



Mercy Care Provider Manual



Visit: www.MercyCareAZ.org

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Content highlighted in yellow represents changes since the last Provider Manual iteration.

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1.00 - Welcome

Welcome to Mercy Care (herein MC)! Our ability to provide excellent service to our members is dependent on the quality of our provider network. By joining our network, you are helping us serve those Arizonans who need us most.

1.01 - About Mercy Care

MC, when referring to all lines of business, is a not-for-profit partnership sponsored by Dignity Health and Ascension Care Management. MC is committed to promoting and facilitating quality health care services with special concern for the values upheld in Catholic social teaching, and preference for the poor and persons with special needs. Aetna Medicaid Administrators, LLC administers MC for Dignity Health and Ascension Care Management.

MC has an established, comprehensive model to accommodate service needs within the communities served. This section of the provider manual contains general requirements about MC that applies to all lines of business which all Participating Healthcare Professionals (PHPs) must adhere. Please refer to MC's website for a listing of [Forms](#) and [Provider Notifications](#). You can print the **MC Provider Manual** from your desktop by accessing our [Provider Information](#) web page.

Effective July 1, 2018, both Mercy Care Plan and Mercy Maricopa Integrated Care came together to form one company. The new company's name will be, simply, **Mercy Care**. We will also have a new logo and a new website address: www.MercyCareAZ.org.

Mercy Care includes the following lines of business:

- Mercy Care Complete Care
- Mercy Care Advantage
- Mercy Care Long Term Care
- Mercy Care RBHA
- Division of Developmental Disabilities
- KidsCare – Children's Health Insurance Program (CHIP)

Our phone number will remain the same: **602-263-3000** or **1-800-624-3879** (TTY/TDD **711**).

Member benefits will remain the same.

GENERAL REQUIREMENTS FOR ALL PLANS

1.02 - Disclaimer

Providers are contractually obligated to adhere to and comply with all terms of the plan and provider contract, including all requirements described in this manual in addition to all federal and state regulations governing the plan and the provider. MC may or may not specifically communicate such terms in forms other than the contract and this provider manual. While this manual contains basic information about the Arizona Health Care Cost Containment System (AHCCCS), providers are required to fully understand and apply AHCCCS requirements when administering covered services.

According to 42 CFR 438.3 - Standard Contract Requirements, it states:

AHCCCS, CMS, the Office of the Inspector General, the Comptroller General, and their designees may, at any time, inspect and audit any records or documents of MC, or its subcontractors, and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit under this section exists for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

Please refer to the [AHCCCS](#) website for further information on AHCCCS.

To assist in providing a better understanding of the provider manual, the following definitions are being provided:

Contractor: An organization, or entity that has a prepaid capitated contract with AHCCCS pursuant to A.R.S. §36-2904, §36-2940, or §36-2944 to provide goods and services to members either directly or through subcontracts with providers, in conformance with contractual requirements, AHCCCS Statute and Rules, and Federal law and regulations.

Provider:

- 1) A provider of health care who agrees to furnish covered services to members;
- 2) A person, agency or organization with which the Contractor has contracted or delegated some of its management/administrative functions or responsibilities;
- 3) A person, agency or organization with a fiscal agent that has entered into a contract, agreement, purchase order or lease (or leases of real property) to obtain space, supplies, equipment or services provided under the AHCCCS agreement.

1.03 - MC Policies and Procedures

MC has robust and comprehensive policies and procedures in place throughout its departments that assure all compliance and regulatory standards are met. Policies and procedures are reviewed on an annual basis and required updates made as needed.

GENERAL REQUIREMENTS FOR ALL PLANS

1.04 - Eligibility

DES, Social Security Administration or AHCCCS determines eligibility.

Member ID cards are generated by MC.

1.05 – Hospital Presumptive Eligibility

Based on provisions in the Affordable Care Act and effective January 1, 2015, Arizona has developed a Hospital Presumptive Eligibility (HPE) process that allows qualified hospitals to temporarily enroll persons who meet specific federal criteria for full Medicaid benefits in AHCCCS immediately. Hospitals will use special features in Arizona's electronic application, Health-e-Arizona Plus (HEAplus), to process HPE applications.

Hospitals that choose to participate in HPE must meet performance standards for continued participation. Details about performance standards are included in the [Hospital Presumptive Eligibility Agreement](#).

HPE provides eligible persons with temporary full Medicaid coverage. Persons who are approved for HPE may receive Medicaid services from any registered AHCCCS provider.

For additional detail regarding Hospital Presumptive Eligibility, please review AHCCCS' [Hospital Presumptive Eligibility](#) web page.

GENERAL REQUIREMENTS FOR ALL PLANS

MC CHAPTER 2 – MERCY CARE CONTACT INFORMATION

2.00 – Mercy Care Contact Information

<u>Health Plan</u>	<u>Telephone Number</u>	<u>Health Plan Web Address</u>
Mercy Care	602-263-3000 or 800-624-3879 toll-free	www.MercyCareAZ.org

<u>Internal Contact</u>	<u>Telephone Number/Fax</u>
DD Liaison	Phone: 602-453-6026
Claim Disputes/Appeals	Phone: 602-453-6098 or 800-624-3879 Fax: 602-351-2300
Referrals	Phone: 602-263-3000 or 800-624-3879 Fax: 844-424-3975
Single Case Agreements	Phone: 602-263-3000 or 800-624-3879 Fax: 860-975-1040
Behavioral Health Care Management	Phone: 602-263-3000 or 800-624-3879 Fax: 860-975-3275
Medical Care Management	Phone: 602-453-8391
Member Outreach Team	Phone: 602-263-3000 or 800-624-3879 Fax: 844-745-8477
Dental	DentaQuest Phone: 844-234-9831 DentaQuest Web Address: www.dentaquestgov.com
Inpatient Hospital and Hospice Services	Fax: 800-217-9345
Transplant and ETI	Phone: 602-263-3000 or 800-624-3879 Transplant Fax: 855-671-5914 ETI Fax: 855-671-5915
Newborn Notification	Phone: 602-263-3000 or 800-624-3879 Fax: 844-525-2221

GENERAL REQUIREMENTS FOR ALL PLANS

CRS

Phone: 602-659-9180

Fax: 855-211-0798

2.01 - Provider Credentialing and Contracting for all Plans

MC is committed to providing quality health care services to our members. And our credentialing and contracting processes help us achieve that goal.

To be eligible to join the MC and MCA networks, providers must have completed all required Arizona State licensure, certifications and AHCCCS registration. The Letter of Interest (LOI) or Letter of Contractual Changes (LOC) should be on the Provider's letterhead or in writing.

Once approved by the MC Contract Committee; new providers will be sent a Participating Agreement (Contract). Providers making changes to an existing contract must also be approved in Contract Committee and sent a Contract Amendment.

Upon completion of credentialing and full execution of the Contract or Contract Amendment, the provider will receive notice from MC's Contracting department with the effective date of participation, along with a copy of the fully executed agreement.

Providers should refrain from scheduling and seeing MC members until notified of the participation effective date.

What to Submit to Contracting

- **Letters of Interest (LOI)** – Any request to participate in the Network – New Contract
- **Letter of Contractual Changes (LOC)** – Any change request to an Existing Agreement – Contract Amendments (A 90 day prior notification of effective date of changes is required)
- **Value Base Solution (VBS)** - VBS proposals or programs request
- **Contract Terminations** – Termination notification (includes loss of locations, programs and services no longer included in the contract)
- **Change of Ownership or Mergers** – All change of ownerships, mergers or stock purchases as contract are not assigned to new owners without prior approval (A 90 day prior notification of change of ownership or merger is required)

The LOI/LOC must include the following:

- AHCCCS ID number
- AZ Dept. of Health License number (if applicable)
- Medicare ID number (if applicable)
- National Provider ID (NPI) (if applicable)
- Geographic Location(s)

GENERAL REQUIREMENTS FOR ALL PLANS

- Information outlining Facility, Specialty and Service Offerings
- Insurance Declaration Page(s)

Include applicable Credentialing Forms with the LOI/LOC. The Credentialing application must be submitted correctly and completely. Incomplete forms will not be accepted.

- [W-9 Form](#)
- [AzAHP Facility Application](#)
- [AzAHP Practitioner Credentialing Form](#)
- [AzAHP Organizational Credentialing Form](#)

Community Service Agencies must be credentialed and sign a letter of Intent to contract with MC prior to submitting the application for AHCCCS Registration.

Contact information for the Mercy Care Contracting Department is as follows:

Email: contractingdepartment@MercyCareAZ.org

Fax: 860-975-3201

Phone: 602-453-6148

If you have questions about the contracting process or to check the status of a contract, please call or email MC's Contracting Department.

2.02 - Health Plan Authorization Services Table

Mercy Care Prior Authorization Information

<u>Department</u>	<u>Phone Number/Fax</u>
Medical Prior Authorization	Phone: 602-263-3000 or 800-624-3879 Fax: 800-217-9345
Utilization Management	Phone: 602-263-3000 or 800-624-3879 Physical Health Admission Fax: 866-300-3926 Behavioral Health Admission Fax: 855-825-3165 Concurrent Review Fax: 855-773-9287
Family Planning Prior Authorization	Phone: 602-798-2745 Fax: 800-573-4165

(Family planning for DES/DDD - Members should also submit their requests to the Family Planning fax number. Final approval determination will be made by the DES/DDD medical director prior to providing sterilization and pregnancy termination procedures for members enrolled in DES/DDD.)

GENERAL REQUIREMENTS FOR ALL PLANS

2.03 - Community Resources Contact Information Table

Community Resource

**Arizona Early Intervention
Program (AzEIP)**

Contact Information

Address: 1780 W. Jefferson, Mail Drop 2HP1
Phoenix, AZ 85007

Phone: 602-532-9960, toll free in AZ 888-439-5609

Fax: 602-200-9820

Email: allazeip2@azdes.gov

Website:

<https://des.az.gov/services/disabilities/developmental-infant>

**Arizona's Smokers Helpline
(Ashline)**

Address: P.O. Box 210482
Tucson, AZ 85721

Phone: 800-556-6222

Fax: 520-318-7222

Website: www.ashline.org

**Arizona Women, Infants &
Children (WIC)**

Address: 150 N. 18th Avenue, Suite 310
Phoenix, AZ 85007

Phone: 800-252-5942 or
800-2525-WIC

To report WIC Fraud & Abuse, call our Fraud Hotline at
866-229-6561 or email azwiccomplaints@azdhs.gov

Website: <http://www.azwic.gov/>

**Community Information and
Referral**

Address: 2200 N. Central Avenue, Suite 601
Phoenix, AZ 85004

Phone: 602-263-8856
800-352-3792 (area codes 520 and 928)

Website: <http://www.cir.org>

**Arizona Department of
Economic Security –
Aging and Adult Service**

Phone: 602-542-4446

Website: <https://www.azdes.gov>

GENERAL REQUIREMENTS FOR ALL PLANS

MC CHAPTER 3 – PROVIDER RELATIONS OVERVIEW

3.00 - Provider Relations Overview

The Provider Relations department serves as a liaison between MCCC and the provider community. They build, facilitate, and maintain professional and positive relations with the provider network, stakeholders, and community partners. They are also responsible for provider training and education, maintaining and strengthening the provider network in accordance with regulations.

Provider Training and Education includes:

- Orienting new providers to Mercy Care and how to use the Provider website
- New provider in-services within 30 days of contract effective date
- Established provider in-services
- Provider Manual overview, including how to locate manual on website
- Claims Processing Manual
- Provider Website
- Provider Portal
- Prior Authorization requirements
- Fraud, Waste and Abuse
- Behavioral Health referrals
- Specialty referrals
- Cultural Competency
- Coordination of Benefits
- Where to mail claims
- Grievances and Appeals
- Review of provider contracts and amendments
- Contractual responsibilities and contract compliance
- Provider deliverables
- Claims dashboards
- Appointment Availability and Access to Care requirements
- Provider communications, including: Provider Notifications and Provider Newsletters

Provider Relations staff may conduct face-to-face visits or use telephonic and/or electronic methods when educating and communicating with providers. Staff also assists providers with specific training needs, problem identification and resolution, claims assistance, and perform accessibility audits.

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A Provider Relations Representative is assigned to each provider's office. You may reach your representative by calling 602-263-3000 or 800-624-3879. Please review our Provider Relations web page to find a listing of your assigned Provider Relations Representative along with their detailed contact information.

In order to meet Regulatory Compliance Standards, all provider inquiries must be acknowledged within three business days of receipt and all issues must be resolved and/or state the results communicated to the provider within 30 business days.

The Provider Relations department conducts at least two provider forums per year which providers are encouraged to attend. The purpose of the forums is to improve communications to the providers and provide training and education on new policies and/or regulations or topics of interest. In addition, Provider Relations conducts frequent webinars on specific topics or areas of concerns that providers may have. Providers will receive information regarding any upcoming forums or webinars through communication with their Provider Representative, a Provider Notification, or via the Provider website.

Please contact the Provider Relations department for:

- Recent practice or provider updates, including adding new providers to your existing practice
- Assistance in finding a participating provider or specialist
- Termination from the health plan
- Notifying the plan of changes to your practice
- Tax ID change
- Change of location
- Obtaining a Secure Portal Login ID
- Electronic Data Information, Electronic Fund Transfer, Electronic Remittance Advice

GENERAL REQUIREMENTS FOR ALL PLANS

MC CHAPTER 4 – PROVIDER RESPONSIBILITIES

General Provider Responsibilities

4.00 - Provider Responsibilities Overview

These responsibilities are minimum requirements to comply with contract terms and all applicable laws. Providers are contractually obligated to adhere to and comply with all terms of the plan, provider contract and requirements in this manual. MC may or may not specifically communicate such terms in forms other than the contract and this manual. This section outlines general provider responsibilities; however, additional responsibilities are included throughout the manual.

Providing Member Care

4.01 - AHCCCS Registration

Each provider must first be registered with AHCCCS and obtain an AHCCCS provider ID number. This also includes non-participating providers. For additional information on registering to get an AHCCCS provider ID, please refer to the [AHCCCS Provider Registration](#) web page or our [Claims Processing Manual, Chapter 8, Non-Par Provider Registration](#) on our [Claims Information](#) web page.

4.02 - Appointment Availability Standards

Providers are required to schedule appointments for eligible members in accordance with the minimum appointment availability standards below. MC will routinely monitor compliance and seek corrective action plans, such as panel or referral restrictions, from providers that do not meet accessibility standards.

Physical Health Appointment Availability Standards

Provider Type	Routine Care	Urgent Care		High Risk	Wait Time in Office Standard
PCP	Within 21 calendar days of request	Within 2 business days of request			Less than 45 minutes
Specialist	Within 45 calendar days of request	Within 3 business days of request			Less than 45 minutes

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Dental Care	Within 45 calendar days of request	Within 3 business days of request			Less than 45 minutes
Maternity	1 st Trimester – within 14 calendar days of request	2 nd Trimester – within 7 calendar days of request	3 rd Trimester – within 3 business days of request	Within 3 business days of identification of high risk identification	Less than 45 minutes
Non-Urgent/ Non-Emergent Transportation					Less than one hour before or after appointment

General Behavioral Health Appointment Standards

Behavioral Health Provider Appointments

- Urgent care appointments within 24 hours from identification of need.
- Routine care appointments:
 - Initial assessment within seven days of referral.
 - The first behavioral health service following the initial assessment within the timeframe indicated by the behavioral health condition, but no later than 23 days after the initial assessment.
 - All subsequent behavioral health services within the timeframe indicated by the behavioral health condition, but no later than 45 days from identification of need.

Referrals for Psychotropic Medications:

- Assess the urgency of the need immediately.
- If clinically indicated, provide an appointment with a Behavioral Health Medical Professional (BHMP) within a timeframe that ensures the member:
 - does not run out of needed medications; or
 - Does not decline in his/her behavioral health condition prior to starting medication, but no later than 30 calendar days from the identification of need.

Appointment Availability Reviews

MC is required to conduct regular appointment availability reviews to assess:

- Routine appointment availability for Primary Care, Specialist, Dental and Behavioral Health Providers;
- Urgent appointment availability for Primary Care, Specialist, Dental, and Behavioral Health providers;

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- Maternity Care appointment availability related to the first, second and third trimesters, as well as high risk pregnancies;
- Routine appointment availability for Behavioral Health providers;
- Urgent appointment availability for Behavioral Health providers; and
- Behavioral Health appointments for persons in the legal custody of DCS;

Monitoring of No-Show Rates

Through a series of monitoring activities, MC reviews data and implements performance improvement activities to ensure the accessibility and availability of health care services including the monitoring of appointment no-show rates by provider and service type. Corrective Action Plans (CAPs) and other forms of corrective action may be taken for providers who continuously fail to meet performance expectations.

The provider is responsible for providing appropriate services so that members understand their health care needs and are compliant with prescribed treatment plans. Providers should strive to manage members and ensure compliance with medical treatment plans and with scheduled appointments. If you need assistance helping non-compliant members, Mercy Care's Provider Assistance Program is available to you. The purpose of the program is to help coordinate and/or manage the integrated medical care for members at risk. Please submit the **Provider Assistance Program Form**, available on our [Forms Library](#) web page, to Member Services for possible intervention.

If you are serving as the member's PCP and elect to remove the member from your panel rather than continue to serve as the medical home, you must provide the member at least 30 days written notice prior to removal and ask the member to contact Member Services to change their PCP. The member will NOT be removed from a provider's panel unless the provider efforts and those of the Health Plan do not result in the member's compliance with medical instructions. If you need more information about the Provider Assistance Program, please contact your Network Relations Specialist/Consultant.

4.03 - Telephone Accessibility Standards

Providers are responsible to be available during regular business hours and have appropriate after-hours coverage. Providers must have coverage 24 hours per day, seven days per week, including on-call coverage. Call coverage does not include referrals to the emergency department.

Examples of after-hours coverage that will result in follow up from MC:

- An answering machine that directs the caller to leave a message (unless the machine will then automatically page the provider to retrieve the message).

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- An answering machine that directs the caller to go to the emergency department.
- An answering machine that has only a message regarding office hours, etc., without directing the caller appropriately, as outlined above.
- An answering machine that directs the caller to page a beeper number.
- No answering machine or service.
- If your answering machine directs callers to a cellular phone, it is not acceptable for charges to be directed to the caller (i.e., members should not receive a telephone bill for contacting their physician in an emergency).
- Telephones should be answered within five rings and hold time should not exceed five minutes. Callers should not get a busy signal.

4.04 - Covering Physicians

MC Provider Relations must be notified if a covering provider is not contracted or affiliated with MC. This notification must occur in advance of providing coverage and MC must provide authorization. Reimbursement to covering physicians is based on the MC Fee Schedule. The covering physician must bill under their own Tax Identification Number. Failure to notify MC of covering physician affiliations may result in claim denials and the provider may be responsible for reimbursing the covering provider.

4.05 – Locum Tenens

AHCCCS requires credentialing of individual providers or those through an organization such as a Federally Qualified Health Center (FQHC) who is contracted with a health plan. This includes the registration and credentialing of Locum Tenens.

Locum Tenens will be provisionally credentialed to expedite the credentialing process.

4.06 - Verifying Member Eligibility

All providers, regardless of contract status must verify a member's enrollment status prior to the delivery of non-emergent, covered services. A member's assigned provider must also be verified prior to rendering primary care services. MC will not reimburse providers for services rendered to members that lost eligibility or were not assigned to the primary care provider's panel (unless, s/he is physician covering for a provider).

Member eligibility may be verified through one of the following ways:

Website*: www.MercyCareAZ.org. Link available on homepage or you can login to the secure website portal. *You must have a confidential password to access. To register, either contact your Network Relations Specialist/Consultant or fill out the **Mercy Care Provider Web Portal Registration Form** available in our [Forms](#) section of our website.

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More information is available in this Provider Manual under **MC Chapter 4 – Provider Requirements, Section 4.40 - Mercy Care Web Portal**.

MediFax: MediFax is an electronic product available through AHCCCS that stores key member information. It is used to verify MC member eligibility for pharmacy, dental, transportation and specialty care. In Maricopa County only, providers can request faxed documentation through Medifax EDI: 1-800-444-4336.

AHCCCS Interactive Voice Response (IVR): To use, dial 602-417-7200. For providers outside of Maricopa County only please dial 1-800-331-5090.

MC Telephone Verification: Use as a last resort. Call Member Services to verify eligibility at 602-263-3000. To protect member confidentiality, providers are asked for at least three pieces of identifying information such as member identification number, date of birth and address, before any eligibility information can be released. When calling MC, use the prompt for the providers.

Monthly Roster: Monthly rosters are found on the secure website portal. Contact your Network Relations Specialist/Consultant for more information. Note that rosters are only updated once a month. More information is available in this Provider Manual under section **4.40 – Mercy Care Web Portal** regarding provider rosters.

4.07 - Preventive or Routine Services

Providers are responsible for providing appropriate preventive care for eligible members. Preventive health guidelines are located on the MC website in the [Member Handbook](#). These preventive services include, but are not limited to:

- Age-appropriate immunizations, disease risk assessment and age-appropriate physical examinations
- Early and Periodic Screening, Diagnostic and Testing (EPSDT)

Provider requirements for well-woman preventative care services are included below.

Covered Services included as part of a Well-Woman Preventative Care Visit

An annual well-woman preventative care visit is intended for the identification of risk factors for disease, identification of existing medical/mental health problems, and promotion of healthy lifestyle habits essential to reducing or preventing risk factors for various disease processes. As such, the well-woman preventative care visit is inclusive of a minimum of the following:

- A physical exam (well exam) that assesses overall health.

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- Clinical breast exam.
- Pelvic exam (as necessary, according to current recommendations and best standards of practice).
- Review and administration of immunizations, screenings and testing as appropriate for age and risk factors. Refer to 310-H, *Health Risk Assessment and Screening Tests* for further information pertaining to health risk assessments and associated screening tests.

NOTE: Genetic screening and testing is not covered, except as described in Chapter 300, *Medical Policy for Covered Services*.

- Screening and counseling are included as part of the well-woman preventive care visit and is focused on maintaining a healthy lifestyle and minimizing health risks, that addresses at a minimum the following:
 - Proper nutrition
 - Physical activity
 - Elevated BMI indicative of obesity
 - Tobacco/substance use, abuse, and/or dependency
 - Depression screening
 - Interpersonal and domestic violence screening, that includes counseling involving elicitation of information from women and adolescents about current/past violence and abuse, in a culturally sensitive and supportive manner to address current health concerns about safety and other current or future health problems
 - Sexually transmitted infections
 - Human Immunodeficiency Virus (HIV)
 - Family planning counseling
 - Preconception counseling that includes discussion regarding a healthy lifestyle before and between pregnancies that includes:
 - Reproductive history and sexual practices
 - Healthy weight, including diet and nutrition, as well as the use of nutritional supplements and folic acid intake
 - Physical activity or exercise
 - Oral health care
 - Chronic disease management
 - Emotional wellness
 - Tobacco and substance use (caffeine, alcohol, marijuana and other drugs), including prescription drug use
 - Recommended intervals between pregnancies
- NOTE:** Preconception counseling does not include genetic testing.
- Initiation of necessary referrals when the need for further evaluation, diagnosis, and/or treatment is identified.

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Well-Woman Preventative Care Service Standards

Immunizations – MC will cover the Human Papilloma Virus (HPV) vaccine for female members 11 to 26 years of age. For adult immunizations, this information is covered in the AHCCCS Policy 310-M, *Immunizations*. Providers must coordinate with The Arizona Department of Health Services (ADHS) Vaccines for Children (VFC) Program in the delivery of immunization services if providing vaccinations to Early and Periodic Screening, Diagnostic and Treatment (EPSDT) aged members less than 19 years of age. Immunizations must be provided according to the Advisory Committee on Immunization Practices Recommended Schedule. (Refer to the [CDC website](#) where this information is included). Providers must enroll and re-enroll annually with the VFC program, in accordance with AHCCCS contract requirements in providing immunizations for EPSDT aged members less than 19 years of age and must document each EPSDT age member's immunizations in the Arizona State Immunization Information System (ASIS) registry.

Screenings – Information regarding screening tests is contained in the AHCCCS Policy 310-H, *Health Risk Assessment and Screening Tests*. Please feel free to review for further details pertaining to specific screening and limitations related to health risk assessments and associated screening tests for those members over 21 years of age. You may also refer to AHCCCS Policy 430, *EPSDT Services* for further details related to covered services for members less than 21 years of age.

4.09 - Educating Members on their own Health Care

MC does not restrict or prohibit providers, acting within the lawful scope of their practice, from advising or advocating on behalf of a member who is a patient for:

- the member's health status, medical care or treatment options, including any alternative treatment that may be self-administered;
- any information the member needs to decide among all relevant treatment options;
- the risks, benefits, and consequences of treatment or non-treatment; and,
- The member's right to participate in decisions regarding his or her behavioral health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

4.10 - Urgent Care Services

While providers serve as the medical home to members and are required to adhere to the AHCCCS and MC appointment availability standards, in some cases, it may be necessary to refer members to one of MC's contracted urgent care centers (after hours in most cases). Please reference [Find a Provider](#) on MC's website and select Urgent Care Facility in the specialty drop down list to view a list of contracted urgent care centers.

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MC reviews urgent care and emergency room utilization for each provider panel. Unusual trends will be shared and may result in increased monitoring of appointment availability.

MC educates its members regarding the appropriate use of Urgent Care Services. Urgent Care Services are to be used when a member needs care right away but is not in danger of lasting harm or of loss of life. Examples of this may include medical care for:

- Flu, colds, sore throats, earaches
- Urinary tract infections
- Prescription refills or requests
- Health conditions that you have had for a long time
- Back strain
- Migraine headaches

4.11 - Emergency Services

Prior authorization is not required for emergency services. In an emergency, members should go to the nearest emergency department. Emergency medical services are provided for the treatment of an emergent physical or behavioral health condition.

MC educates its members regarding the appropriate use of Emergency Services. An emergency is a medical or behavioral health condition, including labor and delivery, which manifests itself by acute symptoms of enough severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person, including mental health, in serious jeopardy,
- Serious impairment of bodily functions,
- Serious dysfunction of any bodily organ or part, or
- Serious physical harm to another person. Examples of this may include:
 - Poisoning
 - Sudden chest pains - heart attack
 - Car accident
 - Convulsions
 - Very bad bleeding, especially if you are pregnant
 - Broken bones
 - Serious burns
 - Trouble breathing
 - Overdose

Non-emergency service examples are also provided under our **4.10 – Urgent Care Services** and may include:

- Flu, colds, sore throats, earaches

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- Urinary tract infections
- Prescription refills or requests
- Health conditions that you have had for a long time
- Back strain
- Migraine headaches

This above list is not all inclusive but only provided as examples of non-emergency care.

