Medical Management/Utilization Management Requirements

Securing Services and Prior Authorization/Retrospective Authorization

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

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

Prior authorization processes are used to promote appropriate utilization of behavioral health services while effectively managing associated costs. Except during an emergency situation, AHCCCS requires prior authorization before accessing inpatient services in a licensed inpatient facility and for accessing medications reflected as requiring prior authorization on the AHCCCS Minimum Required Prescription Drug List. In addition to the prior authorization of inpatient services, the Health Plan also requires prior authorization for certain other covered behavioral health services. For members with dual coverage (Medicare and AHCCCS) the Medicare plan is the primary payer for all services covered under the Medicare benefit. If the service is not covered under the Medicare plan, the AHCCCS Health Plan would be the primary payer for services covered by AHCCCS.

BUHP Evidence-Based Care Guidelines

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

Prior authorization procedures for providers contracted by the Health Plan

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

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

Electroconvulsive Therapy (includes necessary monitoring)	

Prior Authorization Decisions

The Health Plan has staff available 24 hours a day, seven days a week to receive requests for any service that requires prior authorization. The Health Plan utilizes MCG evidence-based guidelines and Arizona-licensed staff with appropriate training to apply the Health Plan prior authorization criteria and make prior authorization decisions. The Health Plan will request additional information from the requesting provider, as needed, to make a determination. A decision to deny for medical necessity must be made by the Health Plan physician.

Securing services that do not require prior authorization

The ART/CFT is responsible for identifying and securing the service needs of each member through the assessment and Service Planning/Complete Care planning processes. The ART/CFT should focus on identifying the underlying needs of the member, including the type, intensity and frequency of supports needed.

As part of the Service Planning/Complete Care Planning process, it is the ART/CFT's responsibility to identify available resources and the most appropriate provider(s) for services. This is done in conjunction with the member, family, natural supports, and others who comprise the ART/CFT. If the service is available through a contracted provider, the member can access the service directly. If the requested service is only available through a non-contracted provider or if the ART/CFT requests services from a non-contracted provider, the provider must submit a Behavioral Health Prior Authorization for consideration.

Emergency Services

Prior authorization for inpatient services must never be applied in an emergency. If upon review of the circumstances, the behavioral health service did not meet admission authorization criteria, payment for the service may be denied. The test for appropriateness of the request for emergency services must be whether a prudent lay member, similarly situated, would have requested such services.

23 Hour Observation/Care Transitions/Discharge Planning

Email to BUHPCareMgmtBHMailbox@bannerhealth.com.

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

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

1. Member Name
2. AHCCCS Identification Number
3. Date of Birth
4. Date of Admission
5. Diagnosis and Reason for Admission
6. Disposition, if applicable

Level of Care/ Code	Fax Number	Documentation to Submit	Time of Submission
Level 1 Psychiatric Hospital Admission (excluding BHIF/RTC)	**520-874-3420 (Banner UM)**	**For Admission Notification: All** of the following information is required for all inpatient **notifications/requests:** 1) Admission Face Sheet, which includes the following: a) Member's name and member's identification number, and b) Member's date of birth, and c) Admission date, and d) National Provider Identifications (NPI) of Facility, and e) Attending physician name and admitting hospital name, and f) Admitting diagnosis and ICD 10 Code, and g) Level of care admitted to, and h) Contact name and phone number/e-mail of in-patient Utilization Reviewer, and i) Other insurance. 2) Certificate of Need (CON)Certification of Need (CON) Clinical documentation submitted **prior** to the submittal of Notification of admission will not be saved and considered for the medical necessity review.	Within 72 hours of admission
Level 1 Psychiatric Hospital Initial Authorization	**520-874-3411 (BH UM)**	1) Attending/Psychiatrist admitting evaluation. Initial evaluation is to include: a) Admitting diagnosis b) Differential diagnosis, or possible impact of medical conditions/symptoms	Within 24 hours of request from UM Reviewer

		(e.g. UTI, Dehydration) c) Mental status examination d) ELOS (estimated length of stay) e) Proposed treatment plan (titration of meds, initiating injectable, etc.), f) Proposed discharge plan (BHRF, med boxes, etc.) g) Discharge criteria. h) Justification for current level of care and why member is not able to be discharged to lower level of care. 2) History and Physical 3) Admission/Intake Assessment 4) Medication Administration Record 5) CIWA/CINA/COWS protocols, as applicable	
Emergent BHIF Admission	**520-694-0599** **(Banner BH PA)**	1) Behavioral Health Prior Authorization Form, 2) Certificate of Need (CON), 3) Request for Out of Home Application, and 4) Out of Home Admission Notification Form	Within 2 business days of admission
Non-Emergent Admission for BHIF	**520-694-0599** **(Banner BH PA)**	**Prior to Admission:** Submit **all** of the following: 1) Behavioral Health Prior Authorization Form, 2) Updated Service Plan/Complete Care Plan, 3) Recent psychiatric progress notes, 4) Out of Home Application, 5) The most recent assessment, or an assessment updated within the past year, 6) Child and Family Team note indicating team recommendation, 7) Other reports from outpatient providers,	Prior to Admission to BHIF

		8) Any psychological reports or other relevant reports from specialty provider, and 9) **Submit a CON within 72 hours of admission.** If approved, the authorization is valid up to 45 days only. Submit additional clinical documentation if the member does not admit within 45 days of approval.	
Non-Emergent Admission for Behavioral Health Residential Facility (H0018)	**520-694-0599 (Banner BH PA)**	1) Behavioral Health Prior Authorization Form, and 2) Out of Home Application with supporting clinical documentation 3) If Substance abuse- ASAM and/or related clinical documentation If approved, authorization is valid up to 45 days only. Submit additional clinical documentation if the member does not admit within 45 days of approval.	Submit Up to 45 days Prior to Admission
Emergent Admission For Behavioral Health Residential Facility (H0018)	**520-694-0599 (Banner BH PA)**	1) Behavioral Health Prior Authorization Form, 2) Out of Home Admission Notification Form, and 3) Out of Home Application Form If member requires a continued stay, the out of home provider **must submit a Concurrent Review Form by the last covered day.**	Submit within 2 days
Non-emergent Admission to HCTC (TFC) (S5109-HB, ages 18-64) (S5109-HC, over 65) (S5109-HA, age 0-17)	**520-694-0599 (Banner BH PA)**	1) Behavioral Health Prior Authorization Form, and 2) Out of Home Application Form with supporting clinical documentation	Up to 45 days Prior to Admission (If approved, the authorization is valid up to 45 days only)
Emergent Admission to HCTC (TFC) (S5109-HB, ages 18-64) (S5109-HC, over 65) (S5109-HA, age 0-17)	**520-694-0599 (Banner BH PA)**	Submit **all** of the following within 2 days: 1) Behavioral Health Prior Authorization Form, 2) Out of Home Admission Notification Form, and 3) Out of Home Application Form	Within 2 days of admission

		If member requires a continued stay, the out of home provider must **submit a Concurrent Review Form by the last covered day.**	
Concurrent Review Requirements for Inpatient, BHIF, BHRF, HCTC	**Fax Number**	**Documentation to Submit**	**Time of Submission**
Inpatient Concurrent Review	**520-874-3411 or Banner Behavioral Health UM Reviewer will contact facility and provide e mail address. Facility must send documentation securely to UM reviewer e mail address when requested.**	Submit **all** of the following clinical documentation to support medical necessity: 1) A. Attending Behavioral Health Medical Practitioner (BHMP) notes for each day of hospitalization and subacute detox level of care. B. For subacute facilities not providing detox, BHMP notes must be provided at a minimum for 5 days (M-F) out of the week 2) Estimated length of stay 3) Medication Administration Record (MARS) 4) CIWA/CINA/COWS protocols as applicable 5) All physician orders 6) RN notes 7) Lab results, if indicated 8) Discharge plan/barriers, including updates every 24 hours if barriers are resulting in avoidable days.	Submit clinical documentation prior to noon on the last covered day (LCD) of the current authorization; delayed submittals may result in a denial.
Behavioral Health Inpatient Facility Concurrent Review	**520-874-3411 or Banner Behavioral Health UM Reviewer will contact facility and provide e mail address. Facility must send documentation securely to UM reviewer e mail address when requested.**	Submit **all** of the following clinical documentation to support medical necessity: 1) Psychiatric notes, 2) Concurrent Review Form, 3) CFT notes, 4) Medication Administration Record (MARS), 5) Discharge plan, and 6) After 30 days, submit a Recertification of Need (RON)	Submit clinical documentation prior to noon on the last covered day (LCD) of the current authorization; RON Submitted every 30 days.

Behavioral Health Residential Facility (BHRF) Concurrent Review	**520-874-3411 or Banner Behavioral Health UM Reviewer will contact facility and provide e mail address. Facility must send documentation securely to UM reviewer e mail address when requested.**	1) Out of Home Concurrent Review Form 2) CFT/ART notes 3) Medication and psychiatric progress notes, if applicable 4) Revised Service Plan/Complete Care Plan (as applicable)- The revised Service Plan/Complete Care Plan should include revisions to address identified barriers	Within 14 calendar days of the last covered day
HCTC (Therapeutic Foster Care) Non-Emergent Concurrent Review	**520-874-3411 or Banner Behavioral Health UM Reviewer will contact facility and provide e mail address. Facility must send documentation securely to UM reviewer e mail address when requested.**	1) Out of Home Concurrent Review Form 2) CFT/ART notes 3) Medication and psychiatric progress notes	Within 14 calendar days of the last covered day
HCTC (TFC) Emergent Concurrent Review	**520-874-3411 or Banner Behavioral Health UM Reviewer will contact facility and provide e mail address. Facility must send documentation securely to UM reviewer e mail address when requested.**	1) Out of Home Concurrent Review Form	Submit by noon of the last covered day.
Other Out Patient Services/ Codes	**Fax Number**	**Documentation to Submit**	**Time of Submission**
Electroconvulsive Therapy (90870)	**520-694-0599 (Banner BH PA)**	1) Behavioral Health Prior Authorization Form, and 2) Supporting clinical documentation	Prior to initiation of services
Out of Network Provider (varied)	**520-594-0599 (Banner BH PA)**	Behavioral Health Prior Authorization Form	Prior to initiation of services.
Transportation-Ground 100+ mileage (A0425)	**520-594-0599 (Banner BH PA)**	Behavioral Health Prior Authorization Form	Prior to initiation of services.
23 Hour Crisis Observation	**BUHPCareMgmtBHMailbox@bannerhealth.com**	1) Member name 2) AHCCCS ID 3) Date of Birth 4) Diagnosis/Reason for admission 5) Date of Admission 6) Disposition, if applicable	Per the BUHP template.
Psychotropic Medication (varied)	**866-349-0338**	Submit the following: Pharmacy Prior Authorization Form	Prior to dispensing

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

https://www.banneruhp.com/-/media/files/project/uahp/provider-manuals/buhp_comprehensive-provider-manual_jan2019.ashx?la=en&hash=168A67D69AAB0216C1B548421D2645206230FC11

Hospital/Inpatient Level of Care

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

Notification of Inpatient Admission

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

- By fax: 520-874-3420
- Notifications can be faxed 24 hours a day, 7 days a week.
- The following information is required for all inpatient notification requests:
  - Member's name
  - Member's identification number
  - Member's date of birth
  - Admission date
  - National Provider Identification (NPI) of Facility
  - Attending physician name and Admitting hospital name
  - Admitting diagnosis/ICD 10 Code
  - Level of care admitted to
  - Contact name and phone number/e mail of in-patient Utilization Reviewer
  - Other Insurance, and
  - Certification of Need (CON) For Medicaid (BUFC) members
- Please note, clinical information submitted ***prior*** to the notification or prior to the Health Plan issuing an authorization will not be acknowledged. Facilities must send the clinical documentation upon request of the Utilization Management (UM) reviewer.

