agencies shall cease the utilization of their CFT curriculum no later than December 31, 2022 and utilize the AHCCCS approved training curriculum (AMPM 580), which will be made available to the CFT Champion upon completion of their CFT TtT session.

- **Initiative 2: CFT Facilitator Train the Trainer (TtT)**
  - The CFT Facilitator TtT session is approximately 6 hours in length and is delivered via virtual instructor-led training. TtT sessions are offered throughout the year for the new 2-day CFT Facilitator Course. These sessions are intended for employees who will be delivering the 2-day CFT training course in-house in their own agency. These identified employees will be known as "CFT Champions."
  - CFT Champions who participate in the TtT session must be seasoned employees who possess skills equivalent to lead training sessions and must have completed CFT training requirements already in place and certainly be competent in CFT facilitation. It is left to the discretion of each provider agency to verify trainer competency. Presumption will be that participants have been internally vetted as competent by their provider agency prior to enrollment.
- **Initiative 3: CFT Supervisor Training**
  - The CFT Supervisor Training Course is approximately 5 hours in length, is intended for in-person delivery, and is for leaders who supervise employees who facilitate CFT's. The CFT Supervisor Training course will be required for all new and existing leaders at the agency once the agency has a CFT Champion who successfully completes the Supervisor TtT session. The training will provide guidance related to identified competency measurements.
- **Initiative 4: CFT Supervisor Facilitator Train the Trainer**
  - The CFT Supervisor TtT session will be approximately 2.5 hours in length and will be delivered via virtual instructor-led training. CFT Supervisor TtT sessions will be offered throughout the year. These sessions are intended for employees who will be training the CFT Supervisor Training Course in-house within their own agency. These identified staff will be the same CFT Champions that took the CFT Facilitator TtT.
- **AzAHP – CFT Champion Certification Process**
  - An *AZAHP- CFT Champion Certification training plan has been created in Relias for the identified CFT Champions meeting the above noted requirements.
    - Agency leadership will need to enroll the identified CFT Champion in the training plan.
    - Within the training plan there are three module requirements:
      - The *AzAHP- CFT Overview (a self-paced course expected to be completed before attending the TtT session),
      - *AZAHP- CFT Facilitator TtT, and
      - *AZAHP- CFT Supervisor Facilitator TtT.
  - If the identified CFT Champion has taken CFT Overview in the last two years, they will not have to take it again and will be given credit automatically in Relias.
- **Initiative 5: Triannual CFT Collaborative Sessions**

- In addition to CFT Champions attending a TtT Facilitator Courses, delivering the 2-day CFT Facilitator Training, and CFT Supervisor Training; CFT Champions are required to attend triannual CFT Collaborative Sessions. During these sessions CFT Champions will meet with Health Plan Trainers and leaders to discuss as a group, best practices, challenges, and opportunities for growth and development regarding CFT administration and implementation.

- **Training and Supervision Expectations**
  - Provider agencies who have employees that are designated to facilitate/lead CFT's shall be trained in the elements of the CFT Practice Guide, complete and in-person, AHCCCS approved CFT facilitator curricula and demonstrate competency via the Arizona Child and Family Team Supervision Tool. The CFT Supervision Tool must be completed within 90 days, and facilitators must maintain or enhance proficiency within six months as attested to by a supervisor, and annually thereafter (AMPM 580, Attachment C & D).
- **Monitoring Process**
  - CFT Champion Certification
    - All agencies who are required to have CFT Champion will be tracked in Relias.
    - Workforce Development will maintain a list of all CFT Champions and their provider agencies.
- **Arizona Child and Family Team Supervisions Tool**
  - The Supervision Tool requirements will be tracked in Relias for all employees who facilitate/lead CFT's.
- **CFT Facilitator Training Hardship Waiver**
  - In the event the 2 Day CFT training becomes a barrier or hardship for an organization, provider organizations may request a CFT Facilitator Training Hardship Waiver. Within the waiver, providers will need to identify why delivering the course as originally designed presents a hardship. They must also supply a detailed plan of what changes they will make to the 2 Day CFT Facilitator training while still meeting all the elements of the training. The plan will be submitted to the Workforce Development Team at workforce@azahp.com. Provider organizations must obtain approval before the training occurs.

