Section 3.13 Covered Health Services

3.13.2 Introduction

The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) system of care offers an assortment of covered behavioral health services to meet the individual needs of persons eligible for behavioral health services. Covered behavioral health services assist and encourage each person to achieve and maintain the highest possible level of health and self-sufficiency. The type of behavioral health service covered is contingent on each person's current eligibility status and, for some persons, is based on available funding.

3.13.2 Terms:

Definitions for terms are located online at http://www.azdhs.gov/bhs/definitions/index.php or http://www.narbha.org/for-providers/provider-resources/provider-policy-manual/definitions. The following terms are referenced in this section:

Geographic Service Area (GSA)

Flex Funds

Medically necessary covered services

RBHA

Transportation Services

Tribal RBHA

3.13.3 References

The following citations can serve as additional resources for this content area:
42 CFR Part 400
42 CFR Part 403
42 CFR Part 411

42 CFR Part 417
42 CFR Part 422
42 CFR Part 423
9 A.A.C. 21
R9-22-1205
R9-31-1205
AHCCCS/ADHS Contract
ADHS/RBHA Contracts
ADHS/TRBHA IGAs
Section 3.1, Eligibility for AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage, and the Limited Income Subsidy Program
Section 3.4, Co-payments
Section 3.19, Special Populations
Section 3.25, Crisis Intervention Services
Section 5.1, Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons
Section 5.4, Special Assistance for Persons Determined to Have a Serious Mental Illness
Section 5.5, Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI)
ADHS/DBHS Covered Behavioral Health Services Guide
A.R.S. § 36-2233
A.A.C. R9-22-211
AHCCCS Medical Policy Manual (AMPM) Chapter 300, Policy 310 Covered Services,
AHCCCS Medical Policy Manual (AMPM) Chapter 300, Policy 310 Covered Services, 310 BB-Transportation
AHCCCS Contractor Operations Manual Chapter 200, Policy 205 Ground Ambulance Transportation Reimbursement Guidelines for Non-Contracted Providers

3.13.4 Scope

To whom does this apply?

All Title XIX/XXI (Medicaid/SCHIP) and Title XVIII (Medicare) eligible persons; and all Non-Title XIX/XXI persons determined to have a Serious Mental Illness and all other persons receiving services as part of the behavioral health system, based on available funding.

3.13.5 Did you know…?

The ADHS/DBHS Covered Behavioral Health Services Guide contains information regarding each of the covered behavioral health services that are available through the publicly funded behavioral health system including: a definition of each service; the requirements of individuals or agencies providing the service; and any limitations to using or billing for the service.

Providers must screen individuals for AHCCCS eligibility and, as applicable, assist individuals with applying for AHCCCS and/or enrolling in Medicare Part D (see Section 3.1, Eligibility Screening for AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage and the Limited Income Subsidy Program). Medicare eligible behavioral health recipients, including persons who are dually eligible for Medicare (Title XVIII) and Medicaid (Title XIX/XXI), receive Medicare Part D prescription drug benefits through Medicare Prescription Drug Plans (PDPs) or Medicare Advantage Prescription Drug Plans (MA-PDs). Prescription drug coverage for Medicare eligible behavioral health recipients enrolled in Part D is based on Part D plans'

formularies. Individuals who refuse to participate in the AHCCCS screening and eligibility application process or to enroll in a Medicare Part D plan are ineligible for state funded behavioral health services. In addition, providers must obtain documentation from individuals during the screening process to verify lawful presence in the United States (see Section 3.27, Verification of U.S. Citizenship or Lawful Presence for Public Behavioral Health Benefits). Individuals unable to provide such documentation to verify citizenship or lawful presence are not eligible for state funded behavioral health services, other than crisis services. Crisis services are provided to any person presenting with a behavioral health crisis in the community, regardless of eligibility or enrollment status (see Section 3.25, Crisis Intervention Services).

Services for Non-Title XIX/XXI persons determined to have a Serious Mental Illness are subject to available funding, as appropriated by the Arizona Legislature. T/RBHAs must ensure that Non-Title XIX/XXI funding allocated by ADHS/DBHS for each geographic service area (GSA) is available for services throughout the fiscal year.

Decisions made with respect to the coverage and provision of services are subject to Notice and Appeal requirements (see 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 Non-SMI/Non-Title XIX/XXI). Behavioral health services must be medically necessary, based upon the needs of the person, and providers must operate within their scope of practice.

Services must be provided in collaboration with other agencies to coordinate the culturally appropriate delivery of covered behavioral health services with other services and supports provided to the person and the person's family.

