Section 3.14 Securing Services and Prior Authorization

3.14.1 Introduction

It is important that persons receiving behavioral health services have timely access to the most appropriate services. It is also important that limited behavioral health resources are allocated in the most efficient and effective ways possible. Prior authorization processes are used to promote appropriate utilization of behavioral health services while effectively managing associated costs. Except during an emergency situation, the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) requires prior authorization before accessing inpatient services in a licensed inpatient facility (a psychiatric acute hospital, a Behavioral Health Inpatient Facility for persons under the age of 21 or a sub-acute facility). In addition, a Regional Behavioral Health Authority (RBHA) may require prior authorization of covered behavioral health services other than inpatient services with the prior written approval of ADHS/DBHS.

Behavioral health services can be accessed for a person by one of two ways:

Securing Most Behavioral Health Services:
Most behavioral health services do not require prior authorization. Based upon the recommendations and decisions of the clinical team (i.e., Child and Family Team or Adult clinical team), any and all covered services that address the needs of the person and family will be secured. During the treatment planning process, the clinical team may use established tools to guide clinical practice and to help determine the types of services and supports that will result in positive outcomes for the person. Clinical teams should make decisions based on a person's identified needs and should not use these tools as criteria to deny or limit services.

Securing Services that Need Prior Authorization:
Prior authorization is required for certain covered behavioral health services. Behavioral health services requiring prior authorization include:

- Non-emergency admissions to an inpatient facility;
- Continued stay in an inpatient facility;

When it is determined that a person is in need of a behavioral health service requiring prior authorization, a behavioral health professional applies the designated authorization and continued stay criteria to approve the provision of the covered service. When appropriate, the RBHA will provide a consultation with the requesting provider to gather additional information to make a determination. A decision to deny a prior authorization request must be made by the RBHA Medical Director or physician designee, or for TRBHAs, by the ADHS/DBHS Medical Director or physician designee.

This section is intended to:

- Present the distinctions between prior authorization of select behavioral health services and securing of all other behavioral health services;
- Describe federal requirements associated with authorization and denial of inpatient services;
- Identify the covered behavioral health services that must be prior authorized; and
- Identify how to access a covered behavioral health service that does not require prior authorization.

3.14.2 Terms

Definitions for terms are located online at http://www.azdhs.gov/bhs/definitions/index.php and http://www.magellanofaz.com/for-providers/provider-manual/definitions.aspx. The following terms are referenced in this section:
Adult Clinical Team
Behavioral Health Inpatient Facility
Behavioral Health Professional
Behavioral Health Residential Facility
Certification of Need (CON)
Child and Family Team
Clinical Teams
Denial
Emergency Behavioral Health Services
Inpatient Services
Medically Necessary Covered Services
Prior authorization
Prudent Layperson
Psychiatric Acute Hospital
Recertification of Need (RON)
Sub-Acute Facility

3.14.3 Procedures

3.14.3-A. Securing services that do not require prior authorization

Who can secure behavioral health services that do not require prior authorization?
The clinical team is responsible for identifying and securing the service needs of each behavioral health recipient through the assessment and service planning processes. Rather than identifying pre-determined services, the clinical team should focus on identifying the underlying needs of the behavioral health recipient, including the type, intensity and frequency of supports needed.

As part of the service planning process, it is the clinical team's responsibility to identify available resources and the most appropriate provider(s) for services. This is done in conjunction with the clinical team, the behavioral health recipient, family, and natural supports. If the service is available through a contracted provider the person can access the service directly. If the requested service is only available through a non-contracted provider or if the clinical team requests services from a non-contracted provider, the clinical team is responsible for coordinating with Magellan Care Management and obtaining the requested service as outlined below. Magellan Care Management can be reached at 1-800-564-5465.

How can services with a non-contracted provider be secured?
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 a clinical team's request. The process for securing services through a non-contracted provider is as follows:

Magellan and its Provider Network Organizations (PNOs) secure services through non-contracted providers with single case (ad hoc) agreements. Decisions regarding single case (ad hoc) services will be made within the timeframes identified for standard or expedited requests in section 3.14.3-D.