General Mental Health (GMSH)/Substance Use (SU)

Employees completing assessments of substance use disorders and subsequent levels of care must complete the American Society of Addiction Medicine (ASAM) criteria-specific training. This training is required before staff may use the assessment tool with members. They must also complete any approved substance use/abuse course every year. The assessment should align with the most recent ASAM criteria.

Network Workforce Data Collection

Provider Workforce Development Plan (P-WFDP)

The purpose of the P-WFDP is to encourage Provider organizations to work together and ensure members receive services from a workforce that is qualified, competent, and sufficiently staffed. The P-WFDP shall include a description of organizational goals, objectives, tasks, and timelines to develop the workforce. The overall approach and philosophy to Workforce Development is to ensure a comprehensive, systematic, and measurable structure that incorporates best practices at all levels of service delivery and utilizes Adult/Children's Guiding Principles, Adult Learning Theories/Methods, Trauma-informed Care, Equitable Services and Culturally Competent practices. All training initiatives, action steps, and monitoring procedures outlined in the P-WFDP are to include targeted efforts for all employees (e.g., direct care Providers, supervisors, administrators, and support staff) who are paid by, partially paid by, or support an agency's Health Plan contract(s).

The ACC, ACC-RBHA Providers, under the provider types listed at the link below, complete the annual P-WFDP. The P-WFDP Template is provided for this deliverable by the ACC, ACC-RBHA AWFDA to providers. P-WFDP's will be submitted between 2/1 – 2/28, annually. Early and late submissions will not be accepted

unless an extension was received and granted by the deadline, determined by the ACC, ACC-RBHA AWFDA.

- **Extension Requests:** must be submitted to the workforce@azahp.org email before the date specified by the ACC, ACC-RBHA AWFDA for each year. Non-submittals are subject to contract health plan policies as it pertains to the P-WFDP deliverable.
- **Exemption Requests:** Federally Qualified Healthcare Providers (FQHCs), may request an exemption from their contracted Health Plan(s). Exemptions may be granted on a case-by-case basis and will consider the following: Portion of AHCCCS Members enrolled in the network and served by that Provider, the geographic area serviced, and the number of other service Providers in the surrounding area. Exemption requests must be submitted on/before December 31st and will be reviewed by the Alliance.

Required ACC, ACC-RBHA Provider Types can be found at this link: https://azahp.org/wp-content/uploads/2022/07/AZAHP-Website-All-LOB-Provider-Types-Requirements-Tracker-2022-1.xlsx

Failure to submit your completed annual P-WFDP deliverable by the annual due date may result in corrective action and/or sanctions (including suspension, fines, or termination of contract).

ACC, ACC-RBHA AWFDA Provider Forums

The ACC/RHBA AWFDA consists of representatives from the AzAHP, Relias, and the Workforce Development Administrators from all seven ACC Health Plans. Providers are encouraged to attend the virtual ACC, ACC-RBHA AWFDA provider forum on the second Thursday of each month for up-to-date information on WFD related topics, including: WFD initiatives, professional development, training, Relias, and opportunities to receive technical assistance. To review previous forums, you may access the recordings at the following link: https://azahp.org/azahp/azahp-accrhba-awfda/resources-2/

Out of State Placement

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

- Member needs a specialized program not currently available in Arizona to effectively treat a specified behavioral health condition
- An out of state placement's approach to treatment incorporates and supports the unique cultural heritage of the member
- A lack of current in state bed capacity
- The geographic proximity of the out of state placement supports and facilitates family involvement in the member's treatment
- The member's family/guardian/designated representative agrees with the out of state placement (for minors and members between 18 and under 21 years of age under guardianship)
- The out of state provider is an AHCCCS registered provider
- A plan for the provision of non-emergency medical care must be established prior to placement and the non-emergency care providers must be AHCCCS registered providers

AHCCCS requires that decisions for out-of-state placements for behavioral health care and treatment are examined closely and made after the ART, CFT and B – UHP Behavioral Health Department have reviewed all in-state options. Other options may include single case agreements with in-state providers that would allow enhanced programming or staffing to meet the specific needs of the member or the development of a Service Plan, that incorporates a combination of support services and clinical interventions and takes advantage of the full extent of all available covered services to meet the clinically identified needs of the member.

In the event an out-of-state placement is necessary, the steps and procedures outlined in this section must be followed. Services provided out-of-state must meet the same requirements as those rendered in

state. Out-of-state providers must follow all AHCCCS reporting requirements, policies and procedure.