Certification of Need (CON)

A CON is a certification made by a physician that inpatient services are or were needed at the time of the member's admission. Although a CON must be submitted prior to a member's admission (except in an emergency), a CON is **not** an authorization tool designed to approve or deny an inpatient service. It is a federally required attestation by a physician that inpatient services are or were needed at the time of the member's admission. The decision to authorize a service

that requires prior authorization is determined through the application of admission and continued stay authorization criteria **(See Behavioral Health Provider Manual Supplement Certificate of Need.)**

The following documentation is needed on a CON:

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

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

In the event of an emergency, the CON must be submitted:

- For members age 21 or older, within 72 hours of admission; and
- For members age 18-20, within 14 days of admission.

(When a member has exhausted their Medicare inpatient lifetime limit of 190 days in a psychiatric facility, a CON must be submitted to initiate the member's Medicaid benefit.)

Additional CON requirements

If a member becomes eligible for Title XIX or Title XXI services while receiving inpatient services, upon request, the CON must be completed and submitted to the Health Plan's Medical Management Department via fax: 520-874-3420 prior to the authorization of payment. Federal rules set forth additional requirements for completing CONs when members age 18-20 are admitted to a Behavioral Health Inpatient Facility and are receiving services.

These requirements include the following:

- For a member who is Title XIX/XXI eligible when admitted, the CON must be completed by the ART/CFT that is independent of the facility and must include a physician who has knowledge of the member's situation and who is competent in the diagnosis and treatment of mental illness.
- For emergency admissions, the CON must be completed by the team responsible for the treatment plan. This team is defined in 42 CFR §441.156 as "an interdisciplinary team of physicians and other personnel who are

employed by, or provide services to patients in the facility"; and for members who are admitted and then become Title XIX or Title XXI eligible while at the facility, the team responsible for the treatment plan must complete the CON. The CON must cover any period for which claims for payment are made.

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

Hospital /Inpatient Admission Criteria

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

1. Acute dangerousness: Member presents with a level of risk related to harm towards themselves through suicide, self-injury, irritability or mania; or to others through aggression, assaultive, or homicidal behavior. This dimension identifies elements of dangerousness that represent or describe a member's behavior. To evaluate dangerousness, the mental health practitioner is to assess suicidal intent and homicidal intent; including psychosocial stressors.
2. Functional impairment: Member presents a temporary and reversible reduction in ability to function such as performing personal hygiene and bodily care activities, obtaining adequate nutrition, sleep, functioning in the work place or at school, or becoming socially isolated. This dimension addresses the degree to which psychological problems affect the member's functioning, vary from the member's own typical baseline, and contribute to the ability to survive or maintain him/herself in the environment. The assessment of functional impairment must be made each time the member is assessed, to determine whether the member's level of functioning may have changed from the previous baseline level of functioning.
3. Mental status changes or co-occurring conditions: Member presents with disrupted mood, disordered thinking, disorientation, or other mental status changes that need care at the level requested; or there are medical or substance related issues that require care at the level requested.

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

4. Primary diagnosis: A valid diagnosis causing the symptoms that require professional intervention and the intensity of services needed. At least one valid DSM-5 diagnosis/ICD 10 code and the member's condition must be directly attributable to the designated mental disorder and not to an antisocial personality or be a part of a pervasive pattern of antisocial conduct. Professional intervention is considered likely to be effective and is essential to contain risks presented and provide for improvement.

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

Hospital Inpatient Admission Criteria for Eating Disorders

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

Admission Criteria for Eating Disorders requires an objective professional evaluation of the member's current condition indicating a level of severity appropriate to the requested care as evidenced by features for all of the following:

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

2. Supervisory needs, motivation to recover, weight related behaviors and comorbidities are appropriate for inpatient treatment as indicated by all of the following:

   a) Strict staff supervision of meals (may include monitoring of specialized feeding modality, such as nasogastric tube) and bathroom use (direct monitoring in bathroom is necessary.

b) Motivation to recover is very poor to poor (member condition requires involuntary treatment, or if voluntary member, highly structured, inpatient setting is necessary for compliance with care.)
c) Behaviors or clinical findings (e.g. weight gain pattern, food refusal, purging, medication use for weight control) are appropriate for inpatient level of care.

3. Behaviors or clinical findings (e.g. weight gain pattern, food refusal, purging, medication use for weight control) are appropriate for inpatient level of care as indicated by 1 or more of the following:

a) There has been substantial inability to achieve or maintain clinically appropriate weight goals.
b) There has been continued or renewed compensatory weight-loss behavior (e.g., food refusal, self-induced vomiting, or excessive exercise).
c) There has been continued or renewed use of pharmaceuticals with intent to control weight (e.g., laxatives, diuretics, stimulants, cocaine, or over-the-counter weight loss preparations).

4. Treatment services at proposed level of care are indicated due to presence of 1 or more of the following:

a) Specific condition related to admission diagnosis is present that is judged likely to further improve at proposed level of care
b) Specific condition related to admission diagnosis is present and judged likely to deteriorate in absence of treatment at proposed level of care.
c) Member is receiving continuing care (e.g. transition of care from less intensive level of care) and services available at proposed level of care are necessary to meet member needs.

5. Situation and expectations are appropriate for inpatient care as indicated by 1 or more of the following:

a) Member is unwilling to participate voluntarily and requires treatment (e.g. legal commitment) in an involuntary unit.
b) Voluntary treatment at lower level of care is not feasible (e.g. residential care unavailable or unacceptable for member condition)
c) Around the clock medical or nursing care to address symptoms and initiate intervention if required, specific need must be identified.
d) Member management at lower level of care is not feasible or is inappropriate (e.g. less intensive level of care is unavailable or not suitable for member condition or treatment history).

Required Documentation for All Inpatient Admission Initial Authorization

Providers must submit the following clinical information to support the medical necessity for an inpatient admission within 24 hours upon request from the UM Reviewer. Information is to be faxed to 520-874-3411.

1) Attending/Psychiatrist admitting evaluation. Initial evaluation is to include:
    a. Admitting diagnosis
    b. Differential diagnosis, or possible impact of medical conditions/symptoms (UTI, Dehydrated)
    c. Mental status examination
    d. Medication Administration Record (MARS)
    e. CIWA/CINA/COWS protocols, as applicable
    f. ELOS (estimated length of stay)
    g. Proposed treatment plan (titration of meds, initiating injectable, etc.),
    h. Proposed discharge plan (BHRF, med boxes, etc.)
    i. Discharge criteria.
    j. Justification for current level of care and why member is not able to be discharged to lower level of care.
2) History and Physical
3) Admission/Intake

Court Ordered Evaluation/Court Ordered Treatment

Reimbursement of court-ordered screening and evaluation services are the responsibility of the County pursuant to A.R.S § 36-545. In addition, if the county is responsible to pay (as stated in ARS 36-545.04), then per SSA Sec. 1862, paragraph 3, Medicare will not pay if paid for directly or indirectly by a governmental entity. Banner-UFC has no current financial agreements with counties or RBHAs for blended payments for Court Ordered Evaluations.

Banner-UFC will reimburse for court ordered treatment when services are medically necessary. However, for members undergoing Court Ordered Evaluation, medical necessity is not established until the required Psychiatric Evaluations have been completed, since the initial admission of the member is based on statutory processes, rather than a clinical determination. It is the responsibility of the facility to notify the Health Plan when there is a change of payer related to the end of Court Ordered Evaluation. The issue of voluntarily participating in treatment is not, in and of itself, a factor in the determination of medical necessity. Furthermore, the refusal of a Title

XIX/XXI member to accept medication is not, in and of itself, a factor in determining the medical necessity of the service, responding to a prior authorization request, or adjudicating the claim.

Per AHCCCS Contractors Operations Manual Policy 437, the Health Plan reimburses for medically necessary services when the Court Ordered Evaluation ends and when one of the following occur:

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

The Health Plan **must** have legal documentation submitted to evidence one of the three items above has taken place to initiate the authorization of services.

Hospital/Inpatient Concurrent Review

It is always the responsibility of the provider to request authorization for specific days. Failure to request further authorization and timely submittal of clinical documentation will result in an Administrative Denial. If the facility is requesting additional days, clinical documentation is due by noon on the last covered day to the assigned UM Reviewer whether they request it or not. Any additional requests from the UM Reviewer must be submitted within 24 hours or will be considered untimely and subject to an Administrative Denial.

Required Documents for Concurrent Review

Providers must submit the following clinical information to support the medical necessity for concurrent review prior to noon on the last covered. Information is to be faxed to 520-874-3420 or directly to the UM Reviewer per their request. **If the UM Reviewer and the facility agree to send concurrent review documents directly to the UM Reviewer's email, the facility must send these documents securely.**

1. Attending Behavioral Health Medical Practitioner (BHMP) notes for each day of hospitalization and subacute detox level of care, including a specific description of the member's residual symptoms and level of risk/impairment, as well as a detailed plan, specific to the individual member, that describes the medication changes or other treatment interventions that are to be employed to address remaining clinical needs.
2. For sub-acute facilities not providing detox, BHMP notes must be provided at a minimum for Monday through Friday.

3. Estimated length of stay.
4. Medication Administration Record (MARS).
5. CIWA/CINA/COWS protocols, as applicable.
6. All physician orders.
7. Lab results, if clinically indicated.
8. Discharge barriers (including updates every 24 hours if barriers are resulting in avoidable days).

To facilitate effective collaboration, the appropriate and efficient utilization of health care resources, and optimal care management, all inpatient psychiatric providers are required to participate in timely submittal of clinical information to support the concurrent review of the services provided for which reimbursement is sought.

To justify remaining in an inpatient level of care, submission of all required clinical information/documentation must be evident to show that the condition or its symptoms are treatment responsive. The member must ***continue*** to manifest symptoms justifying the principal DSM-5 diagnosis/ICD 10 code, and the following:

1. The intensity of service being delivered should be appropriate to the risk level that justified the admission
2. Documentation of medical necessity throughout the member's hospital stay, including ongoing symptoms and specific responses to medication changes and other therapeutic interventions, including complications arising from initiation of, or change in, medications or other treatment modalities.
3. Need for continued observation
4. Persistence of symptoms such that continued observation or treatment is required
5. Increased risk of complications as a result of intervention or as a product of newly discovered conditions
6. Effective planning for transition to a less restrictive level of care has begun and additional time in treatment days will reduce the probability of a readmission to a more restrictive level of care.