For services for children, PNOs contract directly with providers for all levels of care except Level I (Including Sub-Acute), Behavioral Health Residential Facility, ECT, and psychological testing. It is the assigned BHP/BHTs responsibility to secure all clinically necessary services in support of the treatment plan, to include those from non-contracted providers. In the event the BHP/BHTs are unable to secure services through a contracted PNO provider, they will contact the Contract Manager from their respective PNO to initiate the single case (ad hoc) agreement process.

For services for adults, Magellan contracts directly with providers for all levels of care. In the event the BHP/BHT's are unable to secure necessary services through the contracted network, they will call Magellan's Customer Service Department at 1-800-564-5465.

Magellan requires the following information in order to activate the single case/ad hoc agreement:

- Requested service (including covered service codes)
- Provider demographic information (name, license, address, phone number)
- Copy of the service plan indicating needed services have been documented

- Reason for going to a non-contracted provider (e.g., specialty not available otherwise).

If Magellan is not able to create a single case/ad hoc agreement, Magellan will contact the requestor of services to identify alternate providers until appropriate services have been obtained.

Magellan uses a single case/ad hoc agreement to ensure payment to a non-contracted provider.

In the event that a request to secure covered services through a non-contracted provider is denied, notice of the decision must be provided in accordance with Section 5.1, Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons, and Section 5.5, Notice and Appeal Requirements (SMI and General).

It is Magellan's policy to minimize the use of single case agreements. When adequate, alternative in-network providers are available in a timely manner to meet the need, these can and should be used.

Requests for Single Case Agreements will be reviewed by the RBHA to ensure that network resources have been exhausted as an option for the service and will be completed based on clinical appropriateness. The RBHA will periodically review all SCAs for ongoing need; all decisions will be based on the individual recipient's needs. The cost to the recipient for out of network services will be no greater than if services were provided within the network.

What is the purpose of a utilization review process?
Behavioral health providers may choose to adopt tools, such as service planning guidelines, to retrospectively review the utilization of services. The goals of utilization review include:

- Detecting over and under-utilization of services;
- Defining expected service utilization patterns;
- Facilitating the examination of clinicians and clinical teams that are effectively allocating services; and
- Identifying clinicians and behavioral health providers who could benefit from technical assistance.

Magellan monitors for potential under/over utilization of services in the following areas:

- Court-ordered services for adults
- Crisis/Inpatient Psychiatric Acute Hosptial and Sub-Acute)
- Post Psychiatric Acute Hosptial and Sub-Acute) treatment plan timeliness and compliance along with Residential (Behavioral Health Inpatient Facility, Behavioral Health Residential Facility, and HCTC)
- Specific pharmacy practices.

These areas have been identified for review as they are either high risk, high volume or of high strategic importance for implementing the recovery model for adults or the Arizona Vision and Principles for children and families.

3.14.3-B. Accessing services that require prior authorization

What does prior authorization do?
Prior authorization seeks to ensure that persons are treated in the most appropriate, least restrictive and most cost effective setting, with sufficient intensity of service and supervision to safely and adequately treat the person's behavioral health condition. When a clinical team initiates a request for a service requiring prior authorization, the request must immediately be forwarded to the personnel responsible for making prior authorization decisions.

When is prior authorization available?
RBHAs or behavioral health providers must have staff available 24 hours a day, seven days a week to receive requests for any service that requires prior authorization.

What about emergencies?
Prior authorization must never be applied in an emergency situation. A retrospective review may be conducted after the person's immediate behavioral health needs have been met. 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 layperson, similarly situated, would have requested such services.

What is 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 person's admission. Although a CON must be submitted prior to a person's admission (except in an emergency), a CON is not an authorization tool designed to approve or deny an inpatient service, rather it is a federally required attestation by a physician that inpatient services are or were needed at the time of the person's admission. The decision to authorize a service that requires prior authorization is determined through the application of admission and continued stay authorization criteria. In the event of an emergency, the CON must be submitted:

- For persons age 21 or older, within 72 hours of admission; and
- For persons under the age of 21, within 14 days of admission.