Covered behavioral health services may be available to family members of Title XIX/XXI eligible persons enrolled with a T/RBHA to the extent that services are provided in support of the treatment goals of the identified eligible or enrolled person.

3.13.6 Objectives

The intent of this section is to identify the covered services available to behavioral health recipients based upon their eligibility status.

3.13.7 Procedures

3.13.7-A: Covered services matrix

a. T/RBHAs must include in the T/RBHA Provider Manual a description of covered services. T/RBHAs must communicate the availability of covered services to members through the T/RBHA member handbooks.

b. T/RBHAs must cover behavioral health services consistent with the table below.

AVAILABLE BEHAVIORAL HEALTH SERVICES*

SERVICES		TITLE XIX/XXI CHILDREN AND ADULTS	NON-TITLE XIX/XXI PERSONS DETERMINED TO HAVE SMI
TREATMENT SERVICES			
Behavioral Health Counseling and Therapy	Individual	Available	Not Available
	Group	Available	Not Available
	Family	Available	Not Available
Behavioral Health Screening, Mental Health Assessment and Specialized Testing	Behavioral Health Screening	Available	Not Available
	Mental Health Assessment	Available	Available
	Specialized Testing	Available	Not Available
Other Professional	Traditional Healing	Not Available with TXIX/XXI funding**	Not Available**
	Auricular Acupuncture	Not Available with TXIX/XXI funding**	Not Available**
REHABILITATION SERVICES			
Skills Training and Development	Individual	Available	Available
	Group	Available	Available
	Extended	Available	Available
Cognitive Rehabilitation		Available	Available
Behavioral Health Prevention/Promotion Education		Available	Available
Psycho Educational Services and Ongoing Support to Maintain Employment	Psycho Educational Services	Available	Available
	Ongoing Support to Maintain Employment	Available	Available
MEDICAL SERVICES			
Medication Services***		Available	Available
Lab, Radiology and Medical Imaging		Available	Available
Medical Management		Available	Available
Electro-Convulsive Therapy		Available	Not Available

SERVICES		TITLE XIX/XXI CHILDREN AND ADULTS	NON-TITLE XIX/XXI PERSONS DETERMINED TO HAVE SMI
SUPPORT SERVICES			
Case Management		Available	Available (See Case Manager Assignment Criteria in Attachment A)
Personal Care		Available	Available
Home Care Training (Family)		Available	Available
Self-help/Peer Services		Available	Available
Home Care Training to Home Care Client (HCTC)		Available	Not Available
Respite Care****		Available	Available
Supported Housing		Provided based on available grant funding**	Provided based on available grant funding**
Sign Language or Oral Interpretive Services		Provided at no charge to the member	Provided at no charge to the member
Flex Fund Services		Provided based on available grant funding**	Provided based on available grant funding**
Transportation	Emergency	Available	Limited to crisis service-related transportation
	Non-emergency	Available	Available
CRISIS INTERVENTION SERVICES			
Crisis Intervention – Mobile		Available	Available
Crisis Intervention – Telephone		Available	Available
Crisis Services – Stabilization		Available	Available
INPATIENT SERVICES			
Hospital		Available	Available but limited*****

SERVICES	TITLE XIX/XXI CHILDREN AND ADULTS	NON-TITLE XIX/XXI PERSONS DETERMINED TO HAVE SMI
Behavioral Health Inpatient Facility	**Available**	**Available but limited*****
RESIDENTIAL SERVICES		
Behavioral Health Residential Facility	**Available**	**Available but limited*****
Room and Board	**Not Available with TXIX/XXI funding****	**Not Available**
BEHAVIORAL HEALTH DAY PROGRAMS		
Supervised Day	**Available**	**Available**
Therapeutic Day	**Available**	**Not Available**
Medical Day	**Available**	**Not Available**

Limitations:
*Services may be available through federal block grants**Services not available with TXIX/XXI funding or state funds, but may be provided if grant funding or other funds are available.
***See the ADHS/DBHS Drug List for further information on covered medications.
****No more than 600 hours of respite care per contract year (October 1st through September 30th) per person.
*****Coverage is limited to 23 hour crisis observation/stabilization services, including detoxification services. Up to 72 hours of additional crisis stabilization may be covered, based upon the availability of funding.