The Health Plan bases concurrent review determinations solely on the medical information obtained by the reviewer at the time of the review determination. Frequency of the reviews are based on the severity or complexity of the member's condition or on necessary treatment and discharge planning activity but will also meet the prescribed review timelines according to MCG criteria. Authorization for hospital stays may have a specified date and time by which requested clinical documents will be submitted for review. This information will be provided to the

requesting provider to ensure coordination and understanding of when additional member condition updates are required.

Psychiatric inpatient admissions now are characterized as acute care hospitalizations, rather than long term hospital stays. The associated expectation is that the care of psychiatric patients who are admitted to these acute care facilities will be managed in a manner that is consistent with short-term hospitalization, including **daily clinical assessments by an attending provider,** accompanied by any clinically appropriate modifications to the patient's treatment regimen and care plan. If a patient is admitted to an inpatient psychiatric unit on a Friday afternoon (typically with only standard admission orders, and at best, perhaps the continuation of outpatient medication orders that have not been effective in treating or controlling the patient's mental health symptoms in the community), but with no follow-up by a psychiatric clinician or assigned treatment team until the following Monday, the stay of that patient inevitably will be prolonged, secondary to this 2-day delay in initiating meaningful care. With a median length of stay of just 4.5 days, the lack of weekend coverage by a psychiatric clinician could potentially extend the patient's hospitalization (which frequently has occurred on an involuntary basis) in a locked and highly restricted environment to 6.5 days or more (with continued decompensation of the patient, even in an inpatient setting, while awaiting the initiation of treatment that presumably cannot be provided at a lower level of care). In addition, the more symptomatic a patient becomes while awaiting additional clinical assessment and treatment, the more difficult (and time-consuming) his/her symptoms ultimately will be to control, potentially requiring an even lengthier period of hospitalization.

Administrative Denials During Inpatient Hospitalization

An Administrative Denial is based on the following:

- Failure of the facility to submit ALL of the required documentation/clinical information to conduct comprehensive utilization review activities to determine medical necessity for admission and/or concurrent review/continued stay within the required time frame **and/or**:
- Failure to provide the services required

Administrative denials are based on the lack of information timely submitted and/or deficiency in provision of services required and not based on medical necessity criteria. As a result, they do not require physician review or involvement in the denial decision. These denials will result in the termination of the authorization where there is a deficiency in documentation/information or services for the entire or remaining length of stay or denial of specified days where required documentation/information or services, for example a BHMP note is not provided during specified days.

After an Administrative Denial has been issued, the facility can submit the claim/request as a Retrospective Review through the Claims Department. However, Retrospective Review cannot be utilized in lieu of good faith participation in the Concurrent Review process. The request for reimbursement through a Retrospective Review must include an explanation as to why the facility was unable to submit timely and comprehensive clinical documentation required to determine medical necessity at the time of admission, concurrent review or the UM reviewers request. The facility must also include information related to the member being admitted on Court Ordered Evaluation and provide legal documentation to support the end of the Court Ordered Evaluation. Requests for Retrospective Reviews that include the days the member was under a Court Ordered Evaluation will be denied as the county is the payer. See Section on Retrospective Reviews.

For concurrent review/continued stay Administrative Denials will be issued in the following situations:

- **For Psychiatric hospitalization and sub-acute detox**: Administrative Denials will be issued when there is lack of documentation/information to demonstrate appropriate BHMP services daily for each day, including weekends and holidays. This includes documentation of a Psychiatric Evaluation and H & P within 24 hours of the member's admission. All Psychiatric hospitals and sub-acute facilities providing detoxification services are required to submit BHMP progress notes for each day.

- **For sub-acute facilities that do not conduct detox**: Administrative Denials will be issued when there is lack of documentation/information to demonstrate BHMP services for any weekday or if a psychiatric assessment has not been conducted within 24 hours of admission. All sub-acute facilities that are providing services that exclude detoxification services must submit BHMP progress notes at a minimum of all weekdays and a psychiatric assessment within 24 hours of admission.

- Administrative Denials of reimbursement for weekend days when no clinical coverage is provided is not intended to be punitive. Such denials rather represent advocacy on behalf of our members with mental health disorders. These members are entitled to receive appropriate care and treatment, on par with the services received by patients on other medical units. They are entitled to remain on locked and highly restricted units for the minimum amount of time necessary to safely and adequately treat their symptoms, and to allow for a transition to a lower level of care.

Hospital Avoidable Days

At times, potentially avoidable delays may occur in discharging members from an acute level of behavioral health care to a less restrictive treatment setting. Such delays typically occur because the less restrictive, community-based treatment and supports that are necessary for a safe and successful discharge are not yet fully arranged or available. Potentially avoidable inpatient days are periods of continued hospitalization on a Level I or subacute behavioral health unit that are authorized by the health plan when medical necessity no longer is demonstrated, but services at a lower level of care are not yet available, despite active, comprehensive, and timely discharge planning efforts by the facility or provider. Potentially avoidable inpatient days will be authorized only when discharge planning activities are documented appropriately by the facility or provider from the time of the member's initial admission, and when evidence of continued, comprehensive discharge planning efforts is submitted daily to the health plan for review, until discharge of the member occurs.

Potentially avoidable inpatient days must be preceded by at least one acute inpatient day (24 hours in duration) that meets medical necessity criteria. Authorization will not be provided for direct admission from an outpatient or residential treatment setting to a more acute level of care for which medical necessity has not been demonstrated, or for which prior authorization has not been obtained. Potentially avoidable inpatient days also will not be authorized solely for convenience, or when appropriate services in an alternative setting are available, but refused or declined by the member, the member's family, or the inpatient treatment team.

When potentially avoidable inpatient days are authorized, the facility or provider must continue to assure that appropriate behavioral health treatment and services are provided to the member until the time of discharge to a lower level of care. Types of potentially avoidable inpatient days include: (1) lack of an available residential treatment bed in a BHRF, BHIF, or HCTC level of care; (2) lack of available specialty services (such as those that are medically necessary for members with an autism spectrum diagnosis, sexually maladaptive behaviors, cognitive limitations, a significant history of aggression toward others, accompanying medical disorders, or other similar conditions), and (3) lack of access to other community-based treatment and supports that are necessary to sustain adequate functioning in the community.

Required Reporting of Avoidable Days

To justify avoidable/administrative bed days the following must be provided to the UM Reviewer during concurrent review. Failure to provide this information may result in an Administrative or Medical Necessity Denial:

- Clinical documentation must support that alternative discharge arrangements available are not adequate to safely meet the needs of the member.
- If a required service is not currently available, the Discharge Plan must clearly state this and identify the steps to be able to access needed services. Entries such as "deferred until patient stabilizes," "to be determined," or "placement pending," are not acceptable.
- Evidence of active attempts to effectuate discharge to a specified placement/level of care or community-based service must be provided and resubmitted/updated and reviewed by staff every 24 hours. If there are insufficient discharge planning activities a denial may be issued.

Hospital/Inpatient Discharge Criteria

The member is ready for discharge when any of the following criteria have been satisfied:

1. The planned course of treatment has been completed.
2. The member's symptom intensity or impairment in functioning no longer requires the level of observation or intensity of service at the requested level of care.
3. Further professional intervention is not expected to result in significant improvement in the member's condition
4. The member leaves against medical advice (AMA). *Please refer to **Section Discharge Planning** in this manual

Hospital Discharge Planning

Discharge planning is expected to begin on the date of admission. If the member is not enrolled with an outpatient behavioral health provider, the inpatient team must initiate a request to enroll the member with an outpatient agency chosen by the member or by zip code. Timely identification and documentation of the member's outpatient behavioral health provider must also include active engagement of such providers in the discharge process. The Health Plan Behavioral Health Department can provide assistance with facilitating urgent enrollment and the referral process by contacting: **BUHPCareMGMTBHMailBox@bannerhealth.com.**

Contracted behavioral health providers must develop and implement a discharge planning process to address the post-discharge clinical and social needs of members upon discharge. The process shall be initiated by a qualified health care professional who is expected to participate in development of the discharge plan and update the plan periodically during the inpatient admission to ensure that continuing care needs have been accurately determined. The following must be included as part of this process:

- Proactive discharge assessment by qualified healthcare professionals identifying and assessing the specific post discharge bio-psychosocial and medical needs of the member prior to discharge. This process shall include the involvement and participation of the member and representative(s), as applicable. The member and representative(s) must be provided with the written discharge plan instructions and recommendations identifying resources, referrals, and possible interventions to meet the member's assessed and anticipated needs after discharge.
- The coordination and management of the care that the member receives following discharge from an acute setting. This must include as applicable:

    - Providing appropriate post discharge community referrals and resources or scheduling follow up appointments with the member's primary care provider and/or other outpatient healthcare providers within 7 days or sooner of discharge.
    - Coordination of care involving effective communication of the member's treatment plan and medical history across the various outpatient providers to ensure that the member receives medically-necessary services that are both timely and safe after discharge. This includes access to nursing services and therapies.
    - Coordination with the member's outpatient clinical team to explore interventions to address the member's needs such as case management, disease management, placement options, intensive community-based services and community supports. This must include a post-acute transition plan to enhance support and intensive community-based services for at least 30 days post discharge or until stabilization.
    - Adherence to all prior authorization requirements before transfer of a member to another Level I inpatient psychiatric facility or to an alternative level of care (including a BHRF).
    - Access to prescribed discharge medications.
    - Coordination of care with the Health Plan including submission of prior authorization, when applicable.
    - Post discharge follow up contact to assess the progress of the discharge.

Requirements for Discharge Plan/Summary

All facilities are required to submit the Discharge Plan/Summary to the Health Plan and the outpatient behavioral health provider within 24 hours of discharge. Discharge Plan/Summary must be submitted to: BUHPUMPAMailbox@bannerhealth.com**.**

At a minimum the Discharge Plan/Summary must contain the following information:

- Date of discharge
- Discharge diagnosis
- Discharge instructions, including follow up services and discharge appointments (required to have an appointment with prescriber or BHMP within 7 days)
- Discharge medications including the following: dosage, instructions and number of days of medications provided if applicable (for hospitals and BHIFs)

Delays in submitting the Discharge Summary to the Health Plan may result in a delay of claims payment. The Health Plan must have accurate documentation to confirm the date of discharge and the discharge information.

Behavioral Health Inpatient Facility (BHIF)

BHIF services provide treatment for children and adolescents who demonstrate severe and persistent psychiatric disorders, when ambulatory care services in the community or services in a less restrictive therapeutic level of care do not meet their treatment needs and they require services under the direction of a Behavioral Health Medical Professional (BHMP). These services are designed for children and adolescents who have a DSM 5/ICD-10 psychiatric diagnosis, significant deficits in functioning, and who require active treatment in a controlled environment with a high degree of psychiatric oversight, 24-hour nursing services, comprehensive programming and treatment. Active treatment focuses on specific targeted goals identified by the Child and Family Team (CFT) and are designed to enable the child/adolescent to be discharged at the earliest possible time. A lack of available outpatient services or services in a less restrictive therapeutic level of care is not, in and of itself, the sole criterion for admission to a BHIF.

Admissions to a BHIF level of care can be either **Emergent or Non-Emergent**. But all admissions must meet medical necessity criteria.