4.12 - Primary Care Providers (PCPs)

The primary role and responsibilities of primary care providers participating in MC include, but are not be limited to:

- Providing initial and primary care services to assigned members;
- Initiating, supervising, and coordinating referrals for specialty care and inpatient services and maintaining continuity of member care;
- Maintaining the member's medical record.

The PCP is responsible for rendering, or ensuring the provision of, covered preventive and primary care services to the member. These services will include, at a minimum, the treatment of routine illness, maternity services if applicable, immunizations, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services for eligible members under age 21, adult health screening services and medically necessary treatments for conditions identified in an EPSDT or adult health screening.

PCPs in their care coordination role serve as the referral agent for specialty and referral treatments and services provided to MC members assigned to them and attempt to ensure coordinated quality care that is efficient and cost effective. Coordination responsibilities include, but are not limited to:

- Referring members to providers or hospitals within the MC network, as appropriate, and if necessary, referring members to out-of-network specialty providers;
- Coordinating with MC's Prior Authorization Department about prior authorization procedures for members;
- Conducting follow-up (including maintaining records of services provided) for referral services that are rendered to their assigned members by other providers, specialty providers and/or hospitals;
- Coordinating the medical care of the MC members assigned to them, including at a minimum:
 - Oversight of drug regimens to prevent negative interactive effects;
 - Follow-up for all emergency services;
 - Coordination of inpatient care;
 - Coordination of services provided on a referral basis; and

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- Assurance that care rendered by specialty providers is appropriate and consistent with each member's health care needs.
- The Controlled Substance Prescription Monitoring Program (CSPMP) will be checked 100% of the time prior to prescribing controlled substances.

PCPs are required to, when necessary, provide care coordination which includes the referral and/or transition of members to behavioral health care who:

- Have been admitted to an inpatient hospital for a behavioral health diagnosis.
- Do not respond to treatment and therefore need additional behavioral health services such as counseling and/or more intense medication monitoring.
- Present with a behavioral health diagnosis other than ADHD, alcohol use disorder, anxiety, depression, or postpartum depression, or opioid use disorder (MAT services).
- Have experienced a sentinel event (e.g. attempted suicide, danger-to-self, danger-to-others).
- Require services outside the PCP's scope of expertise.
- To facilitate a member's access to behavioral health services in a timely manner, PCP's must call MC member services for BH provider identification or coordinate with "in-network" providers directly for coordination after considering member's clinical presentation, preferred locations, and cultural preferences. They should assist the member with scheduling an intake appointment with the identified BH provider, as necessary.
- Additionally, PCPs are responsible for the collecting of basic information about the member to determine the urgency of the situation and assist with the subsequent scheduling of intake session within the required timeframes and with an appropriate provider. Keeping information or documents gathered in the referral process confidential and protected in accordance with applicable federal and state statutes, regulations and policies.
- Informing, as appropriate, any changes in referrals (refusing services, change in need, etc.) to referred organizations. Including notification to behavioral health providers, if known, when a member's health status changes, medication change, or new medications are prescribed.

PCPs, in their care coordination role, serve as the referral agent for specialty and treatment services deemed medically appropriate to MC members assigned to them, and attempt to ensure coordinated quality care that is efficient and cost effective. Coordination responsibilities include, but are not limited to:

- Referring members to providers or hospitals within the MC network, as appropriate, and if necessary, referring members to out-of-network specialty providers;
- Coordinating with MC's Prior Authorization Department about prior authorization procedures for members;

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- Conducting follow-up (including maintaining records of services provided) for referral services that are rendered to their assigned members by other providers, specialty providers and/or hospitals;
- Coordinating the medical care of the MC members assigned to them, including at a minimum:
 - Oversight of drug regimens to prevent negative interactive effects
 - Follow-up for all emergency services
 - Coordination of inpatient care
 - Coordination of services provided on a referral basis, and
 - Assurance that care rendered by specialty providers is appropriate and consistent with each member's health care needs.

4.13 - Specialist Providers

Specialist providers are responsible for providing services in accordance with the accepted community standards of care and practices. Specialists should only provide services to members upon receipt of a written referral form from the member's primary care provider or from another MC participating specialist. Specialists are required to coordinate with the primary care provider when members need a referral to another specialist. The specialist is responsible for verifying member eligibility prior to providing services.

When a specialist refers the member to a different specialist or provider, then the original specialist must share these records, upon request, with the appropriate provider or specialist. The sharing of the documentation should occur with no cost to the member, other specialists or other providers.

The Controlled Substance Prescription Monitoring Program (CSPMP) will be checked 100% of the time prior to prescribing controlled substances.

4.14 - Second Opinions

A member may request a second opinion from a provider within the contracted network. The provider should make a recommendation and refer the member to another provider.

4.15 - Provider Assistance Program for Non-Compliant Members

The provider is responsible for providing appropriate services so that members understand their health care needs and are compliant with prescribed treatment plans. Providers should strive to manage members and ensure compliance with treatment plans and with scheduled appointments. If you need assistance helping non-compliant members, MC's Provider Assistance Program is available to you. The purpose of the program is to help coordinate and/or manage the medical care for members at risk. You may complete the **Provider Assistance**

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Program Form located on MC's [Forms](#) website and submit it to Member Services for possible intervention.

If you elect to remove the member from your panel rather than continue to serve as the medical home, you must provide the member at least 30 days written notice prior to removal and ask the member to contact Member Services to change their provider. **The member will NOT be removed from a provider's panel unless the provider efforts and those of the Health Plan do not result in the member's compliance with medical instructions.** If you need more information about the Provider Assistance Program, please contact your Network Relations Specialist/Consultant.

[Documenting Member Care](#)

4.16 - Member's Medical Record

The provider serves as the member's "medical home" and is responsible for providing quality health care, coordinating all other medically necessary services and documenting such services in the member's medical record. The member's medical record must be kept in a legible, detailed, organized and comprehensive manner and must remain confidential and accessible and in accordance with applicable law to authorized persons only. The medical record will comply with all customary medical practice, Government Sponsor directives, applicable Federal and state laws and accreditation standards.

- a) **Access to Information and Records** - All medical records, data and information obtained, created or collected by the provider related to member, including confidential information must be made available electronically to MC, AHCCCS or any government agency upon request. Medical records necessary for the payment of claims must be made available to MC within fourteen (14) days of request. Clinical documentation related to payment incentives and outcomes, including all pay for performance data will be made available to MC or any government entity upon request. MC may request medical records for transitioning a member to a new health plan or provider. The medical record will be made available free of charge to MC for these purposes.

Each member is entitled to one copy of his or her medical record free of charge. Members have the right to amend or correct medical records. The record must be supplied to the member within fourteen (14) days of the receipt of the request.

When a member changes PCPs, his or her medical records or copies of medical records must be forwarded to the new PCP within 10 business days from receipt of the request for transfer of the medical records.

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All providers must adhere to national medical record documentation standards. Below are the minimum medical record documentation and coordination requirements. This information comes from the AHCCCS *Policy 940 – Medical Records and Communication of Clinical Information* contained in [Chapter 900 – Quality Management and Performance Improvement Program](#):

- Member identification information on each page of the medical record (i.e., name or AHCCCS identification number)
- Documentation of identifying demographics including the member's name, address, telephone number, AHCCCS identification number, gender, age, date of birth, marital status, next of kin, and, if applicable, guardian or authorized representative
- Initial history for the member that includes family medical history, social history and preventive laboratory screenings (the initial history for members under age 21 should also include prenatal care and birth history of the member's mother while pregnant with the member)
- Past medical history for all members that includes disabilities and any previous illnesses or injuries, smoking, alcohol/substance abuse, allergies and adverse reactions to medications, hospitalizations, surgeries and emergent/urgent care received
- Immunization records (required for children; recommended for adult members if available)
- Dental history if available, and current dental needs and/or services
- Current problem list
- Current medications
- Current and complete EPSDT forms (required for all members age 0 through 20 years)
- Documentation, initialed by the member's PCP, to signify review of:
- Diagnostic information including:
 - Laboratory tests and screenings
 - Radiology reports
 - Physical examination notes, and
 - Other pertinent data.
- Reports from referrals, consultations and specialists
- Emergency/urgent care reports
- Hospital discharge summaries
- Behavioral health referrals and services provided, if applicable, including notification of behavioral health providers, if known, when a member's health status changes or new medications are prescribed
- Behavioral health history

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- Documentation as to whether an adult member has completed advance directives and location of the document
 - Documentation related to requests for release of information and subsequent releases, and
 - Documentation that reflects that diagnostic, treatment and disposition information related to a specific member was transmitted to the PCP and other providers, including behavioral health providers, as appropriate to promote continuity of care and quality management of the member's health care.
- b) **Medical Record Maintenance** – The provider must maintain member information and records for the longer of six (6) years after the last date provider services were provided to Member, or the period required by applicable law or Government Sponsor directions. The maintenance and access to the member medical record shall survive the termination of a Provider's contract with MC, regardless of the cause of the termination.
- c) **PCP Medication Management and Care Coordination with Behavioral Health Providers** - When a PCP has initiated medical management services for a member to treat a behavioral health disorder, and it is subsequently determined by the PCP or MC that the member should receive care through the behavioral health system for evaluation and/or continued medication management services, MC will require and assist the PCP with the coordination of the referral and transfer of care through the behavioral health care management team at MC. The PCP will document in the medical record the care coordination activities and transition of care. The PCP must document the continuity of care.

The medical record contains clinical information pertaining to a member's physical and behavioral health. Maintaining current, accurate, and comprehensive medical records assists providers in successfully treating and supporting member care.

Providers must maintain legible, signed and dated medical records in paper or electronic format that are written in a detailed and comprehensive manner, conform to good professional practices; permit effective professional review and audit processes; and facilitate an adequate system for follow-up treatment.

Paper or Electronic Format

Paper medical records and documentation must include:

- Date and time;
- Signature and credentials;
- Legible text written in blue or black ink or typewritten;
- Corrections with a line drawn through the incorrect information, a notation that the incorrect information was an error, the date when the correction was made, and the initials of the member altering the record. Correction fluid or tape is not allowed; and

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- If a rubber-stamp signature is used to authenticate the document/entry, the individual whose signature the stamp represents is accountable for the use of the stamp.
- A progress note is documented on the date that an event occurs. Any additional information added to the progress note is identified as a late entry.

Electronic medical records and documentation must include:

- Safeguards to prevent unauthorized access:
 - The date and time of entries in a medical record as noted by the computer's internal clock;
 - The personnel authorized to make entries using provider established policies and procedures;
 - The identity of the member making an entry; and
 - Electronic signatures to authenticate that a document is properly safeguarded and the individual whose signature is represented is accountable for the use of the electronic signature.

Electronic medical records and systems must also:

- Ensure that the information is not altered inadvertently;
- Track when, and by whom, revisions to information are made; and
- Maintain a backup system including initial and revised information.

Transportation Services Documentation

- For providers that supply transportation services for members using provider employees (i.e. facility vans, drivers, etc.) the following documentation requirements apply:
 - Complete service provider's name and address;
 - Signature and credentials of the driver who provided the service;
 - Vehicle identification (car, van, wheelchair van, etc.);
 - Member's Arizona Health Care Cost Containment System (AHCCCS) identification number;
 - Date of service, including month day and year;
 - Address of pick up site;
 - Address of drop off destination;
 - Odometer reading at pick up;
 - Odometer reading at drop off;
 - Type of trip – round trip or one way;
 - Escort (if any) must be identified by name and relationship to the member being transported; and
 - Signature of the member, parent and/or guardian/caregiver, verifying services were rendered. If the member refuses to sign the trip validation form, then the

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driver should document his/her refusal to sign in the comprehensive medical record.

- For providers that use contracted transportation services, for non-emergency transport of members, that are not direct employees of the provider (i.e. cab companies, shuttle services, etc.) see Policy 201, Covered Services for a list of elements recommended for documenting non-emergency transportation services.
- It is the 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.
- MC communicates documentation standards listed under Covered and Non-Covered Services for each line of business to their contracted providers.

Disclosure of Records

All medical records, data and information obtained, created or collected by the provider related to member, including confidential information must be made available electronically to MC, AHCCCS or any government agency upon request.

When a member changes his or her PCP, the provider must forward the member's medical record or copies of it to the new PCP within ten (10) business days from receipt of the request for transfer of the record. Medical records must be made available free of charge.

Behavioral health records must be maintained as confidential and must only be disclosed according to the following provisions:

- When requested by a member's primary care provider (PCP) or the member's Department of Economic Security/Division of Developmental Disabilities/Arizona Long-Term Care System (DES/DDD/ALTCS) support coordinator, the behavioral health record or copies of behavioral health record information must be forwarded within ten (10) days of the request.
- MC and subcontracted providers must provide each member who makes a request one copy of his or her medical record free of charge annually.
- MC and subcontracted providers must allow, upon request, members to view and amend their medical record as specified in 45 C.F.R. § 164.524, 164.526 and A.R.S. § 12-2293.

Health Risk Assessment for Mercy RBHA

The Health Risk Assessment (HRA) is a best practice approach and key component of Mercy RBHA. The standardized question tool puts members in the driver seat by asking them to self-report their medical, psychosocial, cognitive and functional needs. The assessment score is one of the tools used by the clinical and care management team to determine the member's acuity

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level, based on the member's perception of their health and health risks. The information provided by members via the health risk assessment, is reviewed along with data from the medical record, claims and other sources to develop a care plan. The care plan is shared with the clinical team to inform the Individual Service Plan (ISP) that provides a roadmap to the member's recovery.

The health risk assessment shall be conducted for all members with Serious Mental Illness (SMI) by the member's assigned clinic. Results shall be inputted into the clinic's electronic health record (E.H.R.) and transmitted to Mercy RBHA per required specifications. Every question on the assessment is required and must be answered. Responses must be entered exactly as shown on the tool provided by Mercy RBHA. Clinics are responsible to complete the assessment in its entirety and per the provided specifications. Failure to submit complete and accurate assessments may result in sanctions and/or corrective action.

The Centers of Medicare and Medicaid Services and Mercy RBHA require the health risk assessment be completed:

- Initially within 90 days of a member's enrollment.
- Annually, within 365 days of their previous health risk assessment.
- When the member experiences a change in health status or level of care.

Behavioral Health Record for Mercy RBHA

For Seriously Mentally Ill (SMI), and Children (CA), the comprehensive medical record must contain the following elements:

- Intake paperwork documentation that includes:
 - For members receiving substance abuse treatment services under the Substance Abuse Block Grant (SABG), documentation that notice was provided regarding the member's right to receive services from a provider to whose religious character the member does not object to (see Chapter 2.10 – Special Populations);
 - Documentation of member's receipt of the Member Handbook and receipt of Notice of Privacy Practice; and
 - Contact information for the member's PCP if applicable.
- Assessment documentation that includes:
 - Is there a screening and assessment for trauma in children and families?
 - Is there evidence of documentation of identification of trauma related needs and plans to address those needs (Children)?
 - For children in Child Welfare, if the member is displaying dangerous or threatening behaviors and a request for residential treatment is made by out of home placement, was the request submitted within 24 hours of request?
 - Documentation of all information collected in the behavioral health assessment,

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any applicable addenda completed within 45 days of intake, and required demographic information (see Chapter 2.2 – Referral and Intake Process, Chapter 2.4 – Assessment and Service Planning and Chapter 18.0 - Enrollment, Disenrollment and Other Data Submission);

- Diagnostic information including psychiatric, psychological and medical evaluations;
- Copies of [Notification of Members in Need of Special Assistance](#) (see Chapter 2.13 – Special Assistance for Members Determined to have a Serious Mental Illness).
- An English version of the assessment and/or service plan if the documents are completed in any other language other than English; and
- For members receiving services via telemedicine, copies of electronically recorded information of direct, consultative or collateral clinical interviews.
- CASII (CHILDREN ONLY)
 - The CASII is completed within the initial 45-day assessment period;
 - The CASII is completed every 6 months following the initial assessment period;
 - The CASII has been completed in collaboration with the child/adolescent and family and other members of the CF;
 - For children/adolescents with CASII levels of 4, 5, and 6 of service intensity, there is a designated care manager to coordinate services and activities of CFT practice; and
 - Based on all clinical and supporting documentation, the CASII service intensity is appropriate to the child/adolescent's current functioning.
- Treatment and service plans documentation that includes:
 - The member's treatment and service plan;
 - Child and Family Team (CFT) documentation;
 - Clinically recommended service on the treatment plan are implemented within 21 days (Children);
 - Adult Recovery Team (ART) documentation; and
 - Progress reports or service plans from all other additional service providers.
- Progress notes documentation that includes:
 - Documentation of the type of services provided;
 - The diagnosis, including an indicator that clearly identifies whether the progress note is for a new diagnosis or the continuation of a previous diagnosis. After a primary diagnosis is identified, the member may be determined to have co-occurring diagnoses. The service providing clinician will place the diagnosis code in the progress note to indicate which diagnosis is being addressed during the provider session. The addition of the progress note diagnosis code should be included, if applicable;

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- The date the service was delivered;
- Duration of the service (time increments) including the code used for billing the service;
- A description of what occurred during the provision of the service related to the member's treatment plan;
- If more than one provider simultaneously provides the same service to a member, documentation of the need for the involvement of multiple providers including the name and roles of each provider involved in the delivery of services;
- The member's response to service; and
- For members receiving services via telemedicine, electronically recorded information of direct, consultative or collateral clinical interviews.
- Medical services documentation that includes:
 - Laboratory, x-ray, and other findings related to the member's physical and behavioral health care;
 - The member's treatment plan related to medical services;
 - Physician orders;
 - Requests for service authorizations;
 - Documentation of facility-based or inpatient care;
 - Documentation of preventative care services;
 - Medication record, when applicable; and
 - Documentation of Certification of Need (CON) and Re-Certification of Need (RON)
- Reports from other agencies that include:
 - Reports from providers of services, consultations, and specialists;
 - Emergency/urgent care reports; and
 - Hospital discharge summaries.
- Paper or electronic correspondence that includes:
 - Documentation of the provision of diagnostic, treatment, and disposition information to the PCP and other providers to promote continuity of care and quality management of the member's health care;
 - Documentation of any requests for and forwarding of behavioral health record information.
 - The Controlled Substance Prescription Monitoring Program (CSPMP) will be checked 100% of the time prior to prescribing controlled substances.
- Financial documentation that includes:
 - Documentation of the results of a completed Title XIX/XXI screening
 - Information regarding establishment of any copayments assessed, if applicable
- Legal documentation including:
 - Documentation related to requests for release of information and subsequent

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- releases
- Copies of any advance directives or mental health care power of attorney
 - Documentation that the adult member was provided the information on advance directives and whether an advance directive was executed;
 - Documentation of authorization of any health care power of attorney that appoints a designated member to make health care decisions (not including mental health) on behalf of the member if they are found to be incapable of making these decisions;
 - Documentation of authorization of any mental health care power of attorney that appoints a designated member to make behavioral health care decisions on behalf of the member if they are found to be incapable of making these decisions. Documentation of general and informed consent to treatment pursuant to **General and Informed Consent** and **Pharmacy Management** under each line of business;
 - Authorization to disclose information pursuant to RBHA Chapter 13 – Contract Compliance, Section 13.00 – Confidentiality. All applicable release of Information (ROI's) documentation to be reviewed and updated annually with the member; and,
 - Any extension granted for the processing of an appeal must be documented in the case file, including the Notice regarding the extension sent to the member and his/her legal guardian or authorized representative, if applicable
 - For youth in Child Welfare, documentation of verification of the Notice to Provider (Educational-Medical).
- Integrated Health Care (SMI ONLY)
 - Does documentation reflect strategies to support earlier identification and intervention that reduces the incidence and severity of serious physical, and mental illness;
 - Is use of health education and health promotion services evidenced;
 - Does documentation reflect an increased use of primary care prevention strategies;
 - Is there evidence of use of validated screening tools for early identification and intervention;
 - Evidence of focused, targeted, consultations for behavior health conditions;
 - Evidence of cross-specialty collaboration;
 - Evidence of enhanced discharge planning and follow-up care between provider visits;
 - Evidence of ongoing outcome measurement and treatment plan modification related to health promotion and prevention;
 - Evidence of care coordination through effective provider communication and

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- management of treatment; and
- Family and community education related to health promotion and prevention.

Medical Record Maintenance

Providers must retain the original or copies of member medical records as follows:

- For an adult, for at least six (6) years after the last date the adult member received medical or health care services from the provider; or
- For a child, either for at least three (3) years after the child's eighteenth birthday or for at least six (6) years after the last date the adult member received medical or health care services from the provider, whichever occurs later.

The maintenance and access to the member medical record shall survive the termination of a Provider's contract with MC, regardless of the cause of the termination.

PCP Medication Management and Care Coordination with Behavioral Health Providers

When a PCP has initiated medical management services for a member to treat depression, anxiety, and/or ADD/ADHD, and it is subsequently determined by the PCP or MC that the member should receive care through the behavioral health system for evaluation and/or continued medication management services, MC will require and assist the PCP with the coordination of the referral and transfer of care. The PCP will document in the medical record the care coordination activities and transition of care. The PCP must document the continuity of care.

Medical Record Audits

MC conducts routine medical record audits to assess compliance with established standards. Medical records may be requested when MC is responding to an inquiry on behalf of a member or provider, administrative responsibilities, and quality of care issues. Providers must respond to these requests within fourteen (14) days or in no event will the date exceed that of any government issues request date. Medical records must be made available to AHCCCS for quality review upon request. MC shall have access to medical records for assessing quality of care, conducting medical evaluations, audits, and performing utilization management functions.

Substance Abuse and Mental Health Services Administration (SAMHSA) evidence-based practices include the following:

- ACT teams
- Permanent supportive housing
- Consumer-operated services
- Supported employment

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It is the expectation for fidelity scores to continue to improve, with a minimum expectation of sustaining fidelity scores for all the evidence-based practices listed above.

Reviews and self-monitoring

In addition to participating in formal fidelity reviews, all providers are expected to:

- Participate in quality management and fidelity review processes.
- Conduct ongoing self-monitoring activities according to the self-monitoring plan outlined by each provider.
- Report quarterly on results of their self-monitoring activities.

Performance improvement activities, including but not limited to PIPS, CAPS and/or sanctions may be imposed by MC.

Transition of Medical Records

Transfer of the behavioral health member's medical records, due to transitioning of the behavioral health member to a new T/RBHA and/or provider, it is important to ensure that there is minimal disruption to the behavioral health member's care and provision of services. The behavioral health medical record must be transferred in a timely manner that ensures continuity of care.

Federal and state law allows for the transfer of behavioral health medical records from one provider to another, without obtaining the member's written authorization if it is for treatment purposes (**45 C.F.R. § 164.502(b)**, **164.514(d)** and **A.R.S. 12-2294(C)**). Generally, the only instance in which a provider must obtain written authorization is for the transfer of alcohol/drug and/or communicable disease treatment information. Other situations may require written authorization.

The original provider must send that portion of the medical record that is necessary to the continuing treatment of the behavioral health member. In most cases, this includes all communication that is recorded in any form or medium and that relate to patient examination, evaluation or behavioral health treatment. Records include medical records that are prepared by a health care provider or other providers. Records do not include materials that are prepared in connection with utilization review, peer review or quality assurance activities, including records that a health care provider prepares pursuant to section **A.R.S. §36-441, 36-445, 36-2402 and 36-2917**.

Federal privacy law indicates that the Designated Record Set (DRS) is the property of the provider who generates the DRS. Therefore; originals of the medical record are retained by the terminating or transitioning provider in accordance with **DISCLOSURE OF RECORDS** of this

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chapter. The cost of copying and transmitting the medical record to the new provider shall be the responsibility of the transitioning provider (see the [AHCCCS Contractors Operation Manual, Section 402](#)).

Requirements for Community Service Agencies (CSA), Home Care Training to Home Care Client (HCTC) Providers and Habilitation Providers

Mercy RBHA requires that CSA, HCTC Provider and Habilitation Provider clinical records to the following standards. Each record entry must be:

- **Dated and signed with credentials noted;**
- **Legible text, written in blue or black ink or typewritten; and**
- **Factual and correct.**

If required records are kept in more than one location, the agency/provider shall maintain a list indicating the location of the records.

CSAs, HCTC Providers and Habilitation Providers must maintain a record of the services delivered to each behavioral health member. The minimum written requirement for each behavioral health member's record must include:

- The service provided (including the code used for billing the service) and the time increment;
- Signature and the date the service was provided;
- The name title and credentials of the member providing the service;
- The member's CIS identification number and AHCCCS identification number;
- Mercy RBHA conducts routine audits to ensure that services provided by the agency/provider are reflected in the behavioral health member's service plan. CSAs, HCTC Providers and Habilitation Providers must keep a copy of each behavioral health member's service plan in the member's record; and
- Daily documentation of the service(s) provided and monthly summary of progress toward treatment goals.

Community Service Agency/HCTC Provider/Habilitation Provider Daily Clinical Record

Documentation Form is a recommended format that may be utilized to meet the requirements identified in this chapter.

Every thirty (30) days, a summary of the information required in this chapter must be transmitted from the CSA, HCTC Provider or Habilitation Provider to the member's clinical team for inclusion in the comprehensive clinical record.

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Adequacy and Availability of Documentation

Mercy RBHA and subcontracted providers must maintain and store records and data that document and support the services provided to members and the associated encounters/billing for those services. In addition to any records required to comply with Mercy RBHA contracts, there must be adequate documentation to support that all billings or reimbursements are accurate, justified and appropriate.

All providers must prepare, maintain and make available to AHCCCS and Mercy RBHA, adequate documentation related to services provided and the associated encounters/billings.

Adequate documentation is electronic records and “hard-copy” documentation that can be readily discerned and verified with reasonable certainty. Adequate documentation must establish medical necessity and support all medically necessary services rendered, and the amount of reimbursement received (encounter value/billed amount) by a provider; this includes all related clinical, financial, operational and business supporting documentation and electronic records. It also includes clinical records that support and verify that the member’s assessment, diagnosis and Individual Service Plan (ISP) are accurate and appropriate and that all services (including those not directly related to clinical care) are supported by the assessment, diagnosis and ISP.

For monitoring, reviewing and auditing purposes, all documentation and electronic records must be made available at the same site at which the service is rendered. If requested documents and electronic records are not available for review at the time requested, they are considered missing. All missing records are considered inadequate. If documentation is not available due to off-site storage, the provider must submit their applicable policy for off-site storage, demonstrate where the requested documentation is stored and arrange to supply the documentation at the site within 24 hours of the original request.