3.13.7-B: Transportation Services

Transportation services involve the transporting of a person from one place to another to facilitate the receipt of, or benefit from, medically necessary covered health services, and to allow the person to achieve their service plan goals. Covered transportation services include:

- Emergency transportation
- Medically necessary non-emergency transportation, and
- Medically necessary maternal and newborn transportation

The service may also include the transportation of a person's family/caregiver with or without the presence of the person if provided for the purposes of carrying out the person's service plan (e.g., counseling, family support, case planning meetings). Urban transports are defined as those originating within the Phoenix or Tucson metropolitan areas. All other transports are defined as rural. Odometer readings or other NARBHA approved documentation methods that clearly and accurately support mileage may be used when billing transportation services.

Transportation Services may be provided by:

i. Non-emergency transportation providers (e.g., vans, buses, taxis) who are registered with AHCCCS as a non-emergency transportation provider and have proof of insurance, a valid driver's license, and insurance as required by state law.
ii. Emergency transport providers (e.g. air or ground ambulance) who are registered with AHCCCS as emergency transportation providers and have been granted a

certificate of necessity by the Arizona Department of Health Services/Bureau of Emergency Medical Services (A.R.S. 36-2233)

iii. In most instances, transportation services should be provided by non-emergency transportation providers.

Emergency ground and air ambulance services required to manage an emergency medical condition of a member at an emergency scene and/or to transport to the nearest appropriate facility are covered for all members. Emergency transportation is needed:

a. When an individual's condition is such that the use of any other method of transportation is contraindicated and medically necessary health care services are not available in the hospital from which the person is being transported and/or;

b. When an individual's condition is such that the use of any other method of transportation is contraindicated and medically necessary health care services are not available in the hospital from which the person is being transported and/or;

c. A sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such as the absence of immediate medical attention could be expected to result in:
   i. Placing the member's health in serious jeopardy;
   ii. Serious impairment of bodily functions; or
   iii. Serious dysfunction of any bodily part or organ.

Emergency transportation service shall not require prior authorization.
For additional information regarding the amount, duration, and scope of covered emergency transportation services see the AHCCCS Medical Policy Manual 310-BB Transportation Policy.
Non-emergency transportation is provided for all members including persons and/or families who are unable to arrange or pay for their transportation or who do not have access to free transportation in order to access medically necessary covered health services under the following conditions:

a. The behavioral health service for which the transportation is needed is a covered AHCCCS service.
b. The member is not able to provide, secure, or pay for their own transportation and free transportation is not available; and
c. The transportation is provided to and from the nearest appropriate AHCCCS registered provider.

For additional information regarding amount, duration, scope, and additional requirements for ambulance and non-ambulance providers see the AHCCCS Medical Policy Manual 310-BB Transportation Policy.

Access to non-emergency transportation may be a necessary support service for non-Title XIX/XXI SMI individuals to access other covered behavioral health services, such as

medication appointments. Non-emergency transportation for non-Title XIX/XXI SMI members may be covered as a support service with the following limitations:

i Transportation is covered only to and from providers of covered behavioral health services;
ii. Transportation is covered only when no other means of transportation are available to the member to access covered behavioral health services; and
iii. Only the most cost effective mode of transportation that meets the individual clinical needs of the member will be covered. The determination of the appropriate mode of transportation must be based upon the functional limitations of the member, and not as a matter of convenience for the member.

It is the Subcontracted Provider's responsibility to ensure that if a member needs medically necessary transportation, that the transportation is provided and that the member arrives at his/her appointment no sooner than one hour before the appointment, and does not have to wait for more than one hour after the end of their appointment for transportation back to his/her home. For further information regarding appointment standards, please refer to the ADHS/DBHS Policy and Procedures Manual section on appointment standard.

It is the Subcontracted Provider's responsibility to maintain documentation that supports each transport provided. Transportation providers put themselves at risk of recoupment of payment IF the required documentation is not maintained or covered services cannot be verified.

The following elements for record-keeping are recommended for documentation of non-emergency transportation services:

i Complete Service Provider's Name and Address
ii Name and signature of the driver who provided the service
iii Vehicle Identification (car, van, wheelchair van, etc.)
iv Recipient (being transported) name
v Recipient's AHCCCS ID
vi Complete date of service, including month, day and year
vii Complete address of the pick-up site
viii Complete address of drop off destination
ix Type of trip (round trip or one way)
x Escort (if any) must be identified by name and relationship to the member being transported
xi Signature of recipient, verifying services were rendered

When a contract does not exist between a Ground Ambulance Transportation provider and NARBHA, providers are reimbursed for services according to fees established with ADHS or through the AHCCCS Capped Fee for Service Schedule. For further information regarding criteria and reimbursement processes for Ground Ambulance Transportation Reimbursement please refer to AHCCCS ACOM Policy 205, Ground Ambulance Transportation Reimbursement Guidelines for Non-Contracted Providers.

