

## Securing Services and Prior Authorization Matrix

Level of Care/ Code	Fax Number	Documentation to Submit	Time of Submission
<p><b>Level 1 Psychiatric Hospital Admission (excluding BHIF/RTC)</b></p>	<p>520-874-3420 (Banner UM)</p>	<p><b>For Admission Notification: All of the following information is required for all inpatient notifications/requests:</b></p> <ol style="list-style-type: none"> <li>1) Admission Face Sheet, which includes the following:               <ol style="list-style-type: none"> <li>a) Member's name and member's identification number, and</li> <li>b) Member's date of birth, and</li> <li>c) Admission date, and</li> <li>d) National Provider Identifications (NPI) of Facility, and</li> <li>e) Attending physician name and admitting hospital name, and</li> <li>f) Admitting diagnosis and ICD 10 Code, and</li> <li>g) Level of care admitted to, and</li> <li>h) Contact name and phone number/e-mail of in-patient Utilization Reviewer, and</li> <li>i) Other insurance.</li> </ol> </li> <li>2) Certificate of Need (CON) Certification of Need (CON)</li> </ol> <p>Clinical documentation submitted <b>prior</b> to the submittal of Notification of admission will not be saved and considered for the medical necessity review.</p>	<p>Within 72 hours of admission</p>
<p><b>Level 1 Psychiatric Hospital Initial Authorization</b></p>	<p>520-874-3411 (BH UM)</p>	<ol style="list-style-type: none"> <li>1) Attending/Psychiatrist admitting evaluation. Initial evaluation is to include:           <ol style="list-style-type: none"> <li>a) Admitting diagnosis</li> </ol> </li> </ol>	<p>Within 24 hours of request from UM Reviewer</p>

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		<ul style="list-style-type: none"> <li>b) Differential diagnosis, or possible impact of medical conditions/symptoms (e.g. UTI, Dehydration)</li> <li>c) Mental status examination</li> <li>d) ELOS (estimated length of stay)</li> <li>e) Proposed treatment plan (titration of meds, initiating injectable, etc.),</li> <li>f) Proposed discharge plan (BHRF, med boxes, etc.)</li> <li>g) Discharge criteria.</li> <li>h) Justification for current level of care and why member is not able to be discharged to lower level of care.</li> </ul> <ul style="list-style-type: none"> <li>2) History and Physical</li> <li>3) Admission/Intake Assessment</li> <li>4) Medication Administration Record</li> <li>5) CIWA/CINA/COWS protocols, as applicable</li> </ul>	
<b>Emergent BHIF Admission</b>	<b>520-694-0599 (Banner BH PA)</b>	<ul style="list-style-type: none"> <li>1) Behavioral Health Prior Authorization Form,</li> <li>2) Certificate of Need (CON),</li> <li>3) Request for Out of Home Application, and</li> <li>4) Out of Home Admission Notification Form</li> </ul>	Within 2 business days of admission
<b>Non-Emergent Admission for BHIF</b>	<b>520-694-0599 (Banner BH PA)</b>	<p><b>Prior to Admission:</b> Submit <b>all</b> of the following:</p> <ul style="list-style-type: none"> <li>1) Behavioral Health Prior Authorization Form,</li> <li>2) Updated Service Plan/Complete Care Plan,</li> <li>3) Recent psychiatric progress notes,</li> <li>4) Out of Home Application,</li> </ul>	Prior to Admission to BHIF

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		<ol style="list-style-type: none"> <li>5) The most recent assessment, or an assessment updated within the past year,</li> <li>6) Child and Family Team note indicating team recommendation,</li> <li>7) Other reports from outpatient providers,</li> <li>8) Any psychological reports or other relevant reports from specialty provider, and</li> <li>9) <b>Submit a CON within 72 hours of admission.</b></li> </ol> <p>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.</p>	
<p><b>Non-Emergent Admission for Behavioral Health Residential Facility (H0018)</b></p>	<p><b>520-694-0599 (Banner BH PA)</b></p>	<ol style="list-style-type: none"> <li>1) Behavioral Health Prior Authorization Form, and</li> <li>2) Out of Home Application with supporting clinical documentation</li> <li>3) If Substance abuse- ASAM and/or related clinical documentation</li> </ol> <p>If approved, authorization is valid up to 45 days only. Submit additional clinical documentation if the member does not admit within 45 days of approval.</p>	<p>Submit Up to 45 days Prior to Admission</p>
<p><b>Emergent Admission For Behavioral Health Residential Facility (H0018)</b></p>	<p><b>520-694-0599 (Banner BH PA)</b></p>	<ol style="list-style-type: none"> <li>1) Behavioral Health Prior Authorization Form,</li> <li>2) Out of Home Admission Notification Form, and</li> <li>3) Out of Home Application Form</li> </ol> <p>If member requires a continued stay, the out of home provider <b>must submit a Concurrent Review Form by the last covered day.</b></p>	<p>Submit within 2 days</p>
<p><b>Non-emergent Admission to HCTC (TFC) (S5109-HB, ages 18-64) (S5109-HC, over 65) (S5109-HA, age 0-17)</b></p>	<p><b>520-694-0599 (Banner BH PA)</b></p>	<ol style="list-style-type: none"> <li>1) Behavioral Health Prior Authorization Form, and</li> <li>2) Out of Home Application Form with supporting clinical documentation</li> </ol>	<p>Up to 45 days Prior to Admission</p> <p>(If approved, the authorization is valid up to 45 days only)</p>