Mercy RBHA’s failure to prepare, retain and provide to AHCCCS adequate documentation and electronic records for services encountered or billed may result in the recovery and/or voiding (not to be resubmitted) of the associated encounter values or payments for those services not adequately documented and/or result in financial sanctions to the provider and Mercy RBHA.

Inadequate documentation may be determined to be evidence of suspected fraud or program abuse that may result in notification or reporting to the appropriate law enforcement or oversight agency. These requirements continue to be applicable in the event the provider discontinues as an active participating and/or contracted provider as the result of a change of ownership or any other circumstance.

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4.17 - Advance Directives

Providers are required to comply with federal and state law regarding advance directives for adult members. The advance directive must be prominently displayed in the adult member's medical record. Requirements include:

- Providing written information to adult members regarding each individual's rights under state law to make decisions regarding medical care and any provider written policies concerning advance directives (including any conscientious objections).
- Documenting in the member's medical record whether the adult member has been provided the information and whether an advance directive has been executed.
- Not discriminating against a member because of his or her decision to execute or not execute an advance directive and not making it a condition for the provision of care.

FOR MERCY CARE LONG TERM CARE

A recent update was noted regarding the inclusion of Advance Directives and DNR availability/access monitoring in certain placement settings in the AHCCCS Medical Policy Manual (AMPM) under section 930-2e Advance Directive. The AMPM states:

“For members in a HCBS or a behavioral health residential setting that have completed an Advance Directive, the document must be kept confidential but be readily available. For example: in a sealed envelope attached to the refrigerator.”

The rationale is that 1st responders arriving to a facility/home did not know whether there were DNR/DNI orders for an individual, and without them, they were required to perform resuscitative functions. If the DNR orders were readily available, this would help the 1st responders upon arrival.

FOR MERCY CARE RBHA

Advance directives not only identify services a member would desire if he or she becomes unable to decide, but they also:

- Promote individual treatment planning;
- Provide opportunities to create a team approach to treatment; and
- Foster recovery approaches.

The Arizona Secretary of State (www.azsos.gov) maintains a free registry called the “Arizona Advance Directive” where individuals can send advance directives for secure storage and can be accessible to individuals, loved ones and health care providers. This webpage also has other resources available on advanced directives.

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If changes occur in State law regarding advance directives, adult members receiving behavioral health services must be notified by their provider regarding the changes as soon as possible, but no later than 90 days after the effective date of the change.

Health Care Power of Attorney

A health care power of attorney gives an adult member the right to designate another adult member to make health care treatment decisions on his or his/her behalf. The designee may make decisions on behalf of the adult member if/when he/she or he is found incapable of making these types of decisions. The designee, however, must not be a provider directly involved with the health treatment of the adult member at the time the health care power of attorney is executed.

Behavioral Health Care Power of Attorney

A behavioral health care power of attorney gives an adult member the right to designate another adult member to make behavioral health care treatment decisions on his or her behalf. The designee may make decisions on behalf of the adult member if/when she or he is found incapable of making these types of decisions. The designee, however, must not be a provider directly involved with the behavioral health treatment of the adult member at the time the behavioral health care power of attorney is executed.

Power and Duties of Designee(s)

The designee:

- May act in this capacity until his or her authority is revoked by the adult member or by court order;
- Has the same right as the adult member to receive information and to review the adult member's medical records regarding proposed healthcare treatment and to receive, review, and consent to the disclosure of medical records relating to the adult member's treatment;
- Must act consistently with the wishes of the adult member as expressed in the health care power of attorney or mental health care power of attorney. If, however, the adult member's wishes are not expressed in a health care power of attorney or behavioral health care power of attorney and are not otherwise known by the designee, the designee must act in good faith and consent to treatment that she or he believes to be in the adult member's best interest; and
- May consent to admitting the adult member to an inpatient behavioral health facility licensed by the Arizona Department of Health Services if this authority is expressly stated in the behavioral health care power of attorney or health care power of attorney.

See **A.R.S. §36-3283** for a complete list of the powers and duties of an agent designated under a behavioral health care power of attorney.

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Requirements for Adult Member at Time of Enrollment

At the time of enrollment, all adult members, and when the individual is incapacitated or unable to receive information, the enrollee's family or surrogate, must receive information regarding (see **42 C.F.R. § 422.128**):

- The member's rights, in writing, regarding advance directives under Arizona State law;
- A description of the applicable state law and information regarding the implementation of these rights;
- The healthcare member's right to file complaints directly with AHCCCS; and
- Written policies including a clear and precise statement of limitations if the provider cannot implement an advance directive as a matter of conscience. This statement, at a minimum, should:
 - Clarify institution-wide conscience objections and those of individual physicians;
 - Identify state legal authority permitting such objections; and
 - Describe the range of medical conditions or procedures affected by the conscience objection.

If an enrollee is incapacitated at the time of enrollment, healthcare providers may give advance directive information to the enrollee's family or surrogate in accordance with state law.

Healthcare providers must also follow up when the member is no longer incapacitated and ensure that the information is given to the member directly.

Assistance for Adult Member to Develop Advance Directive

Healthcare providers must assist adult members who are interested in developing and executing an advance directive. MC can offer the **Advanced Directives**, available under our [Forms Library](#) web page.

Other Requirements for Health Care Providers

Healthcare providers must:

- Document in the adult member's clinical record whether the adult member was provided the information and whether an advance directive was executed;
- Note condition provision of care or discriminate against an adult member because of his or her decision to execute or not to execute an advance directive;
- If provider is not the Primary Care Physician (PCP), provide a copy of a member's executed advanced directive, or documentation of refusal, to the PCP for inclusion in the member's medical record; and
- Provide education to staff on issues concerning advance directives including notification of direct care providers of services, such as home health care and personal care, of any advance directives executed by behavioral health members to whom they are assigned

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to provide services.

For additional resources about Advance Directives, contact Mercy RBHA Member Services at 800-564-5465.

4.18 - Documenting Member Appointments

When scheduling an appointment with a member over the telephone or in person (i.e. when a member appears at your office without an appointment), providers must verify eligibility and document the member's information in the member's medical record.

4.19 - Missed or Cancelled Appointments

Providers must:

- Document and follow-up on missed or canceled appointments.
- Notify Member Services by completing a **Provider Assistance Program** form located on MC's [Forms](#) section for a member who continually misses appointments.

MC encourages providers to use a recall system. MC reserves the right to request documentation supporting follow up with members related to missed appointments. Providers may also notify MC Quality Management of missed appointments utilizing the **Missed Appointment Log** located in our [Forms](#) section for the QM staff to follow-up with members.

4.20 - Documenting Referrals

The provider is responsible for initiating, coordinating and documenting referrals to specialists, including dentists and behavioral health specialists within the MC organization. The provider must follow the respective practices for emergency room care, second opinion and noncompliant members.

4.21 - Respecting Member Rights

MC is always committed to treating members with respect and dignity. Member rights and responsibilities are shared with staff, providers and members each year. Member rights are incorporated herein and may be reviewed in the **Member Handbook** located on our [Member Information](#) web page in the MC website.

MC member rights and responsibilities are listed below:

Member Rights

- Members are entitled to the name of their PCP and/or case manager.
- Members are entitled to have a copy of the MC Member Handbook, which includes a description of covered services.

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- How MC provides after hours and emergency care.
- The right to file a complaint about MC.
- The right to request information about the structure and operations of MC or their subcontractors.
- How MC pays providers, controls costs and uses services. This information includes whether MC has Physician Incentive Plans (PIP) and a description of the PIP.
- The right to know whether stop loss insurance is required.
- General grievance results and a summary of member survey results.
- Member costs to get services or treatments that are not covered by MC.
- How to get services, including services requiring authorization.
- How MC evaluates new technology to include as a covered service.
- Changes to the member's services or what action to take when a member's PCP leaves MC.
- Members have the right to be treated fairly and get covered services without concern about race, ethnicity, national origin (to include those with limited English proficiency), religion, gender, age, mental or physical disability, sexual orientation, genetic information or ability to pay or speak English.

Confidentiality and Privacy

- Members have a right to privacy and confidentiality regarding their health care information.
- Members have the right to talk to health care professionals privately.
- A "Privacy Rights" notice is included in the member's welcome packet. The notice has information on ways MC uses a member's records, which includes information their health plan activities and payments for services. Health care information will be kept private and confidential. It will be given out only with the member's permission or if the law allows it.

Treatment Decisions

- Members have the right to agree to, or refuse, treatment and to choose other treatment options available to them. Members can get this information in a way that helps them to better understand and is appropriate to their medical condition.
- Members can choose a MC PCP to coordinate their health care.
- Members can change their PCP.
- Members can talk with their PCP to get complete and current information about their health care and condition. This will help members and their family to better understand their condition and be a part of making decisions about their health care.
- Within the limits of applicable regulations, MC staff may help manage a member's health care by working with the member, community and state agencies, schools, their doctor.

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- Members have the right to information on which procedures they will have and who will perform them.
- Members have the right to a second opinion from a qualified health care professional within the network. A second opinion can be arranged outside of the network, at no cost to the member, only if there is not adequate in-network coverage.
- Members have the right to know treatment choices or types of care available to them and the benefits and/or drawbacks of each choice.
- Members can decide who they want to be with for their treatments and exams.
- Members can have a female in the room for breast and pelvic exams.
- Member eligibility or medical care does not depend on the member's agreement to follow a treatment plan. A member can say "no" to treatment, services or PCPs. The member will be informed about what may happen to their health if they do not have the treatment.
- MC will notify a member in writing when any health care services requested by their PCP are reduced, suspended, terminated or denied. Members must follow the instructions in the notification letter sent to them.
- Members have the right to be provided with information about creating advance directives. Advance directives tell others how to make medical decisions for the member if the member is not able to make those decisions for themselves.

Medical Records Requests

- At no cost to themselves, the member has the right to annually request and receive one copy of their medical records and/or inspect their medical records. Members may not be able to get a copy of medical records if the record includes any of the following information: psychotherapy notes put together for a civil, criminal or administrative action; protected health information that is subject to the Federal Clinical Laboratory Improvements Amendments of 1988; or protected health information that is exempt due to federal codes of regulation.
- MC will reply to the member's request within 30 days. MC's reply will include a copy of the requested record or a letter denying the request. The written denial letter will include the basis for the denial and information on ways to get the denial reviewed.
- Members have the right to request an amendment to their medical records. MC may ask that the member put this request in writing. If the amendment is made, whole or in part, we will take all steps necessary to do this in a timely manner and let the member know about changes that are made.
- MC has the right to deny a member's request to amend their medical records. If the request is denied, in whole or in part, then MC will provide the member with a written denial within 60 days. The written denial includes the basis for the denial, notification of member's right to submit a written statement disagreeing with the denial and how to file the statement.

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Reporting Member Concerns

- Tell MC about any complaints or issues the member has with their health care services.
- Members may file an appeal with MC and get a decision in a reasonable amount of time.
- Members can give MC suggestions about changes to policies and services.
- Members have the right to complain about MC.
- Personal rights.
- Members have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- Members have the right to receive information on beneficiary and plan information.

Respect and Dignity

- Members have the right to be treated with respect and with due consideration for their dignity and privacy.
- Members have the right to participate in decisions regarding their health care, including the right to refuse treatment.
- Members can get quality medical services that support their personal beliefs, medical condition and background. Members can get these services in a language they understand. Members have the right to know about other providers who speak languages other than English.
- Members can get interpretation services if they do not speak English. Sign language services are available if you are deaf or have difficulty hearing. You may ask for materials in other formats or languages from MC Member Services.
- The type of information about a member's treatment is available to the member in a way that helps them have a better understanding given their medical condition.

Members Who are Part of Division of Developmental Disabilities

- Members have the right to get a replacement caregiver for "critical services" within two hours.

Emergency Care and Specialty Services

- Members can get emergency health care services without the approval of their PCP or MC when they have a medical emergency. Members may go to any hospital emergency room or other setting for emergency care.
- Members may get behavioral health services without the approval of their PCP or MC.
- Members can see a specialist with a referral from their PCP.
- Members can refuse care from a doctor they were referred to and can ask for a different doctor.
- Members may request a second opinion from another MC physician/specialist.

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4.22 – Consent to Treat Minors or Disabled Members under Guardianship

Health care professionals and organizational providers who treat or provide services for MC members must comply with federal and state laws requiring consent for the treatment of minors or disabled members under guardianship to be HIPAA compliant.

Both participating and nonparticipating practitioners and providers are responsible for determining whether consent is needed for a service being provided to a member and must obtain appropriate consent as required. Since this involves Protected Health Information (PHI) and needs to be shared with the member's guardian or Durable Power of Attorney, providers are required to meet all HIPAA regulations.

If during a review or audit it is discovered that appropriate consent was not attained, it will be reported to our Quality Management Department or Chief Medical Officer.

4.23 - Health Insurance Portability and Accountability Act of 1997 (HIPAA)

The Health Insurance Portability and Accountability Act of 1997 (HIPAA) has many provisions affecting the health care industry, including transaction code sets, privacy and security provisions. HIPAA impacts what is referred to as covered entities; specifically, providers, health plans and health care clearinghouses that transmit health care information electronically. HIPAA has established national standards addressing the security and privacy of health information, as well as standards for electronic health care transactions and national identifiers. All Participating Health Providers (PHP) are required to adhere to HIPAA regulations. For more information about these standards, please visit the [Health Information Privacy](#) website. In accordance with HIPAA guidelines, providers may not interview members about medical or financial issues within hearing range of other patients.

4.24 - Cultural Competency, Health Literacy and Linguistic Services

As the U.S. population becomes more diverse, medical providers and other people involved in health care delivery are interacting with patients/consumers from many different cultural and linguistic backgrounds. Because culture and language are vital factors in how health care services are delivered and received, it is important that health care organizations and their staff understand and respond with sensitivity to the needs and preferences that culturally and linguistically diverse patients/consumers bring to the health encounter.

Responding to Cultural and Linguistic Needs of our Members

The Institute of Medicine report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* demonstrated that racial and ethnic minorities often receive lower-quality care than their white counterparts, even after controlling for factors such as insurance, socioeconomic status, comorbidities, and stage of presentation. Among other factors found to contribute to healthcare disparities are inadequate resources, poor patient-provider

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communication, a lack of culturally competent care, and inadequate linguistic access. Through the application of cultural competency knowledge and health literacy techniques, providers will help remove barriers to care.

Required Culturally and Linguistically Appropriate Services (CLAS) Standards

The enhanced National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for individuals as well as health and health care organizations to implement culturally and linguistically appropriate services. The enhanced standards are a comprehensive series of guidelines that inform, guide, and facilitate practices related to culturally and linguistically appropriate health services.

Mercy Care Requirements

The Mercy Care RBHA requires and monitors all adherence to Annual Cultural Competence plan requires adherence to all areas of the CLAS standards.

Mercy Care Acute Care and Long Term Care expect all providers to uphold all the CLAS standards and check for education/knowledge and monitor for non-compliance through the member complaint and grievance process.

CLAS Standards

Principal Standard (Standard 1): Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce (Standards 2-4): Provide greater clarity on the specific locus of action for each of these standards and emphasizes the importance of the implementation of CLAS as a systemic responsibility, requiring the investment, support, and training of all individuals within an organization.

Communication and Language Assistance (Standards 5-8): Provides a broader understanding and application of appropriate services to include all communication needs and services, including sign language, braille, oral interpretation, and written translation.

Engagement, Continuous Improvement, and Accountability (Standards 9-15): Underscores the importance of establishing individual responsibility in ensuring that CLAS is supported, while retaining the understanding that effective delivery of CLAS demands actions across an organization. This revision focuses on the supports necessary for adoption, implementation, and maintenance of culturally and linguistically appropriate policies and services regardless of one's role within an organization or practice. All individuals are accountable for upholding the values and intent of the National CLAS Standards.

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Language Access Services (LAS)

Providers must deliver information in a manner that is understood by the member. Mercy Care providers must comply with federal and state laws by offering interpreter and translation services, including sign language interpreters, to LEP members. MC strongly recommends the use of professional interpreters, rather than family or friends

To comply with the LAS requirements, MC and subcontracted providers must:

- Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services;
- Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing;
- Ensure the competence of individuals providing language assistance (qualified staff members must pass the ALTA Language Proficiency Test with a minimum score of 9 to interpret and bill the T1013 HCPCS code), recognizing that the use of untrained individuals and/or minors as interpreters should be avoided;
- Ensure providers identify the prevalent non-English language within provider service areas to ensure service capacity meets those needs;
- Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area. Have services provided in a culturally competent manner, with consideration for members with limited English proficiency or reading skills, and those with diverse cultural and ethnic backgrounds as well as members with visual or auditory limitations. Options include access to a language interpreter, a member proficient in sign language for the hearing impaired and written materials available in Braille for the blind or in different formats, as appropriate;
- Ensure qualified oral interpreters and bilingual staff as well as certified sign language interpreters provide access to oral interpretation, translation, sign language and disability-related services, and provide auxiliary aids and alternative formats on request. Oral interpretation and sign language services are provided at no charge to AHCCCS eligible members and members determined to have a Serious Mental Illness (SMI); and
- MC will conduct evaluations of the primary non-English languages spoken within the Geographical Service Areas (GSAs) and programs that affect cultural competence, access and quality of care.

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Accessing Oral Interpretation Services

In accordance with [Title VI of the Civil Rights Act](#), Prohibition against National Origin Discrimination, and [President's Executive Order 13166](#), Mercy Care and their subcontracted providers must make oral interpretation services available to members with Limited English Proficiency (LEP) at all points of contact. Oral interpretation services are provided at no charge to AHCCCS eligible members and Non-Title XIX/XXI members determined to have a Serious Mental Illness (SMI). Members must be provided with information instructing them how to access these services.

Voiance is the service provider contracted with Mercy Care for telephone oral interpretation services. They provide telephonic interpretation services in over 200 languages. This service is available at no cost to you or the member. To access telephone interpretation services to assist Mercy Care members who speak a language other than English call Voiance directly at the phone number in the table below.

<u>Mercy Care RBHA Providers</u>	<u>Mercy Care Complete Care and Long Term Care Providers</u>
Clinical Services: 1-877-756-4839, pin 1031 Non-Clinical Services: 1-877-756-4839, pin 1033	Clinical Services: 1-877-756-4839, pin 1028; Non-Clinical Services: 1-877-756-4839, pin 1030

The determination between clinical vs. non-clinical is made by the service location and service type. If interpretive services are occurring in a clinical setting (hospital, SMI clinic, etc.), it is considered clinical interpretation. If the interpretive service occurs in a non-clinical setting (i.e., court room, school) and for a non-clinical reason (i.e., scheduling appointment), it is considered non-clinical interpretation.

Mercy Care RBHA Requirements

- All Mercy RBHA providers are required to provide interpretation services for any member that requests or needs the service. (See 42 CFR 438.10, Section 601 of the Title VI of the Civil Rights Act).
- Mercy RBHA providers will contact Akorbi to provide face-to-face and Video Remote Interpreting (VRI). Further information regarding Akorbi is available in our Reference Material and Guide document, [Akorbi – Accessing Interpretive Services](#) that is posted to our website.

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- Mercy RBHA providers will contact Akorbi at their Scheduling Hotline: 480-739-9233.
- Interpretive services must be billed using the following criteria:

Interpretive Services Billing

When billing Interpretive Services, the provider must bill as follows:

HCPCS Code	Modifier	Description
T1013		Qualified staff delivering services is also interpreting.
T1013	Q6	Separate but employed qualified staff is interpreting.
T1013	CR	External vendor used.

Accessing Interpretation Services for the Deaf and the Hard of Hearing

Mercy Care and their subcontracted providers must adhere to the rules established by the Arizona Commission for the Deaf and Hard of Hearing, in accordance with **A.R.S. § 36-1946**, which covers the following:

- Classification of interpreters for the deaf and the hard of hearing based on the level of interpreting skills acquired by that member;
- Establishment of standards and procedures for the qualification and licensure of each classification of interpreters;
- Utilizing licensed interpreters for the deaf and the hard of hearing; and
- Providing auxiliary aids or licensed sign language interpreters that meet the needs of the individual upon request. Auxiliary aids include computer-aided transcriptions, written materials, assistive listening devices or systems, closed and open captioning, and other effective methods of making aurally delivered materials available to members with hearing loss.

The [Arizona Commission for the Deaf and the Hard of Hearing](#) provides a listing of licensed interpreters, information on auxiliary aids and the complete rules and regulations regarding the profession of interpreters in the State of Arizona. You can review their website or contact them at 602 542-3323 (V/TTY)).

Mercy Care has a TTY line in their Member Services department for members who are hearing impaired at 866-796-5598 (TTY/TDD) 711.

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Translation of Written Material

Mercy Care translates written translated materials when a language is spoken by 3,000 or 10% (whichever is less) of members. Mercy Care translates all materials to all members in English and Spanish. All vital materials are translated when Mercy Care is aware that a language is spoken by 1,000 or 5% (whichever is less) of the members. Vital materials must include at a minimum:

- Notice for denials, reductions, suspensions or termination of services;
- Service plans;
- Consent forms;
- Communications requiring a response from the healthcare member;
- Grievance notices; and
- Member Handbooks.

All written notices informing members of their right to interpretation and translation services must be translated when Mercy Care is aware that 1000 or 5% (whichever is less) of Mercy RBHA's members speak that language and have LEP.

Members with Limited English Proficiency (LEP), whose languages are not considered commonly encountered, are provided written notice in their primary or preferred language of the right to receive competent translation of written material.

Mercy Care provides member materials in other formats to meet specific member needs. Providers must also deliver information in a manner that is understood by the member.

Culturally Competent Care

To comply with the Culturally Competent Care requirements, providers must adhere to the following requirements:

- Recruit, promote, and support culturally and linguistically diverse representation within governance, leadership, and the workforce that are responsive to the population in the service area.
- Educate and train representatives within governance, leadership, and the workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.
- Mercy Care RBHA Providers with direct care responsibilities must complete mandated Cultural Competency training.

Assessment

If the behavioral health member requests a copy of the assessment, those documents must be provided to the behavioral health member in his/her primary/preferred language.

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Documentation in the assessment must also be made in English; both versions must be maintained in the member's record. This will ensure that if any members, who must review the member's record for purposes such as coordination of care, emergency services, auditing and program integrity, have an English version available.

Individual Service Plan (ISP) and Inpatient Treatment and Discharge Plan (ITDP)

The Mercy Care Individual Service Plan (ISP) is intended to fulfill several functions, which include identification of necessary medical and behavioral health services (as evaluated during the assessment and through participation from the member and his/her team), documentation of the member's agreement or disagreement with the plan, and notification of the member's right to a **Notice of Adverse Benefit Determination** or Notice of Decision and Right to Appeal. If the member does not agree with the plan, MC provides the service plan templates in both English and Spanish. The Individual Service Plan is a vital document as defined in the AHCCCS/Mercy Care contract.

Service plans specifically incorporate a member's rights to disagree with services identified on the plan. If the plan is not in the member's preferred language, the member has not been appropriately informed of services he/she will be provided and afforded the opportunity to exercise his/her rights when there is a disagreement.

In general, any document that requires the signature of the member, and that contains vital information such as the treatment, medications, notices, or service plans must be:

- Translated into their preferred/primary language.
- If the member or his/her guardian declines the translation, documentation of this decision must be in the member's medical record.
- If the primary/preferred language of the behavioral health member is other than English and any of the service plans have been completed in English, the provider must ensure the service plans are translated into the behavioral health member's primary/preferred language for his/her signature.

Mercy Care and subcontracted providers must also maintain documentation of the ISP in both the preferred/primary language as well as in English. If the member declines to have their service plan in their preferred language, the **provider must** document this decision in the member's medical record.

These requirements apply also to the ITDP (Inpatient Treatment and Discharge Plan), in accordance with the 9 A.A.C. 21, Article 3.

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Organizational Supports for Cultural and Linguistic Need

Under AHCCCS guidance, and to comply with the Organizational Supports for Cultural Competence, Mercy Care and subcontracted providers must:

- Establish culturally and linguistically appropriate goals, policies, and management accountability and infuse them throughout the organization's planning and operations.
- Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
- Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
- Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
- Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
- Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.
- Ensure the use of multi-faceted approaches to assess satisfaction of diverse individuals, families, and communities, including the identification of minority responses in the analysis of client satisfaction surveys, the monitoring of service outcomes, member complaints, grievances, provider feedback and/or employee surveys;
- Include prevention strategies by analyzing data to evaluate the impact on the network and service delivery system, with the goal of minimizing disparities in access to services and improving quality; and
- Consult with diverse groups to develop relevant communications, outreach and marketing strategies that review, evaluate, and improve service delivery to diverse individuals, families, and communities, and address disparities in access and utilization of services.

Documenting Clinical Cultural and Linguistic Need

To advance health literacy, reduce health disparities, and identify the individual's unique needs, Mercy Care and subcontractors must:

- Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery;
- Ensure documentation of the cultural (for example: age, ethnicity, race, national origin, sex (gender), gender identity, sexual orientation, tribal affiliation, disability) and linguistic (for example, primary language, preferred language, language spoken at home, alternative language) needs within the medical records;
- Maintain documentation within the medical record of oral interpretation services provided in a language other than English. Documentation must include the date of

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service, interpreter name, type of language provided, interpretation duration, and type of interpretation services provided;

- Ensure that the cultural preferences of members and their families are assessed and included in the development of treatment plans; and
- Assess the unique needs of the GSA, as communities' cultural preferences are critical in the development of goals and strategies of prevention within documentation of cultural and linguistic need.

Cultural Competence Reporting and Accountability

Reporting and accountability measures are intended to track, monitor, and ensure access to quality and effective care. Equity in the access, delivery, and utilization of services is accomplished by Mercy Care and subcontracted providers:

- Conducting annually and ongoing strategic planning in Cultural Competency with the inclusion of national level priorities, contractual requirements, stakeholder input, community involvement and initiative development in areas, including but not limited to: Continuing Education, Training, Community Involvement, Health Integration, Outreach, Prevention, Data Analysis/Reporting, Health Literacy, and Policies/Procedures Development.
- Capturing and reporting on language access services which include: linguistic needs (primary language, preferred language, language spoken at home, alternative language); interpretive services; written translation services; and maintaining documentation on how to access qualified/licensed interpreters and translators.
- Assessing and developing reports quarterly, semi-annually, and annually within the areas of cultural competency and workforce development to review the initiatives, activities, and requirements impacting diverse communities, geographical services areas (GSAs), and the individuals accessing and receiving services.
- Continuous and ongoing reporting provides insight to strengths, gaps, and needs within communities served by Mercy Care and Mercy Care subcontracted providers with a goal of health and wellness for all.