For a sample CON form, see PM Form 3.14.1.

What is Re-certification Of Need (RON)?
A RON is a re-certification made by a physician, nurse practitioner or physician assistant that inpatient services are still needed for a person. A RON must be completed at least every 60 days for a person who is receiving services in a Level I facility. An exception to the 60-day timeframe exists for inpatient services provided to persons under the age of 21. The treatment plan (individual plan of care) for persons under the age of 21 in an inpatient facility must be completed and reviewed every 30 days. The completion and review of the treatment plan in this

circumstance meets the requirement for the re-certification of need. For a sample RON form, see PM Form 3.14.2.

What must be documented on a CON or RON?
The following documentation is needed on a CON and RON:

- Proper treatment of the person'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 person'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 person; and
- CONs, a dated signature by a physician;
- RONs, a dated signature by a physician, nurse practitioner or physician assistant.

Additional CON requirements

- If a person becomes eligible for Title XIX or Title XXI services while receiving inpatient services, the CON must be completed and submitted to Magellan's Care Management Department at fax number 1-888-290-1285 prior to the authorization of payment.
- For persons under the age of 21 receiving inpatient psychiatric services:
- Federal rules set forth additional requirements for completing CONs when persons under the age of 21 are admitted to, or are receiving services in an inpatient facility. These requirements include the following:
- For an individual who is Title XIX/XXI eligible when admitted, the CON must be completed by the clinical team that is independent of the facility and must include a physician who has knowledge of the person's situation and who is competent in the diagnosis and treatment of mental illness, preferably child psychiatry;
    - For emergency admissions, the CON must be completed by the team responsible for the treatment plan within 14 days of admission. This team is defined in 42 CFR §441.156 as "an interdisciplinary team of physicians and other personnel who are employed by, or provide services to patients in the facility"; and
    - For persons 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 of time for which claims for payment are made.

What criteria are used to determine whether to approve or deny a service that requires prior authorization?

For services in a psychiatric acute hospital or a sub-acute facility, ADHS/DBHS has developed the following criteria to be used by all T/RBHAs and behavioral health providers:

- ADHS/DBHS Admission to Psychiatric Acute Hospital or Sub-Acute Facility Authorization Criteria (see PM Attachment 3.14.1); and

- ADHS/DBHS Continued Psychiatric Acute Hospital or Sub-Acute Facility Authorization Criteria (see PM Attachment 3.14.2).

For services in a Behavioral Health Inpatient Facility for persons under the age of 21, ADHS/DBHS has developed the following criteria to be used by all T/RBHAs and behavioral health providers:

Prior to denials for Behavioral Health Inpatient Facility or sub-acute facility placement, RBHA Medical Directors or designees are expected to talk with the treating psychiatrist/psychiatric nurse practitioner most familiar with the child in order to gather any additional information that could be helpful in making the determination. If a psychiatrist or psychiatric nurse practitioner has not yet been involved, an evaluation should be arranged in order for the RBHA Medical Director or designee to obtain the professional opinion of a behavioral health clinician.

In addition, if a denial is issued for admission to a Behavioral Health Inpatient Facility or sub-acute facility, the RBHA is expected to provide a clearly outlined alternative plan at the time of the denial. This may require development of a Child and Family Team (CFT), if one has not already been established, or consultation with the CFT. It is expected that the alternative treatment plan will adequately address the behavioral health treatment needs of the child and will provide specific information detailing what services will be provided, where these services will be provided, and when these services will be available and what specific behaviors will be addressed by these services. It is also expected that the alternative treatment plan will include what crisis situations can be anticipated and how the crises will be addressed.

