CHAPTER 6:

Authorizations and Notifications

Reviewed/Revised: 4/26/19, 1/1/20, 4/30/20, 7/15/20, 1/1/21, 3/1/21, 6/1/21, 10/1/21, 9/1/22, 10/1/22, 3/17/23, 10/1/23, 1/1/24, 7/15/24, 1/1/25, 5/1/25, 12/19/25

6.0 MEDICAL AUTHORIZATION AND NOTIFICATIONS OVERVIEW

We are committed to making the prior authorization process as efficient and streamlined as possible in partnership with the requesting provider. It's important to submit a complete prior authorization request form and provide clinical documentation to facilitate an effective review process.

We maintain a list of services/codes which require prior authorization. This list is referred to as the Prior Authorization Grid (PA Grid). The Chief Medical Officer (CMO), Medical Director(s), or their designees make medical necessity determinations based upon nationally recognized, evidence-based standards of care and the AHCCCS program benefits.

Accurate and prompt medical necessity determinations depend upon the comprehensive content and the quality of medical documentation we (or our delegated entities) receive with each request.

6.1 MEDICAL PRIOR AUTHORIZATION AND NOTIFICATIONS

For a complete listing of services which require Prior Authorization (PA), please refer to the Prior Authorization Grid effective to the applicable date of service at www.azblue.com/health-choice-az. This "PA grid" can also serve as a reference guide and answer many questions which may arise, but which are not directly referred to in the chapter text.

Please follow these key steps when requesting a medically necessary prior authorization**:**

1. Legibly complete all necessary fields of the most current Medical Prior Authorization Request Form (Exhibit 6.2). The most current forms can be accessed on our website: www.azblue.com/health-choice-az and are available through your Provider Performance Representative.

2. Include ALL appropriate clinical documentation, ICD-10, CPT, HCPCS, and J-Code or Q-codes to effectuate the Prior Authorization request. The CPT, HCPC, and J or Q codes must also identify quantity being requested for each code. Providers should only request PA for services listed on the Plan's PA Grid.

3. Blue Cross Blue Shield of Arizona Health Choice is a payor of last resort when a member has

other health insurance.

4. Notification is required for Transplant, Inpatient, and Dental. [42 CFR 433.135 et seq., A.R.S. § 36-2903, and A.A.C. R9-22-1001 et seq].

5. Include ALL necessary clinical documentation to support medical necessity to avoid inappropriate denials or unnecessary delays in the medical review process. Requests without supporting clinical documentation will be denied for lack of clinical information.

6. Clearly indicate on the prior authorization request form if the request is "Expedited" (see below for details). All expedited PA request forms MUST be signed by the ordering provider. Receipt of "Expedited" requests is taken very seriously and monitored to ensure member's emergent/urgent medical needs are met in a timely manner. Inappropriate "Expedited" requests will be downgraded to "Standard."

7. Submit prior authorization requests through the secure provider portal or by fax using the Prior Authorization form posted on the website. Requests are received 24 hours a day, 7 days per week. Providers are encouraged to submit Prior Authorization in the secure provider portal.
    - Provider Portal: Secure Provider Portal
        - Note: Documentation can be uploaded and can also check authorization status
    - Medical PA Fax Line (877) 422- 8120
    - Pharmacy PA Fax Line (877) 422-8130
        - If submitting by fax, then the office must confirm the fax receipt, and this record should be kept for your documentation.

8. EviCore Healthcare ("EviCore") – Manages prior authorization for advanced imaging services, including MRI, MRA, CT and PET scans. The full list of service codes that require authorization is detailed on the PA grid. Prior Authorization for these services must be requested via the EviCore online web portal (https://www.evicore.com), by phone (866) 706-2108 or by fax (800) 540-2406. Prior authorization forms for each service type can be accessed at https://www.evicore.com/resources.

PRIOR AUTHORIZATION NOTES:

- Receipt of authorization does not guarantee payment of services. The claim must be billed correctly and timely.
- Services rendered must be covered under the AHCCCS program.
- The member must be determined to be eligible on the date of service. AHCCCS is (generally) the payer of last resort and primary insurance and/or other credible coverage must be billed first, regardless of primary benefit coverage.
- Only one Medical and/or Pharmacy service may be requested per prior authorization request form.
- All Out-of-Network Providers (OON) require prior authorization. OON Providers should not be requested unless there is a compelling medical necessity reason.

- Any service request resulting in a member being seen outside of the state of Arizona requires prior authorization.
- Expedited requests which do not meet the AHCCCS definition of "Expedited" may be downgraded to a "Standard" level request by the Plan.
- We do not require prior authorization for emergency services.
- We do not cover or pay for experimental and/or investigational services.

6.2 PRIMARY CARE REFERRALS FOR BEHAVIORAL HEALTH

Members can access behavioral health care without authorization. All eligible members are auto assigned to a behavioral health home based on the member's address. Members can change their behavioral health home at any time, but auto-assignment ensures all members have access to behavioral health services. To initiate services with a behavioral health provider, the member, PCP, or medical provider has options.

(1) Contact our Behavioral Member Services department at 877-923-1400 to determine the member's assigned behavioral health home, and

(2) Fax the referral form to 855-408-3409

6.3 SECURING SERVICES THAT DO NOT REQUIRE PRIOR AUTHORIZATION

The behavioral health home clinical team (Adult Recovery Team or Child and Family Team) is responsible for identifying and securing the service needs of each behavioral health recipient through the assessment and service planning processes. Rather than identifying pre-determined services, the clinical team should focus on identifying the underlying needs of the behavioral health recipient, including the type, intensity, and frequency of support needed.

As part of the service planning process, it is the behavioral health home clinical team's responsibility to identify available resources and the most appropriate provider(s) for services. This is done in conjunction with the clinical team, the behavioral health recipient, family, and natural support.

If the service is available through the assigned behavioral health home, the patient can access the service directly. If the requested service is only available through a non-contracted provider or if the clinical team requests services from a non-contracted provider, the clinical team is responsible for coordinating with us to obtain the requested service as outlined below.

Services that are not secured through the behavioral health home clinical team process are subject to retrospective review.

6.4 SECURING SERVICES WITH NON-CONTRACTED PROVIDERS OR NON-CONTRACTED SERVICES WITH A CONTRACTED PROVIDER

If the network does not have in-network providers to perform the requested covered service or

when it is clear a member would be better served by a non-network provider, we will enter into a single case agreement with that provider for a limited time. The Plan and Behavioral Health Homes are not required to offer services outside of the contracted provider network if the service is available within the network.

- **Non-Contracted providers must be registered with AHCCCS.**
- **All out-of-network services require prior authorization**.

Process to obtain a Single Case Agreement (SCA):
When a provider/facility Behavioral Health Home has defined the need for an enrolled member to have services provided by a non-contracted provider or for a non-contracted service by a contracted provider, the team shall submit a prior authorization request.

The Behavioral Health Home is required to submit the prior authorization request form via fax to (877) 422-8120. All authorization forms are available on our **request forms** page. For residential services, the request form should be faxed to (480)-760-4732.

We will review prior authorization requests and complete a single case agreement as needed.

In the event a request to secure covered services through a non-contracted provider is denied, a Notice of Adverse Benefit Determination must be provided in accordance with the Provider Manual, *Chapter 15: Claim Disputes, Members Appeals and Member Grievances*.

Once the single case agreement has been negotiated and executed, the single case agreement provider will be given the signed copy.

If out-of-network services that require prior authorization are **not** prior authorized or if the established single case agreement process is not utilized, the service performed by the out-of-network provider may not be reimbursed. Additionally, the member may not be billed if providers fail to follow our policies.

Both referring and receiving providers must comply with our policies, documents, and requirements that govern the prior authorization process. Failure to comply may result in delay in care for the member and a delay or denial of reimbursement.

Claims are not eligible for payment (does not apply to emergency services) unless the single case agreement is in place, and the authorization (if required) has been obtained.

6.5 EMERGENCY SITUATIONS

Emergency Condition – A medical or behavioral health condition, including labor and delivery, which manifests itself by acute symptoms of sufficient 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:

1. Placing the health of the person, including mental health, in serious jeopardy
2. Serious impairment to bodily functions
3. Serious dysfunction of any bodily organ or part. Per 42 CFR 422.113
4. Serious physical harm to another person

To determine whether a member is experiencing an emergency medical condition, the focus must be on the member's current medical condition and whether that condition satisfies the criteria specified above at the time the service is rendered. The type of facility where a member presents or where service is delivered is not a factor in the determination of an emergency condition. Emergency services can be provided in any setting. Even though an initial injury or condition may be stabilized, it does not necessarily mean that the emergency medical condition has ended.

Prior authorization is never applied when emergency services are sought or rendered. Blue Cross Blue Shield of Arizona Health Choice defines emergency services as covered inpatient and outpatient services that are as follows:

- Furnished by a provider that is qualified to provide these services under Title 42 and
- Needed to evaluate or stabilize an emergency medical condition.

A retrospective review may be conducted after the person's immediate behavioral or physical health needs have been met. If upon review of the circumstances, the service did not meet admission authorization criteria, payment for the service may be denied. The test for appropriateness of the request for emergency services must be whether a prudent layperson, similarly situated, would have requested such services.

6.6 COVERAGE AND PAYMENT OF EMERGENCY MEDICAL CONDITION AND POST-STABILIZATION SERVICES

Emergency health services for Title XIX or Title XXI eligible members must be covered, and reimbursement made to providers who furnish the services regardless of whether the provider has a contract with us.

