

**Arizona Department of Health Services
Division of Behavioral Health Services
PROVIDER MANUAL
NARBHA Edition**

Section 3.13 Covered Behavioral Health Services

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3.13.1 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 seeking behavioral health services. The continuum of available services includes supervised and semi-supervised facility-based care, an array of treatment services and support services. Covered behavioral health services assist and encourage each person to achieve and maintain the highest possible level of health and self-sufficiency. The provision of covered behavioral health services is contingent on each person's current eligibility status and, for some persons, may be based on available funding.

3.13.2 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](#)
- [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 3.21, Service Package for Non-Title XIX/XXI Persons Determined to Have a Serious Mental Illness \(SMI\)](#)
- [ADHS/DBHS Covered Behavioral Health Services Guide](#)

3.13.3 Scope

To whom does this apply?

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All Title XIX/XXI (Medicaid/SCHIP) and Title XVIII (Medicare) eligible persons; and

All Non-Title XIX 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 according to [Section 3.21, Service Package for Non-Title XIX/XXI Persons Determined to Have a Serious Mental Illness \(SMI\)](#)

3.13.4 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.

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.

3.13.5 Definitions

[Flex funds](#)

[Medically necessary covered services](#)

3.13.6 Objectives

The intent of this section is as follows:

Behavioral health providers must provide medically necessary covered behavioral health services, within their scope of practice, based upon the needs of the person.

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 must be available to family members of 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.

3.13.7 Procedures

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3.13.7-A: Covered services matrix

[PM Attachment 3.13.1, Covered Services Matrix](#), lists the available covered behavioral health services for T/RBHA enrolled persons and Non-Title XIX/XXI, SMI persons. These services must be provided by AHCCCS registered providers, ADHS-only providers or Medicare registered providers.

[PM Attachment 3.13.1, Covered Services Matrix](#) is a condensed summary of available behavioral health services and related funding sources. Behavioral health providers may reference the [ADHS/DBHS Covered Behavioral Health Services Guide](#) for more detailed information.

3.13.7-B: 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-C: Flex Funds

T/RBHAs and/or their 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. 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, including arrests, delinquency, victimization and exploitation; 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;

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- 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.

T/RBHAs and/or their 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?

Each T/RBHA 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; and 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 shall forward 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 shall forward the request to ADHS/DBHS on behalf of the Responsible Agency.

T/RBHAs and/or subcontracted behavioral health providers **NARBHA** must forward requests for approval of flex fund expenditures of \$1,525 or more to flexfund@azdhs.gov to the attention of the Medical Director for Children Services for children age birth to 18 years of age and the Chief Medical Officer for adults 18 years of age and older.

3.13.7–D: Non-Discrimination

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