3.13.7-C: Medicare Part D Prescription Drug Coverage

Persons eligible for Medicare Part D must access the Medicare Part D prescription drug coverage by enrolling with a Medicare Prescription Drug Plan (PDP) or Medicare Advantage Prescription Drug plan (MA-PD). Persons eligible for both Medicare Part D and Title XIX/XXI (AHCCCS) will continue to have coverage of the following excluded Part D drugs through Title XIX/XXI, if not included in the PDP or MA plans' formulary:

- Benzodiazepines;
- Barbiturates; and
- Certain over the counter drugs.

3.13.7-D: Flex Funds

NARBHA and the Arizona Department of Health Services has allocated a limited amount of grant monies to be utilized as flex funds. NARBHA's subcontracted providers may provide flex funds based on available funding.

When can flex funds be used?

Flex funds may only be used for goods and/or services that are described in the person's service plan that cannot be purchased by any other funding source. Furthermore, the member receiving flex funds must meet population requirements of the respective Block Grant of which the funds originated. The goods and/or services to be provided using flex funds must be related to one or more of the following outcomes:

- Success in school, work or other occupation;
- Living at the person's own home or with family;
- Development and maintenance of personally satisfying relationships;
- Prevention or reduction in adverse outcomes; and/or
- Becoming or remaining a stable and productive member of the community.

When can flex funds not be used?

Flex funds must not be used for:

- Inpatient or other covered behavioral health services;
- The purchase or improvement of land;
- The purchase, construction or permanent improvement of any building or other facility (with the exception of minor remodeling consistent with this Section); and
- The purchase of major medical equipment.
- Any other prohibited activity as detailed in 45 CFR Part 96.135 et seq.

NARBHA's subcontracted providers must use flex funds for the direct purchase of goods and/or services and may not provide flex funds as direct cash payments to behavioral health recipients

or their families. See the ADHS/DBHS Covered Behavioral Health Services Guide for additional information regarding flex funds and applicable billing limitations.

How are flex funds accessed?
NARBHA may approve flex fund services of up to $1,525 per individual/family per year. Clinical teams may access flex funds by:

- Typically, when a child/family team or adult team approves the use of flex funds for a member/family, NARBHA approval is not required.
- However, to support special programs or initiatives, NARBHA may establish and require prior approval of specially-designated flex funds for certain populations or purposes.
- NARBHA shall notify the Responsible Agencies when prior NARBHA approval is required for access to specially-designated flex funds, the conditions for the use of specially-designated flex funds, and the process for requesting prior NARBHA approval of specially-designated flex funds.

The use of all flex funds shall be documented by the Responsible Agency in the member's clinical record. Documentation shall include:

- The good or service that is being purchased with flex funds;
- The goal or outcome identified in the member's service plan that the use of flex funds supports;
- The amount of flex fund monies approved for the good or service;
- A receipt from the individual or entity selling the good or service that includes the actual purchase price of the good or service and the date purchased.

If a child/family team or adult team identifies that a member/family requires more than $1,525.00 in flex funds per individual in a calendar year, the member's Responsible Agency forwards a written request to the NARBHA Clinical Operations Department. The NARBHA Clinical Operations Department shall review the request, ensure it is consistent with the requirements established in the Covered Behavioral Health Services Guide and forward the request to ADHS/DBHS on behalf of the Responsible Agency.

NARBHA's subcontracted behavioral health providers must forward requests for approval of flex fund expenditures of $1,525 or more using the SAPT/CMHS Flex Fund request (see Attachment B), to the attention of NARBHA substance Use Clinical Coordinator.

13.7–E: Non-Discrimination

Discrimination is prohibited against providers who serve high-risk populations or that specialize in conditions that result in costly treatment.

Attachment A
Case Manager Assignment Criteria for Non-Title XIX/XXI Persons Determined to have SMI
All non-Title XXI/XXI persons determined to have a Serious Mental Illness (SMI) are eligible to receive case management services, but only some Non-Title XXI/XXI persons determined to have SMI will be assigned a Case Manager. The assignment of an identified Case Manager for non-TXIX/XXI adults determined to have SMI shall be based upon an objective and individualized determination of member need using standardized criteria as outlined below. Assigned Case Managers shall be Behavioral Health Professionals or Behavioral Health Technicians as defined by 9 A.A.C. 10. The Behavioral

Health Medical Practitioner (BHMP) shall make the final determination based upon both the criteria outlined below and clinical judgment. This determination shall be documented as follows:

- Document on the **initial comprehensive assessment** upon completion of the assessment;
- Document on the **annual update to the assessment** upon completion of the annual update;
- Document in the **psychiatric progress note** at any time between comprehensive assessments when it is determined that (a) the member qualifies for assignment of an identified Case Manager or (b) the member no longer qualifies for assignment of an identified Case Manager.