There are two types of BHIFs as follows:
Secure - A BHIF which may employ security guards and/or uses monitoring equipment and alarms
Non-secure – A BHIF that is unlocked, and continuous supervision is provided by professional behavioral health staff.

Admission Criteria for BHIF Level of Care for Emergent/ Non-Emergent Admissions

1) Diagnosis: There is clinical evidence and documentation that the child/adolescent has a primary psychiatric ICD-10/DSM 5 diagnosis that is amenable to active treatment. Any co-occurring diagnosis or diagnoses must be identified and documented prior to admission.

2) Behavior and functioning; Criteria a, b and c below must all be met as follows:

a) Symptoms or functional impairment of the individual's psychiatric condition are of a severe and persistent nature and

b) Result in the member being a Danger to Self (DTS), Danger to Others (DTO) or unable to engage in daily activities safely in a less restrictive setting and

c) All the following in i-iii must be met to ensure appropriate, cost- effective treatment in the least restrictive and most appropriate setting:

i. Ambulatory care resources (outpatient behavioral health services in the community) or services in a less restrictive therapeutic level of care do not meet the treatment needs of the child/adolescent as demonstrated by at least **one** of the following:

- Unsuccessful treatment within the last month in at least one of the following:
  a. Intensive community-based treatment
  b. HCTC services
  c. Behavioral Health Residential Facility
  d. Psychiatric hospital **or,**
- Professional judgement that the youth's clinical needs cannot safely and comprehensively be met in a lower level of care **and,**
- The support system is unable to manage the intensity of child/adolescent symptoms to ensure safety **and,**

ii. The child/adolescent does not require a level of medical or professional supervision that surpasses that which is available at the BHIF

iii. The child/adolescent's Service Plan/Complete Care Plan (as applicable) must be aligned with the facility care plan. Comprehensive and ongoing assessment and treatment is planned for prior authorization and being provided for concurrent review authorization.

BHIF Exclusion Criteria

The admission cannot be used as an intervention for any of the following:

- An alternative to incarceration, preventative detention, or to ensure community safety in a child/adolescent exhibiting primarily delinquent/antisocial behavior including runaway behavior; or
- The equivalent of safe housing, permanency placement, or

- An alternative to parents'/guardian's or another agency's capacity to provide for the child or adolescent; or
- An intervention when other less restrictive alternatives are available and not being utilized.

BHIF Non-Emergent Admissions

Prior authorization must occur prior to admission to a BHIF for non-emergent admissions. The Health Plan determines medical necessity for standard decisions within 14 calendar days upon receipt of the request. If appropriate, the Health Plan may issue an extension of an additional 14 calendar days to request additional information. The Health Plan requires active involvement of the CFT to facilitate discussion of admission for all levels of care. Expedited authorization may be requested when the provider determines that using the standard timeframe could seriously jeopardize the member's life and/or health or ability to attain, maintain or regain maximum function. The Health Plan will look to the CFT to facilitate discussion of admission in consideration of the member when the member is in an inpatient hospital setting- expedited authorization may be granted. If approved, the Health Plan will issue an authorization for up to 45 days. Upon admission during the 45-day period, another authorization is activated to secure the date range. Providers are required to submit additional clinical documentation if the member does not admit within 45 days of approval.

Request for Prior Authorization for Non-Emergent Admission to a BHIF must include the following, submitted via fax to 520-694-0599:

- The Behavioral Health Prior Authorization Form,
- An updated Individual Service Plan (or Complete Care Plan, when applicable) indicating the goal for the admission to the BHIF,
- A recent psychiatric evaluation or psychiatric progress note that reflects current behaviors and functioning and diagnoses, and
- Certificate of Need (CON) (from the facility upon admission/ no later than 72 hours after admission)
- Out of Home Application,
- The most recent assessment or an assessment that has been updated in the past year,
- The Child Family Team (CFT) note indicating the team's recommendations,
- Any other reports from outpatient providers or other treatment providers, and
- Any psychological reports or other reports from specialty providers.

BHIF Emergent Admissions

Notification of Emergent Admission to a BHIF must include the following and be submitted via fax to 520-694-0599 within two business days of admission:

For emergent admissions, a member may be placed in the facility if the referring provider and accepting facility have documented information to suggest medical necessity criteria are met as stated above (Diagnosis and Behavior and Functioning). For emergent admissions, when documentation supports medical necessity, an authorization will be issued when the notification has been received within no later than two business days of the admission. Initial authorizations that meet medical necessity for an emergent admission will receive a short-term authorization to address the emergent admission and then ongoing concurrent review is needed for any additional days that are requested. If the notification is received later than the two business days, then authorization will be effective the date of receipt of the notification.

Documentation Required for Emergent Admission to a BHIF within 2 business days of the admission:

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

Concurrent Review for Emergent BHIF

If the member requires a continued stay past the initial authorized days, submit the following via fax to 520-694-0599.

- Concurrent Review Form prior to noon on the last covered day.

Concurrent Review for Non-Emergent BHIF

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

Documents that must be submitted to support medical necessity for concurrent review:

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

For concurrent review authorization, if the youth is not demonstrating improvement, the facility care plan must be revised as part of the CFT process resulting in an expectation of improvement to achieve discharge from the BHIF at the earliest possible time and facilitate return to outpatient care or less restrictive therapeutic level of care. The child/adolescent must be actively participating in treatment.

The Health Plan bases concurrent review determinations solely on the medical information obtained by the reviewer at the time of the review determination. Frequency of the reviews are based on the severity or complexity of the member's condition or on necessary treatment and discharge planning activity but will also meet the prescribed review timelines according to MCG criteria. Authorization for BHIF will have a specified date and time by which requested clinical information/ documents will be required for review. This information will be provided to the requesting provider to ensure coordination and understanding of when additional member condition updates are required. Please note section on issuance of Administrative Denials when clinical information is not submitted timely or fully.

To justify remaining in a BHIF level of care, progress must be evident to show that the condition or its symptoms are treatment responsive, the member must ***continue*** to manifest symptoms justifying the principal DSM-5 diagnosis/ICD 10 code, and one or more of the following:

1. The intensity of service being delivered should be appropriate to the risk level that justified the admission
2. Persistence of symptoms such that continued observation or treatment is required
3. Increased risk of complications as a result of intervention or as a product of newly discovered conditions
4. Effective planning for transition to a less restrictive level of care has begun and additional time in treatment days will reduce the probability of a readmission to a more restrictive level of care.

Concurrent review documentation should include a description of the active treatment and interventions that are being provided (and documented in the clinical record) that is assisting the member in achieving identified Service Plan/Care Planning goals for a successful discharge.

Active treatment services should include the following:

1) Psychiatric services at a minimum of *every other week*, or more as indicated, to provide active psychiatric treatment including a focus on psychosocial

interventions and pharmacotherapy to meet individualized needs
2) Clinical assessment at a minimum on a daily basis that includes close, continuous, 24 hour skilled medical/nursing supervision
3) Individual and family therapy each *a minimum of once a week or more to meet individualized* needs. If family therapy is not being provided rationale must be documented in the clinical record
4) Group therapy and/or an individualized or family therapy service on a daily basis
5) Active and individualized ongoing positive behavioral management
6) School or vocational programming

Re-certification Of Need (RON)

A RON is a re-certification made by a physician, a nurse practitioner or physician assistant. The RON must recertify for each applicant or beneficiary that continued inpatient services in a BHIF are needed. A RON must be completed at least **every 30 days for a member under the age of 18 who is receiving services in a Behavioral Health Inpatient Facility**. The completion and review of the Service Plan/Complete Care Plan in this circumstance meets the requirement for the re-certification of need. For a sample RON form see **Provider Manual Form - Recertificate of Need.**

The following documentation is needed on a RON:

- Fax RONS to 520-874-3411.
- Proper treatment of the member's behavioral health condition requires services on an inpatient basis under the direction of a physician;
- The service can reasonably be expected to improve the member's condition or prevent further regression so that the service will no longer be needed;
- Outpatient resources available in the community do not meet the treatment needs of the member;
- RONs must have a dated signature by a physician, nurse practitioner or physician assistant.

Administrative Denials During BHIF Hospitalization

An Administrative Denial is based on the following:

- Failure of the facility to submit ALL of the required documentation/clinical information to conduct comprehensive utilization review activities to

determine medical necessity for admission and/or concurrent review/continued stay **and/or**
- Failure to provide the services required

Administrative denials are based on the lack of information timely submitted and/or deficiency in provision of services required and not based on medical necessity criteria. As a result, they do not require physician review or involvement in the denial decision. These denials will result in the termination of the authorization where there is a deficiency in documentation/information or services for the entire or remaining length of stay or denial of specified days where required documentation/information or services, for example a BHMP note is not provided during specified days.

After an Administrative Denial has been issued, the facility can submit the claim/request as a Retrospective Review through the Claims Department. The request for reimbursement through a Retrospective Review must include an explanation as to why the facility was unable to submit timely and comprehensive clinical documentation required to determine medical necessity at the time of admission, concurrent review or the UM reviewers request.

BHIF Administrative Denials

Administrative denials will be issued for concurrent review/continued stay of BHIFs when there is lack of documentation/information to demonstrate required services have been provided consistent with the required interventions including the following:

1. Psychiatric services at a minimum of every other week, or more as indicated, to provide active psychiatric treatment including a focus on psychosocial interventions and pharmacotherapy to meet individualized needs
2. Clinical assessment at a minimum on a daily basis that includes close, continuous, 24 hour skilled medical/nursing supervision
3. Individual and family therapy each a minimum of once a week or more to meet individualized needs. If family therapy is not being provided rationale must be documented in the clinical record
4. Group therapy and/or an individualized or family therapy service on a daily basis'
5. Active and individualized ongoing positive behavioral management
6. School or vocational programming

Discharge Criteria

The member is ready for discharge when any of the following criteria have been satisfied:

1. The planned course of treatment has been completed.
2. The member's symptom intensity or impairment in functioning no longer requires the level of observation or intensity of service at the requested level of care.

3. Further professional intervention is not expected to result in significant improvement in the patient's condition
4. The member leaves against medical advice (AMA). *Please refer to Section Discharge Planning in this manual

Hospital/BHIF Discharge Planning

Discharge planning is expected to begin on the date of admission. If the member is not enrolled with an outpatient behavioral health agency, the inpatient team is to initiate a request for enrollment with an outpatient agency chosen by the member or by zip code. The Health Plan Behavioral Health Department can provide assistance with referral process by contacting: **BUHPCareMGMTBHMailbox@bannerhealth.com.**

Discharge planning should include a written plan for discharge with specific discharge criteria and recommendations for aftercare treatment that includes involvement of the Child and Family Team and complies with current standards for medically necessary covered behavioral health services, cost effectiveness, and least restrictive environment and is in conformance with 42 CFR.1. Discharge plans must continue to be refined throughout treatment to ensure all needs have been addressed to prepare for a safe and supported transition to lower level services.