Payment must not be denied when:

- The provider instructs a person to seek emergency services. An Illness, injury, symptom, or condition (including severe pain) that a reasonable person could expect that not getting medical attention right away would:
  - Put the person's health in danger; or
  - Put a pregnant woman's baby in danger; or
  - Cause serious damage to bodily functions; or
  - Cause serious damage to any body organ or body part. to bodily functions; or

- Emergency conditions must not be limited to a list of diagnoses or symptoms.
- A person who has an emergency health condition must not be held liable for payment of

subsequent screening and treatment needed to diagnose the specific condition or stabilize the person; and
- The attending emergency physician, or the provider treating the person, is responsible for determining when the person is sufficiently stabilized for transfer or discharge.

The following conditions apply with respect to coverage and payment of post-stabilization care services for persons who are Title XIX or Title XXI eligible. We are responsible for ensuring adherence to the following requirements, even in situations when the function has been delegated to a subcontracted provider.

Post-stabilization care services must be covered without authorization and reimbursement made to providers that furnish the services regardless of whether the provider has a contract with us for the following situations as per **R9-22-210**:
- Post-stabilization care services that were prior authorized by us
- Post-stabilization care services that were not prior authorized by us or because we did not respond to the treating provider's request for pre-approval within one hour after being requested to approve such care or could not be contacted for pre-approval; or
- The treating physician and the Plan can't reach agreement concerning the member's care, and a Plan physician advisor is not available for consultation. In this situation, we give the treating physician the opportunity to consult with a contracted physician and the treating physician may continue with care of the member until a contracted physician is reached or one of the following criteria is met:
  - Physician with privileges at the treating hospital assumes responsibility for the person's care;
  - Physician assumes responsibility for the person's care through transfer;
  - The treating physician and we reach an agreement concerning the person's care; or
  - The person is discharged.

6.7 TIME FRAMES FOR HEALTH PLAN PRIOR AUTHORIZATION REVIEW

[Defined by the AHCCCS Medical Policy Manual, Chapter 1000 Medical Management series, AHCCCS Contractor Operations Manual, Chapter 400 policy 414: Requirements for Service Authorization Decisions and Notices of Adverse Benefit Determination and 42 CFR § 438.210 d1 and d2 (Code of Federal Regulations, Public Health section)].

- **"Standard": up to 7 calendar days -** Standard means a request for which we must provide a decision as expeditiously as the member's health condition requires, but not later than calendar days following receipt of the authorization request, with a possible extension*(see "*AHCCCS-required 14-day Extensions*" below) of up to 14 calendar days if the member or provider requests an extension or if we justify a need for additional information and the delay is in the enrollee's best interest.

- **"Expedited": up to 72 hours -** Expedited means a request for which a provider indicates, or a Contractor determines using the standard time frame for issuing an authorization

decision could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.

- The ordering provider **must** sign the prior authorization request form to certify critical need as "Expedited". We must make an expedited authorization decision and provide notice as expeditiously as the member health condition requires, but no later than 72 hours following the receipt of the authorization request, with possible extension*(see "AHCCCS- required 14-day Extensions" below) of up to 14 days if the member or provider requests an extension or if the Contractor justifies a need for additional information and the delay is in the enrollee's best interest.

Time frames for review of provider-administered medical drugs/medications, please refer to Chapter 17: *Pharmacy and Drug Formulary*.

6.8 PRIOR AUTHORIZATION DETERMINATIONS

Prior authorization requests received with the correct and appropriate clinical documentation (and/or EviCore) will be processed and completed in one of the following standard methods:

- **Approved** - The information received met all clinical documentation requirements to determine medical necessity to authorize the requested services. The requesting provider office is responsible for informing the member and provider (if applicable) that services have been authorized.
- **Denied** - The information received did not meet all requirements, and authorization is not granted. The requesting provider and member will receive a Notice of Adverse Benefit Determination (NOA) letter.
- ***14-day Extension-** In some instances where PA has been requested, the documentation received *may* suggest medical necessity exists for the service, but the records provided are insufficient to render an authorization. When this occurs, additional information will be requested via fax or direct phone contact. When additional information cannot be obtained to meet AHCCCS mandated Expedited or Standard PA timeframes, an AHCCCS required document titled "*Notice of Extension for Service Authorization*" (NOE) will be issued to both the member and the requesting provider. This 14-day extension will afford both the requesting Provider and the Plan 14 additional calendar days to obtain the additional information necessary to render a final determination. If at the end of the 14- day the necessary additional information hasn't been submitted, the request will be denied, and both the Provider and member will be notified.

  Note: The prior authorization decision will be issued no later than a total of twenty-eight (28) days for Standard requests or seventeen (17) days for Expedited requests from the date the PA request was received.
- **Modified**: The information received met medical necessity requirements, but a partial authorization is granted. Requested services may be reduced when the documentation provided does not support the full amount, duration, and/or scope of service at the time of request. The requesting provider and member will receive a Notice of Adverse Benefit

Determination (NOA) letter.

- **Peer to Peer Consultation:** Providers may discuss denial determination by requesting a Peer to Peer with a Medical Director if a request is made within 10 business days of receiving the denial notification.

6.9 SUPPORTING DOCUMENTATION

Documentation of medical necessity must accompany all requests for prior authorization. For most PA requests, supporting documentation should include:

- Current diagnosis and treatment already provided by the PCP/requesting provider
- All pertinent medical history and physical examination findings
- Diagnostic imaging and laboratory reports (if applicable)
- Indications for the procedure or service
- Alternative treatments, risks, and benefits (including the indication of such discussions with the patient)
- Specific information supporting medical necessity is required for all requests for Out-Of-Network (OON) providers/facilities/services and Non-Formulary (NF) or non-preferred medication and product requests. A PA is required for any service to be covered at OON providers/facilities. The OON provider/facility must be registered with AHCCCS.

6.10 PRE-SERVICE DENIALS

Members will be notified of an adverse benefit determination within 72 hours for Expedited requests, and within 7 *calendar* days for Standard request (excluding situations in which a 14-days extension is exercised). When an adverse determination is issued, the health plan must inform the member of the reason for denial in clearly understood language in the form of a "Notice of Adverse Benefit Determination" (NOA) letter.

Please be aware that AHCCCS requires NOA letters to communicate the basis for a denial in "easily understood" language, therefore NOA letters will be written in a simplistic fashion to comply with this specific AHCCCS requirement. For more information about what a member can do if they receive an NOA, please see Chapter 15: *Claims Disputes, Member Appeals and Member Grievances*.

Written information which communicates with an adverse benefit determination will also be sent to the requesting Provider (or their designee). Provider letters are sent to the Physician or Facility who initiated the request for prior authorization and will contain varying degrees of detail to explain the basis for denial.

Special considerations and information regarding Medical Prior Authorizations

- The Primary Care Provider (PCP) should initiate the prior authorization request (see Prior

Authorization Grid).

- Members should be instructed not to self-refer to specialists without the express recommendation of their PCP.
- Blue Cross Blue Shield of Arizona Health Choice will provide notice of approval, extension, denial, or modification within the allowable time frames via fax and/or phone to the requesting provider.
- If a service requires prior authorization and an authorization was not approved, or if the member was ineligible at the time of service, the claim will be denied.
- The authorization number or denial should be noted in the member's medical record.
- Prior Authorization approval number(s) should be provided by the requesting provider TO the Specialist/Facility/Vendor PRIOR to the member's appointment.
- The Specialist, facility, or vendors are responsible for ensuring necessary authorizations have been issued prior to rendering service.
- The PCP (or requesting/ordering Provider) is responsible for facilitating coordination of care and assist/alert the member to make the necessary appointments for approved services.
- When difficulty arises in coordinating and/or facilitating care, the referring provider should contact the plan for additional assistance.
- Authorization is NOT a guarantee of payment for services.
- Authorizations are valid for 90 days, except for diabetic supplies which may be approved for a duration of up to 365 days based on clinical review. Some medical drug codes are approved for a duration of longer than 90 days based on clinical review.
- Contracted health professionals, hospitals, and other providers are required to comply with Prior Authorization policies and procedures.

6.11 INFORMAL RESOLUTIONS OF DENIALS

We use the following protocol to resolve issues regarding authorizations:

1. The requesting provider may resubmit a new prior authorization request with new/additional information pertinent to the original non-authorized request to the Prior Authorization Department.

   Please note: Requests should only be resubmitted to the Plan PA Department; if new and/or additional, pertinent information is being provided with the resubmission.

2. The original information (denial packet) will be retrieved if necessary and combined with the current request which contains new/additional information and will be presented to the Chief Medical Officer, Medical Director, or their designee for reconsideration.

3. If no new and/or additional information is received, the resubmitted request will be "Cancelled" (C) and the office notified by Telephone, Email or Fax. New and/or additional information is needed to constitute a new prior authorization request. If the member wishes to file a formal appeal on a denied authorization, please refer them to their Member Handbook, Member Services, or Chapter 15 of this Provider Manual for details.

4. Providers may request a Peer to Peer with the Medical Director who denied their prior authorization request within 10 business days of the denial notification. After 10 business days, the denial stands, and the provider may resubmit a new request with additional information as referenced above or file an appeal.