Conditions Before a Referral for Out-Of-State Placement Is Made

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

- A minimum of three in state facilities have declined to accept the member.
- The CFT/ART has been involved in the service planning process and in agreement with the out of state placement.
- The CRT/ART has documented how it will remain active and involved in the service planning once the out of state placement has occurred.
- A Service Plan has been developed and includes a discharge plan addressing the needs and strengths of the member.
- All applicable prior authorizations have been met.
- All less restrictive, clinically appropriate approaches have either been provided or considered by the CFT/ART and found not to meet the member's needs.
- Coordination has occurred with all other state agencies involved with the member.
- For Child/Adolescent members, the Arizona Department of Education has been consulted to ensure that the educational program at the out-of-state placement meets the Arizona Department of Education Academic Standards and the specific educational needs of the member.
- The member's primary health care provider and B – UHP have been contacted and a plan for the provision of any necessary non-emergency medical care has been established and is included in the medical record by the assigned case manager.

The Service Plan

For an out-of-state placement, the Service Plan developed by the CFT/ART must require:

- Discharge planning is initiated at the time of referral or notification of admission, including:
  - Measurable treatment goals being addressed by the out-of-state placement and criteria necessary for discharge back to in-state services.
  - Possible or proposed in-state residence where the member will be returning.
  - Recommended services and supports required once member returns from the out- of-state placement.
  - What needs to be changed or arranged to accept member for subsequent in- state placement that will meet the member's needs?
  - How effective strategies implemented in the out-of-state placement will be transferred to the members' subsequent in-state placement.
  - The actions necessary to integrate the member into family and community life upon discharge.
- The CFT/ART actively reviews the member's progress with clinical staffing's occurring at least every 30 days Clinical staffing's must include the staff of the out-of-state facility.
- The member's family/guardian is involved throughout the duration of the placement. This may include family counseling in person or by teleconference or video conference.
- The CFT/ART must ensure that essential and necessary health care services are provided.
- Home passes are allowed as clinically appropriate and in accordance with B – UHP Medicaid Behavioral Health Covered Services Guide
- The member's needs, strengths and cultural considerations have been addressed.
- Strategies and interventions to address and coordinate the care of the member's physical health.

- needs including dental, if applicable

Initial notification to the Health Plan Behavioral Health Care Management Department

B – UHP providers are required to notify the B – UHP Behavioral Health Care Management Department and submit an Out of Home Request Packet prior to initiating a referral for an out-of-state placement. B – UHP providers are also required to assist B – UHP in gathering the required information to notify AHCCCS's Medical Management, if requested, prior to a referral for out-of-state placement and upon discovering the member is in an out-of-state placement using Form 3.9.1 - Out-of-State Placement, Initial Notice. Prior authorization must be obtained prior to making a referral for out-of-state placement, in accordance with B – UHP criteria.

Process for Providing Initial Notification to B – UHP

B – UHP Providers must notify the B – UHP Behavioral Health Care Management Department of the intent to make a referral for out-of-state placement on the B – UHP Behavioral Health Provider Manual Form Out-of-State placement. B – UHP will review the documentation and forward it to AHCCCS's Office of Medical Management, if required, for approval of the out-of-state placement request.

Periodic updates to AHCCCS Office of Medical Management

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

Required Reporting of an Out-of-State Provider

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

Employment Services

Employment services are available to all members interested in obtaining or maintaining employment. There are no exclusions for perceived lack of readiness, substance use, homelessness, certain diagnoses or symptoms. Banner members can self-refer at any time to any Banner contracted organization that provides employment services.

Employment First

Service providers are expected to implement an Employment First approach to improve employment outcomes for working-age members with disabilities. Using the Employment First philosophy providers will emphasize:

1. Employment as the first and preferred outcome for all working aged Arizonans who have disabilities.
2. Members who have disabilities will have access to integrated work settings.
3. Members receive information to help them make informed decisions about employment, including, but not limited to, the following:
    a. Employment supports and services,
    b. The value of employment on their quality of life, and
    c. How work affects public benefits and resources so that employment remains an option to the member without fear of losing essential benefits.
4. Long term supports and services, if needed, are made available to be successful in the workplace.

