

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

Section 3.14 **Securing Services and Prior Authorization**

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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 typically used to promote appropriate utilization of behavioral health services while effectively managing associated costs. Except during an emergency situation, ADHS/DBHS requires prior authorization before accessing inpatient services in a licensed (OBHL) Level I facility (a psychiatric acute hospital, a residential treatment center 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 OBHL Level I facility;

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- Continued stay in an OBHL Level I facility;
- Admission to and continued stay in OBHL Level II and Level III behavioral health residential facilities and HCTC; and

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. 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 References

The following citations can 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. 20](#)

[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 Intake, Assessment and Service Planning](#)

[Section 3.16 Medication Formulary](#)

[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 \(SMI\)](#)

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[Section 5.5 Notice and Appeal Requirements \(SMI and Non-SMI/Non-Title XIX/XXI\)](#)
[Practice Improvement Protocol 8, The Adult Clinical Team](#)
[Practice Improvement Protocol 9, The Child and Family Team](#)
[Technical Assistance Document 3, The Child and Family Team Process](#)
[The Arizona Vision and Twelve Principles](#)
[ADHS/DBHS Policy Clarification Memorandum: Prior Authorization](#)

3.14.3 Scope

To whom does this apply?

All persons who receive behavioral health service

3.14.4 Did you know...?

- It is important for a behavioral health professional to document enough information in the comprehensive clinical record to validate that the prior authorization request meets all elements of the authorization criteria.
- The RBHA may require prior authorization of behavioral health services other than inpatient services only with the prior written approval of ADHS/DBHS.
- A Title XIX eligible person that is receiving services in a Level I residential treatment center who turns age 21 may continue to receive services until the point in time in which services are no longer required or the person turns age 22, whichever comes first.
- Prior authorization criteria may not include any one of the following as a sole criteria for denial of services:
 - Lack of family involvement;
 - Presence or absence of a particular mental health diagnosis; or
 - Presence of substance use, abuse or dependence.

3.14.5 Definitions

[Adult Clinical Team](#)

[Behavioral Health Professional](#)

[Certification of Need \(CON\)](#)

[Child and Family Team](#)

[Clinical Teams](#)

[Denial](#)

[Emergency Behavioral Health Services](#)

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[Inpatient Services](#)

[Level I Facility](#)

[Level II Facility](#)

[Medically Necessary Covered Services](#)

[Post Stabilization Services](#)

[Prior authorization](#)

[Prudent Layperson](#)

[Psychiatric Acute Hospital](#)

[Recertification of Need \(RON\)](#)

[Residential Treatment Center \(RTC\)](#)

[Sub-Acute Facility](#)

3.14.6 Objectives

To ensure that behavioral health services are secured or prior authorized:

- Consistent with the Arizona Principles for persons receiving services through the public behavioral health system; and
- According to federal, state and T/RBHA requirements; and
- In a manner that allows timely access to care based on the person's clinical needs.

3.14.7 Procedures

3.14.7-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. In fulfilling this responsibility, the clinical team should focus on identifying the underlying needs of the behavioral health recipient, including the type, intensity and frequency of supports needed, rather than identifying pre-determined specific services.

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

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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 NARBHA and obtaining the requested service as outlined below.

Member Choice of a Specific In-Network Provider for Services Determined to Be Medically Necessary Behavioral Health Services:

NARBHA contracts with geographically based comprehensive service providers in the NARBHA region, the Responsible Agencies. In addition, NARBHA contracts with a variety of specialized providers located within and outside the NARBHA geographical region. Contracted providers comprise the **NARBHA network**. (Providers who do not hold a contract with NARBHA, including those who are Single Case Agreements, are defined as **outside the NARBHA network**.)

NARBHA block purchases some services, including in-network adult Inpatient/Subacute Facility and CD residential services, in order to provide accessible and available services to NARBHA members. Additionally, NARBHA assigns members a local primary inpatient facility according to their geographic region and Responsible Agency. (**See Section [10.6](#) NARBHA Block Purchased Inpatient/ Sub-Acute and CD Residential Facilities.**)

Adult Inpatient/ Subacute Facility Block Purchased Services:

- Once it has been determined that the service is a medically necessary covered behavioral health service, persons presenting in the NARBHA geographic region and who are experiencing emergency behavioral health conditions which, by definition, require immediate medical attention, must be admitted to the area's designated primary facility or to the nearest block purchased inpatient/subacute facility if there is an available bed.
- Once it has been determined that the service is a medically necessary covered behavioral health service, persons presenting outside the NARBHA geographic region and who require inpatient psychiatric hospitalization for an emergency behavioral health condition do not require prior authorization for admission to the closest inpatient psychiatric facility if it is determined that admission to an NARBHA block purchased inpatient/subacute facility is not appropriate or is not available. However, the member should be transferred by the out-of-area inpatient facility to the member's primary NARBHA block purchased inpatient/subacute facility as soon as possible if the anticipated length of stay will be over 72 hours.