Cultural Competence Administrator

Mercy Care has a Cultural Competence Administrator who acts as a point of contact to implement and oversee compliance requirements as described in the Annual Cultural Competence Plan, Cultural Competence Policy and Procedures and Provider Manual policies, and must participate in Cultural Competence Committees.

Cultural Competence Plan

Mercy Care's cultural competency plan is designed to address the needs of Arizona's diverse and underserved/underrepresented populations. Mercy Care develops and implements an Annual Cultural Competence Plan based on current initiatives in the field of cultural

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competence, with a focus on national level priorities, contractual requirements, and initiatives developed by internal and external stakeholders, including providers and experts in cultural competence. The Annual Cultural Competence Plan is submitted to the AHCCCS Cultural Competence Manager each year as required.

Annually, Mercy Care develops and/or modifies initiatives based on the identified needs of their members, with a goal of eliminating health disparities.

Cultural Competence Reporting

Mercy Care has developed a comprehensive service structure designed to address the needs of Arizona's diverse populations and underserved/underrepresented populations. The following reports assist in the analysis and evaluation of the system.

- Annual Effectiveness Review of the Cultural Competence Plan Report:
 - Mercy Care will annually evaluate the impact of the annual cultural competence plan's initiatives and activities towards developing a culturally competent service delivery system. The report must be submitted to the AHCCCS Cultural Competence Manager in accordance with Mercy RBHA's contract.
- Annual Language Services Report: Mercy Care will submit annual reports to the AHCCCS Cultural Competence Manager. The report captures linguistic need (primary language, Deaf and Hard of Hearing, sign language services, interpretive services, and translation services) and provides comprehensive lists of interpreter language abilities and billing unit usage.
 - Language Access Plan: The Language Access Plan (LAS) helps establish a strategy to ensure meaningful access by individuals with LEP to services available to them at Mercy Care and contracted providers.

Mercy Care RBHA Workforce Development

Mercy Care RBHA and their subcontracted providers must:

- Ensure all staff receives training in cultural competence and culturally and linguistically appropriate services during new employee orientation;
- Provide annual training to all staff in diversity awareness and culturally relevant topics customized to meet the needs of their GSA;
- Provide continuing education in cultural competence, to include but not limited to: review of CLAS standards, use of oral interpretation and translation services, and alternative formats and services for LEP clients;
- Ensure all staff has access to resources for behavioral health members with diverse cultural needs;

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- Recruit, retain and promote, at all levels of the organization, a culturally competent, diverse staff and leadership;
- Maintain full compliance with all mandatory trainings; and
- Develop and implement cultural-related trainings/curriculums as determined by AHCCCS, Mercy Care, Cultural Competence Committees, policies, and contract requirements.

Laws Addressing Discrimination and Diversity

Mercy Care and provider agencies will abide by the following referenced federal and state applicable rules, regulations and guidance documents:

- Title VI of the Civil Rights Act prohibits discrimination based on race, color, and national origin in programs and activities receiving federal financial assistance.
- Department of Health and Human Services - Guidance to Federal Financial Assistance Members Regarding Title VI Prohibition Against National Origin Discrimination affecting Limited English Proficient Members.
- Title VII of the Civil Rights Act of 1964 prohibits employment discrimination based on race, color, religion, sex, or national origin by any employer with 15 or more employees. (The Civil Rights Act of 1991 reverses in whole or in part several Supreme Court decisions interpreting Title VII, strengthening and improving the law and providing for damages in cases of intentional employment discrimination.)
- President's Executive Order 13166 improves access to services for members with Limited English Proficiency. The Executive Order requires each Federal agency to examine the services it provides and develop and implement a system by which LEP members can meaningfully access those services consistent with, and without unduly burdening, the fundamental mission of the agency.
- State Executive Order 99-4 and President's Executive Order 11246 mandates that all members regardless of race, color, sex, age, national origin or political affiliation shall have equal access to employment opportunities.
- The Age Discrimination in Employment Act (ADEA) prohibits employment discrimination against employees and job applicants 40 years of age or older. The ADEA applies to employers with 20 or more employees, including state and local governments. The Older Workers Benefit Protection Act (Pub. L. 101-433) amends the ADEA to prohibit employers from denying benefits to older employees.

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- The Equal Pay Act (EPA) and A.R.S. 23-341 prohibit sex-based wage discrimination between men and women in the same establishment who are performing under similar working conditions.
- Section 503 of the Rehabilitation Act prohibits discrimination in the employment or advancement of qualified members because of physical or mental disability for employers with federal contracts or subcontracts that exceed \$10,000. All covered contractors and subcontractors must also include a specific equal opportunity clause in each of their nonexempt contracts and subcontracts.
- The Americans with Disabilities Act prohibits discrimination against members who have a disability. Providers are required to deliver services so that they are readily accessible to members with a disability. Mercy Care and their subcontracted providers who employ less than fifteen members and who cannot comply with the accessibility requirements without making significant changes to existing facilities may refer the member with a disability to other providers where the services are accessible. Mercy Care or its subcontracted provider who employs fifteen or more members is required to designate at least one member to coordinate its efforts to comply with federal regulations that govern anti-discrimination laws.

Further Information Regarding Cultural Competency

The Partnership for Clear Health Communication (PCHC) defines health literacy as the ability to read, understand and act on health information. Health literacy relates to listening, speaking, and conceptual knowledge. Health literacy plays an important role in positive patient outcomes. According to PCHC, people with low functional Health Literacy:

- Have poorer overall health status.
- Are less likely to adhere to treatment and incur a greater number of medication/treatment errors.
- Require more health-related treatment and care, including 29-69% higher hospitalization rates.
- Increase higher health care costs - health care costs as high as \$7,500 more per annum for a member with limited health literacy.

To increase health literacy, Mercy Care has created a **Patient Care Checklist**, available on our [Reference Material and Guides](#) web page, which can be used as an effective tool designed to improve health communication between patients and providers.

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In accordance with **Title VI of the 1964 Civil Rights Act**, national standards for culturally and linguistically appropriate health care services and state requirements, Mercy Care is required to ensure that Limited English Proficient (LEP) enrollees have meaningful access to health care services. Because of language differences and inability to speak or understand English, LEP members are often excluded from programs they are eligible for, experience delays or denials of services or receive care and services based on inaccurate or incomplete information.

Enrollees are to receive covered services without concern about race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information or medical history, ability to pay or ability to speak English. PHPs are required to treat all enrollees with dignity and respect, in accordance with federal law. Providers must deliver services in a culturally effective manner to all enrollees, including:

- Those with limited English proficiency (LEP) or reading skills.
- Those with diverse cultural and ethnic backgrounds.
- The homeless.
- Individuals with physical and mental disabilities.

Definitions

- “Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. ‘Culture’ refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. ‘Competence’ implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities” (Based on Cross, T., Bazron, B., Dennis, K., & Isaacs, M., (1989). *Towards a Culturally Competent System of Care* Volume I. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center)
- Health Literacy: “The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.” (Ratzan and Parker, 2000)
- Health Equities: In a report designed to increase consensus around meaning of health equity, the Robert Wood Johnson Foundation (RWJF) provides the following definition: “Health equity means that everyone has a fair and just opportunity to be healthier. This requires removing obstacles to health such as poverty, discrimination, and their

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consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.” Robert Wood Johnson Foundation (RWJF) provides the following definition: “Health equity means that everyone has a fair and just opportunity to be healthier. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.”

4.25 - Individuals with Disabilities

Title III of the Americans with Disabilities Act (ADA) mandates that public accommodations, such as a physician’s office, be accessible to those with disabilities. Under the provisions of the ADA, no qualified individual with a disability may be excluded from participation in or be denied the benefits of services, programs or activities of a public entity, or be subjected to discrimination by any such entity. Provider offices must be accessible to persons with disabilities. Providers must also make efforts to provide appropriate accommodations such as large print materials and easily accessible doorways.

4.26 - Primary Care Provider (PCP) Assignments

MC automatically assigns members to a provider upon enrollment. Members have the right to change their provider at any time. Member eligibility changes frequently, as a result, providers must verify eligibility prior to delivering services.

4.27 - Plan Changes

MC members generally are not allowed to change their health plan until their Annual Enrollment Choice (AEC) period, which occurs on the anniversary date of their enrollment. Only in certain circumstances may a member request a change outside of this timeframe:

- A member was entitled to freedom of choice but was not sent an auto-assignment/freedom of choice notice.
- A member was entitled to participate in an Annual Enrollment Choice but:
 - Was not sent an Annual Enrollment Choice notice or
 - Was sent an Annual Enrollment Choice notice but was unable to participate in the Annual Enrollment Choice due to circumstances beyond the member’s control.
- Family members were inadvertently enrolled with different Contractors. A member who is enrolled in a Contractor through the auto-assignment process may inadvertently be enrolled with a different Contractor than other family members. Upon receipt of notification by AHCCCS, the member who was inadvertently enrolled will be dis-enrolled from the Contractor of assignment and enrolled in the Contractor where the other

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family members are enrolled when AHCCCS is notified of the problem. Other family members will not be permitted to change to the Contractor to which the new member was auto-assigned. This process shall not apply if a member was afforded an enrollment choice during their Annual Enrollment Choice period.

- A member, who was enrolled with a Contractor, lost eligibility and was dis-enrolled, then was subsequently re-determined eligible and reenrolled with a different Contractor within 90 days from the date of disenrollment. In this case the member shall be reenrolled with the Contractor that the member was enrolled with prior to the loss of eligibility. If this does not occur, AHCCCS, upon notification, will enroll the member with the correct Contractor.
- Newborns will automatically be assigned to the mother's Contractor. If the mother is Title XIX or Title XXI eligible she will be given 30 days from notification to select another Contractor for the newborn. Newborns of Federal Emergency Services (FES) mothers will be auto assigned and the mother will be given 30 days from notification to select another Contractor.
- Adoption subsidy children will be auto-assigned and the guardian will be given 30 days from notification to select another Contractor.
- A Title XIX eligible member who is entitled to freedom of choice but becomes eligible and is auto-assigned prior to having the full choice period of 30 days will be given an opportunity to request a Contractor change following auto-assignment. The member will be given 30 days from the date of the choice letter to request a Contractor change. A member who does not select within 30 days will remain with the auto-assigned Contractor.
- A member whose eligibility category changed from Sixth Omnibus Budget Reconciliation Act (SOBRA) to the SOBRA Family Planning Extension Program may change to another available Contractor if their current primary care provider (PCP) will not be providing Family Planning Extension Program services.

Plan change requests may be granted based on continuity of medical care. Medical continuity of care situations are as follows:

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Medical Continuity of Prenatal Care

A pregnant member who is enrolled with a Contractor through auto-assignment or freedom of choice, but who is receiving or has received prenatal care from a provider who is affiliated with another Contractor, may be granted a medical continuity Contractor change if the medical directors of both Contractors concur.

If there are other individuals in the pregnant member's family who are also AHCCCS eligible and enrolled, they have the option to remain with the current Contractor or transition to the new Contractor if the medical continuity plan change is granted. The member may not return to the original Contractor or change to another Contractor after the medical continuity Contractor change has been granted except during the AEC period.

Medical Continuity of Care

In unique situations, Contractor changes may be approved on a case-by-case basis if necessary to ensure the member access to medical/health care.

A plan change for medical continuity is not an automatic process. The member's PCP, or other medical provider, must provide documentation to both the receiving and relinquishing Contractors that supports the need for a Contractor change. The Contractors must be reasonable in the request for documentation. However, the burden of proof that a Contractor change is necessary rests with the member's medical provider. The Contractor change must be approved by both Contractor Medical Directors.

When the Medical Directors of both the receiving and relinquishing Contractors have discussed the request and have not been able to come to an agreement, the relinquishing Contractor shall submit the request to the AHCCCS Chief Medical Officer (CMO) or designee. The AHCCCS Acute Care Change of Contractor Form (Attachment A) and the supporting documentation must be sent to the AHCCCS DHCM/Medical Management Manager within 14 business days from the date of the original request.

The results of the review will be shared with both Medical Directors. The relinquishing Contractor will be responsible for issuing a final decision to the member. If the member request is denied, the relinquishing Contractor will send the member a Notice of Adverse Benefit Determination.

The plan change determination will be made by the MC medical director or designee based on information provided by the PCP.

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Contractor Responsibilities When a Contractor Change is Not Warranted

The current Contractor has the responsibility to promptly address the member's concerns regarding availability and accessibility of service and quality of medical care or delivery issues that may have caused a Contractor change request to be initiated. These issues include, but are not limited to:

- Quality of care delivery
- Care management responsiveness
- Transportation convenience and service availability
- Institutional care issues
- Physician or provider preference
- Physician or provider recommendation
- Physician or provider office hours
- Timing of appointments and services
- Office waiting time
- Network limitations and restrictions

When quality of care and delivery of medical service issues raised by the member cannot be solved through the normal care management process, the current Contractor must refer the issue for review by:

- The current Contractor's Quality Management Department and/or
- The AHCCCS Medical Director

Additionally, the current Contractor must explore all options available to the member, such as resolving transportation problems, provider availability issues, allowing the member to choose another PCP, or to see another medical provider, if appropriate.

Quality of care and delivery of medical services issues raised by the member must be referred to the current Contractor's quality management staff and/or the Contractor's Medical Director for review within one day of the Contractor's receipt/notification of the problem.

The delivery of covered services remains the responsibility of the current Contractor if a Contractor change for medical continuity of prenatal or other medical care is not approved.

The current Contractor must notify the member, in writing, that a Contractor change is not warranted. If the Contractor change request was the result of a member concern, the notice must include the Contractor's resolution of this concern. The notice must also advise the member of the AHCCCS and Contractor grievance policy and include timeframes for filing a grievance.

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Contractors may reach an agreement with an out-of-network provider, to care for the member on a temporary basis, for the members' period of illness and/or pregnancy to provide continuity of care.

Relinquishing Contractor Responsibilities

If a member contacts the current Contractor, verbally or in writing, and states that the reason for the plan change request is due to situations outlined above, the relinquishing Contractor shall advise the member to telephone the AHCCCS Verification Unit at 602-417-7000 or 800-962-6690 for AHCCCS to process the change.

If the member contacts the relinquishing Contractor, verbally or in writing, to request a plan change for medical continuity of care, the following steps must be taken:

- The relinquishing Contractor will contact the receiving Contractor to discuss the request. If a plan change is indicated for medical continuity of care, the AHCCCS Contractor Change Request Form (Attachment A) must be completed. All the members to be affected are added to the form and the form signed by the medical directors or physician designees of both Contractors. When the AHCCCS Contractor Change Request Form is signed it is to be submitted to the AHCCCS Chief Medical Officer.
- To facilitate continuity of prenatal care for the member, Contractors shall sign off and forward the AHCCCS Contractor Change Request Form to the AHCCCS Chief Medical Officer within two business days of the member's Contractor change request. The timeframe for other continuity of care issues is 10 business days.
- The AHCCCS Chief Medical Officer will review the Contractor change documentation and forward to the Communications Center for processing.

Receiving Contractor Responsibilities

The member must be transitioned within the requirements and protocols outlined in AHCCCS' [ACOM Policy 402](#) and in [AMPM Chapter 500](#).

Member Responsibilities

The member shall request a change of Contractor directly from AHCCCS only for situations defined in above. The member shall direct all other Contractor change requests to the member's current Contractor.

AHCCCS Administration Responsibilities

The AHCCCS Administration shall process change of Contractor requests listed above and shall send notification of the change via the daily recipient roster to the relinquishing and receiving Contractors. It is the Contractor's responsibility to identify members from the daily recipient roster who are leaving the Contractor.

GENERAL REQUIREMENTS FOR ALL PLANS

If the AHCCCS Administration denies a change of Contractor request, the AHCCCS Administration will send the member a denial letter. The member will be given 60 days to file a grievance.

If the AHCCCS Administration receives a letter or verbal request from a member requesting a Contractor change, that also references other problems (i.e., transportation, accessibility or availability of services), that information will be sent to the current Contractor.

If the AHCCCS Administration receives a letter or verbal request from a member requesting a Contractor change for reasons above, the information will be forwarded to the current Contractor.

Provider Guidelines and Plan Details

4.28 - Cost Sharing and Coordination of Benefits

Providers must adhere to all contract and regulatory cost sharing guidelines. When a member has other health insurance such as Medicare, a Medicare HMO or a commercial carrier, MC will coordinate payment of benefits in accordance with the terms of the PHPs contract and federal and state requirements. AHCCCS registered providers must coordinate benefits for all MC members in accordance with the terms of their contract and AHCCCS guidelines.

MC is the payer of last resort, unless specifically prohibited by State or Federal law. This means that MC shall be used as a source of payment for covered services only after all other sources of payment have been exhausted. MC will take reasonable measures to identify potentially legally liable third-party sources and reports these to AHCCCS.

MC coordinates benefits in accordance with AHCCCS regulations so that costs for services that would otherwise be payable by MC are cost avoided or recovered from a liable third party. The two methods used for coordination of benefits are cost avoidance and post-payment recovery.

Cost Avoidance

MC will take reasonable measures to determine all legally liable parties - any individual, entity or program that is or may be potentially liable to pay all or part of the expenditures for covered services. MC will cost avoid a claim if it has established the probable existence of a liable party at the time the claim is filed. For purposes of cost avoidance, establishing probable liability takes place when MC receives confirmation that another party is, by statute, contract, or agreement, legally responsible for the payment of a claim for a healthcare item or service delivered to a member. If the probable existence of a party's liability cannot be established, MC will adjudicate the claim for payment. MC will then utilize post-payment recovery which is described in further detail below if it turns out a legally liable party is responsible for the payment of covered services.

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If a third-party insurer other than Medicare requires the member to pay any copayment, coinsurance or deductible, MC is responsible for making these payments.

Claims for an inpatient stay for labor, delivery and postpartum care, including professional fees when there is no global OB package, will be cost avoided by MC.

In addition, effective for dates of services on or after October 1, 2018, prenatal care for pregnant women, including services which are part of a global OB Package, will also be cost avoided.

MC shall not deny a claim for timely filing if the untimely claim submission results from a provider's efforts to determine the extent of liability.

Post Payment Recoveries

Post-payment recovery is necessary in cases where MC has not established the probable existence of a liable third party at the time services were rendered or paid for, was unable to cost-avoid, or post-payment recovery is required. In these instances, MC will adjudicate the claim and then utilize post-payment recovery processes which include: Pay and Chase, Retroactive Recoveries Involving Commercial Insurance Payer Sources, and Other Third-Party Liability Recoveries.

Pay and Chase: MC will pay the full amount of the claim due per the contracted rate with the provider and then seek reimbursement from any third party if the claim is for the following reasons:

- Prenatal care for pregnant women, including services which are part of a global OB Package;
- Preventive pediatric services, including Early and Periodic Screening Diagnosis and Treatment (EPSDT) and administration of vaccines to children under the Vaccines for Children (VFC) program;
- Services covered by third-party liability that are derived from an absent parent whose obligation to pay support is being enforced by the Division of Child Support Enforcement; or
- Services for which MC fails to establish the existence of a liable third party at the time the claim is filed.

Retroactive Recoveries Involving Commercial Insurance Payer Sources: For a period of two years from the date of service, MC will engage in retroactive third-party recovery efforts for claims paid to determine if there are commercial insurance payer sources that were not known at the time of payment. In the event a commercial insurance

GENERAL REQUIREMENTS FOR ALL PLANS

payer source is identified, MC Care will seek recovery from the commercial insurance. **MC will not recoup related payments from providers, requiring providers to act, or requiring the involvement of providers in any way.**

MC has two years from the date of service to recover payments for a claim, or to identify claims having a reasonable expectation of recovery. A reasonable expectation of recovery is established when MC has affirmatively identified a commercial insurance payer source and has begun the process of recovering payment. After two years from the date of service, AHCCCS will direct recovery efforts for any claims not identified by MC.

The overall timeframe for submission of claims for recovery is limited to three years from the date of service.

Other Third-Party Liability Recoveries: MC will identify the existence of potentially liable parties using a variety of methods, including referrals, and data mining using trauma code edits, utilizing codes provided by AHCCCS. MC shall not pursue recovery in the following circumstances, unless the case has been referred to MC by AHCCCS or AHCCCS' authorized representative:

- Motor Vehicle Cases
- Other Casualty Cases
- Tort feasons
- Restitution Recoveries
- Worker's Compensation Cases

MC works directly with AHCCCS regarding Other Third-Party Liability Recoveries.

4.29 - Copayments

Collecting Copayments

Copayments must be assessed and collected consistent with state law and Arizona Administrative Code requirements. Providers are responsible for collecting copayments. Providers may take reasonable steps to collect on delinquent accounts.

Any copayments collected are retained by the provider, but the provider must report that information to Mercy RBHA when submitting the encounter/claims data. All providers must report in their annual audited financial statements the separately identified amounts for copayments received from eligible members for covered behavioral health services and reported to AHCCCS in the encounter.

GENERAL REQUIREMENTS FOR ALL PLANS

The collection of copayments is an administrative process, and as such, copayments must not be collected in conjunction with a member's treatment. All efforts to resolve non-payment issues, as they occur, must be clearly documented in the member's comprehensive clinical record.

Copayments

Copayments are specified dollar amounts members pay directly to a provider for each item or service they receive. There are federal limits for certain services and populations.

Copayments are never charged to the following members:

- Children under age 19;
- People determined to be Seriously Mentally Ill (SMI) by the Arizona Department of Health Services;
- Individuals up through age 20 eligible to receive services from the Children's Rehabilitative Services program;
- People who are acute care AHCCCS members and who are residing in nursing homes or residential facilities such as an Assisted Living Home and only when the acute care member's medical condition would otherwise require hospitalization. The exemption from copayments for acute care members is limited to 90 days in a contract year;
- People who are enrolled in the Arizona Long Term Care System (ALTCs);
- People who are eligible for Medicare Cost Sharing in 9 A.A.C. 29 Copayment;
- People who receive hospice care;
- American Indian members who are active or previous users of the Indian Health Service, tribal health programs operated under P.L. 93-638, or urban Indian health programs;
- Adults eligible under A.A.C. R9-22-1427(E). These individuals are known as the Adult Group. Members in the Adult Group are individuals 19-64, who are not pregnant, do not have Medicare and are not eligible in any other eligibility category and whose income does not exceed 133% of the federal poverty level (FPL). The adult group includes individuals who were previously eligible under the AHCCCS Care program with income that did not exceed 100% of the FPL as well as other adults described in A.A.C. R9-22-1427(E) with income above 100% FPL but not greater than 133% FPL;
- Individuals in the Breast & Cervical Cancer Treatment Program; and
- Individuals receiving child welfare services under Title IV-B of the Social Security Act because of being a child in foster care or receiving adoption or foster care assistance under Title IV-E.

NOTE: Copayments referenced in this chapter means copayments charged under Medicaid (AHCCCS). It does not mean a member is exempt from Medicare copayments.

Copayments are never charged for the following services for anyone:

GENERAL REQUIREMENTS FOR ALL PLANS

- Inpatient hospital services and services in the Emergency Department;
- Emergency services;
- Family Planning services and supplies;
- Pregnancy related health care and health care for any other medical condition that may complicate the pregnancy, including tobacco cessation treatment for pregnant women;
- Preventative services such as well visits, immunizations, pap smears, colonoscopies, and mammograms;
- Services paid on a fee-for-service basis;
- Provider Preventable Conditions as described in the [AHCCCS Medical Policy Manual, Chapter 1000](#).

Members with nominal (optional) copayments are:

- Caretaker relatives under R9-22-1427(A) (also known as AHCCCS for Families with Children under section 1931 of the Social Security Act);
- Individuals eligible under the Young Adult Transitional Insurance (YATI) for young adults who were in foster care;
- Individuals eligible for the State Adoption Assistance for Special Needs Children who are being adopted;
- Individuals receiving Supplemental Security Income (SSI) through the Social Security Administration for people who are age 65 or older, blind or disabled;
- Individuals receiving SSI Medical Assistance Only (SSI MAO) for individuals who are age 65 or older, blind or disabled; and
- Individual in the Freedom to Work (FTW) program.

Provider needs to look up the member's eligibility to find out what copays they may have by going to [Mercy Care Web Portal](#) or [Mercy Care RBHA's Web Portal](#). Most people who get AHCCCS benefits are asked to pay the following nominal copayments for medical services:

Mandatory Copayments for Certain AHCCCS Members

Nominal Copay Amounts for Some Medical Services	
Service	Copayment
Prescriptions	\$2.30
Out-patient services for physical, occupational and speech therapy	\$2.30
Doctor or other provider outpatient office visits for evaluation and management of your care	\$3.40

Members with higher income who are determined eligible for AHCCCS through the Transitional Medical Assistance (TMA) program will have mandatory copayments for some medical services. TMA members are described in AHCCCS rule **R9-22-1427(B)**.

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When a member has a mandatory copayment, a provider can refuse to provide a service to a member who does not pay the mandatory copayment. A provider may choose to waive or reduce any copayment under this chapter. TMA members are not charged copayments if they are in a population or category listed in the above sections.

Mandatory copayments for TMA members

Mandatory Copayments	
Service	Copayment
Prescriptions	\$2.30
Doctor or other provider outpatient office visits for evaluation and management of care. This excludes emergency room/emergency department visits	\$4.00
Physical, Occupational and Speech Therapies	\$3.00
Outpatient non-emergent or voluntary surgical procedures. This excludes emergency room/emergency department visits	\$3.00

5% Aggregate limit for nominal (optional) and mandatory copayments

The total aggregate amount of copayments for members who have nominal (optional) and/or mandatory copayments cannot exceed 5% of the family's income on a quarterly basis. The AHCCCS Administration will review claims and encounters information to establish when a member's copayment obligation has reached 5% of the family's income and will communicate this information to providers. The member may also establish that the aggregate limit has been met on a quarterly basis by providing the AHCCCS Administration with records of copayments incurred during the quarter.

Copayments for Non-Title XIX/XXI eligible members determined to have a Serious Mental Illness (SMI)

AHCCCS Copayments for Non-Title XIX/XXI eligible members who are determined to have a Serious Mental Illness (SMI):

- For individuals who are Non-Title XIX/XXI eligible members determined to have a SMI, AHCCCS has established a copayment to be charged to these members for covered services (**A.R.S. 36-3409**).
- Copayment requirements in this policy are not applicable to services funded by the Substance Abuse Block Grant (SABG), Mental Health Block Grant (MHBG) or Project for Assistance in Transition from Homelessness (PATH) federal block grant.
- Copayments are not assessed for crisis services or collected at the time crisis services are provided.