Provider Expectations

Organizations providing employment services are required to have at minimum one fully dedicated Employment Specialist whose only duties are employment and rehabilitation-related activities for all

members. Contracted behavioral health providers and integrated health care providers who bill for employment services are also required to employ enough employment staff to meet the needs of their members seeking these services. It may be permissible for the employment/rehabilitation staff to cover more than one clinical team or split time with other duties, based on staffing availability, regional locations, and enrollment numbers. Providers may contact Banner's Employment Administrator for additional information.

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

Employment Competencies

Providers must ensure that they have access to the AHCCCS standardized employment module of the New Employee Orientation (NEO). Providers are responsible for ensuring employee completion of the employment module of at least 80% on the post-assessment. In addition, supervisors must evaluate their staff's competency in the provision of employment services as outlined in the AHCCCS policy ACOM 447 – Employment, specifically with respect to the following areas:

1. AHCCCS AMPM Policy 310-B – Title XIX XXI Behavioral Health Service Benefit and AMPM Exhibit 300-2A – AHCCCS Behavioral Health Covered Services
2. Arizona Disability Benefits 101 (AZDB101)
3. Member Engagement
4. RSA Vocational Rehabilitation (RSA/VR)

For details on what each of the above listed topics entail, please see the AHCCCS ACOM Policy 447 – Employment.

Per AHCCCS ACOM Policy 447 – Employment, there are eight (8) competency skills checklists to be completed by supervisors overseeing employment and other clinical staff at integrated clinics and behavioral health outpatient clinics:

1. *AzAHP – ACOM 447 AMPM Policy 310-B and AHCCCS Behavioral Health Services Matrix Skills Checklist: Initial
2. *AzAHP – ACOM 447 AMPM Policy 310-B and AHCCCS Behavioral Health Services Matrix Skills Checklist: Annual
3. *AzAHP – ACOM 447 DB101 Skills Checklist: Initial
4. *AzAHP – ACOM 447 DB101 Skills Checklist: Annual
5. *AzAHP – ACOM 447 Member Engagement Skills Checklist: Initial
6. *AzAHP – ACOM 447 Member Engagement Skills Checklist: Annual
7. *AzAHP – ACOM 447 RSA/VR Skills Checklist: Initial
8. *AzAHP – ACOM 447 RSA/VR Skills Checklist: Annual

In addition, the following training is designed to assist supervisors with this process: *AzAHP - Employment Competency Skills Checklist Training for Supervisors.

Appendix – ALTCS Specific

Please note, this section of the provider manual for **ALTCS providers and groups only**. Any information that is helpful for all types of providers is covered in the main sections of the Provider Manual.

Overview

Arizona Health Care Cost Containment System (AHCCCS) is Arizona's Medicaid plan. Arizona Long-Term Care System (ALTCS) is a branch of AHCCCS. Three Managed Care Organizations (MCOs) are contracted with AHCCCS to provide ALTCS services. The MCOs are Banner – University Family Care, Mercy Care Plan and United Healthcare Community Partners.

The Eligibility requirements used by AHCCCS are as follows (at least one must be met):

- Age 65 or older OR
- Blind OR
- Disability (at any age)

Qualifiers:

- Need ongoing services at a nursing facility (or equivalent) level of care
- Citizen or qualified immigrant
- Social Security Number or apply for one
- Arizona Resident
- Apply for all cash benefits available
- Living in approved living arrangement (own home, AHCCCS certified nursing facility or assisted living facility)

Financial Eligibility requirements are as follows:

- Gross monthly income limit $2,313 for an individual
    - Special Income Trust may be appropriate if income over limit
- Countable Resources not more than $2,000 for an individual
    - Includes checking, savings, and credit union accounts; real property that applicant does not live in; cash value of some life insurance policies, cash, stacks, bonds, certificates of deposits, non-exempt vehicles
    - Does not include that applicant lives in unless held in trust, one vehicle, burial plots, and irrevocable burial plans, $1500 designated for burial, household, and personal belongings
    - Special rules for married applicants

Once a member is determined eligible by AHCCCS members are assigned an MCO. AHCCCS will inform the MCO of the eligibility date and if the member qualifies for "Prior period coverage (PPC)." If the member qualifies for PPC the assigned MCO could be responsible for medically necessary services that occurred during this time.

Upon enrollment with B – UHP, each member is assigned an ALTCS Case Manager (CM). If you need to identify the assigned CM for an ALTC member call 1 (833) 318-4146.