ADHS/DBHS Admission to Behavioral Health Inpatient Facility Authorization Criteria (see PM Attachment 3.14.3); and

ADHS/DBHS Continued Behavioral Health Inpatient Facility Authorization Criteria (see PM Attachment 3.14.4).

For services in a Behavioral Health Residential Facility, or HCTC facility, ADHS/DBHS has approved Magellan's Admission and Continued Stay authorization criteria. See Magellan Criteria:

- Child and Adolescent Behavioral Health Residential Facility Admission and Continued Stay Authorization Criteria Attachment 3.14.5
- Child and Adolescent Behavioral Health Residential Facility Admission and Continued Stay Authorization Criteria Attachment 3.14.6
- Child and Adolescent HCTC Admission and Continued Stay Authorization Criteria Attachment 3.14.7
- Adult Behavioral Health Residential Facility Admission and Continued Stay Authorization Criteria Attachment 3.14.8

- Adult Behavioral Health Residential Facility Admission and Continued Stay Authorization Criteria Attachment 3.14.9
- Adult HCTC Admission and Continued Stay Authorization Criteria Attachment 3.14.10

See section 13.0 - Forms (under 3.14) for Magellan's Electroconvulsive Therapy (ECT) Criteria and Magellan's Psychological Testing Criteria.

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

3.14.3-C. Prior authorization procedures for behavioral health providers contracted by a RBHA

What services must be prior authorized?
Services requiring prior authorization are:

- Non-emergency admission to and continued stay in an inpatient facility;
- Admission to and continued stay in a Behavioral Health Residential Facility (Adults, Child/Adolescent)
- Admission to and continued stay in treatment for Home Care Training to Home Care Client (HCTC) services;
- Non-emergency services outside the geographic service area of the RBHA
- Non-emergency services outside the RBHA contracted Provider Network
- Psychological and Neuropsychological Testing;
- Specific Pharmacy Practices; (Refer to Section 3.16, Behavioral Health Drug List
- Electroconvulsive Therapy (ECT) and;
- Non-emergency out of network single case agreement

Who makes prior authorization decisions?
A RBHA behavioral health professional is required to prior authorize services unless it is a decision to deny. A decision to deny must be made by the RBHA Medical Director or physician designee.

How is prior authorization applied in an emergency admission?
Prior authorization must never be applied in an emergency situation.

What are the considerations for denials?
A denial of a request for admission to or continued stay in an inpatient facility can only be made by the RBHA's Medical Director or physician designee after verbal or written collaboration with the requesting clinician.

For Title XIX/XXI covered services requested by persons who are Title XIX/XXI eligible or who have been determined to have a serious mental illness, Magellan must provide the person(s) requesting services with a Notice of Action (see PM Form 5.1.1) following:

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

Notice must be provided in accordance with Section 5.1, Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons. Before a final decision to deny is made, the person's attending psychiatrist can ask for reconsideration and present additional information.

Magellan ensures 24-hour access to a delegated psychiatrist or other physician designee for any denials of inpatient admission.

What documentation must be submitted to obtain a prior authorization and what are the timeframes for making a decision?
For requests for admission, authorization will not be provided without all the requested documentation. Decisions will be made in accordance with timeframes for standard and expedited requests in this section.
The following documentation is required:

- Requests for authorization to a non-emergent Psychiatric Acute Hospital or Sub-Acute facility admission must be made telephonically by the provider to Magellan's Customer Service Department at 1-800-564-5465, 24 hours a day, 365 days a year. A determination will be made within 1 hour.
- Requests for authorization for a non-emergent admission to a Psychiatric Acute Hospital or Sub-Acute Facility require a Certification of Need (CON) (PM Form 3.14.1) CON – Adult Psychiatric Acute Hospital; CON – Adult Sub-Acute Facility; CON – Adult Psychiatric Hospital - Detox; CON – Child and Adolescent Psychiatric Acute Hospital must be submitted to Magellan via fax at: for adults 1-888-290-1285; for child and adolescents 1-866-568-6147.
- Requests for authorization to a non emergent Behavioral Health Inpatient Facility must be made telephonically to Magellan's Customer Service Department at 1-800-564-5465. The CFT must submit at time of pre service request a signed Guardian Request for Behavioral Health Inpatient Facility form 3.14.8, and all applicable information listed on the Behavioral Health Inpatient Facility Additional Requested Information, form 3.14.9, to Magellan Care Management at fax number 1-866-568-6147.
- Requests for authorization to a Behavioral Health Inpatient Facility require a CON (PM Form 3.14.1; CON –Behavioral Health Inpatient Facility, CON –Behavioral Health