6.12 BEHAVIORAL HEALTH SERVICES THAT REQUIRE PRIOR AUTHORIZATION AND CRITERIA

Behavioral Health Services requiring prior authorization include but are not limited to the following:

Services requiring prior authorization include but are not limited to the following:

- Non-emergency Out of Network request for services
- Non-emergency admission to and continued stay in a Behavioral Health Hospital or Sub-Acute Facility
- Residential Treatment Facility (RTC)/Behavioral Health Inpatient Facility (BHIF) for persons under the age of 21
- Behavioral Health Residential Facilities inclusive of substance abuse conditions (BHRF)
- Electroconvulsive Therapy (ECT)
- Transcranial Magnetic Stimulation (TMS)
- Therapeutic Foster Care (TFC)
- Adult Behavioral Health Therapeutic Homes (ABHTH)
- Some medications and prescribing practices

For a complete listing of services which require Prior Authorization (PA), please refer to the Prior Authorization Grid effective to the applicable date of service at www.azblue.com/health-choice-az.

This "PA grid" can also serve as a reference guide and answer many questions which may arise, but which are not directly referred to in the chapter text.

A behavioral health professional is required to apply the designated authorization criteria and continued stay criteria to approve the provision of the covered service. Submitted clinical information and documentation relevant to the authorization request are reviewed by a behavioral health professional to determine medical necessity. If enough clinical information relevant to the medical necessity criteria is not provided with the request, the Plan will reach out and attempt to gather the clinical information needed to decide. A decision to deny must be made by the Medical Director or physician designee. When appropriate, the Plan will provide a consultation with the requesting provider to obtain additional information to make a decision. Before a final decision to deny is made, the person attending behavioral health/medical practitioner can ask for reconsideration and present additional information.

Provider Denial Notifications

We provide written notification of behavioral health service denial to the member and requesting practitioners. The written denial notification contains the following:

- The specific reasons for the denial, in easily understandable language.
- A reference to the benefit provision, guideline, protocol, or other similar criterion on which the denial decision was based.
- A statement that the member can obtain a copy of the actual benefit provision, guidelines, protocol, or other similar criterion on which the denial decision was based, upon request.
- Termination, suspensions, or reduction of previously authorized Medicaid-covered services; we provide electronic or written advance notice to practitioners and members at least 10 days before the date of action. In cases of probable fraud, we may shorten to 5 days before date of action if:
  - We have facts indicating actions should be taken because of probable fraud by the member, **and**
  - The facts have been verified through secondary sources. If possible.

For Title XIX/XXI covered services requested by persons who are Title XIX/XXI eligible or who have been determined to have a serious mental illness, we must provide the person requesting services with a **Notice of Adverse Benefit Determination (NOA)** following:

- The denial or limited authorization of a requested service, including the type or level of service;
- The reduction, suspension, or termination of a previously authorized service; and
- The denial in whole or in part, of payment for a service

The Notice must be provided in accordance with Chapter 15 of the Provider Manual: *Claim Disputes, Member Appeals, and Member Grievances*.

Prior and Continued Authorization for Behavioral Health Services

Behavioral Health Inpatient Facility (BHIF) for persons under the age of 21-Residential Treatment Center/Residential Treatment Facility

Prior to admission submit all the following:

- Blue Cross Blue Shield of Arizona Health Choice BHIF, BHRF, TFC, and SUD-BHRF Prior Authorization and Continued Stay Request form.
- Certificate of Need (CON)
- Current Child and Adolescent Level of Care Utilization System (CALOCUS) reflecting current clinical presentation, or Early Childhood Level of Care Utilization System (ECSII) to demonstrate sufficient medical necessity for admission
- ASAM if applicable
- Psychiatric/Psychosocial Evaluation within the last 30 days

- Specialized testing e.g., ASD, SMB if applicable
- An updated Treatment Plan reflecting BHIF level of care and the goal of treatment for this level of care

- Most recent CFT indicating need for service requested

All authorization requests must have an identified Licensed Attending/Treating Practitioner indicated on the request with a valid fax number.

- Prior authorizations for BHIF are valid for up to 30 days. If placement is not secured within 30 days, the CFT/ART is required to submit a new updated authorization request describing current clinical presentation and treatment. The number of days authorized are based on medical necessity, diagnosis, condition, and projected discharge, up to 30 days. Requests should be faxed to (480) 760-4732.

- Blue Cross Blue Shield of Arizona Health Choice determines medical necessity within 7 calendar days for Standard decisions and 72 hours for Expedited decisions.

- If a member is not enrolled with an outpatient provider, the BHIF must initiate a request to enroll the member with an outpatient agency chosen by the member or by zip code.

BHIF Continued Stay

Submit all of the following seven days prior to the last authorized day:

- Blue Cross Blue Shield of Arizona Health Choice Behavioral Health BHIF, BHRF, TFC, SUD-BHRF Prior Authorization and Continued Stay Request form
- Monthly treatment summary
- Incident reports
- Updated medication lists
- Psychiatric Evaluation, testing, or other evaluation documentation
- Updated Treatment Plan with measurable discharge goals and progress towards achievement
- Child and Adolescent Level of Care Utilization System (CALOCUS)
- CFT notes
- RON - Every thirty days
- ASAM if applicable

All authorization requests must have an identified Licensed Attending/Treating Practitioner indicated on the request with a valid fax number.

- BH Medical Management Specialist provides the due date for each request. It is the responsibility of the BHIF to submit requests in a timely manner. The number of days authorized are based on medical necessity, diagnosis, condition, and projected discharge date.
- BHIF's are required to schedule follow-up appointments with the (PCP) and/or

BHMP/specialist within seven business days of discharge. Please refer to our Provider Directory for a list of contracted providers.

- BHIF's are required to submit the Blue Cross Blue Shield of Arizona Health Choice Notification of Admission, Transfer, and Discharge Form and facilities DC summary within one business day of the event. Forms should be submitted by fax to (480) 760-4732 or BHAuthorizations@azblue.com. BHIF providers are required to notify and provide a discharge summary within one business day to the outpatient treatment team.

- If a member is not enrolled with a provider, the BHIF team must initiate a request to enroll the member with an outpatient agency chosen by the member or by zip code.

Determination Timeline: Determination of prior authorization for BHIF is required prior to admission. Standard request determination 7 days from receipt and Expedited 72 hours from receipt.

Discharge Plan

There is a written plan for discharge with specific discharge criteria and recommendations for aftercare treatment that includes involvement of the Child and Family Team and complies with current standards for medically necessary covered behavioral health services, cost effectiveness, and least restrictive environment and is in conformance with 42 CFR.

Criteria for Discharge

- Sufficient symptom or behavior relief are achieved as evidenced by completion of BHIF 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 the monitoring and follow-up services, or a caregiver is available to provide monitoring at a less restrictive level of care.

- Appropriate services, providers, and support are available to meet the members' current behavioral health needs at a less restrictive level of care.

- There is no evidence to indicate that continued treatment in a BHIF would improve a member's clinical outcome.

- There is potential risk that continued stay in BHIF may precipitate regression or decompensation of members' condition.

Behavioral Health Residential Facilities (BHRF) inclusive of Substance Use Disorders Process and Requirements

Prior to Admission submit all the following:

- Blue Cross Blue Shield of Arizona Health Choice Behavioral Health BHIF, BHRF, TFC, SUD-BHRF Prior Authorization and Continued Stay Request form
- Current Child and Adolescent Level of Care Utilization System (CALOCUS) reflecting current clinical presentation, or Early Childhood Level of Care Utilization System (ECSII) to demonstrate sufficient medical necessity for admission. (Child Only)
- Information demonstrating medical necessity for BHRF
- ASAM, substance use assessments for members with substance abuse or co-occurring disorder
- Update assessments Psychiatric/Psychosocial Evaluation
- Updated Treatment Plan indicating the level of care being requested
- Most recent CFT/ART indicating need for service requested for non-SUD BHRF'S

All authorization requests must have an identified Licensed Attending/Treating Practitioner indicated on the request with a valid fax number.

BHRF decisions are always expedited, and decisions are made in 72 hours unless an extension is necessary for clinical information necessary to make a medical necessity decision.

The request should be faxed to (480)-760-4732. Authorizations are valid for up to 30 days. If placement is not secured within 30 days, the CFT/ART is required to submit a new authorization request. The number of days authorized are based on medical necessity, diagnosis, condition, and projected discharge, up to 45 days.

BHRF Continued Stay Requests

Submit all of the following seven days prior to the last authorized day:

- Blue Cross Blue Shield of Arizona Health Choice Behavioral Health BHIF, BHRF, TFC, SUD-BHRF Prior Authorization and Continued Stay Request from
- Monthly treatment summary
- Progress notes
- Current medication list
- Psychiatric Evaluation, testing, or other evaluation documentation
- Updated Treatment Plan with progress towards goals related to admission
- Updated Discharge Plan

The request should be faxed to (480)-760-4732. The number of days authorized are based on medical necessity, diagnosis, condition, and projected discharge, up to 45 days.

BHRF Discharge Requirements

Upon a member's discharge, Behavioral Health Residential Facility (BHRF) providers are required to notify Blue Cross Blue Shield of Arizona Health Choice and submit the discharge plan, which must detail the member's disposition and include scheduled follow-up appointments with

outpatient behavioral health services. Please include the completed Notification of Admission, Transfer, and Discharge for Out of Home Placements within one business day of discharge.

Requirements outline in AHCCCS 320V.