- Case Managers complete an in-person assessment with each member according to the following timeframes:
    - NF members are assessed at least every 180 days
    - ALF members and Home-based members are assessed at least every 90 days
- Case Managers use a person-centered approach to assess for the appropriateness of the current

placement, cost effectiveness of the services and to coordinate care

- Case Managers also assess the quality of care delivered by the providers involved in the member's care
- Case Managers advocate for the members, act as a gatekeeper for the members' health care services

For members that need behavioral health services, B – UHP's CMs can assist in finding the appropriate behavioral health provider to see a member. A team of qualified Behavioral Health Professionals (BHP) are available to support our CM through consultation.

For members that have high medical needs, B – UFC/ALTCS CM can assist. A team of qualified Registered Nurses (RN) are available to support the CM, coordinates care, provide referral assistance, and other support as required.

Based on the level of care a member need, B – UHP members are eligible for:

- Assisted Living Facility (ALF)
- Home and Community Based Service (HCBS)
- Residential Skilled Nursing Facilities (SNF)

Assisted Living Facilities

B – UFC/ALTCS offers different types of medically necessary living arrangements for eligible members. These different types of settings provide supervisory care, personal care or directed care, and are delivered by licensed or certified facilities. Members are required to pay room and board fees in these settings. Room and board is the amount the member pays each month towards their cost of food and shelter.

The ALTCS case manager will assess the member's need for the appropriate type of setting. The case manager will notify the member and/or health care decision maker and the provider of the room and board fee required of the member. B – UFC will authorize the remainder of the required amount. B – UHP cannot authorize services costing greater than a member's determined cost of a nursing home stay.

The provider at an Assisted Living Facility must collect room and board fee from the member. B – UFC/ALTCS room and board agreement identifies the level of payment for the setting, placement date, and room and board amount the member must pay and is determined by the ALTCS case manager at the time of placement. The room and board agreement is used for all assisted living facilities. The amount of room and board periodically changes based on a member's income. The Room and Board agreement form is completed at least once a year or more often if there are changes in income. Payment issued to the provider is always the contracted amount minus the member's room and board.

LTC Service Types Table

Setting Description

LTC Setting	Description
Adult Foster Care	This setting includes up to 4 residents. The owner of the home must live in the home and provide the care.
Adult Therapeutic Home Care	Provides behavioral health and ancillary services for a Minimum of 1 and a maximum of 3 people.
Child Therapeutic Home Care	Provides services by those licensed with DES as a professional foster care home.
Assisted Living Home	This setting provides care and supervision for up to 10 people.
Assisted Living Center	This setting provides resident rooms or residential units and services to 11 or more residents. Three meals /day are provided in

	the main dining hall. Personal care and medication monitoring/administration provided as needed.

Home & Community Based Services (HCBS)

Below is a partial list of HCB services that can be provided in the member's home when determined medically necessary and cost-effective.

- Adult Day Health Care: supervision, assistance with medication, recreation and socialization or personal living skills training. Health monitoring and/or other health related services such as preventive, therapeutic, and restorative health care services are also included.
- Attendant Care Services: assistance with a combination of services in the member's home, which may include homemaking, personal care, and general supervision. Traditional attendant care services are supervised by the providing agency. Member-Directed Options: Agency with Choice (AWC) and Self-Directed Attendant Care (SDAC) is supervised by the member or the health care decision maker who must be present during all service hours.
- Community Transition Service (CTS): is a fund to assist ALTCS institutionalized members to reintegrate into the community.
- Emergency Alert System: Monitoring devices/systems for ALTCS members who are unable to access assistance in an emergency situation and/or live alone.
- Habilitation: Services are designed to assist individuals in acquiring, retaining, and improving the self-help, socialization and adaptive skills necessary to reside successfully in Home and Community Based (HCB) settings.
- Home Delivered Meals: Nutritious meals, prepared and delivered to a member's home.
- Home Health Services: include home health skilled nursing visits, home health aide services, medically necessary supplies, and therapy services in the member's home.
- Homemaker: assistance in performing Instrumental Activities of Daily Living for cleaning and upkeep of the member's living area and the nutritional value of food/meals for the member.
- Home Modification: physical modifications to the home that enable the member to function with greater independence in the home and that have a specific adaptive purpose.
- Hospice Services: Provider palliative and support care for terminally ill members and their family members or caregivers during the final stages of illness and during dying and bereavement.
- Personal Care: Assistance to meet essential personal physical needs to members who reside in their own home.
- Private Duty Nursing: For members who need continuous care for chronic conditions.
- Respite: A service that provides an interval of rest and/or relief to a family member or other person(s) providing informal support for the ALTCS member. It is available for up to 24 hours per day and is limited to 600 hours per benefit year.