A case manager is assigned to non-TXIX eligible adults with SMI when the member has been determined to be at-risk for safely and successfully managing themselves in the community due to treatment non-adherence, severity of symptoms, or inability to independently coordinate their own care or transition between systems, as evidenced by one of the criteria below and documented on PM Form 3.13.1 NARBHA SMI Non-TXIX Case Manager Assignment Determination. Persons with "required" criteria should be assigned a case manager at least until this status is no longer applicable. All persons are given a Notice of Decision (PM Form 5.5.1), including the right to appeal, as per ADHS/DBHS Policy GA 3.5 Notice of Appeal, Requirements (SMI and Non-SMI, NXIX/XXI).

Timing: All SMI Non-TXIX persons as of July 1, 2012 will have this review completed and documented no later than Sept 30, 2012. New enrollees will have the review completed as part of the SMI Determination process. Non-TXIX eligible adults with SMI may be referred to a NARBHA Responsible Agency Behavioral Health Medical Practitioner at any time for a determination/re-determination as needed.

Reporting: Responsible Agencies are required to provide a copy of the PM Form 3.13.1 NARBHA SMI Non-TXIX Case Manager Assignment Determination and PM Form 5.5.1 Notice of Decision for each Non-TXIX/TXXI SMI Determination as a part of the SMI Determination deliverable submitted every 2 weeks to smi.determination@narbha.org.

ADHS/DBHS Criteria:

Individuals who require ongoing assistance to access, maintain and monitor needed services
Individuals who frequently access crisis services
Individuals in need of frequent hospitalizations or inpatient services
Individuals under civil court ordered treatment pursuant to ARS 36-501 et seq **(REQUIRED)**
Individuals residing in the community under the jurisdiction of the Psychiatric Security Review Board (PSRB) as Guilty Except Insane (GEI) or Not Guilty by Reason of Insanity (NGRI) **(REQUIRED)**
Individuals under the jurisdiction of the Arizona Community Protection and Treatment Center (ACPTC) that are living in the community **(REQUIRED)**
Individuals discharged from long term hospitalization or an institutional setting, including the Arizona State Hospital **(REQUIRED)**
Individuals with active involvement in the criminal justice system, including probation, parole or repeated arrests
Individuals on an Assertive Community Treatment (ACT) or Intensive Recovery Team
Individuals who have been determined to need special assistance (see ADHS/DBHS Policy and Procedure Manual GA 3.4. Special Assistance for Persons Determined to have a Serious Mental Illness.**(REQUIRED)**

3.13.8 PM Forms

PM Form 3.13.1 NARBHA SMI Non-TXIX Case Manager Assignment Determination

3.13.9 PM Attachments

PM 3.13.1 Covered Services Matrix

Signature on file 04/01/14

Mary Jo Gregory Date
President and Chief Executive Officer

Signature on file 04/01/14

Teresa Bertsch, MD Date
Chief Medical Officer

Reference ADHS/DBHS Policy 201

ATTACHMENT B

SAPT / CMHS FLEX FUND REQUEST

Client Name		**Date:**	
CIS ID:		**Date of Birth:**	
Request Completed By (Name/Title)			
Provider Name:			
T/RBHA Name:			

Type of funds requested:	☐ SAPT ☐ CMHS	
Amount requested:		
Goods or Services to be purchased:	1.	3.
	2.	4.
Describe how the use of funds relates to the service plan:		
Describe all other avenues of funding that have been explored to meet this need:		
1.		
2.		
3.		
4.		
Payment will be made to:		
In the amount of:		
Client's total year to date flex fund expenditure:		

ALL REQUESTS MUST MEET THE FOLLOWING CONDITIONS:

1. All other avenues of funding for the goods/services requested must have been explored and documented above.
2. The purchase must be directly related to the service plan and the service plan must accompany this document.
3. Receipts must be tracked for all purchases per DBHS policy.
4. Flex funds may not be used to make cash payments to behavioral health recipients or their families
5. All flex funds must be used in accordance with DBHS policy, the T/RBHA Provider Manual, and comply with Federal Block Grant requirements.

Authorizations		
_____ Requesting Provider Staff Member (print)	_____ Signature	_____ Date
_____ RBHA Representative (print)	_____ Signature	_____ Date
_____ ADHS/DBHS Representative (print)	_____ Signature	_____ Date