The final discharge plan shall be documented in the member's medical record and shall include:

a. Progress toward treatment goals,
b. Follow up treatment plan and safety plan compliant with AMPM Policy 320-0,
c. Follow up appointment with the PCP and/or specialist for service, within seven days of discharge, is scheduled,
d. Plan for medication pick up and coordination of outgoing medication management, and
e. The BHRF coordination and/or referral is complete, acceptance confirmed, and discharge date has been communicated to ensure safe and clinically appropriate discharge, with the following:
    i. Confirmation of discharge location or step-down level of care,
    ii. Outpatient providers,
    iii. Community support services,
    iv. Transportation services, and
    v. All other support and services identified in the discharge plan, which may include but not limited to Durable Medical Equipment (DME), home health services, etc.

General BHRF Provider Requirements (AHCCCS 320V-BHRF)

The BHRF is a level of care available to members diagnosed with a behavioral health condition (inclusive of substance use conditions), which is causing significant functional and/or psychosocial impairment, leading to at least one area of significant risk of harm. This impairment and risk of harm warrant the need for 24-hour supervision and support while the member engages in treatment interventions to address behavioral health condition(s) that will allow the member to live safely in the community.

Behavioral health services deemed medically necessary through the assessment and/or outpatient treatment team which are not offered at the BHRF, shall be documented in the member's comprehensive service plan and BHRF treatment plan. Documentation of medically necessary behavioral health services that are outside of the scope of the BHRF shall include:

- A description of the need,
- Identified goals,
- Frequency and duration of services to be provided,
- Identification of provider meeting the need,
- Documentation shall also include why the BHRF, and current BHP are unable to provide these services for the member, and
- Why must the outpatient treatment team provide them separately.

The following services shall be made available and provided by the BHRF and cannot be billed separately unless otherwise noted below:

- Counseling and therapy (group and individual):

    - Behavioral health counseling and therapy.
- 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 planning/use of crisis plan),
    - Health and wellness education (e.g., benefits 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 and vocational skills, educational needs assessment and skill building,
    - Treatment for Substance Use Disorder (SUD) (e.g., substance use counseling, groups), and
    - Personal care services (refer to AAC R9-10-702, R9-10-715, R9-10-814 for additional licensing requirements).

The BHRFs shall demonstrate adherence to best practices for treating specialized service needs as applicable to the population served, within their identified scope of practice, including but not limited to:

- Cognitive/intellectual disability,
- 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).

BHRF providers serving our members shall ensure that the BHRF maintains a separate, individualized medical records for all members admitted which include the medical history, physical examination as required for admission to a BHRF and the individualized treatment plan in accordance with AAC R9-10-707.
BHRF providers serving members shall ensure that each member receives a BHRF treatment plan, which connects back to the member service plan. The applicable outpatient treatment team shall be included and involved in the development of the treatment plan within 48 hours of admission and ensure to include documentation in the event a medically necessary service is identified as a specific member need that cannot otherwise be met as required within the BHRF setting and scope of service, inclusive of the overseeing BHP:

- The BHRF staff, including the BHRF BHP, the outpatient treatment team, the member, and, as applicable, the HCDM, shall meet to review and modify the treatment plan at least once a month,
    - The BHRF treatment plan shall: Align with The Arizona Vision 12 Principles for Children's Behavioral Health Service Delivery as directed in AMPM Policy 580, or The Nine Guiding Principles for Recovery Oriented Adult Behavioral Health Services and Systems.
    - Be specific to the member's physical and behavioral health condition(s), and reason

for admission,
- Be developmentally appropriate,
- Include measurable and achievable goals,
- Be based upon the member's unique needs and tailored to the member, HCDM, and/or family member(s) choices where possible, and
- Support the members' improved or sustained functioning and integration into the community.

BHRF providers must keep a copy of the current treatment plan including documentation of required reviews and updates by the BHRF on a regular basis, and shall include the following:

- Review of all treatment services being provided to the member,
- Review of member's progress towards the treatment goals,
- Assessment of risk and functional impairment because of a behavioral health condition,
- Availability and appropriateness of providers and supports available to meet the member's current behavioral and physical health needs at a less restrictive lower level of care, and
- Adjustments to treatment interventions, frequency, crisis/safety planning, and targeted discharge to support the need for continued stay.
- Documentation of current progress and/or regression toward meeting treatment goals,
- Documentation of the continued display of risk and functional impairment that cannot be supportive in a less restrictive lower level of care, and
- Documentation of treatment interventions, frequency, crisis safety planning, and revised discharge plan.
- All BHRF providers are required to send a copy of the documentation of all participants in the treatment planning process during the continued stay review process.

Discharge Readiness and Planning

Blue Cross Blue Shield of Arizona Health Choice BHRF providers are to ensure discharge criteria include at minimum the following:

- Symptoms or behavior relief is reduced as evidenced by completion of treatment plan goals,
- Functional capacity is improved, 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,
- The Member can participate in needed monitoring, or a caregiver is available to provide monitoring in a less restrictive level of care,
- The Providers and supports are available to meet current behavioral and physical health needs at a less restrictive level of care, and
- Ongoing support and service providers the member will be engaged with upon discharge shall be included in discharge planning meetings, where initial step-down goals and follow up treatment plan will be created.

BHRF shall ensure that the members and HCDM, as applicable:

- Progress toward treatment goals,
- Follow up treatment plan and safety plan compliant with AMPM Policy 320-0,
- Plan for medication pick up and coordination of outgoing medication management, and
- The BHRF coordination and/or referral is complete, acceptance confirmed, and discharge date has been communicated to ensure safe and clinically appropriate discharge, with the following:
    - Confirmation of discharge location or step-down level of care,
    - Outpatient providers,
    - Community support services,
    - Transportation services, and
    - All other support and services identified in the discharge plan, which may include but not limited to Durable Medical Equipment (DME), home health services, etc.

BHRF providers shall on discharge submit the discharge plan with member disposition including follow up appointments with outpatient behavioral health services.

BHRF and Medication Assisted Treatment

BHRF Providers, including BHRF providers serving FFS members, shall establish policies and procedures to ensure members on MAT or MOUD are not excluded from admission and are able to receive MAT to ensure compliance with Arizona Opioid Epidemic Act SB 1001, Laws 2018, First Special Session.

BHRF with Personal Care Services

Examples of services that may be provided include, but are not limited to:

- Administration of oxygen,
- Application and care of orthotic devices,
- Application and care of prosthetic devices,
- Application of bandages and medical supports, including high elastic stockings,
- ACE wraps, arm, and leg braces, etc.,
- Application of topical medications,
- Assistance with ambulation,
- Assistance with correct use of cane/crutches,
- Bed baths,
- Blood sugar monitoring, Accu-Check diabetic care,
- Care of hearing aids,
- Catheter care,
- Denture care and brushing teeth,
- Dressing member,
- G-tube care,
- Hair care, including shampooing,
- Incontinence support, including assistance with bed pans/bedside commodes/ bathroom supports,
- Measuring and giving insulin, glucagon injections,
- Measuring and recording blood pressure

- Non-sterile dressing change and wound care,
- Ostomy and surrounding skin care,
- Passive range of motion exercise,
- Radial pulse monitoring,
- Respiration monitoring,
- Use of pad lifts,
- Shaving,
- Shower assistance using shower chair,
- Skin and foot care,
- Skin maintenance to prevent and treat bruises, injuries, and pressure sores. Members with a stage 3 or 4 pressure sore are not to be admitted to BHRF (AAC R9-10-715(3)), and infections,
- Supervising self-feeding of members with swallowing deficiencies, and
- Use of chair lifts.

Prior and Continued Authorization Request for Therapeutic Foster Care (TFC) Process, Requirements and Criteria

Therapeutic Foster Care (TFC) is a covered behavioral health service that provides structured daily behavioral interventions within a home-based licensed family setting. This service is designed to maximize the members' ability to live in a family setting, participate in the community, and function independently. Services provided in a TFC address behavioral, physical, medical, and development needs including assistance in the self-administration of medication and any ancillary services (such as living skills and health promotion) as appropriately indicated in the member's Individualized Service Plan (ISP).

Prior to admission submit all the following:

- Blue Cross Blue Shield of Arizona Health Choice Behavioral Health BHIF, BHRF, TFC, SUD-BHRF Prior Authorization and Continued Stay Request form.
- Current Child and Adolescent Level of Care Utilization System (CALOCUS) reflecting current clinical presentation, or Early Childhood Level of Care Utilization System (ECSII) to demonstrate sufficient medical necessity for admission. (Child Only)
- ASAM for members with substance abuse or co-occurring disorder.
- Current Psychiatric/Psychosocial Evaluation
- Current Treatment Plan indicating the level of care being requested.
- Most recent CFT/ART indicating need for service

All authorization requests must have an identified Licensed Attending/Treating Practitioner indicated on the request with a valid fax number. Request should be faxed to (480)-760-4732.

Authorizations are valid for up to 90 days. If admission is not secured, a new request must be resubmitted. The number of days authorized are based on medical necessity, diagnosis, condition, and projected discharge, up to 90 days.

All TFC Providers shall ensure appropriate notification is sent to Primary Care Provider (PCP) and Behavioral Health Provider/Agency/TRBHA/Tribal ALTCS program upon intake to and discharge from the TFC.

If a member is not enrolled with an outpatient provider, the TFC team must initiate a request to enroll the member with an outpatient agency chosen by the member or by zip code.

TFC Continued Stay Requirements

Submit all the following seven days prior to the last authorized day:

Blue Cross Blue Shield of Arizona Health Choice Behavioral Health BHIF, BHRF, TFC, SUD-BHRF Prior Authorization and Continued Stay Request form

- Monthly treatment summaries
- Copies of Monthly CFT meetings
- Progress notes
- Current medication list
- Psychiatric Evaluation, testing, or other evaluation documentation
- Treatment Plan with discharge goals and progress

The number of days authorized are based on medical necessity, diagnosis, condition, and projected discharge, up to 90 days.