Contracted providers must develop and implement a discharge planning process to address the post-discharge clinical and social needs of members upon discharge. The process shall be initiated by a qualified health care professional who is expected to participate in development of the discharge plan and update the plan periodically during the inpatient admission to ensure that continuing care needs have been accurately determined. The following must be included as part of this process:

- Proactive discharge assessment by qualified healthcare professionals identifying and assessing the specific post discharge bio-psychosocial and medical needs of the member prior to discharge. This process shall include the involvement and participation of the member and representative(s), as applicable. The member and representative(s) must be provided with the written discharge plan instructions and recommendations identifying resources, referrals, and possible interventions to meet the member's assessed and anticipated needs after discharge.
- The coordination and management of the care that the member receives following discharge from an acute setting. This may include:
    - Providing appropriate post discharge community referrals and resources or scheduling follow up appointments with the member's primary care provider and/or other outpatient healthcare providers within 7 days or sooner of discharge.

- Coordination of care involving effective communication of the member's treatment plan and medical history across the various outpatient providers to ensure that the member receives medically-necessary services that are both timely and safe after discharge. This includes access to nursing services and therapies.
- Coordination with the member's outpatient clinical team to explore interventions to address the member's needs such as case management, disease management, placement options, and community support services.
- Access to prescribed discharge medications.
- Coordination of care with the Health Plan, when applicable
- Post discharge follow up contact to assess the progress of the discharge plan according to the member's assessed clinical (physical health care) and social needs.

Requirements for Discharge Plan/Summary

All facilities are required to submit the Discharge Plan/Summary to the Health Plan and the outpatient behavioral health provider within 24 hours of discharge. Discharge Plan/Summary must be submitted to: BUHPUMPAMailbox@bannerhealth.com**.**

At a minimum the Discharge Plan/Summary must contain the following information:

- Date of discharge
- Discharge diagnosis
- Discharge instructions including follow up services and discharge appointments (required to have an appointment with prescriber or BHMP within 7 days)
- Discharge medications including the following: dosage, instructions and number of days of medications provided if applicable (for hospitals and BHIFs)

Delays in submitting the Discharge Summary to the Health Plan may result in a delay of claims payment. The Health Plan must have accurate documentation to confirm the date of discharge and the discharge information.

BHIF Avoidable Days

At times, potentially avoidable delays may occur in discharging members from an acute level of behavioral health care to a less restrictive treatment setting. Such delays typically occur because the less restrictive, community-based treatment and supports that are necessary for a safe and successful discharge are not yet fully arranged or available. Potentially avoidable inpatient days are periods of continued hospitalization

on a BHIF level of care are authorized by the health plan when medical necessity no longer is demonstrated, but services at a lower level of care are not yet available, despite active, comprehensive, and timely discharge planning efforts by the facility or provider. Potentially avoidable inpatient days will be authorized only when discharge planning activities are documented appropriately by the facility or provider from the time of the member's initial admission, and when evidence of continued, comprehensive discharge planning efforts is submitted daily to the health plan for review, until discharge of the member occurs.

Potentially avoidable inpatient days must be preceded by at least one acute inpatient day (24 hours in duration) that meets medical necessity criteria. Authorization will not be provided for direct admission from an outpatient or residential treatment setting to a more acute level of care for which medical necessity has not been demonstrated, or for which prior authorization has not been obtained. Potentially avoidable inpatient days also will not be authorized solely for convenience, or when appropriate services in an alternative setting are available, but refused or declined by the member, the member's family, or the inpatient treatment team.

When potentially avoidable inpatient days are authorized, the facility or provider must continue to assure that appropriate BH treatment and services are provided to the member until the time of discharge to a lower level of care. Types of potentially avoidable inpatient days include: (1) lack of an available residential treatment bed in a BHRF, or HCTC level of care; (2) lack of available specialty services (such as those that are medically necessary for members with an autism spectrum diagnosis, sexually maladaptive behaviors, cognitive limitations, a significant history of aggression toward others, accompanying medical disorders, or other similar conditions), and (3) lack of access to other community-based treatment and supports that are necessary to sustain adequate functioning in the community.

Required Reporting of Avoidable Days

To justify avoidable/administrative bed days the following must be provided during the UM Reviewer during concurrent review, failure to provide this information may result in an Administrative or Medical Necessity Denial:

- Clinical documentation must support that alternative discharge arrangements available are not adequate to safely meet the needs of the member
- If a required service is not currently available, the discharge plan must clearly state this and identify the steps to be able to access needed services. Entries such as "deferred until patient stabilizes," "to be determined," or "placement pending," are not acceptable.

- Evidence of active attempts to effectuate discharge to a specified placement/level of care or community-based service must be provided and resubmitted/updated and reviewed by staff every 24 hours. If there are insufficient discharge planning activities a denial should be issued.

The Health Plan Behavioral Health UM staff will expedite services requiring prior authorization to ensure prompt placement to lower level of care. The Health Plan may assign a Behavioral Health Care Manager to assist a contracted provider in securing lower level of care and submission of out of home packet.

Retrospective Review for Inpatient Hospitalizations

Retrospective Review is a process that occurs after a treatment has been completed and discharge from the service has been accomplished that encompasses appropriateness, coverage, efficiency and medical necessity of services. The retrospective review process may be initiated upon receipt of delayed notification and/or service and/or admission and must be received within 30 days from completion of the service. Administrative Denials are issued when the request for a Retrospective Review exceeds the 30-day time frame from the completion of service with the exception of Prior Period Coverage.
For purposes of this document, retrospective review refers to a claims submission that occurs following an inpatient psychiatric admission, after treatment has been completed and the member has discharged. Retrospective review will not serve as an alternative to or a substitute for mandatory concurrent review.

The Health Plan does not conduct retrospective reviews for any other level of care except for inpatient psychiatric hospitalizations.

Delayed notification of admission to a psychiatric facility while the member is still hospitalized and receiving active treatment must be submitted through the Notification of Admission process for consideration of admission and concurrent review. The Health Plan reserves the right to determine when a delayed notification of admission should be considered a retrospective review and submitted through the Claims department.

Requests for retrospective reviews must include ALL of the following:

- Requests for Retrospective Reviews must include the date ranges being requested for review.

- The request must be submitted within 30 days of the date of discharge/completion of service. If past 30 days, the record will not be reviewed and returned to the provider.
- The request must include a reasonable explanation of why the provider was not able to notify Banner- UFC of the admission or was not able to provide timely clinical documentation to participate in the utilization management concurrent review process at the time of the hospitalization. If the provider indicates that attempts were made to contact the Health Plan upon admission and no response was received, the provider must submit evidence of the attempts to contact the Health Plan during the hospitalization.
- If a Denial Letter was issued, the provider must submit a copy of the Denial Letter with the record.
- The provider must submit legal documentation if the member was admitted under a Court Ordered Evaluation with the dates of the initiation and completion of the Court Ordered Evaluation period. This must include why the Court Ordered Evaluation was ended (time expired, discharged, voluntary etc.) All requests for Retrospective Review that include the Court Ordered Evaluation period time frame for reimbursement will be denied. All Court Ordered Evaluations are funded by the county. Medicaid is the payer of last resort and does not reimburse for Court Ordered Evaluation.
- All requests for Retrospective Reviews or Appeals must include the required clinical documentation as indicated in the Banner Behavioral Health Provider Manual Supplement for initial authorization, concurrent review and discharge. The entire medical record is not requested for Retrospective Reviews. Providers are to only send the required documents. Records submitted in entirety will be denied. If the provider fails to submit sufficient information to render an authorization determination, the Health Plan will notify the provider and specifically describe the information needed. The facility will be given up to fourteen (14) calendar days to submit the additional information or to inform the Health Plan why the information cannot be submitted for review. The Health Plan will make a one-time request if clinical information is not sufficient to make a decision. Banner recommends providers label each clinical document when submitted to ensure the required documentation is being submitted and not extraneous information that can delay the review process.
- Certificate of Need (CON), as applicable (not required for Prior Period Coverage)

Retrospective review is available **only** when:

1. Documentation is provided to substantiate that timely notification of admission and/or concurrent review was not reasonably possible prior to the member's discharge and/or during the hospitalization. Banner reserves the right to determine what is a reasonable justification to consider a Retrospective Review request.
2. All requested clinical documentation was provided in a timely manner in conjunction with concurrent review, but supplemental information subsequently was identified that warrants further consideration.
3. Review is submitted due to Prior Period Coverage
4. Exceptions for BHRFs and SABG Funding- Retrospective reviews can be submitted by contracted substance abuse providers that used Substance Abuse Block Grant funds (aka SABG) for a non-Medicaid member at the time of admission. When the member receives prior period coverage and Medicaid/ BUHP becomes the payer for the Behavioral Health Residential Facility (BHRF) these requests are appropriate to submit in these circumstances only. These retrospective reviews require a medical necessity review.

Upon receipt of a request for retrospective review, the Health Plan will screen the request to determine if it is eligible for Retrospective Review. If it is determined that the request is not eligible for Retrospective Review based on the above criteria, the provider may submit an appeal.

Retrospective Reviews and supporting medical records should be directly submitted to the Health Plan claims department via mail:

Banner University Family Care/ AHCCCS Complete Care (BUFC- ACC)
P.O. Box 35699
Phoenix, AZ 85069-7169
Electronic ID: 09830

Banner University Family Care/Arizona Long Term Care ALTCS (BUFC/ALTCS)
P.O. Box 37279
Phoenix, AZ 85069
Electronic ID: 66901

Banner University Care Advantage (BUCA)
P.O. Box 38549

Phoenix, AZ 85069-7169
Electronic ID: 09830 (UCA)

RESUBMISSIONS
Be sure to clearly mark "Resubmission" on the claim form or select the appropriate box on the claim form if sending electronically

APPEALS
Banner University Health Plans
Attn: Grievance and Appeals Department
2701 E. Elvira
Tucson, AZ 85756
FAX- (866) 465-8340
Email: BUHPGrievances&Appeals@bannerhealth.com

Adult/Children Behavioral Health Residential Facility (BHRF)

Care and services provided in a contracted BHRF are based on a per diem rate (24-hour day), require prior authorization based on the circumstances outlined below, and do not include room and board.

All BHRF providers are required to employ staff with the competencies and skills to deliver the required interventions and programmatic services, including developing measurable and achievable treatment goals, ability to clinically document the member's progress and participate in clinical meetings to support the member's care, transitions and discharge planning.

All BHRF providers are required to notify the member's Primary Care Provider and Behavioral Health outpatient provider upon intake and discharge from the BHRF.

For providers that offer comprehensive evaluation processes and intensive behavioral interventions for youth that may have had prior multiple out of home treatment services and/or present with very complex needs, the Health Plan requires a prior authorization and single case agreement request. Cases are reviewed on a case by case basis depending on the member's needs, the CFT recommendations, the facility treatment services and approaches to the individual member as it relates to medical necessity.

Individuals may be admitted to a BUFC contracted BHRF level of care on an emergent basis or through an Expedited Prior Authorization Request. All BHRF requests are considered expedited. The Health Plan will make a determination of medical necessity

within 72 hours of the request, including weekends and legal holidays. If the Health Plan is unable to make a decision within the 72-hour time frame due to lack of clinical documentation to substantiate an approval or denial, a Notice of Extension letter will be sent to the provider and member/guardian.