Inpatient Facility - Chemical Dependency must be submitted to Magellan via fax at 1-866-568-6147.

- If a person becomes Title XIX/XXI eligible after discharge from a Psychiatric Acute Hospital or Sub-Acute facility, the rendering provider may request a retrospective authorization. For a retrospective authorization to occur, the provider must submit a CON (PM Form 3.14.1) CON – Adult Psychiatric Acute Hospital; CON – Adult sub-Acute Facility; CON – Adult Psychiatric Acute Hospital - Detox; CON – Child and Adolescent Psychiatric Acute Hospital must be submitted to Magellan and a copy of the medical record to Magellan via secure mail to 4801 E. Washington St. Phoenix, AZ 85034 (Attention Care Management Department).

- Requests for authorization to a Child and Adolescent Behavioral Health Residential facility require a Magellan Request for Child/Adolescent Behavioral Health Inpatient Facility or Behavioral Health Residential Facility Intervention, form 3.14.7 be faxed to Magellan Care Management at 1-866-568-6147 follow by telephonic notification to Magellan Care Management via Magellan's Customer Service Department at 1-800-564-5465 of faxed request.

- Requests for authorization to a Child and Adolescent HCTC facility require that a Magellan Form Request for Child/Adolescent HCTC intervention, form 3.14.6, be faxed to Magellan Care Management at 1-866-568-6147 follow by telephonic notification to Magellan Care Management via Magellan's Customer Service Department at 1-800-564-5465 of faxed request.

- Requests for authorization to an Adult Behavioral Health Residential Facility or HCTC provider require that a Magellan Request for Adult Behavioral Health Residential Facility, and HCTC Preadmission, form 3.14.5, must be completed by the PNO Clinical Director and faxed to Magellan Care Management at 1-888-290-1285. The faxed form must be followed by telephonic notification to Magellan Care Management via Magellan's Customer Service Department at 1-800-564-5465.

For ECT and Psychological and Neuropsychological Testing:
Requests for authorization for ECT, complete the Request for ECT form and fax to 1-888-290-1285; or for urgent requests call 1-800-564-5465 to review with Magellan's Care Management Department.

Requests for authorization for psychological and neuropsychological testing, complete the Request for Testing form and fax it to Magellan's Care Management Department at 1-888-290-1285.

For medications:
For requests for prior authorization for medications, Magellan contracted prescribing clinicians shall refer to Section 3.16, Behavioral Health Drug List. Prior authorization criteria and the PA request form can be found at www.MagellanofAZ.com under the "pharmacy tab" in the "Services" area.

Decisions to prior authorize inpatient admission must be made according to these guidelines:

- Standard requests: For standard requests for prior authorization services, a decision must be made as expeditiously as the member's health condition requires, but not later than fourteen (14) calendar days following the receipt of the authorization request, with a possible extension of up to fourteen (14) calendar days if the member or provider requests an extension, or if the RBHA justifies a need for additional information and the delay is in the member's best interest.

- Expedited requests: An expedited authorization decision for prior authorization services can be requested if the RBHA or 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 RBHA must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires but no later than three (3) working days following the receipt of the authorization request, with a possible extension of up to fourteen (14) calendar days if the member or provider requests an extension, or if the RBHA justifies a need for additional information and the delay is in the member's best interest.