Therapeutic Foster Care Overview

Care and services provided by a TFC Family Provider are based on a per diem rate (24-hour day) which does not include room and board. Services provided by a TFC Family Provider require Prior Authorization (PA). For FFS, refer to AMPM 820 for Prior Authorization requirements.

Blue Cross Blue Shield of Arizona Health Choice determines medical necessity within 7 calendar days for Standard decisions and 72 hours for Expedited decisions.

TFC Requirements

The TFC agencies shall ensure treatment aligns with:

- The Arizona Vision and 12 Principles for Children's Behavioral Health Service Delivery as specified in AMPM Policy 580,
- Collaboration and skill building for identified primary caregiver following discharge as specified in AMPM Policy 586,
- The member's individualized physical, behavioral, and developmental needs,
- Trauma-informed care, and
- Evidence-based best practices.

The TFC treatment goals shall be:

- Specific to the member's behavioral health condition that warranted treatment,
- Measurable and achievable,

- Based on the member's unique needs, and
- Supportive of the members' improved or sustained functioning and integration into the community.

The TFC Treatment Plan shall:

- Be developed in conjunction with the CFT,
- Complement and not conflict with the ISP and other defined treatments, and include reference to the member's current:
  - Physical, emotional, behavioral health, and developmental needs,
  - Educational placement and needs,
  - Medical treatment,
  - Behavioral treatment through other providers, and
  - Prescribed medications.
- Include an updated safety plan in alignment with the TFC setting,
- Be developed in collaboration with the child, at a level that is determined to be age and developmentally appropriate,
- Be developed with the voice of the biological, kinship, and/or adoptive family,
- Include specific elements that build on the members' strengths, while also promoting prosocial, adaptive behaviors, interpersonal skills and relationships, community, family and cultural connections, self-care, daily living skills, and educational achievement,
- Include specifics to coordinate with natural supports and informal networks as a part of treatment,
- Include plans for engagement of the member's biological, kinship, adoptive, and/or transition foster family in the member's treatment
- Include specific goals that prepare the receiving caregiver(s) to care for the member's needs and ensures the member can successfully transition to the new caregiver,
- Include a discharge plan that:
  - Is developed within seven days of admission,
  - Identifies a caregiver for post-discharge,
  - Is reviewed monthly at the CFT meeting,
  - Outlines criteria for the member's discharge,
  - Recommends post-discharge services,
  - Engages the identified caregiver that will support the member post-discharge in planning for transition and transitional visits, or
  - If a member has not been successful in TFC and a higher level of care is required, outlines the steps necessary to make this transition.
- Include respite planning,
- Be reviewed by:
  - The TFC Family Provider and TFC Agency worker at every home visit,
  - The TFC Agency worker and clinical supervisor at each staffing, and
  - The TFC Agency worker at each CFT meeting, or at a minimum quarterly.
- Be maintained by the TFC Family Provider and the TFC Agency and shared at each revision with the CFT

Therapeutic Foster Care Provider Roles/Responsibilities

TFC Provider shall ensure:

- Abide by all licensing regulations as outlined in current and relevant Federal and State statutes and rules, including rules in AAC Title 21, Chapter 6, for family foster parent licensing requirements, therapeutic level of licensure.
- Provide TFC to no more than three children in a professional foster home, as outlined in AAC Title 21, Chapter 6.
- Provide basic parenting functions (e.g., food, clothing, shelter, educational support, meet medical needs, provide transportation, teach daily living skills, social skills, the development of community activities, and support cultural, spiritual/religious beliefs).
- Provide behavioral interventions (e.g., anger management, crisis de-escalation, psychosocial rehabilitation, living skills training and behavioral intervention) that shall aid the member in making progress on TFC Treatment Plan goals.
- Provide a family environment that includes opportunities for: a. Familial and social interactions and activities, b. Use of behavioral interventions, c. Development of age-appropriate living and self-sufficiency skills, and d. Integration into a family and community-based setting.
- Meet the individualized needs of the member, as defined in the member's TFC Treatment Plan.
- Be available to care for the member 24 hours per day, seven days a week for the entire duration that the member is receiving out-of-home treatment services.
- Plan for the members needs to be met when the member is in respite care with other TFC Family Providers.
- Participate in planning processes such as CFTs, TFC discharge planning, and Individualized Education Programs (IEPs).
- Maintain documentation, per AAC Title 21, Chapter 6, and AMPM Policy 940, including:
    - Record behavioral health symptoms,
    - Incident reports,
    - Interventions utilized,
    - Progress toward the TFC Treatment Plan goals, and
    - Discharge plan.
- Assist the members in maintaining contact with their biological, kinship and/or adoptive family and natural support.
- Assist in meeting the member's permanency planning or TFC discharge planning goals.
- Advocate for the member to achieve TFC Treatment Plan goals and to ensure timely access to educational, vocational, medical, or other indicated services.
- Provide medication management consistent with AHCCCS guidelines for members in out-of-home care.
- Allegations of misconduct toward members shall be reported according to all Federal and State regulations.
- Maintain confidentiality according to statutory, Health Insurance Portability and Accountability Act (HIPAA) and AHCCCS requirements.
- Ensure any request to move a member from placement prior to successful completion of TFC Treatment Plan is made through the CFT and written notice is provided following

contractual timeframes with the only exception being immediate jeopardy.

- Follow the safety plan and work to preserve the placement to the best of their ability, including consultation with the CFT for consideration of additional in-home supports and services as appropriate, and necessary to support the member and family.
- Accept TFC Agency worker and BHP support, including the use of respite to maintain the placement until an emergency CFT is convened, services implemented, and the placement is preserved. If the TFC placement cannot be preserved, the TFC Agency shall support the member and TFC Family Provider until a proper transition is identified.

Admission Criteria - (Must Meet All)

- The recommendations for TFC come through the Child and Family Team (CFT) process, or
  - An interim service plan coordinated through Integrated Rapid Response can be used to establish this recommendation for admission, prior to the establishment of a full CFT.
- Blue Cross Blue Shield of Arizona Health Choice uses the recommended level of care determined by CALOCUS/ESCII to demonstrate sufficient necessity for admission to TFC without requiring additional authorization for a period of no less than 30 days.
- An assessment, which indicates the member has been diagnosed with a behavioral health condition and indicates symptoms and behaviors to be treated, or

Special consideration will be given to children with two or more of following:

- Multiple out-of-home placements (foster homes, Behavioral Health Residential Facility (BHRF), Behavioral Health Inpatient Facility (BHIF), Residential Treatment Center (RTC), etc.),
- History of disruption from a foster home due to behaviors,
- One or more hospitalizations due to a behavioral health condition in the last year,
- Chronic pattern of suspensions from school, daycare, or day programming,
- Adoption disruption or potential adoption disruption,
- Significant trauma history or trauma-related diagnosis,
- Placed or at-risk of placement in a congregate care setting,
- At-risk of placement disruption due to behaviors requiring a higher level of supervision,
- Identified as a potential victim of trafficking,
- Criminal justice involvement,
- Co-occurring developmental disability, and
- At-risk of being removed from their home by the Department of Child Safety (DCS) due to behavioral concerns. Or

As a result of the diagnosed behavioral health condition, there is evidence that the member has moderate functional impairment as indicated by the CALOCUS/ECSII score and/or other clinical indicators. This moderate functional and/or psychosocial impairment per the behavioral health assessment and ISP, reviewed and signed by a BHP: (Must Meet All)

- Has not improved or cannot be reasonably expected to improve in response to a less intensive level of care, or
- Could improve appropriate community-based treatment, but treatment is not available,

therefore warranting a more intensive level of care.
- Does not require or meet clinical criteria for a higher level of care.

Criteria for Discharge

- The member demonstrates sufficient symptom or behavior relief as evidenced by completion of the TFC treatment goals,
- The member's functional capacity is improved, at minimum, as evidence by an improved CALOCUS/ECSII score and/or other clinical indicators of improved functioning,
- The member's functional capacity is improved, and the member can be safely cared for in a less restrictive level of care, as identified by the CFT,
- The CFT has identified that appropriate services, providers, and support 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 the member's clinical outcome,
- There is potential risk that continued stay in TFC may precipitate regression or decompensation of the member's condition, or
- A current assessment of the member's symptoms, behaviors, and treatment needs by the CFT has established that continued care in TFC is no longer adequate to provide for the member's safety and treatment and therefore a higher level of care is necessary.

Prior and Continued Authorization Request for Adult Therapeutic Homes Process, Requirements and Criteria (ABHTH)

Prior to admission submit all the following:

- Blue Cross Blue Shield of Arizona Health Choice Behavioral Health BHIF, BHRF, TFC, SUD-BHRF Prior Authorization and Continued Stay Request form.
- Current Child and Adolescent Level of Care Utilization System (CALOCUS) reflecting current clinical presentation, or Early Childhood Level of Care Utilization System (ECSII) to demonstrate sufficient medical necessity for admission (Child Only).
- ASAM for members with substance abuse or co-occurring disorder.
- Current Psychiatric/Psychosocial Evaluation
- Current Treatment Plan indicating level of care being requested.
- Most recent CFT/ART indicating need for service

All authorization requests must have an identified Licensed Attending/Treating Practitioner indicated on the request with a valid fax number. The request should be faxed to (480)-760-4732.