GENERAL REQUIREMENTS FOR ALL PLANS

- Members determined to have SMI must be informed prior to the provision of services of any fees associated with the services (**R9-21-202(A) (8)**), and providers must document such notification to the member in his/her comprehensive clinical record.
- Copayments assessed for Non-Title XIX/XXI members determined to have SMI are intended to be payments by the member for all covered behavioral health services, but copayments are only collected at the time of the psychiatric assessment and psychiatric follow up appointments.
- Copayments are:
 - A fixed dollar amount of \$3;
 - Applied to in network services; and
 - Collected at the time services are rendered.
- Providers will be responsible for collecting copayments. Any copayments collected are reported in the encounter.

Providers will:

- Assess the fixed dollar amount per service received, regardless of the number of units encountered. Collect the \$3 copayment at the time of the psychiatric assessment or the psychiatric follow up appointment.
- *Take reasonable steps to collect on delinquent accounts, as necessary.*
- *Collect copayments as an administrative process, and not in conjunction with a member's behavioral health treatment.*
- *Clearly document in the member's comprehensive clinical record all efforts to resolve non-payment issues, as they occur.*
- *Not refuse to provide or terminate services when an individual states he or she is unable to pay copayments described in this section. Mercy RBHA has established methods to encourage a collaborative approach to resolve non-payment issues, which may include the following:*
 - *Engage in informal discussions and avoid confrontational situations;*
 - *Re-screen the member for AHCCCS eligibility; and*
 - *Present other payment options, such as payment plans or payment deferrals, and discuss additional payment options as requested by the member.*

Other Payment Sources

If a member has third party liability coverage, MC and their providers must follow the requirements for third party liability.

Medicare Part D Prescription Drug Coverage

All members eligible for Medicare Part A or enrolled in Medicare Part B are eligible for Medicare Part D Prescription Drug coverage. Dual eligible members (eligible for Medicaid and Medicare) no longer receive prescription drug coverage through Medicaid. To access Medicare

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Part D coverage, members must enroll in either a Prescription Drug Plan (PDP – fee-for-service Medicare) or a Medicare Advantage-Prescription Drug Plan (MA-PD – managed care Medicare).

Cost sharing responsibilities for members in a Medicare Part D PDP or MA-PD

The Medicare Part D Prescription Drug standard coverage includes substantial cost sharing requirements, which include monthly premiums; an annual deductible and co-insurance (see the Part D Voluntary Prescription Drug Benefit Program Benefits and Costs for People with Medicare).

Members with limited income and resources may be eligible for the Low-Income Subsidy (LIS) or “extra help” program (see the Social Security Administration for income and resource requirements). With this “extra help”, all or a portion of the member’s cost sharing requirements are paid for by the federal government. Dual eligible members on a Medicare Savings Program through AHCCCS (QMB, SLMB, or QI-1) are automatically eligible for the LIS program. Other members must apply for the LIS program. Title XIX/XXI funds are not available to pay any cost sharing of Medicare Part D. Mercy RBHA may utilize Non-Title XIX/XXI funds for cost sharing of Medicare Part D copayments for Non-Title XIX/XXI members determined to have SMI.

4.30 - Clinical Guidelines

To help provide MC members with consistent, high-quality care that utilizes services and resources effectively, we have chosen certain clinical guidelines to help our providers. These are treatment protocols for specific conditions as well as preventive health guidelines.

Please note that these guidelines are intended to clarify standards and expectations. They should not:

- Come before a provider’s responsibility to provide treatment based on the member’s individual needs.
- Constitute procedures for or the practice of medicine by the party distributing the guidelines.
- Guarantee coverage or payment for the type or level of care proposed or provided.

FOR MERCY CARE RBHA

Mercy RBHA has adopted the evidence-based guidelines published by the [National Guideline Clearinghouse](#).

Behavioral health clinical guidelines can be found on the AHCCCS website under [Clinical Guidance Tools](#).

There are minimum expectations for SMI clinical teams to include the following individuals:

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Supportive/Connective Level of Care

- 1 Psychiatrist (BHMP)
- 1 Registered Nurse
- 1 Rehabilitation Specialist
- 1 Peer Support Specialist
- 1 Clinical Coordinator (Team Leader)
- Care Managers (amount based on established clinical targets and maximum ceiling)

ACT Level of Care

- 1 Psychiatrist (BHMP)
- 2 Registered Nurses
- 1 ACT Specialist
- 2 Substance Abuse Specialists
- 1 Independent Living Specialist
- 1 Peer Support Specialist
- 1 Housing Specialist
- 1 Rehabilitation Specialist
- 1 Employment Specialist
- 1 Program Assistant
- 1 Clinical Coordinator (Team Leader)

In addition to already instated state licensure requirements of 2 hours of clinical oversight of Behavioral Health Technician (BHT)/Behavioral Health Paraprofessional (BHPP) staff per month, a supplementary 2 hours of direct one-on-one clinical oversight must take place monthly with their direct supervisor for any clinical staff that has direct contact with members.

4.31 - Office Administration Changes and Training Requirements

Providers are responsible to notify MC's Provider Relations of changes in professional staff at their offices (physicians, physician assistants or nurse practitioners). Administrative changes in office staff may result in the need for additional training. Contact your Network Relations Specialist/Consultant to schedule any needed staff training.

The following trainings are required for participation in the MC network:

- Medical records standards
- Fraud and abuse training
- Behavioral health step therapy for members with depression, post-partum depression, anxiety and attention deficit/hyperactivity disorder (ADHD) in compliance with the AHCCCS medical policy manuals (appendices E and F)
- PCP training regarding behavioral health referral and consultation services

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All providers and facilities must remain in good standing with any licensure or regulatory agency and adhere to all training requirements. This includes clinical supervision, orientation and training requirements.

4.32 - Consent Forms

For additional information, please refer to **Chapter 2.7 General and Informed Consent to Treatment** in the Mercy RBHA Provider Manual.

The following consent forms are available on the AHCCCS website:

- **Certificate of Medical Necessity for Pregnancy Termination** (AHCCCS Medical Policy Manual Exhibit, Policy 410, Attachment C)
- **Consent for Sterilization** (AHCCCS Medical Policy Manual Exhibit, Policy 420, Attachment A)
- **Hysterectomy Consent Form (AHCCCS Medical Policy Manual Exhibit 820-1)**
- **Consent for the release of confidential medical records (Substance Abuse Treatment/HIV/AIDS).**
- [Informed Consent for Psychotropic Medication Treatment](#)

4.33 - Contract Additions or Terminations

To meet contractual obligations and state and federal regulations, providers **must** report any terminations or additions to their contract at least 90 days prior to the change. Providers are required to continue providing services to members throughout the termination period.

4.34 - Continuity of Care

Providers terminating their contracts without cause are required to continue to treat MC members until the treatment course has been completed or care is transitioned. Authorization may be necessary for these services. Members who lose eligibility and continue to have medical needs must be referred to a facility or provider that can provide the needed care at no or low cost. MC is not responsible for payment of services rendered to members who are not eligible.

The Bureau of Health Systems Development has recently posted a new interactive website to help people easily locate a clinic that provides free or low-cost primary, mental and dental health services to people without health insurance. These Sliding Fee Schedule clinics determine, based on gross family income, the portion of billed charges that the uninsured client will be responsible for. Sliding Fee Schedules are based on current Federal Poverty Guidelines. The [Interactive SFS Clinics](#) map will help you find a clinic in your community, simply by moving the cursor over your neighborhood, or by typing in your zip code or city.

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The site also includes a downloadable complete listing of primary care or behavioral health SFS providers.

You can also download a [Mobile App](#) to find federally-funded health centers on the go.

You may also contact MC's Care Management Department for assistance.

4.35 - Contract Changes or Updates

Providers **must** report any changes to demographic information to MC at least 90 days prior to the change to follow contractual obligations and state and federal regulations. Providers are required to continue providing services to members throughout the termination period. For information on where to send change information, refer to the Table 8, Provider Record Updates (below).

Provider Record Updates Table

Type of Change	Notification Requirements	Send to	Time to Process
Individual or group name	Must mail updated W-9 and letter describing change and effective date	Provider Relations	90 days
Tax ID number	Must mail updated W-9 and letter describing change and effective date	Provider Relations	90 days
Address	Must fax 860-975-0841 or mail	Provider Relations	90 days
Staffing changes including physicians leaving the practice	Must fax 860-975-0841 or mail letter describing change and effective date	Provider Relations	90 days
Adding new office locations	Must fax 860-975-0841 or mail letter describing change and effective date	Provider Relations	90 days
Adding new physicians to current contract	Must fax 860-975-0841 or mail letter describing change and effective date	Provider Relations	90 days
Number of Beds Usage (i.e. reducing Residential Beds)	Must BE Pre-APPROVED	Network Administration	90 days

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4.36 - Credentialing/Re-Credentialing

Providers are re-credentialed every three years and must complete the required reappointment application. Updates on malpractice coverage, state medical licenses and DEA certificates are also required. Please note that providers may not treat MC members until they are credentialed.

Temporary/Provisional Credentialing Process

MC shall have 14 calendar days from receipt of a complete application to render a decision regarding temporary or provisional credentialing. Once provisional/temporary credentialing is approved, provider information must be entered into MC's information system to allow payment to the provider effective the date the provisional credentialing is approved.

Providers working in a Federally Qualified Health Center (FQHC) and FQHC Look-alike Center, as well as hospital employed physicians (when appropriate), must be credentialed using the temporary or provisional credentialing process even if the provider does not specifically request their application be processed as temporary or provisional.

For additional details regarding credentialing/re-credentialing, please refer to our **Credentialing/Re-Credentialing Process**, available on our [Reference Material and Guides](#) web page.

4.37 - Licensure and Accreditation

Health delivery organizations such as hospitals, skilled nursing facilities, home health agencies and ambulatory surgical centers must submit updated licensure and accreditation documentation at least annually or as indicated.

4.38 – Contract Enforcement

If a provider fails to meet contract requirements or demonstrates a pattern of non-compliance, the provider may be subject to a contract enforcement action, including but not limited to:

- Corrective Action;
- Notice to Cure;
- Sanctions; or
- Referral Restrictions

MC will review Provider non-compliance to determine contract enforcement action(s) that may be taken against Provider. The contract enforcement actions referenced in this Section 4.38 are in addition to and does not take precedence over or preclude MC from taking any other action(s) available to MC in contract or law arising from the same conduct or occurrence.

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Corrective Action

When MC determines that the Provider is not in compliance with any term of its Contract, MC may request a corrective action plan (CAP) from Provider. CAP's will be due from the Provider within 15 business days of notice for non-compliance. Provider shall immediately implement a MC approved Corrective Action Plan (CAP).

Notice to Cure

When MC determines that the Provider is not in compliance with any term of its Contract, MC may issue a Notice to Cure to the Provider. Upon written Notice to Cure of the Provider's noncompliance, the Provider shall demonstrate compliance by the date specified in the Notice to Cure. If Provider is not in compliance, as determined by MC, at the end of the specified period, provider may be subject to other enforcement action or remedy available to MC.

Referral Restrictions

MC may restrict the referral of Members to a Provider when the Provider's services do not meet the standard of care for the Provider's area of practice or the Provider has failed to meet performance standards or is otherwise out of compliance with its Contract.

Sanctions

In addition to financial sanctions permitted elsewhere in the Provider Manual or the Provider's contract with MC, the Provider may be subject to financial sanctions for failure to comply with any term of its Contract. Sanctions will also be passed down to provider that are incurred by MC from AHCCCS, CMS or another regulator and which may be attributed to Provider. Provider will be notified in writing of the basis for the sanction. A provider may file a claim dispute if MC imposes a sanction against the provider.

- **1st sanction \$5,000 non-compliance contract requirement per location**
- **2nd sanction \$10,000 non-compliance contract requirement per location**
- **3rd sanction \$15,000 non-compliance contract requirement per location**
- **4th sanction \$20,000 non-compliance contract requirement per location**
- **5th sanction \$25,000 non-compliance contract requirement per location**

Referral Restrictions

MC may restrict the referral of Members to a Provider when the Provider's services do not meet the standard of care for the Provider's area of practice or the Provider has failed to meet performance standards or is otherwise out of compliance with its Contract.

Repeat Occurrences

Repeat occurrences of untimely submission of deliverables or reports, or incomplete or inaccurate reports or deliverables will trigger a compounding sanction process. **Under this**

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process, sanction amounts will be increased due to the provider's failure to remediate the problem through the Corrective Action, Notice to Cure or Sanction processes.

Providers who are "Out of Compliance" with Deliverable standards will be contacted by the Network Relations Specialist/Consultant to re-educate the provider on compliance requirements related to Deliverables standards. The Network Relations Specialist/Consultant will continue to monitor provider compliance each month. If a provider remains out of compliance with Provider Deliverables, MC will implement the following schedule of sanctions.

Untimely Deliverable or Reports: \$1,000 sanction per each business day beyond the due date. For repeat untimely submission of the same Deliverable across reporting periods, MC will assess compounding sanctions in the \$1,000 increments for each business day beyond the due date. For example, Deliverable A was submitted two business days late in October and was subsequently late by one business day the following reporting month, a sanction of \$1,000 will be assessed for October and a sanction of \$2,000 for November. Compounding sanctions will not exceed \$5,000 for each business day beyond the specified deadline and, will only be assessed for Deliverables.

Incomplete and/or Inaccurate Deliverables or Reports: \$5,000 for each rejection of a Deliverable due to incomplete and inaccurate reporting. For each repeat rejection of Deliverables which are incomplete or inaccurate across separate reporting periods, Providers may be subject to compounding sanctions in the \$5,000 increments for each rejection, not to exceed \$25,000 per rejected Deliverable. For example:

- **1st time Rejected Sanction \$5,000 per rejection**
- **2nd time Rejected Sanction \$10,000 per rejection**
- **3rd time Rejected Sanction \$15,000 per rejection**
- **4th time Rejected Sanction \$20,000 per rejection**
- **5th time Rejected Sanction \$25,000 per rejection**

Disputes

Although Corrective Actions and Notice to Cures are not subject to appeal, Contracted providers are encouraged to notify MC if any of the performance deficiencies is identified as a dispute, including the factual and contractual basis for that position. Such information must be provided to your Provider Relations Liaison with a copy to ProviderRelations@MercyCareAZ.org.

A provider may file a claim dispute if MC imposes a sanction against the provider. Please refer to Provider Claim Disputes, for details regarding how to file a claim dispute related to sanctions under each Plan Specific Terms section.

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4.39 – Duty to Report Abuse, Neglect or Exploitation***Duty to Report Abuse, Neglect and Exploitation of Incapacitated/Vulnerable Adults***

Mercy Care subcontracted healthcare providers responsible for the care of an incapacitated or vulnerable adult and who have a reasonable basis to believe that abuse or neglect of the adult has occurred or that exploitation of the adult's property has occurred shall report this information immediately either in member or by telephone. This report shall be made to a peace officer or to a protective services worker within APS. Information on how to contact APS to make a report is located by going to the webpage for the [APS Central Intake Unit](#). A written report must also be mailed or delivered within forty-eight hours or on the next working day if the forty-eight hours expire on a weekend or holiday. The report shall contain:

- The names and addresses of the adult and any members who have control or custody of the adult, if known;
- The adult's age and the nature and extent of his/her incapacity or vulnerability;
- The nature and extent of the adult's injuries or physical neglect or of the exploitation of the adult's property; and
- Any other information that the member reporting believes might be helpful in establishing the cause of the adult's injuries or physical neglect or of the exploitation of the adult's property.

Upon written and signed request for records from the investigating peace officer or APS worker, the member who has custody or control of medical or financial records of the incapacitated or vulnerable adult for whom a report is required shall make such records, or a copy of such records, available. Records disclosed are confidential and may be used only in a judicial or administrative proceeding or investigation resulting from the report. If psychiatric records are requested, the custodian of the records shall notify the attending psychiatrist, who may remove the following information from the records before they are made available:

- Personal information about individuals other than the patient; and
- Information regarding specific diagnoses or treatment of a psychiatric condition, if the attending psychiatrist certifies in writing that release of the information would be detrimental to the patient's health or treatment.

If any portion of a psychiatric record is removed, a court, upon request of a peace officer or APS worker, may order that the entire record or any portion of such record contains information relevant to the reported abuse or neglect be made available to the peace officer or APS worker investigating the abuse or neglect.

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Duty to Report Abuse, Physical Injury, Neglect and Denial/Deprivation of Medical or Surgical Care or Nourishment of Minors

Any Mercy Care healthcare subcontracted provider who reasonably believes that any of the following incidents has occurred shall immediately report this information to a peace officer or to a DCS worker by calling the Arizona Child Abuse Hotline at (888) 767-2445; TDD - (602) 530-1831; or (800) 530-1831:

- Any physical injury, abuse, reportable offense or neglect involving a minor that cannot be identified as accidental by the available medical history; or
- A denial or deprivation of necessary medical treatment, surgical care or nourishment with the intent to cause or allow the death of an infant.

If a report concerns a member who does not have care, custody or control of the minor, the report shall be made to a peace officer only. Reports shall be made immediately by telephone or in member and shall be followed by a written report within seventy-two hours. The report shall contain:

- The names and addresses of the minor and the minor's parents or the member(s) having custody of the minor, if known.
- The minor's age and the nature and extent of the minor's abuse, physical injury or neglect, including any evidence of previous abuse, physical injury or neglect.
- Any other information that the member believes might be helpful in establishing the cause of the abuse, physical injury or neglect.

If a physician, psychologist, or behavioral health professional receives a statement from a member other than a parent, stepparent, or guardian of the minor during the course of providing sex offender treatment that is not court ordered or that does not occur while the offender is incarcerated in the State Department of Corrections or the Department of Juvenile Corrections, the physician, psychologist, or behavioral health professional may withhold the reporting of that statement if the physician, psychologist, or behavioral health professional determines it is reasonable and necessary to accomplish the purposes of the treatment.

Upon written request by the investigating peace officer or DCS worker, the member who has custody or control of medical records of a minor for whom a report is required shall make the records, or a copy of the records, available. Records are confidential and may be used only in a judicial or administrative proceeding or investigation resulting from the required report. If psychiatric records are requested, the custodian of the records shall notify the attending psychiatrist, who may remove the following information before the records are made available:

- Personal information about individuals other than the patient.

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- Information regarding specific diagnoses or treatment of a psychiatric condition, if the attending psychiatrist certifies in writing that release of the information would be detrimental to the patient's health or treatment.

If any portion of a psychiatric record is removed, a court, upon request by a peace officer or DCS worker, may order that the entire record or any portion of the record that contains information relevant to the reported abuse, physical injury or neglect be made available for purposes of investigation.

4.40 – Duty to Warn***Duty to Protect Potential Victims of Physical Harm***

All Mercy Care healthcare providers have a duty to protect others against the violent conduct of a patient. When a Mercy Care healthcare provider determines, or under applicable professional standards, reasonably should have determined that a patient poses a serious danger to others, he/she bears a duty to exercise care to protect the foreseeable victim of that danger. The foreseeable victim need not be specifically identified by the patient but may be someone who would be the most likely victim of the patient's violent conduct.

While the discharge of this duty may take various forms, the Mercy Care healthcare provider need only exercise that reasonable degree of skill, knowledge and care ordinarily possessed and exercised by members of that professional specialty under similar circumstances. Any duty owed by a Mercy Care healthcare provider to take reasonable precautions to prevent harm threatened by a patient can be discharged by any of the following, depending upon the circumstances:

- Communicating, when possible, the threat to all identifiable victims;
- Notifying a law enforcement agency in the vicinity where the patient or any potential victim resides;
- Taking reasonable steps to initiate proceedings for voluntary or involuntary hospitalization, if appropriate; or
- Taking any other precautions that a reasonable and prudent mental health provider would take under the circumstances.

4.41 - Marketing

Providers may not market MC's name, logo, or likeness without prior approval. If a provider advertisement refers to MC's name, logo, or likeness, the advertising must be prior approved by AHCCCS.

4.42 - Provider Policies and Procedures - Health Care Acquired Conditions and Abuse

As a prerequisite to contracting with an organizational provider, MC must ensure that the organizational provider has established policies and procedures that meet AHCCCS

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requirements. The requirements must be met for all organizational providers (including, but not limited to, hospitals, home health agencies, attendant care agencies, group homes, nursing facilities, behavioral health facilities, dialysis centers, transportation companies, dental and medical schools, and free-standing surgi-centers): and the process by which the subcontractor reports at a minimum incidences of Health Care Acquired Conditions, abuse, neglect, exploitation, injuries, suicide attempts and unexpected death to MC.

4.43 - Mercy Care Web Portal

MC provides secure web-based platforms enabling health plans to communicate healthcare information directly with providers. Users can perform transactions, download information, and work interactively with member healthcare information.

There are two web portals available.

- [Mercy Care Web Portal](#) – available for Mercy Care Complete Care and Mercy Care Long Term Care.
- [Mercy Care RBHA Web Portal](#) – available for Mercy Care RBHA.

The following information can be attained from the Mercy Care Web Portal platform:

- **Member Eligibility Search** – Verify current eligibility on one or more members. Please note that eligibility may also be verified through the AHCCCS website.
- **Panel Roster** – View the list of members currently assigned to the provider as the primary care provider (PCP).
- **Provider List** – Search for a specific health plan provider by name, specialty, or location.
- **Claims Status Search** – Search for provider claims by member, provider, claim number, or service dates. Only claims associated with the user's account provider ID will be displayed.
- **Remittance Advice Search** – Search for provider claim payment information by member name, member ID, provider name, provider ID, date of service, or date range or specific claim number. Only remits associated with the user's account provider ID will be displayed.
- **Authorization List** – Search for provider authorizations by member, provider, authorization data, or submission/service dates. Only authorizations associated with the user's account provider ID will be displayed.
- **HEDIS** – Check the status of the member's compliance with any of the HEDIS measures. "Yes" means the member has measures that they are not compliant with; "No" means that member has met the requirements.

Important provider documents are also available for your use once you sign into Mercy OneSource, including:

- Mercy Care Web Portal Instructions

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- Mercy Care Web Portal Add User Process
- Mercy Care Web Portal Provider Web Portal Registration Form
- Current and Historical MC Fee Schedules
- Pro-Report Log On

For registration information regarding Mercy Care Web Portal, please access the **Mercy Care Provider Web Portal Registration Form** available on the website under the [Forms](#) section. Once you have your log in you may access [Mercy Care Web Portal](#) by clicking on the link.

4.44 – Provider Directory

Mercy Care's Provider Directory is online and can be found on our [Find A Provider](#) web page. The directory allows you to:

- Search by provider name and/or specialty.
- **Indicate whether providers are accepting referrals and conducting initial assessments.**
- Identify provider locations that provide physical access, accessible equipment, and/or reasonable accommodations for members with physical or cognitive disabilities.

It is very important for providers to promptly notify Mercy Care of any changes that would impact the accuracy of the provider directory (e.g., change in telephone, fax number, or no longer accepting referrals).

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MC CHAPTER 5 – EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT)**5.00 - EPSDT Program Overview**

The Early and Periodic Screening, Diagnostic and Treatment program (EPSDT) is a comprehensive child health program of prevention, treatment, correction, and improvement (amelioration) of physical and mental health problems for AHCCCS members under the age of 21 as described in 42 USC 1396d (a) and (r). The EPSDT program is governed by federal and state regulations and community standards of practice. All PCPs who provide services to members under age 21 are required to provide comprehensive health care, screening and preventive services, including, but not limited to:

- Primary prevention
- Early intervention
- Diagnosis
- All services required to treat or improve a defect, problem or condition identified in an EPSDT screening.

Please refer to the **Claims Processing Manual** on our [Claims Information](#) webpage, **Chapter 3 – Early Periodic Screen and Developmental Testing (EPSDT)** on MCCC’s website for specific claim codes.

5.01 - Requirements for EPSDT Providers

PCPs are required to comply with regulatory requirements and MCCC preventative requirements which include:

- Documenting immunizations within 30 days of administration into Arizona State Immunization Information System (ASIIS) and enroll every year in the Vaccine for Children Program.
- Providing all screening services according to the AHCCCS Periodicity Schedule and community standards of practice. The [Periodicity Schedule](#) can be viewed by accessing the AHCCCS’ website.
- Ensuring all infants receive both the first and second newborn screening tests. Specimens for the second test may be drawn at the PCP’s office and mailed directly to the Arizona State Laboratory, or the member may be referred to MCCC’s contracted laboratory for the draw.
- Using current AHCCCS standardized EPSDT tracking forms to document services provided and compliance with AHCCCS standards. The **EPSDT Tracking Forms** are available on MCCC’s website under [Forms](#). They are also available on the AHCCCS website.
- Sending copies of EPSDT Tracking Forms to MCCC monthly. Please send forms by mail to: 4755 S. 44th Place, Phoenix, AZ 85040 - Attn: Quality Management or fax the forms to 602-431-7157.

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- Using all clinical encounters to assess the need for EPSDT screening and/or services.
- Documenting in the medical record the member's decision not to participate in the EPSDT program, if appropriate.
- Making referrals for diagnosis and treatment when necessary and initiate follow-up services within 60 days.
- Scheduling the next appointment at the time of the current office visit for children 24 months of age and younger.
- Reporting all EPSDT encounters on required claim forms, using the Preventive Medicine Codes.
- Referring members to WIC, AzEIP and Head Start as appropriate.
- Initiating and coordinating referrals to behavioral health providers as necessary.

An EPSDT screening includes the following basic elements:

- Comprehensive health and developmental history, including growth and development screening (includes physical, nutritional and behavioral health assessments).
- Developmental screening (using an AHCCCS approved developmental screening tool) for members age 9, 18 and 24 months.
- Comprehensive unclothed physical examination.
- Appropriate immunizations according to age and health history.
- Laboratory tests appropriate to age and risk for the following: blood lead, tuberculosis skin testing, anemia testing and sickle cell trait.
- Health education and counseling about child development, healthy lifestyles and accident and disease prevention.
- Appropriate dental screening and referral.
- Fluoride varnish application every six months (by providers who have completed training) for members, age 6-24 months, with at least one tooth eruption.
- Appropriate vision and hearing/speech testing.
- Obesity screening using the BMI percentile for children.
- Anticipatory guidance.

5.02 - Health Education

The PCP is responsible for ensuring that health counseling and education are provided at each EPSDT visit. Anticipatory guidance should be provided so that parents or guardians know what to expect in terms of the child's development. In addition, information should be provided regarding accident and disease prevention, and the benefits of a healthy lifestyle.