- When a RBHA receives an expedited request for a service authorization and the requested service is not of an urgent medical nature, the RBHA may downgrade the expedited authorization request to a standard request. Any service authorization request that is identified as expedited, will be reviewed. The review will identify if the person's health will be in serious jeopardy (serious harm to life or health or ability to attain, maintain or regain maximum function) by waiting 14 days for a decision. Based on the information received, if it is determined the request does not meet the criteria, the request will be downgraded from expedited to standard. The requestor will be notified of this process and of the decision to downgrade the request from expedited to standard.

For requests for continued stay, Magellan contracted Level of Care providers must call Magellan's Care Management Department at 1-800-564-5465 to make the request for ongoing care. Requests for continued stay must be submitted within the following timelines:

- Requests for continuing care within a Psychiatric Acute Hospital or sub–acute facility must be initiated by the contracted rendering provider prior to the last day of the expiration of the current authorization.

- For Psychiatric Acute Hospital or sub–acute facility requests for continued stay, Magellan will make a determination within three hours of the request. An appropriate service matching completed Recertification of Need (RON PM 3.14.2 form) must be faxed to Magellan at faxed to 1-888-290-1285 for Adults and Child and Adolescents Fax 1-866-568-6147 at time of review and prior to receiving payment.

- Requests for continuing care within a Behavioral Health Inpatient facility must be initiated by the rendering provider by telephonic review by contacting Magellan Customer Service at 1-800-564-6147 at least one week prior to the expiration of the current authorization. Magellan will make a determination within 24 hours or one business day of the completed request. An accurate and complete RON (see RON PM Form 3.14.2) from the Child and Adolescent Behavioral Health Inpatient Facility must be received prior payment. Fax RON to 1-866-568-6147: and

- **Child and Adolescent Behavioral Health Residential Facilities**: The initial authorization is valid up to 60 days. A request for continued stay authorization must be made telephonically by the rendering provider to Magellan Care Management at 1-800-564-5465 via Customer Service at least two weeks prior to the last day of the expiration of the current authorization; and

- **Child and Adolescent HCTC**: The initial authorization is valid up to 90 days. A request for continued stay authorization must be made telephonically by the rendering provider to Magellan Care Management at 1-800-564-5465 via Customer Service at least two weeks prior to the last day of the expiration of the current authorization; and

- **Adult Behavioral Health Residential Facilities**: The initial authorization is valid up to 60 days. A request for continued stay authorization by the rendering provider must include either a Adult Behavioral Health Residential Facility or HCTC Continued Stay Review form 3.14.4 or a telephonic review to Magellan Care Management at 1-800-564-5465 via Customer Service at least two weeks prior to the last day of the expiration of the current authorization; and

- **Adult HCTC**: The initial authorization is valid up to 90 days. A request for continued stay authorization by the rendering provider must include either an Adult Behavioral Health Residential Facility or HCTC Adult Continued Stay Review form 3.14.4 or a telephonic review to Magellan Care Management at 1-800-564-5465 via Customer Service at least two weeks prior to the last day of the expiration of the current authorization**.**

3.14.3-D. Prior authorization procedures for behavioral health providers contracted by a Tribal RBHA

What services must be prior authorized?
Services requiring prior authorization are:

- Non-emergency admission to and continued stay in an inpatient facility; and

- Admission and continued stay in a Behavioral Health Residential Facility for persons under the age of 21.

Who makes prior authorization decisions?
The T/RBHA behavioral health professional is required to prior authorize services unless it is a decision to deny. A decision to deny must be made by the ADHS/DBHS Medical Director or physician designee.

How is prior authorization applied in emergency admission?
Prior authorization must never be applied in an emergency situation.

What are the considerations for denials?
A denial of a request for admission to or continued stay in an inpatient facility can only be made by the ADHS/DBHS Medical Director or physician designee after verbal or written collaboration with the requesting clinician.

For Title XIX/XXI covered services requested by persons who are Title XIX/XXI eligible or who have been determined to have a serious mental illness, ADHS/DBHS must provide the person(s) requesting services with a Notice of Action (see PM Form 5.1.1) following:

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

Notice must be provided in accordance with Section 5.1, Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons. Before a final decision to deny is made, the person's attending physician can ask for reconsideration and present additional information.