Adult Level II Chemical Dependency (CD) Residential Services:

- Once it has been determined that the service is a medically necessary covered behavioral health service, Adult Teams, which include participation from members and families, must choose a block purchased CD residential facility within the NARBHA network, based on availability of that service and on the members' behavioral health needs; and
- Admission availability is clinically prioritized as per **Section [3.21](#) Service Prioritization NonTXIX/TXXI Funding**. In Arizona's public behavioral health system, persons may be eligible for, or entitled to, services as Title XIX (Medicaid), Title XXI (KidsCare) or as a

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person determined to have a serious mental illness (SMI). Non-Title XIX/XXI funds are available but limited and the behavioral health services offered through this fund source are not considered entitlements. As such, NARBHA must implement priorities for Non-Title XIX/XXI funded service delivery. Non-Title XIX/XXI funds include, but are not limited to: Center for Mental Health Services (CMHS) and Substance Abuse Prevention and Treatment Performance Partnership (SAPT) block grants; State appropriations; and County funds. The following Non-Title XIX/XXI populations are prioritized and covered under the Substance Abuse Prevention and Treatment (SAPT) Performance Partnership Block Grant Populations SAPT Block Grant:

First...Pregnant injection drug users;

Then...Pregnant substance abusers;

Then...Other injection drug users; and

Finally...All other persons in need of substance abuse treatment. Persons in this category who are Non-TXIX/TXXI and who are not Seriously Mentally Ill are not covered for a CD Residential benefit through NARBHA.

- Eligible members who have a CD residential benefit may receive that service at an in-network CD residential Fee-For-Service Provider when all NARBHA block-purchased CD residential facility beds are at licensed capacity after prior authorization by NARBHA. However, the member should be transferred by the CD residential Fee-For-Service Provider to a NARBHA block purchased CD residential facility as soon as possible if the anticipated length of stay will be over 21 days.

Children Level II Services (Therapeutic Group Homes) and Level III Services:

- Once it has been determined that the service is a medically necessary covered behavioral health service, Child and Family Teams may request a specific Level II or Level III residential provider by submitting a request for prior-authorization through NARBHA.. Teams may encourage members to receive services at a location close to where they live, but member choice is the deciding factor if there is not Team consensus on the specific provider being requested.

Specific Clinicians Within the Member's Responsible Agency (RA):

- Once it has been determined that the service is a medically necessary covered behavioral health service, members and Teams may request specific clinicians within their RA. RAs comply with those requests within the limits of the individual clinician's caseload, specialty, clinical assignments, location and availability whenever possible.

Specific Clinicians Outside the Member's Responsible Agency (RA):

- Once it has been determined that the service is a medically necessary covered behavioral health service, members and Teams may request specific clinicians at another RA or an in-network Provider clinician. The requested clinician may accept those requests within the limits of the individual clinician's caseload, specialty, clinical assignments, location, availability and contractual requirements, but the clinician is not required to provide the service to that person; and
- Teams may encourage members to receive services within the member's RA in order to have better continuity of clinical care and/or to be at a location close to where the

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member lives, but member and family choice is the deciding factor if there is not Team consensus on the specific provider being requested.

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:

- **What is the process for securing services with a non-contracted provider (e.g., single case agreement, pursuing a contract, etc.)?**

It is NARBHA's policy to secure the most appropriate care for its members. Accordingly, when a member requires a medically necessary behavioral health service not available within the network, or when it is clear that a member would be better served by a non-network provider; NARBHA will offer to enter into a single case agreement with that provider to provide care to the member. However, NARBHA, its RAs and their Teams are not required to offer services outside the contracted provider network if the service is available within the network.

- When a Responsible Agency (RA) believes that a member requires a service that it cannot itself provide nor is available from another provider in NARBHA's network, that agency contacts NARBHA's network staff at 928-774-7128.
- Once it is confirmed that the service is not available within the subcontracted network, NARBHA Network Staff will work with the RA staff to locate an appropriate and qualified non-network provider.
- NARBHA negotiates a Single Case Agreement to support the non-network provider's delivery of services to the member, and notifies the referring RA of the outcome of the contracting process.
- Single Case Agreement providers must be registered with AHCCCS and meet licensing, accreditation, and liability insurance requirements appropriate to the offered service.
- NARBHA may offer the provider the opportunity to apply to become a Fee-For-Service Network Provider based on prior or anticipated utilization and network needs.