The Health Plan does not authorize emergent admissions to non-contracted BHRFs. All requests for non-contracted BHRFs must be submitted for a prior authorization. Non contracted BHRF authorizations will be determined based on medical necessity regarding special circumstances. Non-contracted BHRFs that admit Banner members without a prior authorization approval will be denied.

Emergent-Admission Criteria for BHRF - For emergent admissions, a member may be placed in the contracted facility, based on documented information that meets medical necessity criteria. The member requiring an emergent admission to a BHRF may be admitted even if they are not currently enrolled with an outpatient behavioral health provider. For emergent admissions, upon receipt of the required documents, and when medical necessity criteria have been met, an initial authorization will be issued for a brief period only when the notification has been submitted within the two business days of admission. If the notification is received later than the two business days and medical necessity criteria are met, then authorization will be effective the date of receipt of the notification. When admitting a member to a BHRF on an emergent basis, it is the responsibility of the BHRF provider to ensure that there is enough clinical information available to support medical necessity. See the criteria stated below. If member requires a continued stay, the out of home provider **must submit a Concurrent Review Form by the last covered day.**

Notification of Emergent Admission to a BHRF must include the following and be submitted via fax to 520-694-0599 within two business days of admission:

- Behavioral Health Prior Authorization
- Out of Home Admission Notification
- Out of Home Application

Below is a list of Banner contracted Adult BHRF providers accepting Emergent Admissions in the southern region. *This list is not a fully inclusive list.*

Facility Name	Program	Accepts SUD (Y/N)	Contact - Phone	Additional Info
COPE - Ocotillo Tucson	BHRF	Y	520 903-1563	
CBI-Tucson	BHRF	Y	520 327-9863	Male Only Program

CBI-Yuma	BHRF	Y	928 341-4880	
CBI-Bisbee	BHRF	Y	520 432-8068	Female Only Program
CBI-Benson	BHRF	Y	520 586-9543	
CODAC Gila - Tucson	BHRF	Y	520 327-4505 x 5433	
CODAC Las Amigas - Tucson	BHRF	Y	520 327-4505 x 4021	Female Only Program-SUD focus

Below is a list of Banner contracted Children's BHRF providers accepting Emergent Admissions in the southern region. *This list is not a fully inclusive list.*

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

Non-Emergent Admissions to BHRF

Prior authorization must occur prior to admission to a BHRF for non-emergent admissions. The Health Plan determines medical necessity for standard decisions within 14 calendar days upon receipt of the request. If appropriate, the Health Plan may issue an extension of an additional 14 calendar days to request additional documentation. The Health Plan requires active involvement of the ART or CFT to facilitate discussion of admission for all levels of care. Expedited authorization may be requested when the provider determines that using the standard timeframe could seriously jeopardize the member's life and/or health or ability to attain, maintain or regain maximum function. If approved, the Health Plan will issue an authorization for up to 45 days. Upon admission during the 45-day period, another authorization is activated to secure the date range. Providers are required to submit additional clinical documentation if the member does not admit within 45 days of approval.

Request for Prior Authorization for Non-Emergent Admission to a BHRF Level of Care must include the following and submit via fax 520-694-0599:

- Behavioral Health Prior Authorization
- Out of Home Application, with supporting clinical documentation
- If the admission is for substance abuse, include supporting clinical

documentation such as American Society of Addiction Medicine (ASAM) Criteria.

Criteria for Admission to a Behavioral Health Residential Facility

Member must have a diagnosed behavioral health condition which reflects the symptoms and behaviors necessary for a request for residential treatment. The behavioral health condition causing the significant functional and/or psychosocial impairment shall be evidenced in the assessment by the following criteria and only used when needs cannot be addressed in a less restrictive level of care or with community-based treatment because of potential danger to self or others:

1. a. At least one area of significant risk of harm within the past three months and expectation of continued significant risk of harm as a result of:
    i. Suicidal/aggressive/self-harm/homicidal thoughts or behaviors resulting in potential risk for danger to self or others without current plan or intent and need for active treatment in this level of care.
    ii. Impulsivity with poor judgment/insight that are not developmentally appropriate
    iii. Maladaptive physical or sexual behavior
    iv. Member's inability to remain safe within his or her environment, despite environmental supports (i.e. Natural Supports), or community-based services.
    v. Medication side effects due to toxicity or contraindications which do not require continuous medical or nursing supervision and are appropriate for supervised medication self-administration.

AND

At least one area of serious functional impairment which cannot be addressed in a less restrictive level of care or community -based treatment because of potential danger to self or others:

b) as evidenced by:
    i. Inability to complete developmentally appropriate self-care or self-regulation due to member's behavioral health condition(s)
    ii. Neglect or disruption of ability to attend to majority of basic needs, such as personal safety, hygiene, nutrition or medical care
    iii. Frequent inpatient psychiatric admissions or legal involvement due to lack of insight or judgment associated with psychotic or affective/mood symptoms or major psychiatric disorders where exclusionary criteria are not met.
    iv. Inability to independently self-administer medically necessary psychotropic medications despite interventions such as education,

regimen simplification, daily outpatient dispensing, and long-acting injectable medications or,

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

2. A need for 24-hour behavioral health care and supervision to develop adequate and effective coping skills that will allow the member to live safely in the community.
3. Anticipated stabilization cannot be achieved in a less restrictive setting.
4. Evidence that appropriate treatment in a less restrictive environment has not been successful or is not available, therefore warranting a higher level of care.
5. Member agrees to participate in treatment. In the case of minors, family/guardian/designated representative also agrees to and participates as part of the treatment team.

Admission, Assessment, and Complete Care Plan

Upon admission to a BHRF, the BHRF provider and the outpatient provider will conduct the following assessment and Service Planning/Complete Care planning process:

1. A behavioral health assessment for a member is completed before treatment is initiated and within 48 hours of admission.
2. The CFT/ART is included in the development of the Service Plan within 7 days of admission.
3. A comprehensive discharge plan is created during the development of the initial Treatment Plan and is reviewed and/or updated at each review thereafter. The discharge plan shall document the following:
   a. Anticipated clinical status upon discharge
   b. Member/guardian/designated representative and CFT/ART understands follow-up treatment, crisis and safety plan
   c. Coordination of care and transition planning are in process (e.g. reconciliation of medications, applications for lower level of care submitted, follow-up appointments made).
   d. Comprehensive services and supports to meet the member's immediate and post-acute needs to support successful transition back to the community
4. The BHRF staff participate in the CFT/ART process and meet to review and modify the Complete Care Plan at least once a month.
5. A Treatment Plan that is completed by a Behavioral Health Professional (BHP) or by a Behavioral Health Technician (BHT) which shall be reviewed and signed off on by a BHP within 24 hours.

6. The provider has a system to document and report on timeliness of BHP signature/review when the Treatment Plan is completed by a BHT.
7. The provider has a process to actively engage family/guardians/designated representative in the treatment planning process as appropriate.
8. The provider's clinical practices, as applicable to services offered and population served, shall demonstrate adherence to best practices for treating specialized service needs, including but not limited to:
    a. Cognitive/intellectual disability,
    b. Cognitive disability with comorbid behavioral health condition(s),
    c. Older adults, and co-occurring disorders (substance use and behavioral health condition(s)), or
    d. Comorbid physical and behavioral health condition(s).
9. Services deemed medically necessary through the assessment and/or CFT/ART, which are not offered at the BHRF, shall be accessed to meet the needs of the member. Services which are part of the BHRF cannot be billed separately and must be included under the BHRF per diem.

    Services to be made available and provided by the BHRF include but are not limited to:

    a. Counseling and Therapy (group or individual): Note: Group Behavioral Health Counseling and Therapy may not be billed on the same day as BHRF services unless specialized group behavioral health counseling and therapy have been identified as a specific member need that cannot otherwise be met as required within the BHRF setting. All counseling services not provided directly by the BHRF provider require a prior authorization.

    b. Skills Training and Development:
        i. Independent Living Skills (e.g. self-care, household management, budgeting, avoidance of exploitation/safety education and awareness).
        ii. Community Reintegration Skill building (e.g. use of public transportation system, understanding community resources and how to use them).
        iii. Social Communication Skills (e.g. conflict and anger management, same/opposite-sex friendships, development of social support networks, recreation).

    c. Behavioral Health Prevention/Promotion Education and Medication Training and Support Services including but not limited to:

i. Symptom management (e.g. including identification of early warning signs and crisis planning/use of crisis plan),
ii. Health and wellness education (e.g. benefit of routine medical check-ups, preventive care, communication with the PCP and other health practitioners)
iii. Medication education and self-administration skills,
iv. Relapse prevention
v. Psychoeducation Services and Ongoing Support to Maintain Employment Work/Vocational skills, educational needs assessment and skill building
vi. Peer and Family Support Services
vii. Treatment for Substance Use Disorder (e.g. substance use counseling), and Medication Assisted Treatment (MAT)
viii. Personal Care Services

BHRFs must be licensed to deliver Personal Care Services (see additional licensing requirements in A.A.C. R9-10-702, R9-10-715, R9-10-814) and must provide documentation in the treatment plan if they are going to provide personal care services for a member. Examples of Personal Care Services may include:

i. Blood sugar monitoring, accu check diabetic care
ii. Administration of oxygen
iii. Application and care of orthotic devices
iv. Application and care of prosthetic devices
v. Application of bandages, medical support including high elastic stockings
vi. ACE wraps, arm and leg braces
vii. Application of topical medications
viii. Assistance with ambulation
ix. Assistance with correct use of cane/crutches
x. Bed Baths
xi. Care of hearing aids
xii. Radial pulse monitoring
xiii. Respiration monitoring
xiv. Denture care and brushing teeth
xv. Dressing member
xvi. Supervising self-feeding of members with swallowing deficiencies
xvii. Hair care, including shampooing
xviii. Incontinence support, including assistance with bed pans, bedside commodes, bathroom supports
xix. Measuring and recording blood pressure

xx. Non-Sterile dressing change and wound care
xxi. Passive range of motion exercise
xxii. Use of pad lifts
xxiii. Shaving
xxiv. Shower assistance using shower chair
xxv. Skin maintenance to prevent and treat bruises, injuries, pressure sores. (If stage 3 or 4 pressure sore no BHRF admission permitted)
xxvi. Use of chair lifts
xxvii. Skin and foot care
xxviii. Measuring and giving insulin, glucagon injection
xxix. G-tube care
xxx. Ostomy and surrounding skin care
xxxi. Catheter Care

Expected Treatment Outcomes and SMART Goals

BHRF can only be utilized if there is an expectation that the member will benefit from the treatment provided at this level of care, with anticipated transition to a lower level of care after identified treatment goals have been met.

Treatment outcomes shall align with the Arizona Vision-Twelve Principles for Children's Behavioral Health Service Delivery or the Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems as outlined in the provider contract, and the member's individualized basic physical, behavioral and developmentally appropriate needs.

Treatment goals must reflect the behaviors and functioning of the member in a language that the member understands what is required for a successful treatment experience and discharge. These goals should focus on Counseling and Therapy, Skill training and Development and Behavioral Health Prevention/Promotion Education and Medication Training and Support Services. The required treatment goals shall be developed in accordance with the following:

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

Requests for BHRF level of care that do not include measurable and meaningful goals that support the requirement for this level of care will be denied.