Upon denial of a service requiring prior authorization by the ADHS/DBHS Medical Director or physician designee, a letter is sent to providers notifying that the service was denied and the reason(s) for the denial.

What documentation must be submitted to obtain a prior authorization and what are the timeframes for making a decision?
Prior to admission (for requests made Monday through Friday 8:00 a.m. to 5:00 p.m.) or within 24 hours of an admission (for requests made after 5:00 pm Monday through Friday, on weekends or State holidays) the following must be submitted to the ADHS/D BHS/ Bureau of Quality & Integration(BQ&I) (Facsimile number (602) 364-4697):

Inpatient:

- CON;
- TRBHA prior authorization request form (see PM Form 3.14.3); and
- The person's service plan (see Section 3.9, Intake, Assessment and Service Planning).

Decisions to prior authorize inpatient admission must be made according to these guidelines:

- Standard requests: For standard requests for prior authorization services, a decision must be made as expeditiously as the member's health condition requires, but not later than

fourteen (14) calendar days following the receipt of the authorization request, with a possible extension of up to fourteen (14) calendar days if the member or provider requests an extension, or if the T/RBHA justifies a need for additional information and the delay is in the member's best interest.

- Expedited requests: An expedited authorization decision for prior authorization services can be requested if the T/RBHA or 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 T/RBHA must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires but no later than three (3) working days following the receipt of the authorization request, with a possible extension of up to fourteen (14) calendar days if the member or provider requests an extension, or if the T/RBHA justifies a need for additional information and the delay is in the member's best interest.

Authorization cannot be provided without all the required documentation. For services provided after hours, on weekends or on State holidays, prior authorization must be obtained on the next business day.

A provider may also telephone the BQ&I at (602) 364-4648 or (602) 364-4642. After hours (after 5:00 pm Monday through Friday, on weekends or State holidays) a voice message can be left at the same number and the call will be returned the next business day.

Prior authorization is not required for Non-Title XIX/XXI individuals. If Title XIX or Title XXI eligibility is determined during the hospitalization, providers may request a retrospective authorization. For retrospective authorization to occur, a provider must submit a CON and the person's service plan to the BQ&I by the next business day following the person's Title XIX or Title XXI eligibility determination.

For requests for continued stay, the following documentation must be submitted to the / BQ& I Facsimile number (602) 364-4697):

Inpatient:

- RON; and
- The person's service plan (Behavioral Health Inpatient Facility only) (see Section 3.9, Intake, Assessment and Service Planning).

3.14.3-E. Prior authorizing medications

DBHS has developed a behavioral health drug list for use for all contractors. This list denotes all drugs which require prior authorization. These prior authorization criteria have been developed by the state wide DBHS pharmacy and therapeutics committee, and must be used by all non-tribal contractors. TRBHAs may choose to participate in implementing these prior authorization criteria. Medications or other prior authorization criteria may not be added to any contractors medication list. For specific information on medications requiring prior authorization, see Section 3.16, ADHS/DBHS Behavioral Health Drug List. The approved prior authorization criteria are

posted on the ADHS/DBHS Behavioral Health Drug List and Prior Authorization Guidance Documents website**.** For implementation of this process for prior authorization the following requirements must be met:

- Adherence to all prior authorization requirements outlined in this section, including:
- Prior authorization availability 24 hours a day, seven days a week;
- Standard requests: For standard requests for prior authorization services, a decision must be made as expeditiously as the member's health condition requires, but not later than fourteen (14) calendar days following the receipt of the authorization request, with a possible extension of up to fourteen (14) calendar days if the member or provider requests an extension, or if the RBHA justifies a need for additional information and the delay is in the member's best interest.
- Expedited requests: An expedited authorization decision for prior authorization services can be requested if the RBHA or 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 RBHA must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires but no later than three (3) working days following the receipt of the authorization request, with a possible extension of up to fourteen (14) calendar days if the member or provider requests an extension, or if the RBHA justifies a need for additional information and the delay is in the member's best interest.
- Assurance that a person will not experience a gap in access to prescribed medications due to a change in prior authorization requirements. RBHAs and behavioral health providers must ensure continuity of care in cases in which a medication that previously did not require prior authorization must now be prior authorized; and
- Incorporation of notice requirements when medication requiring prior authorization is denied, suspended or terminated.