- **What information must the clinical team submit to the T/RBHA to secure services through a non-contracted provider?**

The Clinical Team must submit to NARBHA a NARBHA Provider Contract Request Form fully filled out. The form will have the provider's demographic information, who the Team spoke with concerning the placement/services requested, the member's ID#, contact information, the provider's current AHCCCS ID number, the reason for needing to go out of our network, service codes needed, dates of service and units they wish to request. NARBHA will verify all information supplied, request documents and negotiate rates with the provider. This information is verified through the PMMIS system for correctness and then loaded into NARBHA'S CMHC

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Provider Contracts System and a Schedule 1 is printed out to be sent to the provider with a Single Case Agreement Contract for signature.

- **Describe what happens if the process for securing services with a non-contracted provider does not work (e.g. unable to establish a single case agreement).**

If the process for securing services with a non-contracted provider does not work, NARBHA would then assist the Clinical Team to find another provider that would be willing to work with NARBHA to secure needed services. NARBHA establishes a list of providers to assist Clinical Teams in finding needed services out of the network area.

- **How does the T/RBHA ensure payment to a non-contracted provider?**

After the single case agreement is fully executed and the provider has been sent a Schedule 1 to the single case agreement containing all of the contract information needed (codes, rates, etc), a Notice of Intent to Pay for the services is then provided to the provider with all the information the provider will need to submit a clean claim to NARBHA. NARBHA will assist the provider through the Claims Department Help Desk or the Contracts Unit. A claiming manual will be sent out to the provider also.

NARBHA trains annually on the procedures for doing a single case agreement. NARBHA also supplies a manual that has current lists of previous single case agreement providers for reference and is available on the NARBHA website.

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 \(SMI and General\)](#).

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.

NARBHA has delegated the function of securing services for eligible persons to its Responsible Agencies (RAs) and their qualified clinicians.

Services directly delivered by RAs do not require any notification to NARBHA.

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RAs notify NARBHA of decisions to utilize fee-for-service providers so that NARBHA can ensure timely and appropriate payment for those services as per Section [10.14](#) Notifying NARBHA of Intent to Pay Fee-For-Service Provider Services.

NARBHA reviews utilization retrospectively through various means including clinical record review, lengths of stay, readmission rates and fiscal reports. Utilization review based on clinical appropriateness does not result in retrospective denials by NARBHA when those services, and their subsequent claims, have been delivered by RAs or appropriately secured by RAs on behalf of NARBHA members.

3.14.7-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. NARBHA will complete CONs for non-emergency prior authorized inpatient Level I services. 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](#).

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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 a Level I facility must be completed and reviewed every 30 days. NARBHA will complete RONs for prior authorized Level I services. 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 3.14.1](#).

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 NARBHA prior to 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 a Level I 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

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- 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 residential treatment center 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:

- ADHS/DBHS Admission to Residential Treatment Center Authorization Criteria (see [PM Attachment 3.14.3](#)); and
- ADHS/DBHS Continued Residential Treatment Center Authorization Criteria (see [PM Attachment 3.14.4](#)).
- DBHS/NARBHA Level II Children's Admission and Continued Authorization Criteria (see [PM Attachment 3.14.5](#)).
- DBHS/NARBHA Level III Children's Admission and Continued Authorization Criteria (see [PM Attachment 3.14.6](#)).
- DBHS/NARBHA HCTC Children's Admission and Continued Authorization Criteria (see [PM Attachment 3.14.7](#)).
- DBHS/NARBHA Level II Adult Admission and Continued Authorization Criteria (see [PM Attachment 3.14.8](#)).
- DBHS/NARBHA Level III Adult Admission and Continued Authorization Criteria (see [PM Attachment 3.14.9](#)).
- DBHS/NARBHA HCTC Adult Admission and Continued Authorization Criteria

Prior to denials, T/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 T/RBHA Medical Director or designee to obtain the professional opinion of a behavioral health clinician.

In addition, if a denial is issued, the T/RBHA is expected to provide a clearly outlined alternative plan. This may require development of a 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

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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 Residential Treatment Center Authorization Criteria (see [PM Attachment 3.14.3](#)); and
- ADHS/DBHS Continued Residential Treatment Center Authorization Criteria (see [PM Attachment 3.14.4](#)).

What happens if a person is ready to leave a Level I 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.

3.14.7-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;
- Admissions and continued stay in a Level I Residential Treatment Center;
- Admission and continued stay requests at a Level II, III, HCTC.
- Non-emergency admissions and continued stays to inpatient facilities for electroconvulsive therapy (ECT)

Who makes prior authorization decisions?

A 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, providers 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;

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- 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.

The RBHA or provider (NARBHA requires this of all RAs) must ensure 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?

NARBHA requires all prior-authorization and continued stay requests to be faxed to NARBHA Medical Management Department at (928) 214-1166.

For additional instructions or assistance please contact NARBHA's Medical Management Department at 1-928-774-7128 7days per week/24 hrs per day.