Screenings

5.03 - Periodic Screenings

The AHCCCS EPSDT Periodicity Schedule specifies the screening services to be provided at each stage of the child's development. The [AHCCCS EPSDT Periodicity Schedule \(Exhibit 430-1\)](#) can

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be viewed on the AHCCCS website. This schedule follows the Center for Disease Control (CDC) recommendation. Children may receive additional inter-periodic screening at the discretion of the provider. MCCC does not limit the number of well-child visits that members under age 21 receive. Claims should be billed with the following CPT/ICD-9-CM Diagnosis (prior to 10/1/15) or ICD-10-CM Diagnosis (effective 10/1/15 and after) Codes based on age appropriateness:

Codes to Identify Well-Child Visits – Ages 0 – 15 Months

CPT

99381, 99382, 99391, 99392, 99461

ICD-9-CM Diagnosis Codes for Dates of Service

Prior to 10/1/15

V20.2, V20.31, V20.32, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9

ICD-10-CM Diagnosis Codes for Dates of Service

After 10/1/15

Z00.121, Z00.129, Z00.110, Z00.111, Z02.89, Z00.8, Z00.70, Z00.71

Codes to Identify Well-Child Visits – Ages 3 – 6 Years

CPT

99382, 99383, 99392, 99393

ICD-9-CM Diagnosis Codes for Dates of Service

Prior to 10/1/15

V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9

ICD-10-CM Diagnosis Codes for Dates of Service

After 10/1/15

Z00.121, Z00.129, Z02.89, Z00.8, Z00.5, Z00.70, Z00.71

Codes to Identify Well-Care Visits – Adolescents

CPT

99383-99385, 99393-99395

ICD-9-CM Diagnosis Codes for Dates of Service

Prior to 10/1/15

V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9

ICD-10-CM Diagnosis Codes for Dates of Service

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After 10/1/15

Z00.121, Z00.129, Z02.89, Z00.8, Z00.5, Z00.70, Z00.71

Well Child Visits for sports and other activities should be based on the most recent EPSDT Well Child Visit, as the annual Well Child Visits are comprehensive and should include all of the services required for sports or other activities. AHCCCS does not cover sports or other physicals solely for that purpose. If it can be combined with a regularly scheduled EPSDT visit, it is covered, though no additional payment would be allowable for completing the school or other organization paperwork that would allow the child to participate in the activity.

5.04 - Nutritional Assessment and Nutritional Therapy

MC covers nutritional assessment and nutritional therapy for EPSDT members on an enteral, parenteral or oral basis when determined medically necessary to provide either complete daily dietary requirements, or to supplement a member's daily nutritional and caloric intake.

The following requirements apply:

- Must be assessed at each visit.
- Members in need of nutritional assessment or nutritional therapy should be identified and referred to a registered dietician in MCCC's network.
- Members in need of nutritional supplements may be referred to Option 1 Nutrition Solutions, LLC, MCCC's contracted DME provider for these services.
- Nutritional therapy requires prior authorization and approval by MCCC. In order to determine prior authorization, MCCC requires the AHCCCS [Exhibit 320-2, Certificate of Medical Necessity for Commercial Oral Nutritional Supplements \(EPSDT Aged Members – Initial or Ongoing Requests\)](#) form, along with clinical notes, supporting documentation and evidence of required criteria as indicated in the Certificate of Medical Necessity be sent to Option 1 Nutrition Solutions, LLC. Their fax number is 480-883-1193. Option 1 will contact MCCC to request prior authorization.

For detailed information regarding Nutritional Assessment and Nutritional Therapy, please refer to the [AHCCCS Medical Policy Manual \(AMPM\), Chapter 400 – Medical Policy for Maternal and Child Health](#).

5.05 – Developmental Screening Tools

As of 8/1/14, the following developmental screening tools are available for members at their 9, 18 and 24-month EPSDT visit:

- [Ages and Stages Questionnaires™ Third Edition \(ASQ\)](#) is a tool which is used to identify developmental delays in the first 5 years of a child's life. The sooner a delay or

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disability is identified, the sooner a child can relate to services and support that make a real difference.

- [**Ages and Stages Questionnaires®: Social-Emotional \(ASQ:SE\)**](#) is a tool which is used to identify developmental delays for social-emotional screening.
- The [**Modified Checklist for Autism in Toddlers \(M-CHAT\)**](#) may be used only as a screening tool by a primary care provider, for members 16-30 months of age, to screen for autism when medically indicated.
- [**The Parents' Evaluation of Developmental Status \(PEDS\)**](#) may be used for developmental screening of EPSDT-aged members.

Providers may bill for this service if the following criteria is met:

- The member's EPSDT visit is at either 9, 18, or 24 months;
- Prior to providing the service, the provider is required to complete the required training for the developmental screening tool being utilized and submit a copy of the training certificate to CAQH.
- The code is appropriately billed (96110-EP). Copies of the completed tools must be retained in the medical record.

5.06 – PCP Application of Fluoride Varnish

Effective 4/1/2014, a change was made to the [**AHCCCS Medical Policy Manual \(AMPM\) under Policy 431 - EPSDT Oral Health Care**](#). The change advises that the physician, physician's assistant or nurse practitioner must perform an oral health screening as part of the EPSDT physical examination. Please refer to this document if you have further questions about this change.

Physicians who have completed the AHCCCS required training may be reimbursed for fluoride varnish applications completed at the EPSDT visit for recipients who are at least 6 months of age, with at least 1 tooth eruption. Additional applications occurring every 6 months during an EPSDT visit, up until the recipient's 2nd birthday, will also be reimbursed.

PCPs and attending physicians must refer EPSDT recipients to a dentist for appropriate services based on the needs identified through the screening process and for routine dental care based on the AHCCCS EPSDT Periodicity Schedule (AMPM Exhibit 431-1). Evidence of the referral must be documented on the EPSDT Tracking Form and in the recipient's medical record.

Recipients must be assigned to a dental home by one year of age and seen by a dentist for routine preventative care according to the AHCCCS EPSDT Periodicity Schedule. The physician may refer EPSDT recipients for a dental assessment at an earlier age, if their oral health screening reveals potential carious lesions or other conditions requiring assessment and/or

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treatment by a dental professional. In addition to physician referrals, EPSDT recipients are allowed self-referral to an AHCCCS registered dentist.

AHCCCS recommended training for fluoride varnish application is located at the [Smiles For Life](#) website under Training Module 6 that covers caries risk assessment, fluoride varnish and counseling. Upon completion of the required training, providers should submit a copy of their certificate to CAQH. This certificate will be used in the credentialing process to verify completion of training necessary for reimbursement.

An oral health screening must be part of an EPSDT screening conducted by a PCP. However, it does not substitute for examination through direct referral to a dentist. PCPs must refer EPSDT members for appropriate services based on needs identified through the screening process and for routine dental care based on the AHCCCS EPSDT Periodicity Schedule. Evidence of this referral must be documented on the EPSDT Tracking Form and in the member's medical record.

Please refer to our **Claims Processing Manual** on our [Claims Information](#) web page, **Chapter 3 – Early and Periodic Screen and Developmental Testing (EPSDT), Section 3.3 – PCP Application of Fluoride Varnish** for additional claims processing information.

5.07 - Pediatric Immunizations/Vaccines for Children Program

EPSDT covers all child and adolescent immunizations. Immunizations must be provided according to the [Advisory Committee on Immunization Practices \(ACIP\)](#) guidelines and be up-to-date. Providers are required to coordinate with the Arizona Department of Health Services' (ADHS) Vaccine for Children Program (VFC) to obtain vaccines for MCCC members who are 18 years of age and under.

Additional information can be attained by calling [Vaccine for Children](#) at 602-364-3642 or by accessing their website.

Arizona law requires the reporting of all immunizations administered to children under 19 years old. Immunizations must be reported at least monthly to ADHS. Reported immunizations are held in a central database, the Arizona State Immunization Information System (ASIS) that can be accessed online to obtain complete, accurate records.

Please note that on October 1, 2012 a policy change with the VFC program went into effect. With this update, federal vaccines can no longer be used to immunize privately insured children. Although a newborn may be eligible for Medicaid, hospitals cannot make an absolute determination that a newborn is not also eligible for private insurance at the time that this immunization would be administered. Because of this, the hospitals face the potential of administering VFC vaccines to newborns against the federal requirements. Since many

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hospitals have dis-enrolled from the VFC program due to this new policy, newborns who are delivered at the facilities may not receive the birth dose of the Hepatitis B vaccine.

MCCC requests that all primary care providers and pediatricians caring for newborns review each member's immunization records fully upon the initial visit, and subsequent follow-up visits, regardless of where the child was delivered. It is our intention to ensure that the newborns receive all required vaccines, and that those who have not received the birth dose of the Hepatitis B vaccine in the hospital be "caught up" by their primary care provider.

5.08 - Body Mass Index (BMI)

Providers should calculate each child's BMI starting at 24 months until the member is 21 years old. Body mass index is used to assess underweight, overweight, and those at risk for overweight. BMI for children is gender and age specific. PCPs are required to calculate the child's BMI and percentile. Additional information is available at the CDC website regarding [Body Mass Index \(BMI\)](#).

The following established percentile cutoff points are used to identify underweight and overweight in children:

Body Mass Index (BMI)

Underweight	-	BMI for age <5 th percentile
At risk of Overweight	-	BMI for age 85 th percentile to <95 th percentile
Overweight	-	BMI for age > 95 th percentile

If a child is determined to be below the 5th percentile, or above the 85th percentile, the PCP should provide guidance to the member's parent or guardian regarding diet and exercise for the child. Additional services may be provided, or referrals made if medically necessary.

Additional resources available for your review regarding the prevention of childhood obesity include:

AAP Institute for Healthy Childhood Weight

<https://ihcw.aap.org/Pages/default.aspx>

AAP Clinical Report: The Role of the Pediatrician in Primary Prevention of Obesity

<http://pediatrics.aappublications.org/content/pediatrics/early/2015/06/23/peds.2015-1558.full.pdf>

ADHS

<http://www.azdhs.gov/prevention/nutrition-physical-activity/index.php>

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AzAAP Childhood Obesity Committee Toolkit

<http://www.getfitazkids.org/>

CDC BMI Assessment

http://www.cdc.gov/healthyweight/assessing/bmi/childrens_bmi/about_childrens_bmi.html
!

5.09 - Blood Lead Screening

All children 6 months to 6 years old are required to have a **verbal** lead screening completed at each EPSDT visit. Those screening results should identify members who are at risk for blood lead poisoning, and in need of blood lead **testing**. •

Low-risk: All verbal lead screen questions are answered “No” – blood lead testing is only required if the member resides in a targeted high-risk zip code (see below). •

High-risk: One or more lead screen questions are answered “Yes”. In this case, a blood lead test is required at that visit and each subsequent EPSDT visit.

In addition, in accordance with the AHCCCS Medical Policy Manual (AMPM), all children who are living in targeted high-risk zip codes as indicated in the **Targeted Lead Screening Plan for the Prevention of Childhood Lead Poisoning**, published by the Arizona Department of Health Services, and who are 12 months old, 24 months old, or who are 24-72 months old and have not had a previous blood lead test, **must have a blood lead test**.

5.10 - Eye Examinations and Prescriptive Lenses

EPSDT includes eye exams and prescriptive lenses to correct or ameliorate defects, physical illness and conditions. PCPs are required to perform basic eye exams and refer members to the contracted vision provider for further assessment.

5.11 - Hearing/Speech Screening

Hearing evaluation consists of appropriate hearing screens given according to the EPSDT schedule. Evaluation consists of history, risk factors, parental questions and impedance testing.

- Pure-tone testing should be performed when medically necessary.
- Speech screening shall be performed to assess the language development of the member at each EPSDT visit.

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5.12 - Behavioral Health Screening

Screenings for mental health and substance abuse problems are to be conducted at each EPSDT visit. Treatment services are a covered benefit for members under age 21. The PCP is expected to:

- Initiate and coordinate necessary referrals for behavioral health services.
- Monitor whether a member has received services.
- Keep any information received from a behavioral health provider regarding the member in the member's medical record.
- Initial and date copies of referrals or information sent to a behavioral health provider before placing in the member's medical record.
- If the member has not yet been seen by the PCP, this information may be kept in an appropriately labeled file in lieu of actually establishing a medical record but must be associated with the member's medical record as soon as one is established.

5.13 - Dental Screening and Referrals

Oral health screenings are to be conducted at every EPSDT visit. The PCP must screen children less than three years of age at each visit to identify those who require a dental referral for evaluation and treatment.

In addition to the screening, members three years of age and older must be referred to a dentist at least annually. American Association of Pediatric dentistry recommends that the dental visits begin by age one, but the referral isn't mandatory until age 3. Documented dental findings and treatment must be included in the member's medical record in the PCP's office. Depending on the results of the oral health screening, referral to a dentist should be made according to the following timeframes:

- **Urgent** - (Within 24 hours) Pain, infection, swelling and/or soft tissue ulceration of approximately two weeks duration or longer
- **Early** - (Within three weeks) Decay without pain, spontaneous bleeding of the gums and/or suspicious white or red tissue areas
- **Routine** - (Next regular checkup) none of the above problems identified.

The member's parent or guardian may also self-refer and schedule dental appointments for the member with any MCCC contracted general dentist. They may go directly to the dentist without seeing the PCP first and no authorization is required. For more information regarding PCP Fluoride Application, please refer to section **6.6 – PCP Application of Fluoride Varnish**.

5.14 - Tuberculin Skin Testing

Tuberculin skin testing should be performed as appropriate to age and risk. Children at increased risk of tuberculosis (TB) include those who have contact with persons:

- Confirmed or suspected of TB;

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- In jail during the last five years;
- Living in a household with an HIV-infected person or the child is infected with HIV; and
- Traveling/emigrating from, or having significant contact with persons indigenous to, endemic countries.

5.15 – Metabolic Medical Foods

Children who have been diagnosed with the following genetic metabolic conditions and who need metabolic medical foods may receive services through their genetics provider. MCCC covers medical foods, within the limitations specified in the [AHCCCS Medical Policy Manual, \(AMPM\), Chapter 300 – 320-H Metabolic Medical Foods](#), for any member diagnosed with one of the following inherited metabolic conditions:

- Phenylketonuria
- Homocystinuria
- Maple Syrup Urine Disease
- Galactosemia (requires soy formula)
- Beta Keto-Thiolase Deficiency
- Citrullinemia
- Glutaric Acidemia Type I
- Methylcrotonyl CoA Carboxylase Deficiency
- Isovaleric Acidemia
- Methylmalonic Acidemia

State Programs**5.16 - Arizona Early Intervention Program**

The [Arizona Early Intervention Program](#) (herein AzEIP) is an early intervention program that offers a statewide system of support and services for children birth through three years of age and their families who have disabilities or developmental delays. This program was jointly developed and implemented by AHCCCS and the Arizona Early Intervention Program (AzEIP) to ensure the coordination and provision of EPSDT and early intervention services, such as physical therapy, occupational therapy, speech/language therapy and care coordination under Sec. 1905 [42 U.S.C 1396d]. Concerns about a child's development may be initially identified by the child's Primary Care Provider or by AzEIP.

MCCC coordinates with AzEIP to ensure that members receive medically necessary EPSDT services in a timely manner to promote optimum child health and development. For additional information, please contact the MCCC AzEIP Coordinator.

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MC CHAPTER 6 – CHILDREN’S REHABILITATIVE SERVICES (CRS)**6.00 - Children’s Rehabilitative Services (CRS) Overview**

Arizona’s Children’s Rehabilitative Services (CRS) program provides medical and behavioral health care, treatment, and related support services to Arizona Health Care Cost Containment System (AHCCCS) members who meet the eligibility criteria, have completed the application to be enrolled in the CRS program, and have been determined eligible.

CRS members receive the same AHCCCS covered services as non-CRS AHCCCS members. Services are provided for the CRS condition and other medical and behavioral health services for most CRS members. CRS members can receive care in the community, or in clinics called multispecialty interdisciplinary clinics, which bring many specialty providers together in one location.

6.01 - Integration Initiatives

Arizona’s Children’s Rehabilitative Services (CRS) program, authorized by ARS 36-261 et seq., was originally created in 1929 to serve children with complex health care needs who required specialized services coordinated by a multidisciplinary team. The State of Arizona opted into the Medicaid program in 1982. CRS was folded under the AHCCCS umbrella to leverage federal dollars in providing medically necessary care. However, the CRS program and the services provided remained “carved out” of the AHCCCS managed care model, a model designed to facilitate accessibility to quality cost-effective care.

Historically, the CRS carve-out program provided specialty services to children with specific qualifying medical conditions. Care and services for the CRS qualifying condition(s) were provided through the sole CRS Contractor. However, that same member may also have received other acute care services through a different AHCCCS Contractor or through the American Indian Health Plan (AIHP) or received long-term care services through a different AHCCCS Long Term Care Contractor or the American Indian Fee-for-Service environment, as well as receiving behavioral health services through a Regional Behavioral Health Authority (RBHA) or a Tribal Regional Behavioral Health Authority (TRBHA).

This fragmentation caused confusion for families and providers and created payment and care coordination responsibility issues between delivery systems. Improving the situation required a model design that reduced fragmentation and ensured optimal access to primary, specialty and behavioral care and which offers effective coordination of all service delivery through one AHCCCS Contractor.

AHCCCS proposed an alternative to the “carve out” model of service delivery and payment for services provided to CRS-eligible individuals. Specifically, proposing that the model be replaced

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by a payer integration model that required one contractor/payer to assume responsibility for the delivery and payment of multiple services (i.e. services related specifically to CRS conditions as well as services related to primary care and, potentially, other needs like behavioral health). Ultimately, the purpose of such a model is to ensure optimal access to important specialty care as well as effective coordination of all service delivery.

As of October 1, 2013, AHCCCS integrated all services for most children enrolled in the acute care program with CRS qualifying conditions through one CRS Contractor United Healthcare Community Plan (UCCP) with the goals of improved member outcomes and satisfaction, reduced member confusion, improved care coordination, and streamlined administration. At the same time, children with CRS qualifying conditions enrolled in the Arizona Long Term Care System (ALTCs), other than the Division for Developmental Disabilities, were fully integrated into their ALTCs Contractor for all primary, specialty, long term care, and behavioral health care including care and services related to a CRS condition. To ensure a smooth transition, AHCCCS conducted a comprehensive readiness review process, weekly monitoring of the CRS Contractor's network development efforts, systems testing and oversight of the transition of member data from relinquishing Contractors to UHCCP. In total, over 80 evaluation elements were reviewed to determine readiness to administer members' acute, behavioral health, and CRS-related benefits.

Most AHCCCS members with CRS conditions were enrolled with a single statewide health plan (UnitedHealthcare Community Plan) for all or a portion of their health care services.

Beginning on October 1, 2018, these members will have choice of an AHCCCS Complete Care (ACC) plan for all services (including CRS, other non-CRS physical health services, and all covered behavioral health services). Members who currently see a provider for a CRS condition will still have access to the same array of covered services with ACC health plans.

6.02 - CRS Qualifying Medical Conditions

The AHCCCS published document, [Covered Conditions in the CRS Program](#) lists out medical conditions that are covered by CRS, as well as those conditions that are not covered.

6.03 - Who is Eligible for CRS

Any AHCCCS member under the age of 21 who has a CRS-covered condition as specified in the [Covered Conditions in the CRS Program](#) that requires active treatment. If the CRS applicant is not currently an AHCCCS member they must apply for AHCCCS either online or via phone:

- Online at: www.Healthearizonaplus.gov or
- Call AHCCCS toll free at 1-855-HEA-PLUS (toll-free 1-855-432-7587)

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Anyone can fill out a CRS application form, including, a family member, doctor, or health plan representative. To apply for the CRS program, a CRS application, either in English or Spanish, needs to be filled out and mailed or faxed to the AHCCCS CRS Enrollment Unit, with medical documentation that supports that the applicant has a CRS qualifying condition.

The AHCCCS CRS Enrollment Unit may also assist an applicant with completing the form. You can contact them at: 602-417-4545 or 1-855-333-7828.

CRS Application with Instructions:

- [CRS application form instructions - English](#)
- [CRS application form - English](#)
- [CRS application form - Spanish](#)
- [Instrucciones para completar la solicitud para Servicios de Rehabilitación Infantil \(CRS\)](#)

Once approved for the CRS program, an applicant is enrolled with the ACC Plan of their choice. The ACC health plan will manage care for the CRS condition(s), along with the physical and behavioral health services of the member.

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MC CHAPTER 7 – FAMILY PLANNING**7.00 - Family Planning Overview**

Family planning services are provided through Aetna Medicaid Administrators LLC. Family planning services are those services provided by health professionals to eligible persons who voluntarily choose to delay or prevent pregnancy. To allow members to make informed decisions, counseling should provide accurate, up-to-date information regarding available family planning methods and prevention of sexually transmitted diseases.

Please refer to our **Claims Processing Manual** on our [Claims Information](#) web page, **Chapter 2 – Professional Claim Types by Specialty, Section 2.14 – Family Planning** for the submission of family planning claims.

7.01 - Provider Responsibilities for Family Planning Services

All providers are responsible for:

- Making appropriate referrals to health professionals who provide family planning services.
- Keeping complete medical records regarding referrals.
- Verifying and documenting a member's willingness to receive family planning services.
- Providing medically necessary management of members with family planning complications. Notifying members of available contraceptive services and making these services available to all members of reproductive age using the following guidelines:
 - Information for members who are 17 years of age and younger must be given the information through the member's parent or guardian.
 - Information for members between 18 and 55 years of age must be provided directly to the member or legal guardian.
 - Whenever possible, contraceptive services should be offered in a broad-spectrum counseling context, which includes discussion of mental health and sexually transmitted diseases, including AIDS.
 - Members of any age whose sexual behavior exposes them to possible conception or STDs should have access to the most effective methods of contraception.
 - Every effort should be made to include male or female partners in such services.
- Providing counseling and education to members of both genders that is age appropriate and includes information on:
 - Prevention of unplanned pregnancies.
 - Counseling for unwanted pregnancies. Counseling should include the member's short and long - term goals.
 - Spacing of births to promote better outcomes for future pregnancies.

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- Preconception counseling to assist members in deciding on the advisability and timing of pregnancy, to assess risks and to reinforce habits that promote a healthy pregnancy.
- Sexually transmitted diseases, to include methods of prevention, abstinence, and changes in sexual behavior and lifestyle that promote the development of good health habits.
- Contraceptives should be recommended and prescribed for sexually active members. PHPs are required to discuss the availability of family planning services annually. If a member's sexual activity presents a risk or potential risk, the provider should initiate an in-depth discussion on the variety of contraceptives available and their use and effectiveness in preventing sexually transmitted diseases (including AIDS). Such discussions must be documented in the member's medical record.

7.02 - Covered and Non-Covered Services

Full health care coverage and voluntary family planning services are covered.

The following services are not covered for the purposes of family planning:

- Treatment of infertility;
- Pregnancy termination counseling;
- Pregnancy terminations;
- Hysterectomies;
- Hysteroscopic tubal sterilization;
- Services to reduce voluntary, surgically induced fertilized embryos.

7.03 - Prior Authorization Requirements

Prior authorization is required for family planning services, sterilization or pregnancy termination. Prior authorization must be obtained before the services are rendered or the services will not be eligible for reimbursement.

To obtain authorization for family planning services, please complete the Aetna Medicaid Administrators LLC **Prior Authorization: Aetna Family Planning Service Request Form**, available on [Forms](#) web page. Requests should be faxed to:

Aetna Medicaid Administrators LLC
800-573-4165

To obtain authorization for sterilization or pregnancy - termination:

- Complete applicable form(s)
 - **For sterilization:** Aetna Medicaid Administrators LLC's **Prior Authorization: Aetna Family Planning Service Request Form**, available on our [Forms](#) web page,

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listed above and the **AHCCCS Attachment A - Consent for Sterilization Form** contained in the [AHCCCS Medical Policy Manual, Chapter 420 – Family Planning](#). Permanent sterilization is only covered for MCCC members 21 years of age or older.

- **For pregnancy termination:** Aetna Medicaid Administrators LLC's **Prior Authorization: Aetna Family Planning Service Request Form**, listed above.
- Fax completed prior authorization form and signed consent form prior to the procedure to:

Aetna Medicaid Administrators LLC
800-573-4165

For members enrolled in the Department of Economic Security, Division of Developmental Disabilities (DES/DDD) health professionals must obtain prior authorization from MCCC by faxing your request to 602-431-7155. Final determination will be made by the DES/DDD medical director prior to providing sterilization procedures for members enrolled with DES/DDD, in addition to Aetna Medicaid Administrators LLC. Notification of approved requests will be faxed or mailed to the provider.

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MC CHAPTER 8 - MATERNITY

8.00 - Maternity Overview

MC assigns newly identified pregnant members to a PCP to manage their routine non-OB care. The OB provider manages the pregnancy care for the member and is reimbursed in accordance with their contract.

If a member chooses to have an OB as their PCP during their pregnancy, MC will assign the member to an OB PCP. If an OB provider has been assigned for OB services for a pregnant member, the member will remain with their OB PCP until after their post-partum visit when they will return to their previously assigned PCP.

8.01 - High Risk Maternity Care

In partnership with OB providers, MC care managers identify pregnant women who are "at risk" for adverse pregnancy outcomes. MC offers a multi-disciplinary program to assist providers in managing the care of pregnant members who are at risk because of medical conditions, social circumstances or non-compliant behaviors. MC also considers factors such as noncompliance with prenatal care appointments and medical treatment plans in determining risk status. Members identified as "at risk" are reviewed and evaluated for ongoing follow up during their pregnancy by an obstetrical care manager.

Maternity Care for Members with Developmental Disabilities

Women with developmental disabilities may have higher rates of adverse pregnancy outcomes. MC recognizes the needs of DDD enrolled pregnant women and our intent is to keep our providers updated.

ALL pregnant MC members with a Developmental Disability (DD) designation are considered high risk and require engagement by the high risk perinatal care management team.

Identified DDD enrolled pregnant members enrolled in the care management process receive comprehensive interventions during the perinatal and post-partum periods by skilled professional care managers.

Providers caring for DDD enrolled pregnant women should:

- REFER ALL DDD enrolled pregnant MC members to the High Risk Perinatal Care Management program. The perinatal care management team will assist with coordination of care by providing member specific education and support, along with referrals to community resources as needed.

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- Referrals can be made by faxing both the completed ACOG and referral information electronically to OBfaxes@aetna.com or to the fax number 602-431-7552. Please include the provider group and Tax ID Number.
- When submitting the ACOG form, please clearly document all high risk issues. Submitted forms are reviewed by our perinatal triage RN. All High Risk pregnant members are care managed by a skilled social worker or registered nurses throughout the perinatal and post-partum period.