The number of days authorized are based on medical necessity, diagnosis, condition, and projected discharge. Authorizations are valid (ABHTH) for up to 90 days. If admission is not secure, a new request must be submitted.

All ABTH providers shall ensure appropriate notification is sent to Primary Care

Provider (PCP) and Behavioral Health Provider/Agency/TRBHA/Tribal ALTCS program upon intake to and discharge from the ABHTH.

- If a member is not enrolled with an outpatient provider, the ABHTH team must initiate a request to enroll the member with an outpatient agency chosen by the member or by zip code.

ABHTH Continued Stay Requirements

Submit all the following seven days prior to the last authorized day:

Monthly treatment summaries

- Copies of Monthly CFT meetings
- Progress, nursing, and BHP/BHMP notes
- Current medication list
- Psychiatric Evaluation, testing, or other evaluation documentation
- Updated Treatment Plan with
- Discharge plan
- Monthly updates

The number of days authorized are based on medical necessity, diagnosis, condition, and projected discharge, up to 90 days.

Expected Treatment Outcomes

- 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 members individualized physical, behavioral, and developmentally appropriate needs.
- 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 members' 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 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

Adult Behavioral Health Therapeutic Homes (ABHTH) Treatment Planning

The ABHTH Treatment Plan shall be developed by the CHI in collaboration with the ABHTH Provider and the ART within the first 30 days of placement:

- The Treatment Plan shall:
  - Describe strategies to address ABHTH Provider needs and successful transition for the member to begin service with ABHTH Provider, including pre-service visits when appropriate,
  - Compliment and not conflict with the ART Service Plan and other defined treatments, and shall also include reference to the members:
    - Current physical, emotional, behavioral health and developmental needs,
    - Current educational placement and needs,
    - Current medical treatment,
    - Current behavioral health treatment through other Providers, and
    - Current prescribed medications.
  - Address safety, social, and emotional well-being, discharge criteria, acknowledgement of member's permanency objectives and post-discharge services,
  - Include short-term, proactive treatment goals that are measurable, time-limited, and in keeping with the ART Service Plan,
  - Clearly identify responsible individuals from treatment team to implement each aspect of the ABHTH Treatment Plan and the timing of completion. The CHI has the responsibility to ensure the treatment team is implementing the ABHTH Treatment Plan,
  - Include specific elements that build on the members' strengths while also promoting pro-social, adaptive behaviors, interpersonal skills and relationships, community, family and cultural connections, self-care, daily living skills, and educational achievement,
  - Include specifics to coordinate with natural supports and informal networks as a part of treatment,
  - Include plans for engagement of the member's family of choice and other natural supports that can support the member during ABHTH placement and after transition,
  - Be reviewed by the ABHTH Provider and CHI at every home visit,
  - Be reviewed by the CHI Clinical Supervisor at each staffing,
  - Be revised as appropriate or
  - Include documentation of the ABHTH Treatment Plan which shall be kept by the ABHTH Provider and CHI. quarterly at minimum, and
- Providers shall ensure that members/Health Care Decision Maker and designated representatives receive a copy of the treatment plan and any updated treatment plans.

<u>Adult Behavioral Health Therapeutic Home Discharge Planning</u>

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:

- Clinical status for discharge.

- Follow-up treatment, crisis, and safety plan.
- Coordination of care and transition planning are in process when appropriate.

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.
- The member can participate in needed monitoring and follow-up services, or a Provider is available to provide monitoring at 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 an ABHTH would improve a member's clinical outcome.
- There is potential risk that continued stay in an ABHTH may precipitate regression or decompensation of member's condition.

Electroconvulsive Therapy (ECT)

Submit Blue Cross Blue Shield of Arizona Health Choice Medical Services and Behavioral Health Prior Authorization Form with supporting clinical documents supporting the medical necessity to fax (1-877-422-8120). Required supporting documentation includes but not limited to:

- Consent Form or statement
- ECT consultation documentation
- Medication list of current and previously tried medications
- Supporting Documentation

Transcranial Magnetic Therapy (TMS)

Submit **Blue Cross Blue Shield of Arizona Health Choice Medical Services and Behavioral Health Prior Authorization Form** with supporting clinical documents supporting the medical necessity to fax (1-877-422-8120). Required supporting documentation includes but not limited to:

- Consent Form or statement
- TMS consultation documentation
- Medication list of current and previously tried medications
- Supporting Documentation including previous psychotherapy attempted

Additional Information

- All request forms are available on our website. Visit our **request forms** page.
- All requests must be fully completed with all supporting documentation.
- Authorization is not a guarantee of payment. The member must be eligible at the time the service was rendered.
- Discharge Planning begins within 24 hours of admission to a residential or inpatient facility. Please follow AHCCCS AMPM, Chapter 1000, and Section 1020 (Discharge Planning). This includes a follow-up appointment with a PCP or specialist within 7 days,

safe placement with community support, prescription medications, and medical equipment if needed.

- Providers can call after-hours for assistance at (877) 923-1400.

Medical Necessity Criteria

We apply objective and evidenced-based national, and state-recognized medical necessity criteria applied explicitly to the request included but not limited to InterQual Guidelines, AHCCCS approved Health Choice criteria and ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-occurring Conditions, 3rd addition. All requests consider individual member circumstances and the local delivery system when making medical necessity determinations.

We also adopt clinical practice guidelines (CPGs) that are based on valid and reliable clinical evidence or consensus of providers in a particular field. CPGs consider the needs of our member population, are adopted in consultation with network providers, and are updated annually. CPGs provide a basis for consistent decisions for utilization management, member education, and coverage of services.

To obtain medical necessity criteria or clinical practice guidelines, visit our website page "Clinical Guidelines/Medical Necessity Criteria" or request by calling 1-800-322-8670. (TTY: 711).

Continued Stay When Medically Necessary Services Are Not Available at Discharge

If a person receiving inpatient services no longer requires services on an inpatient basis under the direction of a physician, but services suitable to meet the person's behavioral health needs are not available or the person cannot return to the person's residence because of a risk of harm to self or others, services may continue to be authorized as long as there is an ongoing, active attempt to secure a suitable discharge placement or residence in collaboration with the community or other state agencies as applicable. All such instances shall be logged and provided to AHCCCS upon request.

Institute for Mental Disease (IMD)*:*

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

Members may utilize services provided by an Institute for Mental Disease (IMD). For members aged 21 through 64, Health Plans may reimburse an IMD provider so long as the member does not remain in the IMD for greater than 15 days in a calendar month, and only when the service provided in the IMD meets the requirements for in lieu of services at 42 CFR 438.3(e)(2)(i) through (iii).

We work closely with IMD facilities to ensure members don't exceed 15 inpatient days in a calendar month by the following: notifies the hospital of the number of IMD days, staffs the case with the BH Medical Director if member(s) exceeds 10 days, and assists with transfer to non-IMD facility if required.

6.13 RETROSPECTIVE REVIEWS

Services and corresponding data requiring retrospective review may include but are not limited to the following:

- Services performed during Prior Period of Coverage (PPC)
- Out of state services
- Outlier claims
- Services that were provided in an emergency
- Provider-Preventable Conditions; Healthcare Acquired Conditions

Medical Claim Review staff, in coordination with the Plan Medical Directors, determine medical necessity, quality of care, and the appropriateness of the medical setting. All retrospective reviews are conducted by a qualified nurse and Medical Director who were not involved in the prior authorization process and/or concurrent review process and are independent of any initial review.

We use clinical guidelines including but not limited to InterQual Level of Care Criteria and NCD/LCD as an adjunct for all retrospective reviews. The Medical Claim Review nurse reviews all available and applicable documentation (such as medical records and discharge information), to demonstrate medical necessity and appropriate level of care. Clinical decisions resulting from retrospective reviews are based on the presence of supporting documentation to establish medical necessity.

The Plan does not generally review requests for retrospective authorizations, as these are, by definition, contradictory. It is the responsibility of the Provider or Facility rendering care to verify insurance eligibility, as well as benefit coverage and/or authorization requirements/status and to notify us timely when rendering care/services to our members.

Providers/Facilities have the right to file a Claims Dispute if a claim is denied (see Chapter 15: *Claim Disputes, Member Appeals and Member Grievances*). If the Provider submits a claim which is denied for no PA being obtained, the claim can be grieved along with documentation of medical necessity and a basis for why PA was not obtained.

6.14 PROVIDER-PREVENTABLE CONDITIONS

We review claims in accordance with the AHCCCS AMPM, Chapter 1000 Medical Management, and 42 CFR Section 447.26 which prohibits payment for services related to Provider-Preventable Conditions. A Provider- Preventable Condition means a condition that meets the definition of

a Health Care Acquired Condition (HCAC) or an Other Provider Preventable Condition (OPPC). These terms are defined as:

- **Healthcare Acquired Condition (HAC)** - means a Healthcare Acquired Condition under the Medicare program, except for Deep Vein Thrombosis/Pulmonary Embolism following total knee or hip replacement for pediatric and obstetric patients, which occurs in any inpatient hospital setting and which is not present on admission. (Refer to CMS for a listing of HACs.
- **Other Provider Preventable Condition (OPPC)** - means a condition occurring in the inpatient and outpatient health care setting which AHCCCS has limited to the following:
    - Surgery on the wrong member
    - Wrong surgery on a member and
    - Wrong site surgery

A member's health status may be compromised by hospital conditions and/or medical personnel in ways that are sometimes diagnosed as a "complication." If it is determined the complication resulted from a Health Care Acquired Condition (HCAC) or Other Provider Preventable Condition (OPP), any additional hospital days or other additional charges resulting from the HCAC or OPPC will not be reimbursed.