AHCCCS requires the use of specific codes/modifiers for attendant care as follows:

Traditional Attendant Care:

- Procedure code S5125
- Modifiers
  - U3-Spouse providing care to member
  - U4- Family Not residing in home
  - U5-Family residing in home

Agency with Choice

- Procedure code S5125 with modifier U7
- Additional Modifiers
    - U3-Spouse providing care to member
    - U4-Family Not residing in home
    - U5-Family residing in home

Self-Directed Attendant Care

- Procedure code S5125 with modifier U2
    - Procedure code S5125 with modifier U6 if skilled care is being provided
- Additional Modifiers
    - U4-Family Not residing in home
    - U5-Family residing in home

Skilled Nursing Facilities (SNFs)

Skilled Nursing Facilities (SNFs) provide services to members that need consistent care, but do not have the need to be hospitalized or require daily care from a physician. Many SNFs provide additional services or other levels of care to meet the special needs of members.

The appropriate level of care will be determined by the ALTCS case manager, utilizing the AHCCCS/ALTCS Uniform Assessment Tool (UAT). The RN or BHP Team will authorize specialty placements. In the event the provider disagrees with the level of care authorized, you may request a plan review by B – UFC/ALTCS. Contact your assigned facility Case Manager. Level of care changes authorized by B – UFC/ALTCS will be effective on the day of evaluation. Level of care changes may be retroactive to the date of documented (phone, email, or fax) notification from the Nursing Facility, but not prior to the date of notification.

Level of Care Revenue Codes

- Level I -191
- Level II -192
- Level III -193
- Specialty Placements -194
    - Bariatric
    - Behavioral Health
    - Dialysis
    - Dementia with Behaviors
    - High Acuity Behavioral Health
    - Respiratory
    - Sub-Acute
    - Ventilator Dependent
    - Wandering Dementia
- Hospital Bed Hold 185
- Therapeutic Bed Hold 183

Therapy Services are not included in the B – UFC/ALTCS member per diem rate 191, 192, and 193. Therapy services are inclusive with all specialty placement 194 authorized services. Hospital Bed Hold are approved when the following criteria is met:

- Occupancy level of the facility must be at 90% or greater
- Member must return to the facility

  - Authorization will only be completed once the member returns
- The facility made the request within 1 business day of the member leaving the facility

Therapeutic Bed Hold are approved when the following criteria is met:

- It is the member's behavioral care plan to determine if the member will be successful returning to a home setting
- It must be part of the facility discharge plan

Contract Termination

In the event a Nursing Facility (NF) or an Alternative Home and Community Based Setting (HCBS) contract terminates, the NF or HCBS will continue to provide covered services to Members until their open enrollment period, at which time members must either choose an available Contractor that is contracted with the facility, or move to a setting that is contracted with their current Contractor.

Nursing Facility Responsibilities

Nursing Facilities are required to ensure temporary nursing care registry personnel, including Nurse Aids, are properly certified and licensed before caring for members in accordance with 42 CFR 483.75(e)(3) and (g)(2) and fingerprinted as required by A.R.S. §36-411.

Service Authorizations

ALTCS Case Managers only authorize long term care services, not requiring a doctor's order.

There may be times where an interruption in service may occur due to an unplanned hospital admission for the member. While services may have been authorized during this time, providers should not be billing for any days that fall between the admission date and the discharge date or any day during which services were not provided.

Each provider is responsible for following this process.

The ALTCS case manager is the primary point of contact for providers when there are issues or questions about a member. Providers must also contact the ALTCS case manager whenever there are changes in a member's condition.

Program Contractor Changes

B – UFC/ALTCS has a transition coordinator to assist with all program contractor changes. Members have the option of enrollment change when a member resides in a county with choice and a county with choice is the county of fiscal responsibility of the member. This change can only be made during this member's annual enrollment. AHCCCS distributes a packet of information to each member prior to their annual enrollment choice including information on how to change program contractors and the due dates for selection.