8.02 - OB Care Management

MCCC's perinatal care management provides comprehensive care management services to high risk pregnant members, for the purpose of improving maternal and fetal birth outcomes. The perinatal care management team consists of a social worker, care management associates, and professional registered nurses skilled in working with the unique needs of high risk pregnant women. Perinatal care managers take a collaborative approach to engage high risk pregnant members telephonically throughout their pregnancy and post-partum period.

Members who present with high risk perinatal conditions should be referred to perinatal care management. These conditions include:

- a history of preterm labor before 37 weeks of gestation;
- bleeding and blood clotting disorders;
- chronic medical conditions;
- polyhydramnios or oligohydramnios;
- placenta previa, abruption or accreta;
- cervical changes;
- multiple gestation;
- teenage mothers;
- hyperemesis;
- poor weight gain;
- advanced maternal age;
- substance abuse;
- mental illness;
- domestic violence;
- non-compliance with OB appointments.

Referrals can be made by faxing the member information on the **Perinatal Referral Form**, available on our [Forms](#) web page, electronically to OBfaxes@aetna.com or to the fax number 602-431-7552. Please include the provider group and Tax ID Number.

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8.03 - OB Incentive Program

MC's perinatal care management offers an OB incentive program for providers. The OB incentive program rewards providers with \$25.00 for each member ACOG submitted within the first trimester. Identification of high risk conditions within the first trimester promotes early intervention of care coordination services and serves to improve birth outcomes.

8.04 - Obstetrical Care Appointment Standards

MC has specific standards for the timing of initial and return prenatal appointments. These standards are as follows:

Initial Visit

All OB providers must make it possible for members to obtain initial prenatal care appointments within the time frames identified:

Pre-Natal Care Appointment Availability Table

<u>Category</u>	<u>Appointment Availability</u>
First Trimester	Within 14 days of the request for an appointment
Second Trimester	Within seven days of the request for an appointment
Third Trimester	Within three days of the request for an appointment
Return Visits	<p>Return visits should be scheduled routinely after the initial visit. Members must be able to obtain return prenatal visits:</p> <p>First 28 weeks - every four weeks From 28 to 36 weeks - every two to three weeks From 37 weeks until delivery – weekly</p>
High Risk Pregnancy Care	<p>Visits should be scheduled within three days of identification of high risk by the Contractor or maternity care provider, or immediately if an emergency exists.</p> <p>Return visits scheduled as appropriate to their individual needs; however, no less frequently than listed above.</p>

GENERAL REQUIREMENTS FOR ALL PLANS

Postpartum Visits

Postpartum visits should be scheduled routinely after delivery. Routine postpartum visits should be scheduled within 21 and 60 days after delivery.

8.05 - General Obstetrical Care Requirements

All providers must adhere to the standards of care established by the American College of Obstetrics and Gynecology (ACOG), which include, but are not limited to the following:

- Use of a standardized prenatal medical record and risk assessment tool, such as the ACOG Form, documenting all aspects of maternity care.
- Completion of history including medical and personal health (including infections and exposures), menstrual cycles, past pregnancies and outcomes, family and genetic history.
- Clinical expected date of confinement.
- Performance of physical exam (including determination and documentation of pelvic adequacy).
- Performance of laboratory tests at recommended time intervals.
- Comprehensive risk assessment incorporating psychosocial, nutritional, medical and educational factors.
- Routine prenatal visits with blood pressure, weight, fundal height (tape measurement), fetal heart tones, urine dipstick for protein and glucose, ongoing risk assessment with any change in pregnancy risk recorded and an appropriate management plan.

8.06 - Additional Obstetrical Physician and Practitioner Requirements

- Educate members on healthy behaviors during pregnancy, including proper nutrition, effects of alcohol and drugs, the physiology of pregnancy, the process of labor and delivery, breast feeding and other infant care information.
- Offer HIV/AIDS testing and confidential post testing counseling to all members.
- Ensure delivery of newborn meets MC criteria.
- Remind delivery hospital of requirement to notify MC on the date of delivery.
- Refer member to MC care management, and other known support services and community resources, as needed.
- Encourage members to participate in childbirth classes at no cost to them. The member may call the facility where she will deliver and register for childbirth classes.

Providers may also consult with an MC medical director for members with other conditions that are deemed appropriate for perinatology referral. Please call 602-263-3000 or 800-624-3879 with requests for assignment to a perinatologist.

In non-emergent situations, all obstetrical care physicians and practitioners must refer members to MC providers. Referrals outside the contracted network must be prior authorized.

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Failure to obtain prior authorization for non-emergent OB or newborn services out of the network will result in claim denials. Members may not be billed for covered services if the provider neglects to obtain the appropriate approvals.

8.07 - Provider Requirements for Medically Necessary Termination of Pregnancy

Medically necessary pregnancy termination services are provided through Aetna Medicaid Administrators LLC. An Aetna Medicaid Administrators LLC Medical Director will review all requests for medically necessary pregnancy terminations. Documentation must include:

- A copy of the member's medical record;
- A completed and signed copy of ***Attachment C - Certificate of Necessity for Pregnancy Termination*** in the [AHCCCS Medical Policy Manual, Chapter 410 – Maternity Care Services](#).
- Written explanation of the reason that the procedure is medically necessary. For example, it is:
 - Creating a serious physical or mental health problem for the pregnant member.
 - Seriously impairing a bodily function of the pregnant member.
 - Causing dysfunction of a bodily organ or part of the pregnant member.
 - Exacerbating a health problem of the pregnant member.
 - Preventing the pregnant member from obtaining treatment for a health problem.

If the pregnancy termination is requested as a result of incest or rape, the following information must be included:

- identification of the proper authority to which the incident was reported, including the name of the agency
- the report number
- the date that the report was filed

When termination of pregnancy is considered due to rape or incest, or because the health of the mother is in jeopardy secondary to medical complications, please contact Aetna Medicaid Administrators LLC at 602-798-2745 or 888-836-8147. All terminations requested for minors must include a signature of a parent or legal guardian or a certified copy of a court order.

For members enrolled in the Department of Economic Security, Division of Developmental Disabilities (DES/DDD) health professionals must obtain prior authorization from MC by faxing your request to 602-431-7155. Final determination will be made by the DES/DDD medical director prior to providing sterilization procedures for members enrolled with DES/DDD, in addition to Aetna Medicaid Administrators LLC. Notification of approved requests will be faxed or mailed to the provider.

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8.08 - Reporting High Risk and Non-Compliant Behaviors

Obstetrical physicians and practitioners must refer all “at risk” members to MC’s Care Management department by calling 602-263-3000 or 800-624-3879 and selecting the option for maternity care. Providers may also fax their information to 602-351-2313. The following types of situations must be reported to MC for members that:

- Are diabetic and display consistent complacency regarding dietary control and/or use of insulin.
- Fail to follow prescribed bed rest.
- Fail to take tocolytics as prescribed or do not follow home uterine monitoring schedules.
- Admit to or demonstrate continued alcohol and/or other substance abuse.
- Show a lack of resources that could influence well-being (e.g. food, shelter and clothing).
- Frequently visit the emergency department/urgent care setting with complaints of acute pain and request prescriptions for controlled analgesics and/or mood altering drugs.
- Fail to appear for two or more prenatal visits without rescheduling and fail to keep rescheduled appointment. Providers are expected to make two attempts to bring the member in for care prior to contacting the MCCC Care Management Department.

8.09 - Outreach, Education and Community Resources

MC is committed to maternity care outreach. Maternity care outreach is an effort to identify currently enrolled pregnant women and to enter them into prenatal care as soon as possible. PCPs are expected to ask about pregnancy status when members call for appointments, report positive pregnancy tests to MC and to provide general education and information about prenatal care, when appropriate, during member office visits. Pregnant members will continue to receive primary care services from their assigned PCP during their pregnancy.

MC is involved in many community efforts to increase the awareness of the need for prenatal care. PCPs are strongly encouraged to actively participate in these outreach and education activities, including:

- The [WIC Nutritional Program](#) - Please encourage members to enroll in this program.

Various other services are available in the community to help pregnant women and their families. Please call MC’s Care Management department for information about how to help your patients use these services.

Questions regarding the availability of community resources may also be directed to the Arizona Department of Health Services (ADHS) Hot Line at 800-833-4642.

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8.10 - Providing EPSDT Services to Pregnant Members under Age 21

Federal and state mandates govern the provision of EPSDT services for members under the age of 21 years. The provider is responsible for providing these services to pregnant members under the age of 21, unless the member has selected an OB provider to serve as both the OB and PCP. In that instance, the OB provider must provide EPSDT services to the pregnant member.

Additional Claims Information

While these services are already performed in the initial prenatal visit, additional information is necessary for claims submission. The provider (PCP or OB) providing EPSDT services for members 12-20 years of age, must submit the medical claims for these members. When submitting claims, please include one of the following codes that reflect the appropriate EPSDT visit:

Ages 12 through 17 years

- New patient - 99384
- Established patient - 99394

Ages 18 through 20 years

- New patient - 99385
- Established patient - 99395

8.11 - Loss of AHCCCS Coverage during Pregnancy

Members may lose AHCCCS eligibility during pregnancy. Although members are responsible for maintaining their own eligibility, providers are encouraged to notify MC if they are aware that a pregnant member is about to lose or has lost eligibility. MC can assist in coordinating or resolving eligibility and enrollment issues so that pregnancy care may continue without a lapse in coverage. Please call Member Services at -602-263-3000 or 800-624-3879 to report eligibility changes for pregnant members.

8.12 - Pre-Selection of Newborn's PCP

Prior to the birth of the baby, the mother selects a PCP for the newborn. The newborn is assigned to the pre-selected PCP after delivery. The mother may elect to change the assigned PCP at any time.

8.13 – Newborn Notification Process

Providers must fax a newborn notification to MCCC's dedicated Profax number – 844-525-2221. MC will report newborn information to AHCCCS and in turn will fax back the newborn AHCCCS ID number to the provider.

GENERAL REQUIREMENTS FOR ALL PLANS

Authorization Information

Well Newborn:

- No authorization is required for vaginal delivery (2 days).
- No authorization is required for cesarean section delivery (4 days).

Sick Newborn:

- Authorization will be created and faxed back to provider with newborn AHCCCS ID and authorization number.

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MC CHAPTER 9 – NON-EMERGENCY TRANSPORTATION

9.00 – Non-Emergency Transportation

Non-emergency transportation shall be provided for members who are unable to provide or secure their own transportation for medically necessary services using the appropriate mode based on the needs of the member. The Provider shall ensure that members have coordinated, reliable, medically necessary transportation to ensure members arrive on-time for regularly scheduled appointments and are picked up upon completion of the entire scheduled treatment.

Transportation services involve the transporting of a person from one place to another to facilitate the receipt of, or benefit from, medically necessary covered behavioral health services, allowing the person to achieve their service plan goals.

9.01 – Covered Services

The Provider shall deliver medically necessary non-emergency transportation services under the following conditions:

- The medical or behavioral health service for which the transportation is needed is a covered MC service;
- The member is not able to provide, secure or pay for their own transportation, and free transportation is not available; and
- The transportation is provided to and from the nearest appropriate MC registered provider. (Behavioral Health Providers may schedule outings to grocery stores, parks, etc., which are not an MC registered provider, but is a part of the member's treatment plan).
- 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.

Definitions

The definitions related to covered transportation services are as follows:

- **Ambulatory Vehicle** – Ambulatory transportation means a vehicle other than a taxi but includes vans, cars, minibus or mountain area transport. The MC member must be able to transfer with or without assistance into the vehicle and not require specialized transportation modes.
- **Taxi** – A vehicle that has been issued and displays a special taxi license plate pursuant to A.R.S. § 28-2515.

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- **Wheelchair Van** – The vehicle must be specifically equipped for the transportation of an individual seated in a wheelchair. Doors of the vehicle must be wide enough to accommodate loading and unloading of a wheelchair. Wheelchair vans must include electronic lifts for loading and unloading wheelchair bound transports. The vehicle must contain restraints for securing wheelchairs during transit. Safety features of wheelchair vans must be maintained as necessary. Any additional items being transported must also be secured for safety. The member must require transportation by wheelchair and must be physically unable to use other modes of ambulatory transportation.
- **Stretcher Van** – The vehicle must be specifically designed for the purpose of transportation of a member on a medically approved stretcher device. The stretcher must be secured to avoid injury to the member or other passengers. Safety features of stretcher vans must be maintained as necessary. Any additional items being transported must also be secured for safety. The MC member must need to be transported by stretcher and must be physically unable to sit or stand and any other means of transportation is medically contraindicated.

9.02 – Program Specific Requirements

The following must be adhered to:

- The member must not require medical care while on route;
- Passenger occupancy must not exceed the manufacturer's specified seating occupancy;
- Members, escorts, and other passengers must follow state laws regarding passenger restraints for adults and children;
- Vehicle must be driven by a licensed driver, following applicable State laws;
- Vehicles must be insured;
- Vehicles must be in good working order; and
- Members must be transported inside the vehicle.

Non-emergency transportation must be provided in such a way as to ensure that:

- A person does not arrive sooner than one hour before their scheduled appointment; and
- A person does not have to wait for more than one hour after the conclusion of their appointment for transportation home or to another pre-arranged destination.

9.03 – Documentation Requirements

MC will conduct retrospective audits of non-emergency ground transportation providers to verify that the mileage, wait time, diagnosis, and medical necessity are correct and that all charges are supported and justifiable. The transportation provider will submit a trip report and justification of the transport upon request by MC any time after the date of service. Each service must be supported with the following documentation:

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- Complete transport service provider's name and address
 - Printed name and signature of the driver who provided the service
 - Vehicle identification (license # and state.)
 - Vehicle type (car, van, wheel chair van, stretcher, etc.)
 - Recipient's full name
 - Recipient's AHCCCS ID#
 - Recipient's date of birth
 - Complete date of service, including month, day and year
 - Complete address of pick up destination
 - Time of pick up
 - Odometer reading at pick up
 - Complete address of drop off destination
 - Time of drop off
 - Odometer reading at drop off
 - Type of trip – one way or round trip
 - Escort name and relationship to recipient being transported
 - Signature (or fingerprint) of recipient* verifying services were rendered
- Signature Clarification-** If the member is unable to sign or utilize a fingerprint, the parent/guardian, caretaker/escort or family member can sign for the member. The relationship to the member must be noted. If the member that is unable to sign is traveling alone, the trip report may be signed by the provider at the medical or behavioral health service appointment. The driver can never sign for the member.

Any NEMT service over 100 miles will require submission of a trip ticket or EDI information noting the complete pick up and drop off locations for review prior to payment. Any NEMT over 100 miles without the required documentation will result in a claim denial.

9.04 – Data and Reporting

The Provider must submit all reports outlined in the MC Provider Manual and requested by MC staff.

MC reserves the right to include additional provider reporting requirements at any time it is deemed necessary.

9.05 – Professional Standards and Responsibilities

Professional Standards and Responsibilities include:

- The Provider will ensure all employees and drivers shall have a valid State driver's license free of moving violations and will verify the driver's records through AZ-DMV.
- The Provider shall meet all requirements for provider eligibility including:
 - Licensed by the appropriate State authority.

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- Registered with the Arizona Health Care Cost Containment System (AHCCCS).
- Credentialed with MC. MC is not responsible for payment to non-registered providers. The Provider shall ensure that independent drivers meet these same requirements.
- The Provider must deliver services when and where the individual needs them within the context of safety for the individual and staff providing the service.
- The Provider must maintain complete, accurate, and timely documentation of all delivered services.
- The Provider shall have a sufficient number of qualified staff to deliver, manage and coordinate service delivery.
- The provider will provide additional support for individuals under 12 as clinically appropriate.
- The provider will attempt to utilize all appropriate ways to locate or contact the member prior to determining that the member is a “no-show”.
- The Provider will train all staff and subcontractors in accordance with the MC Provider Manual.
- Each driver should be trained on CPR and first aid every two years and HIPAA training annually.
- The Provider will adhere to all cultural competency requirements as outlined in the MC Provider Manual and Cultural Competency Plan, including cultural competency/sensitivity training, to all drivers and employees. All services provided must consider the member’s and their family’s language and cultural preferences.
- The Provider agrees to meet with MC on a quarterly basis or as needed to review and resolve grievance trends or service issues.
- The Provider must ensure that all subcontractors adhere to the requirements outlined in this scope of work.

9.06 – Vehicle Requirements

Vehicle Requirements include the following:

- Passenger occupancy must not exceed the manufacturer’s specified seating occupancy.
- Members, escorts and other passengers must follow State laws regarding restraints for adults and children.
- Members must be transported inside the vehicle.
- Vehicles must be insured and be driven by a licensed driver, following applicable State laws.
- Vehicles must be clean and maintained and be in good working order.
- All vehicles must have a sign or logo with the company name displayed when transporting a member

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9.07 – Performance Improvement

The Provider must maintain a Quality Assessment and Performance Improvement program designed to evaluate the quality and accessibility of the services they deliver, and customer satisfaction with those services. This information must be collected on a routine and frequent basis, formally communicated to all levels of staff within the organization and used to improve service delivery to all individuals accessing the services outlined in this contract. The Provider's performance improvement program must be described in detail in an Annual Quality Management Plan and Work plan. Each year, the Provider must evaluate its Quality Assessment and Performance Improvement program, incorporating successful programs and interventions into subsequent Plans, and discontinuing programs and interventions that did not meet established goals or yield performance improvements.

The Provider shall develop and maintain a process to collect and analyze member satisfaction information for all programs and report the results to MC.

9.08 – Performance Outcome Measures

The Provider must meet or exceed standards for the performance measures described below.

Performance Measure	Standard
Transport Timeliness	
Average drop off time prior to member appointment.	< 60 minutes
Average wait time for transportation after appointment completion	< 60 minutes
Member Satisfaction	
Member satisfaction with services	85%
Telephone Performance Standards	
Average Service Level	$\geq 75\%$
Average Speed of Answer	≤ 30 seconds
Average Abandonment Rate	$\leq 5\%$
Complaint Rate	
Average Monthly Complaint Rate Per 1000 Trips	< 3.5

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MC CHAPTER 10 – BEHAVIORAL HEALTH ASSESSMENTS AND TREATMENT/SERVICE PLANNING

10.00 – Behavioral Health Assessment and Service Planning Overview

MC supports a model for assessment, service planning, and service delivery that is individualized, member-centered, strength-based, inclusive of family and/or natural supports, culturally and linguistically appropriate, and clinically sound.

The model incorporates the concept of a “team”, established for each member receiving behavioral health services. For children, this team is the Child and Family Team (CFT) and for adults, this team is the Adult Recovery Team (ART).

At a minimum, the functions of the CFT and ART include:

- Ongoing engagement of the member, family and other formal and informal supports who are significant in meeting the behavioral health needs of the member, including their active participation in the decision-making process and involvement in treatment;
- An assessment process is conducted to elicit information on the strengths, needs and goals of the individual member and his/her family, identify the need for further or specialty evaluations, and support the development and updating of a service plan which effectively meets the member’s/family’s needs and results in improved health outcomes;
- Continuous evaluation of the effectiveness of treatment through the CFT and ART process, the ongoing assessment of the member, and input from the member and his/her team resulting in modification to the service plan, if necessary;
- Provision of all covered services as identified on the service plan, including assistance in accessing community resources, as appropriate and, for children, services which are provided in accordance with the Arizona Vision and 12 Principles, and for adults, services which are provided in accordance with the 9 Guiding Principles for Recovery Oriented Adult Behavioral Health Services and Systems;
- Ongoing collaboration, including the communication of appropriate clinical information, important to achieving positive outcomes (e.g., primary care providers, school, child welfare, juvenile or adult probation, other involved service providers);
- Oversight to ensure continuity of care by taking the necessary steps (e.g., clinical oversight, development of facility discharge plans, or after-care plans, transfer of relevant documents) to assist members who are transitioning to a different treatment program, (e.g., inpatient to outpatient setting), changing behavioral health providers and/or transferring to another service delivery system (e.g., out-of-area, out-of-state or to an Arizona Long Term Care System (ALTCS) Contractor); and
- Development and implementation of transition plans prior to discontinuation or modification of behavioral health services.

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For additional information regarding the Child and Family Team practice refer to [AHCCCS Practice Protocol Child and Family Team Practice](#).

10.01 - Assessments

All individuals being served in the public behavioral health system must have a behavioral health assessment upon an initial request for services. For individuals who continue to receive behavioral health services, updates to the assessment must occur at least annually.

Behavioral health assessments must be utilized to collect necessary information that will inform providers of how to plan for effective care and treatment of the individual.

MC does not mandate that a specific assessment tool or format be utilized. However, assessment of substance use disorders and related levels of service provision using the current version of the American Society of Addiction Medicine (ASAM-) must be incorporated for members identified with substance use disorders.

The initial and annual assessment must be completed by a behavioral health professional (BHP) or behavioral technician (BHT) under the clinical oversight of a BHP, who is trained on the minimum elements of a behavioral health. If an assessment is conducted and documented by a BHT, a BHP must review and sign the assessment information that was documented by the BHT within 30 days of the BHT signature.

10.02 - Minimum elements of the behavioral health assessment

MC has established the following minimum elements that must be included in a comprehensive behavioral health assessment and documented in the comprehensive clinical record.

- Presenting issues/concerns;
- History of present illness, including review of major psychiatric symptoms (i.e., mood, depression, anxiety, psychosis, suicidal ideation, homicidal ideation, and other behavioral health symptoms) and frequency/duration of symptoms;
- Psychiatric history, including history of previous psychiatric hospitalization(s) and psychotropic medication trial(s);
- Medical history;
- Current medications, including over the counter (OTC) medications;
- Allergies and other adverse reactions;
- Developmental history for children/youth under the age of 18 and with other populations if clinically relevant;
- Trauma history for children/youth under the age of 18 and with other populations if clinically relevant;
- Family history;*

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- Educational history/status; *
- Employment history/status;
- Housing status/living environment;
- Social history; *
- Legal history, including custody/guardianship status, pending litigation, Court Ordered Evaluation/Court Ordered Treatment (COE/COT) history, criminal justice history, and any history of sex offender adjudication;
- Substance use history including type of substance, duration, frequency, route of administration, longest period of sobriety, and previous treatment history;
- Standardized substance use screen for children age 11 to 18 and referral for comprehensive assessment when screened positive;
- Substance use screen for adults age 18 and older using the American Society of Addiction Medicine (ASAM) Criteria (current required version);
- Labs/ Diagnostics, if applicable;
- Mental Status Examination;
- Risk Assessment: the potential risk of harm to self or others based on self-reports, clinical symptoms, personality factors, history, substance use, criminogenic factors, etc.;
- Summary/Bio-Psycho-Social formulation;
- Axial Diagnoses I-V; and
- Date, begin, and end time of the assessment and printed name, signature, and professional credential of the provider completing the behavioral health assessment. If a privileged BHT completes the assessment, the assessment must also include a printed name, signature, professional credential, date and time of the privileged BHP who reviewed the assessment information.*
 - **REQUIRED FOR ALL TITLE XIX/XXI MEMBERS:** Primary Care Provider (PCP) name and contact information.
 - **REQUIRED FOR ALL TITLE XIX/XXI MEMBERS:** Involvement with other agencies (e.g., Department of Child Safety, Probation, Division of Developmental Disabilities).
 - **ONLY REQUIRED FOR CHILDREN AGE 0 TO 5:** Birth to Five Assessment to be completed within 90 days of intake, with a minimum of 2 documented observations to occur within a 45-60-day period and the first observation to occur within 21 days of intake. Recommendations for treatment to be reviewed with the Guardian/Primary Caregiver and Stakeholders within a Child and Family Team meeting. Developmental screening for children age 0-5 with a referral for further evaluation by the child's Primary Care Provider (PCP), the Arizona Early Intervention Program (AzEIP) for children age 0-3, or the public-school system

*Additionally, confirm that sexual abuse/behavior information was documented as part of the member's Family, Educational, and Social History.

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- for children age 3-5 when developmental concerns are identified.
- **ONLY REQUIRED FOR CHILDREN AGE 6 TO 18:** Child and Adolescent Service Intensity Instrument (CASII) Score and Date.
- **ONLY REQUIRED FOR CHILDREN AGE 6 TO 18 WITH CASII SCORE OF 4 OR HIGHER:** Strength, Needs and Culture Discovery Document.
- **ONLY IF INDICATED:** Seriously Mentally Ill Determination (for members who request SMI determination or have an SMI qualifying diagnosis).

For members referred for or identified as needing ongoing psychotropic medications for a behavioral health condition, the assessor must establish an appointment with a licensed medical practitioner with prescribing privileges. If the assessor is unsure regarding a member's need for psychotropic medications, then the assessor must review the initial assessment and treatment recommendations with his/her clinical supervisor or a licensed medical practitioner with prescribing privileges.

Members with substance use disorders, primarily opioid addiction, may be appropriately referred to Medication Assisted Treatment (MAT). MAT services are a combination of medications and counseling/behavioral therapies to provide a "whole patient" approach to the treatment of substance use disorders. MC contracts with network providers to specifically prescribe and/or dose medications to normalize brain chemistry, block the euphoric effects of alcohol and opioids, relieve physiological cravings and normalize body functions without the negative effects of the used drug. MC members may solely receive behavioral health services from contracted MAT providers; members may also receive behavioral health services from one agency and receive MAT services from another provider. Providers involved are required to provide care coordination to optimize treatment outcomes for these members.

10.03 - Provider Submits a Complex Case Request

In the event a provider determines a need for an action, they may complete a **Complex Case Review Form** available on our [Forms Library](#) web page and submit it to MC Medical Management at ComplexCase@MercyCareAZ.org for review. For additional guidance see Provider Manual, Title XIX/XXI Notice and Appeal Requirements, subsection Complex Case Requests. Medical Management staff will evaluate the request to determine if it requires a notice. If a notice is required, MC will issue the NOA in accordance with ACOM 414, Notice of Adverse Benefit Determination and Notices of Extension for Service Authorizations.

In cases that a member determined to have a Serious Mental Illness and/or legal or designated representative disagree with some or all of the Non-Title XIX/XXI covered services included in the service plan, the member and/or legal or designated representative **must** be given a **Notice of Decision and Right to Appeal (For Individuals With a Serious Mental Illness)** available on our [Forms Library](#) web page by the behavioral health representative on the team.

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In either case, the member and/or legal or designated representative may file an appeal within 60 days of the action.

10.04 - Update to Assessment and Service Plan

BHPs must complete an annual assessment update with input from the member and family, if applicable, that records a historical description of the significant events in the member's life and how the member/family responded to the services/treatment provided during the past year. Following this updated assessment, the service plan should then be updated as necessary. While the assessment and service plan must be updated at least annually, the assessment and service plan may require more frequent updates to meet the needs and goals of the member and his/her family.