Admission /Prior-authorization Documentation to Be Submitted:

- Level I Non-Emergency
 - NARBHA Prior-Authorization PM Form ([3.14.6](#))
 - Treatment Plan
 - Psychiatric Evaluation
- Level I RTC (members under 21)
 - NARBHA Prior-Authorization PM Form ([3.14.7](#))
 - Treatment Plan with discharge plan
 - Child/Family Team note documenting request for service
- Level II, III, HCTC (Adult and Children)
 - NARBHA Prior-Authorization PM Form ([3.14.10](#))
 - Child Family Team Note/Adult note documenting request for service
 - Treatment Plan with discharge criteria and plan
- Level I Facility Electroconvulsive Therapy (ECT) ([3.14.9](#))
 - NARBHA Prior-Authorization PM Form ([3.14.9](#))
 - Treatment Plan
 - Psychiatric Evaluation

Continue Stay Authorization Documentation to Be Submitted:

- Level I RTC
 - NARBHA Prior Authorization Continued Stay PM Form ([3.14.8](#))

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- 30 day review Child Family Team/ Adult Clinical Team Note documenting request for service
- Updated treatment plan with discharge criteria and plan
- RTC Facility monthly treatment summary of progress report

- Level II, III, HCTC for Adults/Children
 - NARBHA Admission and Continued Stay Request Form PM ([3.14.10](#))
 - 30 day review Child Family Team/ Adult Clinical Team Note documenting request for service
 - Updated treatment plan with discharge criteria and plan
 - Facility monthly treatment summary of progress report

Decision Making Timelines:

Level of Care	Prior-authorization Decision	Continued Authorization Decision	Team Request for continued services must be sent for decision:	Maximum Length of Authorization
Level I Hospital Non-emergency	1 Hour	Within three hours of request	Prior to expiration of authorization	Valid up to 30 days
Level I RTC	1 Day	Prior to expiration of Authorization	3 days prior to expiration of authorization	Valid up to 30 days
Level II and III	7 days	Prior to expiration of Authorization	7 day prior to expiration authorization	Valid up to 60 days
HCTC	7 days	Prior to expiration of Authorization	7 day prior to expiration authorization	Valid up to 90 days
ECT	24 hrs	Prior to expiration of Authorization	3 days prior to expiration of authorization	

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.

Decisions to prior authorize inpatient admission must be made

- Within one hour of the request for psychiatric acute hospital or sub-acute facility;
- Within 24 hours of the request for a residential treatment center for persons under the age of 21; and

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3.14.7-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 Level II behavioral health facility for persons under the age of 21.

Who makes prior authorization decisions?

A 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 Arizona Department of

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Health Services/Division of Behavioral Health Services/ Bureau of Quality Management Operations (Facsimile number (602) 364-4749):

Level I:

- 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](#)).

Level II (for persons under the age of 21):

- 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](#)).

Prior authorization decisions for non-emergency admissions to Level I facilities and Level II facilities for persons under the age of 21 will be made within 24 hours of receiving the request, or if the request is received on a weekend or State holiday, the decision will be made on the next business day.

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 Bureau of Quality Management Operations at (602) 364-4785 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 Bureau of Quality Management Operations 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 Arizona Department of Health Services/ Division of Behavioral Health Services/ Bureau of Quality Management Operations (Facsimile number (602) 364-4749):

Level I:

- RON; and
- The person's service plan (RTC only) (see [Section 3.9, Intake, Assessment and Service Planning](#)).

Level II (for persons under the age of 21):

- 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](#)).

Requests for continued stay must be submitted within the following timelines:

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- **Psychiatric acute hospital and sub-acute facility:** The initial authorization is valid for 72 hours. A request for continued stay authorization (see [PM Form 3.14.3](#)) must be submitted within the initial 72 hours or, if on a weekend or State holiday, the request for continued stay authorization must be submitted the next business day. All subsequent continued stay authorizations must be made prior to expiration of the last authorization;
- **Level I residential treatment centers:** The initial authorization is valid for 30 days. A request for continued stay authorization (see [PM Form 3.14.3](#)) must be submitted two weeks prior to the expiration of the current authorization; and
- **Level II facilities (for persons under the age of 21):** The initial authorization is valid for 60 days. A request for continued stay authorization (see [PM Form 3.14.3](#)) must be submitted two weeks prior to the expiration of the current authorization.

3.14.7-E. Prior authorizing medications

RBHAs must obtain approval from the ADHS/DBHS Medical Director prior to establishing prior authorization for any medication, including dosage and dispensing restrictions. For specific information on medications requiring prior authorization, see [Section 3.16, Medication Formulary](#). If a RBHA or behavioral health provider (NARBHA does not require this) requires prior authorization for medications, 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;
 - 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.

3.14.7-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;

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- 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;

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- The T/RBHA and the treating physician reach an agreement concerning the person's care; or
- The person is discharged.