Members may also change program contractors at other times if the circumstance meets AHCCCS criteria. Some circumstance taken into consideration may include:

- moving to another program contractor to maintain continuity of medical care, or
- residing in a facility not contracted with their current program contractor
- moving out of the health plans service area

If you need to identify the assigned CM for an ALTC member call **(833) 318-4146**.

Payment Responsibilities for Contractor Changes

Relinquishing Contractors, who fail to notify receiving Contractors about members that meet the AHCCCS transition notification requirements specified in AMPM Policy 520, will be responsible for the cost of medically necessary services received by the member for the first 30 days. The scope and responsibility for such cases will be reviewed and determined by AHCCCS. In cases where AHCCCS determines that the relinquishing Contractor is responsible for payment of services following the transition date, AHCCCS will require the receiving Contractor to provide AHCCCS with information about all costs incurred by the member during the period determined by AHCCCS. Failure to timely provide the requested information to AHCCCS will void the

receiving Contractor's claim to reimbursement in that case.

The receiving contractor shall be responsible for the payment of obstetrical and delivery services when a pregnant woman who is considered high-risk, is in her third trimester, or is anticipated to deliver within 30 days of transition, elects to remain with her current physician through delivery as specified in AMPM Policy 410. If the member's current physician and/or facility selected as her delivery site are not within the receiving Contractor's provider network, the receiving Contractor must negotiate for continued care with the member's provider of choice for payment of obstetrical services even if delivery is scheduled to occur outside of the receiving Contractor's contracted network.

Customized Medical Equipment:

a. Customized Medical Equipment purchased for members by the relinquishing Contractor will remain with the member after the transition. The purchase cost of the equipment is the responsibility of the relinquishing Contractor,

b. Customized Medical Equipment ordered by the relinquishing Contractor but delivered after the transition to the receiving Contractor shall be the financial responsibility of the relinquishing Contractor, and

c. Maintenance contracts for Customized Medical Equipment will transfer with the member to the new Contractor. Contract payments due after the transition will be the responsibility of the receiving Contractor, if the receiving Contractor elects to continue the maintenance contract.

Augmentative Communication Devices:

a. A 90- day trial period is generally necessary to determine if the Augmentative Communication Device (ACD) will be effective for the member, or if it should be replaced with another device,

b. If a Member Transitions from a Contractor during the 90-day trial period, one of the following shall occur:

    i. If the ACD is proven to be effective, the device will remain with the member. Payment for the device is the responsibility of the relinquishing Contractor. The cost of any maintenance contract necessary for the ACD shall be the responsibility of the receiving Contractor; if the receiving Contractor elects to continue the maintenance contract, or

    ii. If the ACD is proven to be ineffective, it shall be returned to the vendor. The receiving Contractor shall then coordinate a new device trial and purchase if it is determined to meet the member's needs.

When a member is placed in an out of area placement the referring RBHA Contractor shall establish contracts with out-of-area service providers for behavioral health and physical health services and authorize payment for behavioral health services and physical health services.

ALTCS Only: When an enrollment change occurs while the member is hospitalized, the Current Contractor shall notify the hospital of the member's disenrollment prior to the enrollment with the receiving Contractor. If the current Contractor fails to provide such notice to the hospital, the Current Contractor will continue to be responsible for payment of hospital services provided to the member until the date notice is provided to the hospital as required in the AMPM Policy 520.

Housing

General Housing Contract Requirements for Persons Determined to Have SMI

For the populations of persons determined to have a SMI or other eligible populations served by the Contractor (contingent upon available funding) and who are able to live independently, the Contractor shall provide a number of programs to support independent living, such as rent subsidy programs, supportive housing programs and other transitional housing programs. Independent living shall be supported with provider owned or leased homes and apartment complexes that combine housing services with other covered behavioral health services. Housing programs shall include rent subsidy programs, owner occupied home repairs, move-in assistance and eviction prevention programs coupled with needed supportive housing services to maintain independent living.

B – UHP will work in collaboration with RBHA Contractors for the delivery of housing services for members with SMI eligibility.

B – UHP will work with Arizona Behavioral Health Corporation (ABC) to administer AHCCCS Housing Program (AHP) and housing providers to ensure a variety of housing options and supportive services are available to refer members determined to have a Serious Mental Illness (SMI) live as independently as possible.