3.14.3-F. Coverage and payment of emergency behavioral health services

The following conditions apply with respect to coverage and payment of emergency behavioral health services for persons who are Title XIX or Title XXI eligible:

- Emergency behavioral health services must be covered and reimbursement made to providers who furnish the services regardless of whether the provider has a contract with a T/RBHA;
- Payment must not be denied when:
- A T/RBHA or behavioral health provider instructs a person to seek emergency behavioral health services;
- A person has had an emergency behavioral health condition, including cases in which the absence of medical attention would have resulted in:

- Placing the health of the person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.
- Emergency behavioral health conditions must not be limited to a list of diagnoses or symptoms;
- A T/RBHA may not refuse to cover emergency behavioral health services based on the failure of a provider to notify the T/RBHA of a person's screening and treatment within 10 calendar days of presentation for emergency services.
- A person who has an emergency behavioral health condition must not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the person; and
- The attending emergency physician, or the provider actually treating the person, is responsible for determining when the person is sufficiently stabilized for transfer or discharge, and such determination is binding the T/RBHA.

The following conditions apply with respect to coverage and payment of post-stabilization care services for persons who are Title XIX or Title XXI eligible:

- The T/RBHA is responsible for ensuring adherence to the following requirements, even in situations when the function has been delegated to a subcontracted provider;
- Post-stabilization care services must be covered without authorization and reimbursement made to providers that furnish the services regardless of whether the provider has a contract with a T/RBHA for the following situations:
- Post-stabilization care services that were pre-authorized by the T/RBHA;
- Post-stabilization care services that were not pre-authorized by the T/RBHA or because the T/RBHA did not respond to the treating provider's request for pre-approval within one hour after being requested to approve such care or could not be contacted for pre-approval; or
- The T/RBHA and the treating physician cannot reach agreement concerning the member's care and a T/RBHA physician is not available for consultation. In this situation, the T/RBHA must give the treating physician the opportunity to consult with a contracted physician and the treating physician may continue with care of the member until a contracted physician is reached or one of the following criteria is met:

- A T/RBHA physician with privileges at the treating hospital assumes responsibility for the person's care;
- A T/RBHA physician assumes responsibility for the person's care through transfer;
- The T/RBHA and the treating physician reach an agreement concerning the person's care; or
- The person is discharged.

3.14.4 References

The following citations serve as additional resources for this content area:

42 CFR 438.10 (a)
42 CFR 438.114
42 CFR 441
42 CFR 456
9 A.A.C.
9 A.A.C. 34
R9-22-210
R9-22-1204
R9-22-1205
R9-31-210
R9-31-1205
AHCCCS/ADHS Contract
ADHS/RBHA Contract
ADHS/T/RBHA IGAs
Section 3.9 Assessment and Service Planning
Section 3.16 ADHS/DBHS Behavioral Health Drug List
Section 5.1 Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons
Section 5.2 Member Complaints
Section 5.3 Grievance and Request for Investigation for Persons Determined to have a Serious Mental Illness (SMI)
Section 5.5 Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI)
ADHS/DBHS website, Behavioral Health Drug List and Prior Authorization Guidance Documents
Practice Improvement Protocol 8, The Adult Clinical Team
DBHS Practice Protocol , The Child and Family Team
Technical Assistance Document 3, The Child and Family Team Process
The Arizona Vision and Twelve Principles

3.14.5 Forms
Will be added here in final document

3.14.6 Attachments
Will be added here in final document