If it is determined the HAC or OPPC was a result of mistake or error by a hospital or medical professional, Blue Cross Blue Shield of Arizona Health Choice conducts a quality-of-care investigation and reports the occurrence and results of the investigation to the AHCCCS Clinical Quality Management Unit.

6.15 PROVIDER PORTAL

The Provider Portal: https://www.azblue.com/medicaid/providers/provider-portal, listed under "For Providers" link drop-down) of our website allows Providers/Offices who register for secure log-in have access to helpful features, such as:

- Checking member eligibility
    - Dental and Vision history
- Checking claims status
    - Claim reconsideration request and dispute/appeal submission
- Checking Prior Authorization Status
    - Submit Medical and Pharmacy prior authorization request
    - Submit Dental and Dental Specialty Referral prior authorization request
- Manage Provider Demographics

6.16 HOSPITAL SERVICES: INPATIENT AND OUTPATIENT SERVICES

All non-emergency hospital admissions, including Acute, Observation, Rehabilitation, Skilled Nursing, and Hospice require prior authorization.

All facilities must notify us and obtain authorization prior to or at the time of ALL admissions.

In the event acute hospitalization is required to evaluate and stabilize an Emergency Medical Condition, we **must be notified of the admission within one (1) calendar** day of emergent member presentation by faxing to the Inpatient Notification Fax Number: (480) 760-4732.

NOTE: For pre-planned, medically reviewed and/or prior-authorized admissions, the facility must notify us via fax at the time of admission to activate the authorization number **when the member presents for admission to the facility**. Inpatient Notification Fax Number: (480)760-4732. Failure to submit a timely manner will result in an administrative denial.

We will request medical information and/or records to assist in deciding the appropriateness of the admission and level of care based on the clinical criteria. If the information is not received within a 24-hour period, the request will be administratively denied for lack of medical information. For concurrent reviews, the request will be made twice over a 48-hour period. If the information is not received within that timeframe, the continued stay will be administratively denied for lack of medical information. All hospital outpatient services listed on the prior authorization grid require a prior authorization.

NOTE: All Outpatient Procedures must be performed at an in-network Ambulatory Surgical Center (ASC). Claims from locations other than an ASC will not be paid without authorization. We will consider Prior Authorization requests for "medical necessity exceptions" where the provider believes a case must be performed in the hospital outpatient setting.

Blue Cross Blue Shield of Arizona Health Choice needs the following information to efficiently process an admission notification:

- Member Name
- Date of Birth
- Member ID
- Diagnosis
- Day and Time Admitted
- Medical Record Number
- Facility, including TIN or NPI
- Fax Number for Facility
- Admit type (e.g., Inpatient, Observation, Maternity, Behavioral Health)
- Face Sheet, if available.

We appreciate your continued commitment to ensuring the provision of effective and efficient care for our members.

6.17 PSYCHIATRIC INPATIENT HOSPITALIZATION

How to request an authorization for Psychiatric and sub-acute hospitalization.

- Psychiatric and sub-acute facilities are required to submit **Blue Cross Blue Shield of Arizona Health Choice Prior Authorization and Continued Stay Request Form** for Psychiatric Hospitals within one business day of admission. For request forms, visit our

website **request forms** page.
- All requests should be faxed to (480) 760-4732.

Documentation for initial review:
- Demographic Face Sheet
- Eligibility verification
- Initial Assessment
- CIWA, other withdrawal assessments
- Most recent vital signs
- ASAM if Applicable
- Certificate of Need (CON) within 72 hours of admission

Initials reviews are completed by Medical Management within one business day of notification (this does not apply to precertification) [42 C.F.R. 456.125].

Blue Cross Blue Shield of Arizona Health Choice utilizes InterQual criteria to determine medical necessity. The number of days authorized are based on medical necessity, diagnosis, condition, and projected discharge. The facility is responsible for submitting updated clinical information on the last authorized day.

Documentation for Concurrent review:
- Blue Cross Blue Shield of Arizona Health Choice PA and Continued Stay Request Form for Psychiatric Hospitals
- Clinical notes supporting medical necessity
- Physician notes within the last 48 hours
- Updated Treatment Plan including
  - Member's presenting issue
  - Behavioral and physical health services to be provided
  - Documented efforts to engage the member in treatment planning
  - Post discharge needs
  - Member/parent/guardian signature and date signed.
  - If a discharge date has been determined, post discharge needs
- MAR (Including PRNs within the last 48 hours)
- Labs
- Social Services/Discharge Planning Notes
- CIWA, or other withdrawal assessments
- Vital signs within the last 24 hours
- ASAM if applicable
- Recertification of need if applicable
- Continued stay reviews are completed by a Medical Management Specialist. Hospital UR staff are notified of the next review date.
- Blue Cross Blue Shield of Arizona Health Choice takes into consideration the following for medical necessity review determination, but is not limited to:

- Hospital records include, but not limited to history of presenting problem, diagnostic tests, psychiatric prescriber evaluations, psychosocial history, medication records, treatment plans, and progress notes.
- Quality of care
- Length of stay
- Whether services meet the members' needs
- Discharge needs
- Utilization patterns analysis

Reviews not meeting medical necessity are referred to BCBSAZ Behavioral Health Medical Director for secondary review.

Inpatient Care Coordination and Discharge Planning Requirements

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.

The contracted hospital shall develop and implement a discharge planning process that ensures members receiving inpatient services have proactive discharge planning to identify and assess the post-discharge bio-psychosocial and medical needs of the member to arrange necessary services and resources for appropriate and timely discharge from a facility.

Discharge Planning begins within 24 hours of admission.

- If the member is not currently enrolled with an outpatient provider, the inpatient facility should ensure the member is enrolled with a provider within the member's zip code or one chosen by the member.
- Contracted inpatient facilities are required to coordinate discharge planning with the members outpatient provider throughout the member stay. Blue Cross Blue Shield of Arizona Health Choice provides the hospital with an assessment of post-recharge needs throughout the hospital stay.
- Discharge planning shall be performed by a qualified healthcare professional and 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.
  - Coordination of care and discharge planning with outpatient providers, PCP, and others involved in the member's care.
  - Involve the member/guardian/parent/and others in the discharge planning process.
  - Hospitals shall ensure the member/Health Care Decision Maker (HCDM), Designated Representative (DR), as applicable:
    - Understand the written discharge plan, instructions, and recommendations provided by the facility, and
    - Is provided resources, referrals, and possible interventions to meet the member's assessed and anticipated needs after discharge.

- Hospitals are required to submit prior authorization requests or work with the responsible outpatient provider for services requiring prior authorization.
- Inpatient Psychiatric Hospital and sub-acute detox facilities are required to schedule follow-up appointments with a behavioral health provider (or a PCP and/or specialist serving as a member's behavioral health provider) within seven business days, unless the member is discharged to a facility/institution in which these needs are evaluated by a licensed healthcare professional upon admission.
- Inpatient Psychiatric Hospitals and Sub-Acute Facilities must submit a discharge notification and summary within 1 business day of discharge by fax to (480) 760-4732.
- Authorization is NOT a guarantee of payment for services.

6.18 OBSTETRIC PACKAGE

Please see Chapter 16: *Family Planning, Maternal Health, and Children's Services* for information.

6.19 OUTPATIENT LABORATORY SERVICES

The Blue Cross Blue Shield of Arizona Health Choice Provider Network includes both LabCorp and Sonora Quest Laboratories to provide a full array of laboratory services, including reference and specialty. Blue Cross Blue Shield of Arizona Health Choice has specific lab services designated on the POLT (Provider Office Laboratory Testing) list for providers to perform in their office.

Please refer to the prior authorization grid regarding laboratory services that require prior authorization. Note: All genetic testing requires Prior Authorization.
https://www.azblue.com/medicaid/providers/pa-guidelines

In our ongoing efforts to ensure the provision of quality care and services for our members and to ensure that appropriate services are being rendered to our members, we ask that you utilize ONLY contracted In-Network Laboratories.

Please reference below for laboratory services and locations:
- **LabCorp** - www.labcorp.com
- **Sonora Quest Laboratorie**s - www.sonoraquest.com

6.20 OPHTHALMOLOGY AND OPTOMETRY - *Special Coverage Instructions*

AHCCCS covers eye and optometric services provided by qualified eye/optometry professionals within certain limits based on member age and eligibility.

Vision examinations and the provision of prescriptive lenses are only covered for members under the Early and Periodic Screening, Diagnostic and Treatment Program (children under age 21), and for adults when medically necessary following cataract removal.

We contract with Optometry providers statewide including **Nationwide Vision** to provide a full array of Optometry Services, within their scope of practice and as defined by the Arizona State Board of Optometry. Eligible patients can be directed to an in-network provider including Nationwide Vision for initial screening examinations. For adults (>age 21) optometry services are generally not covered, ophthalmological services are only covered for emergency medical eye conditions and cataract extractions.