Exclusionary Criteria

Admission to a BHRF shall not be used as a substitute for the following:

1. An alternative to preventative detention or incarceration
2. As a means to ensure community safety in circumstances where a member is exhibiting primarily conduct disordered behavior without the presence of risk or functional impairment
3. A means of providing safe housing, shelter, supervision, or permanency placement
4. A behavioral health intervention when other less restrictive alternatives are available and meet the member's treatment needs; including situations when the member/guardian/designated representative are unwilling to participate, or
5. An intervention for runaway behaviors unrelated to a behavioral health condition.

Concurrent Review for BHRF

Continued stay must be assessed by the BHRF staff and the ART/CFT during the Treatment Plan review and update. Progress towards the treatment goals and continued display of risk and functional impairment must also be addressed. Treatment intervention, frequency, crisis/safety planning and targeted discharge must be adjusted accordingly to support the need for continued stay. The following criteria will be considered when determining continued stay:

1. The member continues to demonstrate significant risk of harm and/or functional impairment as a result of a behavioral health condition consistent with the criteria for admission.

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

3. Member is making progress towards identified goals or if there is lack of progress the facility and complete care plan are revised resulting in the expectation of improvement.

4. The member is demonstrating marked improvement toward the one or more identified area of significant risk of harm that was identified during the admission/evaluation period such as:

A. Suicidal/aggressive/self-harm/homicidal thoughts or behaviors resulting in potential risk for danger to self or others without current plan or intent and need for active treatment in this level of care.
B. Impulsivity with poor judgment/insight that are not developmentally appropriate
C. Maladaptive physical or sexual behavior
D. Member's inability to remain safe within his or her environment, despite environmental supports (i.e. Natural Supports), or community-based services.
E. Medication side effects due to toxicity or contraindications which do not require continuous medical or nursing supervision and are appropriate for supervised medication self-administration.

AND

The member demonstrates marked improvement in one or more in the area of serious functional impairment which could not have been addressed in a less restrictive level of care or community -based treatment because of potential danger to self or others:
as evidenced by:

i. Inability to complete developmentally appropriate self-care or self-regulation due to member's behavioral health condition(s)
ii. Neglect or disruption of ability to attend to majority of basic needs, such as personal safety, hygiene, nutrition or medical care
iii. Frequent inpatient psychiatric admissions or legal involvement due to lack of insight or judgment associated with psychotic or affective/mood symptoms or major psychiatric disorders where exclusionary criteria are not met.
iv. Inability to independently self-administer medically necessary psychotropic medications despite interventions such as education, regimen simplification, daily outpatient dispensing, and long-acting injectable medications or,
v. Impairments persisting in the absence of situational stressors that delay recovery from the presenting problem.

F. The member continues to demonstrate a need for 24-hour behavioral health care and supervision to develop adequate and effective coping skills that will allow the member to live safely in the community.
G. Anticipated stabilization cannot be achieved in a less restrictive setting.

H. Evidence that appropriate treatment in a less restrictive environment continues to be assessed as either previously unsuccessful or is not available, therefore justifying this level of care.
I. Member agrees to participate in treatment. In the case of minors, family/guardian/designated representative also agrees to and participates as part of the treatment team.

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

Required Documents from the BHRF/Outpatient Provider

To be submitted within 14 calendar days of the last covered day for concurrent review:

1. Out of Home Concurrent Review Form
2. Adult Recovery Team/Child and Family Team note: Notes should reflect the team's treatment recommendations, proposed length of stay, changes to proposed discharge plan, if applicable and progress or lack of progress and barriers to progress.
3. Medication and psychiatric progress notes, if applicable
4. Revised Service Plan/Complete Care Plan (as applicable)- The revised Service Plan/Complete Care Plan should include revisions to address identified barriers.

Discharge Readiness

The BHRF provider must submit a completed Discharge Summary no later than 24 hours after discharge to the assigned BUHP Reviewer. Failure to do so may delay claims payment. Discharge readiness will be assessed by the BHRF staff and CFT/ART team who participate in the CFT/ART during each review of the Individual Service Plan/Complete Care Plan (when applicable). The following criteria shall be considered when determining discharge readiness:

1. Symptoms or behaviors are reduced, as evidenced by completion of Treatment Plan goals
2. Functional impairment is reduced to manageable levels. Essential functions such as eating or hydrating necessary to sustain life has significantly improved or is able to be cared for in a less restrictive level of care
3. Member can participate in needed monitoring or a caregiver is available to provide monitoring in a less restrictive level of care

4. Providers and supports are available to meet current behavioral and physical health needs at a less restrictive level of care.

Requirements for Discharge Plan/Summary

All BHRF providers are required to submit the Discharge Plan/Summary to the Health Plan and the outpatient behavioral health provider within 24 hours of discharge. BHRF providers may use their own Discharge Form or use the Banner UFC Discharge Form found on our website. Plan/Summary must be submitted to: BUHPUMPAMailbox@bannerhealth.com**.**

At a minimum the Discharge Plan/Summary must contain the following information:

- Date of discharge
- Discharge diagnosis
- Discharge instructions including follow up services
- Discharge medications including the following: dosage, instructions and number of days of medications provided if applicable (for hospitals and BHIFs)

Delays in submitting the Discharge Summary to the Health Plan may result in a delay of claims payment. The Health Plan must have accurate documentation to confirm the date of discharge and the discharge information.

Home Care Training for the Home Care Client (HCTC)

"Also known as Therapeutic Foster Care"

Child/Adolescent and Adults

HCTC services provide treatment for children, adolescents and adults who demonstrate moderate functional impairments, when ambulatory care services in the community do not meet their treatment needs. These services are designed for children and adolescents who have a DSM 5/ICD-10 psychiatric diagnosis. HCTC services are provided by a behavioral health therapeutic home to implement the in-home portion of the Service Plan/Complete care plan (when applicable). HCTC services assist and support a child/adolescent or adult in achieving their complete care plan goals and objectives. It also helps the child/adolescent or adult remain in the community setting, thereby avoiding residential, inpatient or institutional care. These services include supervision and the provision of behavioral health support services such as personal care (especially prescribed behavioral interventions), psychosocial rehabilitation, skills training and development, transportation to therapy or visitations and/or the participation in care and

discharge planning. Active treatment focuses on specific targeted goals identified by the Child and Family Team (CFT) or Adult Recovery Team (ART) and are designed to enable the child/adolescent or adult to be discharged at the earliest possible time. A lack of available outpatient services is not in and of itself the sole criterion for admission to a HCTC. Treatment should be at the least restrictive level of care consistent with need and therefore should not be instituted unless there is documentation of a failure to respond to, or professional judgment of an inability to be safely managed in a non-therapeutic community-based placement.

Criteria for Home Care Training to Home Care Client- Adult or Child

Initial Authorization: Initial admission authorization is up to 90 days with initial continued stay/concurrent review to occur within 2 weeks of the last covered day.

The criteria in I-VI below must **all** be met to meet prior authorization and concurrent review for continued stay:

I. **Diagnostic Criteria**: There is clinical evidence and documentation that the member has a primary DSM 5/ICD-10 diagnosis that is amenable to active treatment. Any co-occurring diagnosis or diagnoses must be identified and documented prior to admission.

II. **Behavior and functioning;** As a result of a DSM-5/ICD-10 psychiatric diagnosis, the member has a risk of harm to self or others or disturbance of mood, thought or behavior which renders the child/adolescent incapable of developmentally-appropriate self-care or self-regulation as evidenced by:

The member has demonstrated an inability to function in a typical family setting as evidenced by a history of risk of harm or moderate functional impairment of self-care or self-regulation due to the psychiatric condition that clearly impairs functioning, persists in the absence of stressors, and impairs recovery from the presenting problem.

III. **Active Treatment/Intensity of service (must meet all criteria is a-c below):** Comprehensive and ongoing assessment and treatment is planned for and being provided for continued stay.

a. Homes providing HCTC services are licensed by the Arizona Department of Economic Security (ADES), Office of Licensing Certification and Regulation (OLCR) as professional foster homes or are licensed by federally recognized Indian Tribes that attest to the Centers for Medicare and Medicaid services via the Arizona Health Care Cost

Containment System (AHCCCS), that they meet equivalent requirements. HCTC services assist and support a participant in achieving his/her Individual Service Plan (or Complete Care Plan, when applicable) goals/objectives and help the member remain in the community setting, thereby avoiding residential, inpatient or institutional care.

b. These services in a home setting include supervision and documentation of the provision of behavioral health support services including personal care (especially prescribed behavioral interventions), psychosocial rehabilitation, skills training and development, transportation of the participant when necessary to activities such as therapy and visitations and/or the participation in treatment and discharge planning.

c. Parent/guardian/ caregiver involvement as applicable: For prior authorization there is a plan for active involvement of the parent/guardian/caregiver to successfully discharge the member to the least restrictive community-based setting as quickly as possible. For continued stay there is documentation of active involvement of the parent/guardian/caregiver to successfully discharge the member to the least restrictive community-based setting as quickly as possible.

Non-Emergent Admissions to HCTC

BHIF Non-Emergent Admissions

Prior authorization must occur prior to admission to a HCTC for non-emergent admissions. The Health Plan determines medical necessity for standard decisions within 14 calendar days upon receipt of the request. If appropriate, the Health Plan may issue an extension of an additional 14 calendar days to request additional information. The Health Plan requires active involvement of the CFT to facilitate discussion of admission for all levels of care. Expedited authorization may be requested when the provider determines that using the standard timeframe could seriously jeopardize the member's life and/or health or ability to attain, maintain or regain maximum function. The Health Plan will look to the CFT to facilitate discussion of admission in consideration of the member when the member is in an inpatient hospital setting- expedited authorization may be granted. If approved, the Health Plan will issue an authorization for up to 45 days. Upon admission during the 45-day period, another authorization is activated to secure the date range. Providers are required to submit additional clinical documentation if the member does not admit within 45 days of approval.

Request for Prior Authorization for Non-Emergent Admission to HCTC must include the following and submitted via fax to: 520-694-0599.

Initial authorization:

- Behavioral Health Prior Authorization
- Out of Home Application, with supporting clinical documentation

Emergent Admissions to HCTC

For emergent admissions, a member may be placed in the facility if the referring provider and accepting agency's HCTC home have documented information that meets medical necessity criteria. Out of Home Admission Notification, Behavioral Health Authorization and the Out of Home Application, are to be submitted within 2 business days of admission. For emergent admissions, upon receipt of the required documents, an initial authorization will be issued, provided that medical necessity criteria have been met, for a brief period only when the notification has been submitted within the two business days of admission. If the notification is received later than the two business days, then authorization will be effective the date of receipt of the notification, provided that medical necessity criteria have been met.

The Health Plan will look to the ART or CFT to facilitate discussion of placement in consideration of the member when the member is in an inpatient setting- expedited authorization may be granted.