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<p><b>Emergent Admission to HCTC (TFC)</b>  <b>(S5109-HB, ages 18-64)</b>  <b>(S5109-HC, over 65)</b>  <b>(S5109-HA, age 0-17)</b></p>	<p style="text-align: center;"><b>520-694-0599</b>  <b>(Banner BH PA)</b></p>	<p>Submit <b>all</b> of the following within 2 days:</p> <ol style="list-style-type: none"> <li>1) Behavioral Health Prior Authorization Form,</li> <li>2) Out of Home Admission Notification Form, and</li> <li>3) Out of Home Application Form</li> </ol> <p>If member requires a continued stay, the out of home provider must <b>submit a Concurrent Review Form by the last covered day.</b></p>	<p>Within 2 days of admission</p>
<p><b>Concurrent Review Requirements for Inpatient, BHIF, BHRF, HCTC</b></p>	<p style="text-align: center;"><b>Fax Number</b></p>	<p style="text-align: center;"><b>Documentation to Submit</b></p>	<p style="text-align: center;"><b>Time of Submission</b></p>
<p><b>Inpatient Concurrent Review</b></p>	<p style="text-align: center;">520-874-3411 or  <b>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.</b></p>	<p>Submit <b>all</b> of the following clinical documentation to support medical necessity:</p> <ol style="list-style-type: none"> <li>1) A. Attending Behavioral Health Medical Practitioner (BHMP) notes for each day of hospitalization and subacute detox level of care.              B. For subacute facilities not providing detox, BHMP notes must be provided at a minimum for 5 days (M-F) out of the week</li> <li>2) Estimated length of stay</li> <li>3) Medication Administration Record (MARS)</li> <li>4) CIWA/CINA/COWS protocols as applicable</li> <li>5) All physician orders</li> <li>6) RN notes</li> <li>7) Lab results, if indicated</li> <li>8) Discharge plan/barriers, including updates every 24 hours if barriers are resulting in avoidable days.</li> </ol>	<p>Submit clinical documentation prior to noon on the last covered day (LCD) of the current authorization; delayed submittals may result in a denial.</p>

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<b>Behavioral Health Inpatient Facility Concurrent Review</b>	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 e mail address when requested.	Submit <b>all</b> of the following clinical documentation to support medical necessity: 1) Psychiatric notes, 2) Concurrent Review Form, 3) CFT notes, 4) Medication Administration Record (MARS), 5) Discharge plan, and 6) After 30 days, submit a Recertification of Need (RON)	Submit clinical documentation prior to noon on the last covered day (LCD) of the current authorization;  RON Submitted every 30 days.
<b>Behavioral Health Residential Facility (BHRF) Concurrent Review</b>	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 e mail address when requested.	1) Out of Home Concurrent Review Form 2) CFT/ART notes 3) Medication and psychiatric progress notes, if applicable 4) Revised Service Plan/Complete Care Plan (as applicable)- The revised Service Plan/Complete Care Plan should include revisions to address identified barriers	Within 14 calendar days of the last covered day
<b>HCTC (Therapeutic Foster Care) Non-Emergent Concurrent Review</b>	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 e mail address when requested.	1) Out of Home Concurrent Review Form 2) CFT/ART notes 3) Medication and psychiatric progress notes	Within 14 calendar days of the last covered day
<b>HCTC (TFC) Emergent Concurrent Review</b>	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 e mail address when requested.	1) Out of Home Concurrent Review Form	Submit by noon of the last covered day.
<b>Other Out Patient Services/ Codes</b>	<b>Fax Number</b>	<b>Documentation to Submit</b>	<b>Time of Submission</b>
<b>Electroconvulsive Therapy (90870)</b>	520-694-0599 (Banner BH PA)	1) Behavioral Health Prior Authorization Form, and 2) Supporting clinical documentation	Prior to initiation of services
<b>Out of Network Provider (varied)</b>	520-594-0599 (Banner BH PA)	Behavioral Health Prior Authorization Form	Prior to initiation of services.
<b>Transportation-Ground 100+ mileage (A0425)</b>	520-594-0599 (Banner BH PA)	Behavioral Health Prior Authorization Form	Prior to initiation of services.
<b>23 Hour Crisis Observation</b>	<a href="mailto:BUHPCareMgmtBHMmailbox@bannerhealth.com">BUHPCareMgmtBHMmailbox@bannerhealth.com</a>	1) Member name 2) AHCCCS ID 3) Date of Birth	Per the BUHP template.

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		4) Diagnosis/Reason for admission 5) Date of Admission 6) Disposition, if applicable	
<b>Psychotropic Medication (varied)</b>	<b>866-349-0338</b>	Submit the following: Pharmacy Prior Authorization Form	Prior to dispensing

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

[https://www.banneruhp.com/-/media/files/project/uahp/provider-manuals/buhp\\_comprehensive-provider-manual\\_jan2019.ashx?la=en&hash=168A67D69AAB0216C1B548421D2645206230FC11](https://www.banneruhp.com/-/media/files/project/uahp/provider-manuals/buhp_comprehensive-provider-manual_jan2019.ashx?la=en&hash=168A67D69AAB0216C1B548421D2645206230FC11)