Nationwide Vision provides the following services:

- Annual screening Diabetic Retinal exams
- All exams/corrective lenses for EPSDT-aged members (members under age 21)
- Dilated fundus examinations
- Visual field testing
- Glaucoma testing
- Evaluation and treatment of conjunctivitis
- Evaluation of cataract
- Allergy and dry eye treatment

Please visit our provider directory at:
https://providerdirectory.healthchoiceaz.com/Provider/ShowProviders/en/hca,
Or Nationwide Vision at: for additional details.**m**

6.21 DURABLE MEDICAL EQUIPMENT, INFUSION / ENTERAL THERAPY AND AUGMENTATIVE AND ALTERNATIVE COMMUNICATION DEVICES (AAC)

Requests for DME are to be sent directly to an in-network DME provider who will coordinate with the requesting provider in obtaining any necessary prior authorization. Medical records documenting the medical necessity of the request must also be provided in addition to a current, signed doctor's order(s)/prescription.

Search in-network DME providers in the Provider Directory:
https://providerdirectory.healthchoiceaz.com/Provider/ShowProviders/en/hca

Augmentative and Alternative Communication Devices (AAC)
Augmentative and Alternative Communication Devices (AAC) and Speech Therapy providers who perform the evaluations for these devices. PCPs will assist members and refer to the appropriate providers who can conduct medically necessary evaluations and supply the devices.

Providers can reference the website for in-network Providers to refer for AAC evaluations and devices for members by visiting: Augmentative And Alternative Communication (AAC) - BCBSAZ Health Choice www.azblue.com/health-choice-az

Aveanna is the contracted service provider for Enteral Therapy services. Requests for Enteral Nutrition and DME (pumps, poles, syringes, bag systems, etc.), are to be directed to Aveanna:

https://www.aveanna.com. Medical records documenting the medical necessity of the request must also be provided in addition to a current, signed provider order(s)/prescription. Aveanna will process the request and forward it to us. We will complete the review for medical necessity. Once approved, we send the approval to Aveanna to coordinate with the requesting provider and/or member as needed to ensure delivery.

Submit the request to Aveanna via fax: 1-844-754-1345.

6.22 ORTHOTICS/PROSTHETICS

We have several contracted orthotics and prosthetic providers in the geographical areas we serve. T he requesting provider submits the request to us on a prior authorization form with the supporting clinical documentation.

6.23 PHARMACY AUTHORIZATIONS

Refer to Chapter 17: *Pharmacy and Drug Formulary*. You may also refer to the AHCCCS Medical Policy Manual Chapter 300, Policy 310-V.

6.24 IMPORTANT NOTICE TO ALL HEALTH CHOICE PROVIDERS

Participating providers must hold the Member, Blue Cross Blue Shield of Arizona Health Choice, and AHCCCS harmless as set forth in the Provider Participation Agreement if coverage is denied for failure to adhere to our prior authorization and notification guidelines as outlined in this chapter.

6.25 PRE-ADMISSION SCREENING AND RESIDENT REVIEW (PASRR)

The PASRR screening consists of a two-stage identification and evaluation process and is conducted to assure appropriate placement and treatment for those identified with Mental Illness (MI) and/or Intellectual Disability (ID) prior to initial admission of individuals to a nursing facility (NF) bed that is Medicaid certified or dually certified for Medicaid/Medicare (42 CFR 483.100-483.138, 42 CFR 438.112).

- PASRR Level I screenings are used to determine whether the person has any diagnosis or other presenting evidence that suggests the potential presence of mental illness and/or Intellectual Disability.
- PASRR Level II evaluations are used to confirm whether the person indeed has MI and/or ID. If the person is determined to have MI and/or ID, this stage of the evaluation process determines whether the person requires the level of services in a NF and/or specialized services (inpatient/hospital psychiatric treatment).

Medicaid certified nursing facilities (NFs) must provide PASRR Level I screening, or verify that screening has been conducted, to identify MI and/or ID prior to initial admission of persons to a nursing facility bed that is Medicaid certified or dually certified for Medicaid/Medicare.

Refer also to the AHCCCS Medical Policy Manual (AMPM) 680-C and applicable attachments.

PASRR LEVEL 1 Screening

PASRR Level I screenings can be performed by the following professionals:

- Arizona Long Term Care System (ALTCS) Pre-Admission Screening (PAS) assessors, or case managers
- Hospital discharge planners
- Nurses
- Social workers
- Other NF staff that have been trained to conduct the Level I PASRR screening and make Level II PASRR referrals

ALTCS PAS assessors or case managers may conduct Level I PASRR screenings, but it is the responsibility of the facility where the member is located to ensure that the Level I and Level II PASRR is completed prior to the member being admitted into the receiving NF. The PASRR Level I must be completed by medical professionals such as hospital discharge planners, nurses, or social workers.

A PASRR Level I screening is not required for readmission of persons who were hospitalized and are returning to the NF, or for inter-facility transfers from another NF, if there has not been a significant change in their mental condition. The PASRR Level I screening form and PASRR Level II evaluation must accompany the readmitted or transferred person.

A PASRR Level I screening is not required if a person is being admitted to a NF for a convalescent period, or respite care, not to exceed 30 days. If later it is determined that the admission will last longer than 30 days, a new PASRR Level I screening is required. The PASRR Level II evaluation must be done within 40 calendar days of the admission date.

Review

Upon completion of a PASRR Level I screening, documents are forwarded to the AHCCCS PASRR Coordinator for a Level II evaluation of MI at PASRRProgram@azahcccs.gov. The DES PASRR Coordinator shall be contacted for Level II PASRRs of ID.

The outcome of the Level II PASRR will determine if action is to be taken by the NF. If the individual requires NF services, he/she may be admitted. All ALTCS enrolled members are appropriate for a nursing level of care as determined by the ALTCS Pre-Admission Screening (PAS) tool for medical eligibility. If a member is admitted and is determined to need specialized services, the NF should contact the member's case manager to arrange for the required services. If the outcome of the Level II PASRR determines whether the individual does not require NF services or specialized services, no admission shall take place.

Determinations may be conveyed verbally to nursing facilities and to the individual and must be confirmed in writing.

The need for specialized services for individuals with an ID as specified by DES will result in the implementation of an individualized treatment plan that:

- Allows the acquisition of skills necessary for the ALTCS individual to function as independently as possible, and
- Prevents or decreases regression or loss of the ALTCS individual's current optimal level of functioning

The need for specialized services for individuals with a MI as the result of a Level II PASRR evaluation will result in the implementation of an individualized treatment plan that:

- Is developed and supervised by an interdisciplinary team composed of a physician, qualified behavioral health professionals, and other professionals
- Prescribes specific therapies and services for the treatment of ALTCS individuals experiencing an acute episode of mental illness which requires intervention by trained behavioral health personnel
- Reduces the individual's behavioral symptoms and improves the individual's level of functioning

If the individual's mental health condition changes, or new medical records become available that indicate the need for a Level II PASRR, a new Level I screening must be completed as soon as possible and a referral made.

Any individual can request a hearing when he or she believes the State has made an erroneous determination regarding the preadmission and annual resident review requirements of section 1919(e)(7) of the Act. The AHCCCS rules for the administrative dispute resolution process are delineated in A.A.C. Title 9, Chapter 34.

PASRR LEVEL II Evaluations for Mental Illness

When Health Choice receives a PASRR Level II request from AHCCCS, the Plan will determine which health home should be assigned based on where the member is currently located, not where the member may be enrolled.

- The PASRR Level II for individuals with MI must be completed within 5 business days of the referral.

The PASRR Level II evaluation report must include the components of the PASRR level II Form (**Level II PASRR Psychiatric Evaluation**) and the **Pre-Admission Screening and Resident Review (PASRR) Invoice**.

- *Preexisting data.* Evaluators may use relevant evaluative data, obtained prior to initiation of preadmission screening or annual resident review, if the data are considered valid and accurate and reflect the current functional status of the individual. However, in the case of individualized evaluations, to supplement and verify the currency and accuracy of existing data, the State's PASRR program may need to gather additional information necessary to assess proper placement and treatment. (42 CFR 483.128)
- Personnel requirements (Per 42 CFR 483.134).

- A Behavioral Health Medical Practitioner completes the PASRR psychiatric evaluation
- If the history and physical examination are not performed by a physician, then a physician must review and concur with the conclusions.

Cease Process and Documentation

If at any time in the PASRR process it is determined that the person does not have a MI or ID, or has a principal/primary diagnosis identified as an exemption in the Level I screening (primary diagnosis of dementia including Alzheimer's Disease or a related disorder or a non-primary diagnosis of dementia without a primary diagnosis that is a serious mental illness, and does not have a diagnosis of ID or a related condition), the evaluator must cease the PASRR process of screening and evaluation and document such activity.

Appeal and Notice Process Specific to PASRR Evaluations

Appeals shall be processed, consistent with the requirements in **Title XIX/XXI Notice and Appeal Requirements, under Chapter 15.4.1**) or the appeal process for members determined to have a SMI described in **SMI and Non-SMI/Non-Title XIX/XXI, above under 15.4.2**

For individuals who have a Serious Mental Illness (SMI) designation, appeals shall be processed in accordance with A.A.C. R9-21-401 and ACOM Policy 444 (Contractors).

6.26 DENTAL AUTHORIZATIONS AND NOTIFICATIONS

See Provider Manual Chapter 20: *Oral Health Services.*

6.27 AFFIRMATIVE STATEMENT REGARDING INCENTIVES

Affirmative Statement regarding Incentives

We affirm:

- UM decisions are made based solely on appropriateness of care and service and existence of coverage.
- We do not specifically reward its peer clinical reviewers or clinical review staff for issuing denials of coverage or services.
- Financial incentives for UM decision makers do not encourage decisions that result in underutilization.