Notification of Emergent Admission to HCTC must include the following and be submitted via fax to: 520-694-0599 within two calendar days of admission:

- Behavioral Health Prior Authorization Form
- Out of Home Admission Notification Form
- Out of Home Application Form

Concurrent Review for HCTC after Emergent Admission: For emergent admissions, the Concurrent Review Form is due by noon on the last covered day to support additional days after the initial authorization and is faxed to 520-874-3411.

Concurrent Review for Adult/Child HCTC Level of Care for Non-Emergent Admissions

Requests for a continued stay at an HCTC level of care require submission of the following documents fourteen (14) days prior to the expiration of the current authorization, to be faxed to 520-874-3411:

- Out of Home Concurrent Review form
- CFT/ART notes
- Medication and psychiatric progress notes

Expectation of improvement

For the initial authorization for HCTC there is an expectation that active treatment with the services available at this level of care can reasonably be expected to improve the member's psychiatric condition to achieve discharge from the HCTC at the earliest possible time and facilitate return to outpatient care. There must be an expectation that the member will participate in treatment.

For continued stay in the HCTC level of care, if the member is not demonstrating improvement the HCTC services and Individual Service Plan (or Complete Care Plan, when applicable) must be revised as part of the ART/CFT process resulting in an expectation of improvement in order to achieve discharge from the HCTC at the earliest possible time and facilitate return to outpatient care. The child/adolescent (and adult if applicable) and the parent/guardian/caregiver must be actively participating in treatment.

HCTC and Respite

The AHCCCS Behavioral Health Covered Services Guide explains that respite is available for 600 hours per year (Oct. 1st through Sept. 30th) per member. For a child in the HCTC level of care, respite is available from an eligible provider. The AHCCCS Behavioral Health Covered Services Guide states that HCTC cannot be encountered on the same day respite is provided. If the Child and Family Team believes respite is appropriate, it should be documented on the Individualized Service Plan. A collaborative effort of CFT members should locate an eligible provider through the standard referral process.

It is the responsibility of the HCTC provider to notify the Health Plan prior to the provision of respite services. **Contact the UM Reviewer and submit the following information 3 days before member enters respite care:**

- Name of Member
- Name of HCTC Provider
- Name of Respite Provider
- Date/Time Range of Respite Service
- Confirmation that member Emergency Contact has been given to the Respite Provider.

A "temporary authorization" is not required for a respite provider to bill for respite. A placement change notice would not need to be provided. Respite hours should be billed by the respite provider accordingly. A billing issue should not occur since the HCTC provider does not bill the days during which respite is provided. It is the responsibility of the HCTC provider to ensure that a claim is not submitted for the time period that the member was in respite. Banner will recoup any claim paid if it is identified that the member was in respite services at the time and not receiving services from the HCTC provider that has been authorized by the Health Plan to provide that level of care for the member.

Discharge plan

There is a written plan for discharge with specific discharge criteria and recommendations for aftercare treatment that includes involvement of the ART or CFT and complies with current standards for medically necessary covered behavioral health services, cost effectiveness, and least restrictive environment and is in conformance with 42 CFR.1. Discharge planning must start at time of admission. Discharge plans must continue to be refined throughout treatment to ensure all needs have been addressed to prepare for a safe and supported transition to lower level services.

Exclusion Criteria

Child/adolescent out of home placements must not meet any of the below exclusionary criteria

- An alternative to preventative detention or as a means to ensure community safety in a member /adolescent exhibiting conduct disordered behavior
- The equivalent of safe housing, permanency placement, or an alternative to parent's/guardian's or another agency's capacity to provide for child/adolescent
- An intervention for runaway behavior.
- An intervention when other less restrictive alternatives are available and not being utilized.

Similarly, adult out of home placements must not meet any of the below exclusionary criteria:

- An alternative to preventative incarceration, or as a means to ensure community safety
- The equivalent of safe housing,
- An intervention for homelessness

- An intervention when other less restrictive alternatives are available and not being utilized.
- Active substance abuse
- History of starting fire
- Registered sex offender.

Prior Authorization for Psychotropic Medications

Submit Pharmacy Prior Authorization Form via fax 866-349-0338

The Health Plan has adopted the drug list developed by AHCCCS for use by all providers. This list denotes the utilization management criteria required for all drugs which includes prior authorization. The prior authorization criteria must be used by contracted providers. Antipsychotics and lithium may be prescribed by any contracted behavioral health provider for members over the age of five years without prior authorization. Non-behavioral health providers will need to refer the member to a behavioral health provider or obtain prior authorization. Ongoing therapy will be provided as a bridge until the member is able to be seen by a behavioral health provider. For specific information on medications requiring prior authorization, see **the Health Plan's drug list available on the health plan website under the Provider Section**.

The approved prior authorization criteria are posted on the Health Plan's website. The prior authorization requirements for availability, decision timelines and provision of notice will be provided within the AHCCCS required timelines. The Health Plan and providers must assure that a member will not experience a gap in access to prescribed medications due to a change in prior authorization requirements. The Health Plan and providers are required to ensure continuity of care in cases in which a medication that previously did not require prior authorization is now required to be prior authorized. Please submit a Prior Authorization on the Pharmacy Prior Authorization form and fax to 1-866-349-0338.

Securing Out of Network Provider

Sometimes it may be necessary to secure services through a non-contracted provider in order to provide a needed covered behavioral health service or to fulfill an AFT/CFT's request. The process for securing services through a non-

contracted provider is as follows:

If a needed covered outpatient service is unavailable within the Health Plan's contracted provider network, the provider submits a Behavioral Health Prior Authorization request to the Health Plan Behavioral Health Department via fax at **520-694-0599.**

- All out of network requests must be accompanied by the current individual Service Plan/Complete Care Plan and relevant clinical records.
- All requested providers must be licensed by the ADHS Division of Licensing and/or the applicable Arizona licensing board. All providers must have an AHCCCS Provider ID Number and a National Provider ID (NPI) Number. All out-of-network providers must agree to provide the requested services, possess appropriate insurance, and agree to the Health Plan -approved reimbursement rates. If for any reason the Health Plan Contracts Department is unable to establish a single case agreement with the requested non-contracted provider, the Behavioral Health Department will notify the requesting Clinical Director and/or ART/CFT.
- The ART/CFT then meets to consider alternative services. The ART/CFT is responsible for ensuring that a similar level of equivalent services is in place for the member
- The Health Plan secures services and provides payment to non-contracted providers through single case agreements.

In the event that a request to secure covered services through a non-contracted provider is denied, notice of the decision will be provided by the Health Plan within the AHCCCS required timelines for Notices of Action.

Prior Authorization for Non-Medical Transportation Over 100 Miles

Requests for non-medical transportation over 100 miles for a round trip or one way requires a Prior Authorization regardless of the diagnosis code that will be billed on the claim.

Required Documents to Request Non-Medical Transportation Over 100 Miles Faxed to 520-694-0599:

- Behavioral Health Prior Authorization Form

Clinical Criteria for Electroconvulsive Therapy-Indications for Procedure

Fax Behavioral Health Prior Authorization Form to 520-694-0599

Electroconvulsive therapy (ECT) may be indicated for **1 or more** of the following:

- Acute treatment, as indicated by **ALL** of the following:
  - Diagnosis of a psychiatric condition amenable to ECT treatment, as indicated by **1 or more** of the following:
    - Major depressive disorder
    - Bipolar disorder
    - Schizophrenia and schizoaffective disorders
  - Need for ECT, as indicated by **1 or more** of the following:
    - Catatonia
    - High risk for suicide attempt
    - Inadequate response to pharmacotherapy despite **ALL** of the following:
      - Adequate duration and dosage
      - Documented adherence
      - Trials from 2 or more classes of medications
    - Intractable manic excitement
    - Neuroleptic malignant syndrome
    - Nutritional compromise
    - Pharmacotherapy not preferred due to risk of adverse effects (e.g., pregnant or elderly patients)
    - Unremitting self-injury
  - Patient has undergone medical review and clearance.
  - Pretreatment symptoms rated as severe
- Extension of acute treatment, as indicated by **ALL** of the following:
  - Partial positive response to acute treatment
  - Treatment is being re-evaluated and modified (e.g., switch from unilateral to bilateral lead placement, modification of stimulus parameters).
- Maintenance treatment, as indicated by **ALL** of the following:
  - Clinical determination that maintenance treatment is needed to reduce risk of relapse (e.g., previous relapse without ECT)
  - Adjunctive pharmacotherapy optimized as indicated

- Sessions tapered to lowest frequency that maintains response (e.g., weekly, biweekly, monthly)

Requests for Prior Authorization for Electroconvulsive Therapy must include the following submitted via fax to: 520-694-0599

1) Behavioral Health Prior Authorization Form
2) Supporting clinical documentation

Medical Necessity Denials for all Levels of Care

A denial based on a lack of documentation of medical necessity for an outpatient service, inpatient admission, or continued stay can only be made by the Health Plan's Chief Medical Officer or physician designee after review of all clinical information provided. Denials will only be issued when the information provided verbally and/or through documentation does not support medical necessity for the service provided. For denials of admissions or continued stays, the provider may request a peer-to-peer discussion for reconsideration within 24 business hours of the denial. This request will not result in extension of the authorization period unless information is provided to support medical necessity.

For outpatient authorizations and planned admissions to BHRF, BHIF, HCTC - After the Health Plan notifies a provider of the decision to deny a requested authorization the requesting provider or member/guardian can submit an appeal.

For Title XIX/XXI covered services requested by members who are Title XIX/XXI eligible or who have been determined to have a serious mental illness, the Health Plan must provide the member with a Notice of Adverse Benefit Determination following denial of all prior authorizations for outpatient services, including:

- The denial or limited authorization of a requested service, including the type or level of service
- The reduction, suspension, or termination of a previously authorized service
- The denial in whole or in part, of payment for a service (this is the Health Plan's responsibility).

A copy of the Notice of Adverse Benefit Determination will also be sent to the provider submitting the request. Before a final decision to deny is made, the member's attending psychiatrist can ask for reconsideration and present additional information.

The Health Plan will ensure 24-hour access to a delegated psychiatrist or other physician designee for any denials of hospital admission. For denials related to a concurrent review stay, a copy of the Notice of Adverse Benefit Determination will be sent to the provider. The Health Plan is required to make decisions regarding the prior authorization according to these guidelines:

- For standard requests for prior authorized services, a decision must be made as expeditiously as the member's health condition requires, but not later than fourteen calendar days following the receipt of the authorization request, with a possible extension of up to fourteen calendar days if the member or provider requests an extension, or if the Health Plan justifies a need for additional information and the delay is in the member's best interest;
- An expedited authorization decision for prior authorized services can be requested if the Health Plan or the provider determines that using the standard timeframe could seriously jeopardize the member's life and/or health or the ability to attain, maintain or regain maximum function. The Health Plan will make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires but no later than three working days following the receipt of the authorization request, with a possible extension of up to fourteen calendar days if the member or provider requests an extension, or if the Health Plan justifies a need for additional information and the delay is in the member's best interest
- When the Health Plan receives an expedited request for a service authorization and the requested service is not of an urgent medical nature, the Health Plan may downgrade the expedited authorization request to a standard request. The Health Plan Behavioral Health Utilization Care Manager notifies the requesting provider of such downgrade and gives the provider an opportunity to disagree with the decision.

End of chapter.