Criteria for Continuum of Care Permanent Supportive Housing is as follows:

- Diagnosed with a serious mental illness (SMI)
- Enrolled with the RBHA
- AHCCCS Eligible (Title XIX)
- Be considered homeless according to HUDS definition which is:

*Sleeping in an emergency shelter

*Sleeping in places not meant for human habitation, such as cars, parks, sidewalks, or abandoned or condemned buildings

- Living in a transitional housing program for homeless person. Halfway Houses and Drug Rehab are not considered Transitional Housing. Staying in halfway houses, drug rehab, or living with family or friends does not meet the HUD homeless definition.
- RBHA covered Scattered Site Housing Programs
- Coordinated Entry Subsidy Program

B – UHP will have monitoring and tracking process for each program and will ensure compliance with ACOM Policy 444 for appeals related to supported housing services and ACOM Policy 446 for Housing related grievances and request for investigations.

Seclusion and Restraints and Emergency Safety Responses

It is the policy of B – UHP to ensure that the organization and its providers have the necessary information to ensure that Behavioral Health Inpatient Facilities (BHIFs) and Mental Health Agencies (MHAs) authorized to conduct Seclusion and Restraint, report to the proper authorities as well as B – UHP of such all Seclusion and Restraints and Emergency Safety Responses. The use of seclusion and restraint can be high-risk behavioral health interventions; facilities should only implement these interventions when less restrictive and less intrusive approaches have failed. B – UHP delineates these requirements, by reference, in contracts.

Procedure/Interventions:

B – UHP requires each BHIF and MHA to develop and maintain policies and procedures that comply with the following standards for the use of restrictive behavior management practices, including locked seclusions, mechanical restraints, and drugs used as a restraint.

The B – UHP's Quality Management (QM) Department is the Plan's central repository for all plan member incidents of abuse, neglect, exploitation, and unexpected deaths; this is inclusive of incidents of Seclusion and Restraints occurring in BHIFs (in and out of state).

1. B – UHP requires BHIFs and MHAs to submit each individual report of incidents of S&R to the Plan within five business days of the incident.
    a. If the use of the S&R requires face to face monitoring as outlined in the A.A.C. R9-21-204, the BHIF will submit a supplemental report as an attachment to the individual seclusion and restraint form to the Plan.
    b. If the Seclusion or Restraint episode results in a reportable injury to the member, the BHIF is required to submit a separate Incident/Accident/Death report to B – UHP and to the AHCCCS Quality Team.

c. Contracted Behavioral Health Inpatient facilities must submit these IADs to AHCCCS and the Banner Health Medicaid Plans through the QM Portal within 24 hours of becoming aware of the incident.

B – UHP require complete and accurate reports from BHIFs.

1. B – UHP's Quality of Care (QOC) Team reviews all S&R forms for completeness and returns these to facilities for corrections and resubmittal as warranted.
2. The QOC Team reviews all S&R forms for appropriateness and requests further information as warranted.

The QOC Team reviews all S&Rs for potential Quality of Care concerns. The QOC Team investigates potential Quality of Care concerns for a final determination and follow-through. Reporting for Persons with ALTCS SMI, Child and General Mental Health (GMH)

The QOC Team will submit monthly individual reports of S&R to the AHCCCS QM Portal. The QOC team will ensure that the original AHCCCS Form, Attachment A, or the electronic medical record received from the provider is attached to the record within the AHCCCS QM Portal. The QOC Team is responsible for reviewing each incident of S&R and linking the report to any connected Incident Accident and Death (IAD), Internal Referral (IRF), or Quality of Care (QOC) Concern process within the AHCCCS QM Portal at QMportal.azahcccs.gov as delineated in AMPM Policy 960.

If the use of S&R requires face-to-face monitoring, as outlined in A.A.C. R9-21-204, a supplemental report shall be submitted as an attachment to each individual report. In accordance with A.R.S. §36-509, the QOC Team will redact information on substance use or HIV/AIDS/communicable disease(s) from the reports.

For SMI Grievance and Appeals Procedures please see page 37.

Behavioral Health

Behavioral health case management for ALTCS members is provided by the health plan and is not a reimbursable service for providers.

Customer Care Center

Banner – University Family Care/ACC:
(800) 582-8686 | TTY 711
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