Additionally, SMI Direct Care Clinics' targeted thresholds for ISP and Assessments are identified as 85% per clinic/stand-alone ACT team (not per agency).

10.05 - Transfer Assessments

If a behavioral health assessment that complies with the assessment requirements is received from a behavioral health provider other than the intake agency or the intake agency has a medical record for the patient that contains an assessment that was completed within 12 months before the date of the patient's current admission: (1) the patient's assessment information is reviewed and updated, by a BHP, if additional information that affects the patient's assessment is identified, by utilizing a collateral note. (2) The review and update of the patient's assessment information needs to be documented in the patient's medical record within 48 hours after review.

Please Note: The following instances would not require a BHP review within 48 hours following assessment retrieval: (1) the provider is contracted with another behavioral health provider with whom a formal agreement has been made to provide services; (2) an intake agency receives a referral from another behavioral health provider, following intake (due to additional services being required outside of the array of services offered by the behavioral health provider performing the intake; i.e. HNCM).

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MC CHAPTER 11 – CARE MANAGEMENT AND DISEASE MANAGEMENT

11.00 - Care Management and Disease Management Overview

MC has a comprehensive care management program. The Medical Care Management team considers the medical, social and cultural needs of members by targeting, assessing, monitoring and implementing services for members identified as "at risk." Care Management services are available for all eligible members, excluding MC members who are identified as "at risk," such as transplant and hemophilia, or those who are high-service utilizers, and are assigned a care manager.

A wide spectrum of services is available for members, providers and families who need assistance in finding and using appropriate health care and community resources. The MC Care Management staff:

- Considers the medical, social and cultural needs of members in targeting, assessing, monitoring and implementing services for members.
- Aids members and families in navigating through the complex medical and behavioral health systems.

Please refer to our [Clinical Guidelines](#) web page for treatment protocols under [evidence-based guidelines](#) related to:

- Asthma
- Alcohol Abuse
- ADHD
- CAD
- Chronic Obstructive Lung Disease (COPD)
- Congestive Heart Failure (CHF)
- Diabetes
- HIV/AIDS
- Hypertension
- Major Depressive Disorder
- Opioids for Chronic Pain
- Immunizations
- Preventative Screenings
- Prenatal Services

In addition, the following information is available:

- **Arizona Opioid Prescribing Guidelines**
- **Clinical Guidelines for the Treatment of Children**
- **Treating behavioral health disorders in children**

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- **Treating behavioral health disorders in adults**

11.01 - Referrals

The MC central intake coordinator accepts referrals from any source. Please call the central intake coordinator at 800-624-3879 or 602-263-3000 to make a referral. You may also fax a referral to 844-424-3975. For the most part, the central intake coordinator can respond to questions and resolve the issue during the initial call. However, a care management referral is initiated for members that require more than a single intervention. Care managers will contact the member either by telephone or by letter. The Care Management staff communicates with members, family and the PCP on an ongoing basis while the member's care is open.

11.02 - Care Management

MC provides care management services to medically complex members. The members are assigned to an RN, LPN or social work care manager who works closely with the PCP and member to coordinate care and services. The care manager also collaborates with community resources, home health services and PCPs to coordinate medical care and assure appropriate access to medical and social services.

Members who meet any of the following criteria and do not fall under other identified categories of care management also will be considered for care management services:

- High utilizers of services
- Frequent inpatient readmissions
- Substance abusers
- Poor compliance with prescribed medical treatment
- Experiencing social problems that are impacting medical care
- Overuse of emergency department
- Complex care needs

A health assessment will be conducted of each member accepted into care management. A care plan will be developed and the member's compliance with the plan will be monitored. The care manager interacts routinely with the PCP, the member and the member's care giver/family.

11.03 - HIV/AIDS

Early identification and intervention of members with HIV allows the care manager to assist in developing basic services and information to support the member during the disease process. The care manager links the member to community resources that offer various services, including housing, food, counseling, dental services and support groups. The member's cultural needs are continually considered throughout the care coordination process.

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The MC care manager works closely with the PCP, the MC corporate director of pharmacy, and an MC medical director to assist in the coordination of the multiple services necessary to manage the member's care. PCPs wishing to provide care to members with HIV/AIDS must provide documentation of training and experience and be approved by the MC credentialing process. These PCPs must agree to comply with specific treatment protocols and AHCCCS requirements. PCPs may elect to refer the member to an AHCCCS approved HIV specialist for the member's HIV treatment.

11.04 - High Risk OB

Members that have been identified as high-risk obstetrical patients, either for medical or social reasons, are assigned to an OB care manager to try to ensure a good newborn/mother outcome. Please refer to **MC Chapter 8 – Maternity** of this Provider Manual for additional information. The care manager may refer the expectant mother to a variety of community resources, including WIC, food banks, childbirth classes, smoking cessation, teen pregnancy care management, shelters and counseling to address substance abuse issues. A care manager monitors the pregnant woman throughout the pregnancy and provides support and assistance to help reduce risks to the mother and baby.

Care managers also work very closely with the PCP to make sure that the member is following through with all prenatal appointments and the prescribed medical regimen. Members with complex medical needs are also assigned a medical care manager so that all the member's medical and perinatal care issues are addressed appropriately.

11.05 - Behavioral Health

The Care Management department is available to assist with referrals to RBHA and to help members who are experiencing problems related to behavioral health services. Please refer to MC Chapter 10 – Care Management and Disease Management, Section 10.05 – Behavioral Health of this Provider Manual for additional information.

11.06 - Disease Management

The Disease Management team administers disease management programs intended to enhance the health outcomes of members. Disease management targets members who have illnesses that have been slow to respond to coordinated management strategies in the areas of diabetes, respiratory (COPD, asthma), and cardiac (CHF). The primary goal of disease management is to positively affect the outcome of care for these members through education and support and to prevent exacerbation of the disease, which may lead to unnecessary hospitalization.

The objectives of disease management programs are to:

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- Identify members who would benefit from the specific disease management program.
- Educate members on their disease, symptoms and effective tools for self-management.
- Monitor members to encourage/educate about self-care, identify complications, assist in coordinating treatments and medications, and encourage continuity and comprehensive care.
- Provide evidence-based, nationally recognized expert resources for both the member and the provider.
- Monitor effectiveness of interventions.

The following conditions are specifically included in MC's Disease Management programs and have associated [Clinical Guidelines](#) that are reviewed annually.

11.07 - Asthma

The Asthma Disease Management program offers coordination of care for identified members with primary care providers, specialists, community agencies, the members' caregivers and/or family. Member education and intervention is targeted to empower and enable compliance with the physician's treatment plan.

Providers play an important role in helping members manage this chronic disease by promoting program goals and strategies, including:

- Preventing chronic symptoms.
- Maintaining "normal" pulmonary function.
- Maintaining normal activity levels.
- Maintaining appropriate medication ratios.
- Preventing recurrent exacerbation and minimizing the need for emergency treatment or hospitalizations.
- Providing optimal pharmacotherapy without adverse effects.
- Providing education to help members and their families better understand the disease and its prevention/treatment.

11.08 - Chronic Obstructive Pulmonary Disease (COPD)

The COPD Disease Management program is designed to decrease the morbidity and mortality of members with COPD. The goal of the program is to collaborate with providers to improve the quality of care provided to members with COPD, decrease complication rates and utilization costs, and improve the members' health. The objectives of the COPD Disease Management program are to:

- Identify and stratify members.
- Provide outreach and disease management interventions.
- Provide education through program information and community resources.

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- Provide provider education through the COPD guidelines, newsletters and provider profiling.

11.09 - Congestive Heart Failure (CHF)

The CHF Disease Management program is designed to develop a partnership between MC, the PCP and the member to improve self-management of the disease. The program involves identification of members with CHF and subsequent targeted education and interventions. The CHF Disease Management program educates members with CHF on their disease, providing information on cardiac symptoms, blood pressure management, weight management, nutritional requirements and benefits of smoking cessation.

11.10 - Diabetes

The Diabetes Disease Management program is designed to develop a partnership between MC, the PCP and the member to improve self-management of the disease. The program involves identification of members with diabetes and subsequent targeted education and interventions. In addition, the program offers providers assistance in increasing member compliance with diabetes care and self-management regimens. Providers play an important role in helping members manage this chronic condition. MC appreciates providers' efforts in promoting the following program goals and strategies:

- Referrals for formal diabetes education through available community programs
- Referrals for annual diabetic retinal eye exams by eye care professionals as defined in MC's Diabetes Management Clinical Guidelines
- Laboratory exams that include:
 - Glycohemoglobins at least twice annually
 - Micro albumin
 - Fasting lipid profile annually
- Management of co-morbid conditions like blood pressure, CHF, and blood cholesterol.

11.11 - Active Health

MC has contracted with Active Health Management to administer a patient health-tracking program that was implemented in October of 2008 with providers. Effective March of 2010, members will be receiving letters concerning their "Care Considerations" as well.

Active Health will expand MC's opportunities to identify members at risk for poor health outcomes and to communicate directly with the providers who are responsible for their care, in a time-critical mode. It also enables the member to work closely with their physician to choose treatments and tests that are right for them. Active Health utilizes data received through claim, lab and pharmacy submissions to identify potential opportunities to meet evidence-based guidelines, such as through the addition of new therapies, avoidance of contraindications or prevention of drug interactions. When an opportunity is identified for our member, a formal

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patient-specific communication will be sent to the provider to assist in offering health care to the patient based upon the physician's independent medical judgment. A "Care Consideration" letter will be sent to the member as well, encouraging them to discuss the "Care Consideration" with their physician.

It is important to note that this program is not a utilization review mechanism and does not constitute consultation. MC's goal is to offer timely, accurate and patient-specific information to facilitate patient care and improve outcomes.

Examples of "Care Consideration" are:

- If the member is a diabetic and there are no records that the patient has had their eyes checked or an HgA1c lab has been done.
- If the patient has a heart condition and there are no records to show that the member is on any type of drug to lower cholesterol.

GENERAL REQUIREMENTS FOR ALL PLANS**MC CHAPTER 12 – CONCURRENT REVIEW****12.00 - Concurrent Review Overview**

MC conducts concurrent utilization review on each member admitted to an inpatient facility, including skilled nursing facilities and freestanding specialty hospitals. Concurrent review activities include both admission certification and continued stay review. The review of the member's medical record assesses medical necessity for the admission, and appropriateness of the level of care, using the Milliman Care Guidelines® and the AHCCCS NICU/Nursery/Step-Down Utilization Guidelines. Admission certification is conducted within one business day of receiving notification. It is the responsibility of the facility to notify MC of all member admissions and emergency department visits to assure that a service medical necessity review is conducted so that claims are not delayed. Services rendered without notification will result in the claim being held for retrospective review. Failure to notify MC of an admission or emergency department visit within ten (10) days of the encounter may result in denial of the claim.

Continued stay reviews are conducted by MC concurrent review staff before the expiration of the assigned length of stay. Providers will be notified of approval or denial of length of stay. The concurrent review staff works with the medical directors in reviewing medical record documentation for hospitalized members. MC medical directors may make rounds on site as necessary. MC concurrent review staff will notify the facility care management department and business office at the end of the member's hospitalization stay, by fax, of the days approved and at what level of care.

12.01 - MILLIMAN Care Guidelines®

MC uses the Milliman Care Guidelines® to ensure consistency in hospital-based utilization practices. The guidelines span the continuum of patient care and describe best practices for treating common conditions. The Milliman Care Guidelines® are updated regularly as each new version is published. A copy of individual guidelines pertaining to a specific care is available for review upon request.

12.02 - Discharge Planning Coordination

Effective and timely discharge planning and coordination of care are key factors in the appropriate utilization of services and prevention of readmissions. The hospital staff and the attending physician are responsible for developing a discharge plan for the member and for involving the member and family and assigned outpatient clinical teams in implementing the plan.

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The MC Concurrent Review Staff (CRS) works with the hospital discharge team and attending physicians to ensure that cost-effective and quality services are provided at the appropriate level of care. This may include, but is not limited to:

- Assuring early discharge planning.
- Facilitating or attending discharge planning meetings for members with complex and/or multiple discharge needs.
- Providing hospital staff and attending physician with names of contracted MC providers (i.e., home health agencies, DME/medical supply companies, other outpatient providers). The CRS plays a key role in assisting with discharge planning and may authorize services required for a safe discharge such as pharmacy, home health and DME. MC CRS staff works to make sure there is a safe discharge even when the primary payer is not MC so it is important that the facilities notify MC of all members.
- Informing hospital staff and attending physician of covered benefits as indicated.

12.03 - Physician Medical Review

MC medical directors conduct medical review for each care with the potential for denial of medical necessity. The CRS (Inpatient) or the prior authorization reviewer (Outpatient) reviews the documentation for evidence of medical necessity according to established criteria. When the criteria are not met, the case is referred to an MC medical director. The medical director reviews the documentation, discusses the care with the reviewer and may call the attending or referring physician for more information. The requesting physician may be asked to submit additional information. Based on the discussion with the physician or additional documentation submitted, the medical director will decide to approve, deny, modify, reduce, suspend or terminate an existing or pending service.

Utilization management decisions are based only upon appropriateness of care and service. MC does not reward practitioners, or other individuals involved in utilization review, for issuing denials of coverage or service. The decision to deny a service request will only be made by a physician.

For inpatient denials, hospital staff is verbally notified when MC is stopping payment. The hospital will receive written notification with the effective date of termination of payment or reduction in level of care. The attending or referring physician may dispute the finding of the medical director informally by phone or formally in writing. If the finding of the medical director is disputed, a formal claim dispute may be filed according to the established MC claim dispute process.

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MC CHAPTER 13 – PHARMACY MANAGEMENT**13.00 - Pharmacy Management Overview**

Prescription drugs may be prescribed by any authorized provider, such as a PCP, attending physician, dentist, etc. Prescriptions should be written to allow generic substitution whenever possible and signatures on prescriptions must be legible for the prescription to be dispensed. The [Preferred Drug List](#) (PDL), also referred to as a Formulary, identifies the medications selected by the Pharmacy and Therapeutics Committee (P&T Committee) that are clinically appropriate to meet the therapeutic needs of our members in a cost effective manner.

13.01 - Updating the Preferred Drug Lists (PDLs)

MC's PDLs are developed, monitored and updated by the P&T Committee. The P&T Committee continuously reviews the PDLs and medications are added or removed based on objective, clinical and scientific data. Considerations include efficacy, side effect profile, and cost and benefit comparisons to alternative agents, if available.

Key considerations:

- Therapeutic advantages outweigh cost considerations in all decisions to change PDLs. Market share shifts, price increases, generic availability and varied dosage regimens may affect the actual cost of therapy.
- Products are not added to the list if there are less expensive, similar products on the formulary.
- When a drug is added to the PDL, other medications may be deleted.
- Participating physicians may request additions or deletions for consideration by the P&T Committee. Requests should include:
 - Basic product information, indications for use, its therapeutic advantage over medications currently on the PDL.
 - Which drug(s), if any, the recommended medication would replace in the current PDL.
 - Any published supporting literature from peer reviewed medical journals.

MC may invite the requesting physician to the P&T Committee to support the addition to the PDL and answer related questions. However, MC does not permit pharmaceutical representatives to participate or attend P&T Committee meetings. All PDL requested additions should be sent to:

Aetna Medicaid Administrators LLC
Mercy Care Corporate Director of Pharmacy
4500 E. Cotton Center Blvd.
Phoenix, AZ 85040

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13.02 - Notification of PDL Updates

MC will not remove a medication from the PDL without first notifying providers and affected members. MC will provide at least 60 days' notice of such changes. MC is not required to send a hard copy of the PDL each time it is updated, unless requested. A memo may be used to notify providers of updates and changes and may refer providers to view the updated PDL on the MC website. MC may also notify providers of changes to the PDL via direct letter. MC will notify members of updates to the PDL via direct mail and by notifying the prescribing provider, if applicable.

13.03 - Prior Authorization Required

Prior authorization is required:

- If the drug is not included on the PDL.
- If the prescription requires compounding.
- For injectable medications dispensed by a pharmacy, except for heparin and insulin.
Note: If the member has a primary insurance that reimburses for injectable medications, MC will only coordinate benefits as the secondary payer if the MC pharmacy prior authorization process was followed.
- For injectable medications dispensed by the physician and billed through the member's medical insurance, please call 602-263-3000 or toll-free 800-624-3879 to initiate prior authorization for the requested specialty medication.
- For medication quantities which exceed recommended doses.
- For specialty drugs which require certain established clinical guidelines be met before consideration for prior authorization.
- For certain medications that may require additional documentation, e.g. Peg-Intron.

In instances where a prescription is written for drugs not on the PDL, the pharmacy may contact the prescriber to either request a PDL alternative or to advise the prescriber that prior authorization is required for non-PDL drugs. Please see [Chapter 12 – Pharmacy Management, Section 12.13 – Request for Non-PDL Drugs](#) for additional information.

Decision and Notification Standards

MC makes pharmacy prior authorization decisions and notifies prescribing practitioners/providers, and/or members in a timely manner, according to the standards defined below:

- MC makes decisions within 24 hours of the receipt of all necessary information.
- MC notifies requesting prescribing providers by fax, phone or electronic communication of the approved decisions within 24 hours of receipt of the submitted request for prior authorization.

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- A request for additional information is sent to the prescriber by fax within 24 hours of the submitted request when the prior authorization request for a medication lacks enough information to render a decision. A final decision will be rendered within seven business days from the initial date of the request.
- If an authorization is denied, MC notifies members and practitioners and/or providers regarding how to initiate an expedited appeal at the time they are notified of the denial.
- MC *will fill at least* a 4-day supply of a covered outpatient prescription drug in an emergent situation.

13.04 - Over the Counter (OTC) Medications

A limited number of OTC medications are covered for MC members. OTC medications require a written prescription from the physician that must include the quantity to be dispensed and dosing instructions. Members may present the prescription at any MC contracted pharmacy. OTCs are limited to the package size closest to a 30-day supply. Some medications may require step therapy. Please refer to the [Provider Drug List](#) for more information.

13.05 - Generic vs. Brand

Generic medications represent a considerable cost savings to the health care industry and Medicaid program. As a result, generic substitution with A-rated products is mandatory unless the brand has been specifically authorized or as otherwise noted. In all other cases, brand names are listed for reference only.

13.06 - Diabetic Supplies

Diabetic supplies are limited to a one-month supply (to the nearest package size) with a prescription.

13.07 - Injectable Drugs

The following types of injectable drugs are covered when dispensed by a licensed pharmacist or administered by a participating provider in an outpatient setting:

- Immunizations
- Chemotherapy for the treatment of cancer
- Medication to support chemotherapy for the treatment of cancer
- Glucagon emergency kit
- Hemophilia medications including Ceprotin and Stimate Nasal Spray
- Insulin; Insulin syringes
- Immunosuppressant drugs for the post-operative management of covered transplant services
- Rhogam

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13.08 - Exclusions

The following items, by way of example, are not reimbursable by MC:

- DESI drugs (those considered less than effective by the FDA)
- Non-FDA approved agents
- Rogaine
- Any medication limited by federal law to investigational use only
- Medications used for cosmetic purposes
- Non-indicated uses of FDA approved medications without prior approval by MC
- Lifestyle medications (such as medications for sexual dysfunction)
- Medications used for fertility

13.09 - Family Planning Medications and Supplies

Aetna Medicaid Administrators LLC administers the family planning benefit for MC that includes:

- Over-the-counter items related to family planning (condoms, foams, suppositories, etc.) are covered and do not require prior authorization. However, the member must present a written prescription, to the pharmacy including the quantity to be dispensed. A supply for up to 30-days is covered.
- Injectable medications, administered in the provider's office, such as Depo-Provera will be reimbursed at the MC Fee Schedule, unless otherwise stated in the provider's contract.
- Oral contraceptives are covered for MC members, through Aetna Medicaid Administrators LLC.

13.10 - Behavioral Health Treatment of Attention Deficit Hyperactivity Disorder (ADHD), Anxiety, Depression and/or Opioid Use Disorder (OUD)

PCP Medication Management Services: In addition to treating physical health conditions, MC will allow PCPs to treat behavioral health conditions within their scope of practice. Such treatment shall include but not be limited to substance use disorders, anxiety, depression, and Attention Deficit Hyperactivity Disorder (ADHD). For purposes of medication management, it is not required that the PCP be the member's assigned PCP. PCPs who treat members with these behavioral health conditions may provide medication management services including prescriptions, laboratory and other diagnostic tests necessary for diagnosis, and treatment. For the antipsychotic class of medications, prior authorization may be required.

For PCPs prescribing medications to treat Opioid Use Disorder (OUD), the PCP must refer the member to a behavioral health provider for the psychological and/or behavioral therapy component of the Medication Assisted Treatment (MAT) model and coordinate care with the behavioral health provider.

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Transfer of Care: When a PCP has initiated medication management services for a member to treat a behavioral health disorder, and it is subsequently determined by the PCP that the member should be transferred to behavioral health provider (including RBHA, AIHP, or TRBHA providers) for evaluation and/or continued medication management services, MC requires that the PCP coordinates the transfer of care.

13.13 - Request for Non-PDL Drugs

A physician requesting a change to MC's Preferred Drug List (PDL) should include the following information in the request:

- Basic product information
- Indications for use
- Therapeutic advantage
- Which drug(s) it would replace in the current PDL
- Any supporting literature from medical journals

The requesting physician may be invited to attend the Pharmacy and Therapeutics Committee meeting to support the PDL addition request and answer questions.

Requests should be sent to:

Aetna Medicaid Administrators, LLC
Mercy Care Corporate Pharmacy Director
4500 E. Cotton Center Blvd.
Phoenix, AZ 85040

13.14 – Discarded Physician-Administered Medications

Discarded federally and state reimbursable physician-administered medications shall not be billed to MC. A.A.C. R9-22-209(C) provides that pharmaceutical services are covered only if they are prescribed. The unused portion of a physician administered drug is not covered because it's not medically necessary or prescribed.

A.R.S. §36-2918(A)(1) prohibits a person from making a claim for an item or service that the person knows or has reason to know was not provided as claimed.

A.R.S. §36-2918(A)(3)(b) prohibits a person from submitting a claim for items and services that substantially exceed the needs of the patient.

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MC CHAPTER 14 – QUALITY MANAGEMENT**14.00 - Quality Management Overview**

MC works in partnership with providers to continuously improve the care given to our members. The MC Quality Management (QM) Department is comprised of the following areas:

- The Quality of Care Review unit monitors the quality of care provided by the PHP network, as well as the review and resolution of issues related to the quality of health care services provided to members.
- The Prevention and Wellness unit is responsible for quality improvement activities and clinical studies using data collected from providers and encounters. Findings are reported to AHCCCS and to providers about their performance on specific quality indicators.
- The Credentialing unit is responsible for provider credentialing/re-credentialing activities.
- The Performance Improvement Department monitors and improves HEDIS and other clinical performance measure rates, maternity, family planning and EPSDT quality indicators.

14.01 - Quality Management Plan

A quality management plan is developed each year to guide the efforts of the MC Quality Management (QM) department in accomplishing its goals for the upcoming year. The QM Department works closely with the chief medical officer (CMO) and the MC medical directors on all QM responsibilities. For more information about the MC Quality Management program, or to obtain a written summary of the program, please contact your Provider Relations Consultant/Specialist or call the QM Department at 602-263-3000 or 800-624-3879.

14.02 - Quality of Care, Peer Review and Fair Hearing Process

The QM department reviews potential quality of care (QOC) issues referred by internal and external sources. Applicable medical records are requested from providers as needed for review. The QOC, peer review and fair hearing processes are all confidential. Each QOC issue is assigned a severity level based on potential adverse effect(s) for the member. In addition, cases are trended and reported to the QM/UM Committee. QOC Severity Levels are as follows:

- **Level 0** - No quality of care or utilization issue exists, and no action is needed.
- **Level 1** - Potential for significant adverse effect(s) on the member was not found, no harm or negative outcome occurred, and the risk of further problems is low.
- **Level 2** - Potential for significant adverse effect(s) was evident. Because of the care received or services provided, or because of the omission of care or services, the member required a change in the plan of care or suffered a complication, which caused no major life impact.

GENERAL REQUIREMENTS FOR ALL PLANS

- **Level 3** - Medical management resulted in significant adverse effect(s). Because of the care received or services provided, or omission of care or services, the member suffered a major complication or poor outcome.

14.03 - Escalation Process

All potential QOC issues involving health professionals are forwarded to the CMO or one of the MC medical directors for review. After review, it may be determined that a case should be referred to a specialist for further review. The case is sent to the medical care ombudsman. Program is sent for review by a provider in the same specialty as the subject provider.

If indicated by the evaluation conducted by the MC medical director or specialist review, the QOC case is forwarded to the Executive Session of the QM/Utilization Review (UM) Committee for peer review discussion, final determination and recommendation for action. Health professionals have the right to appeal adverse actions such as termination from MC.

To exercise this option, the appeal process for a fair hearing must be followed. A copy of the peer review/fair hearing policy is available to all providers upon request.

14.04 - Ambulatory Medical Record Review

The purpose of the review is to verify that medical records of contracted family practice, internal medicine, and general practice, obstetric and pediatric physicians comply with established AHCCCS, NCQA, and MC medical record keeping standards. Reviews are completed every three years. In addition, OB/GYN specialists must comply with ACOG standards. Records are reviewed for completeness of documentation, coordination of care and evidence of appropriate health maintenance screenings. QM nurses review the medical records at the physician's office. The steps for conducting a medical records review include:

- Approximately two weeks before a review is scheduled, the office is contacted by telephone to arrange a mutually convenient time for the review.
- A letter or fax is sent further stating when the QM staff will arrive, and which member records should be pulled and ready for review.
- The number of nurses assigned is based on the number of records to be reviewed. The review team will need a private area where they can work.
- A report will be created following the visit. The report will identify trends that were noted, as well as any significant areas that need follow up.
- The report will be sent to the physician's office after the review is completed.
- Physicians with a low score may be asked to provide a quality improvement plan detailing method to improve future service delivery and documentation. Follow-up medical record reviews will be conducted as needed.

GENERAL REQUIREMENTS FOR ALL PLANS

14.05 - Quality Management Studies

MC uses a variety of information sources to conduct quality management studies, including member medical records, claims, prior authorization logs, statistical reports and utilization review reports. As part of the quality improvement process, MC asks its provider network to assist in the collection of medical record information or other information as needed for special studies or reviews. The QM department is managing the following annual clinical studies.

- Reducing hospital readmissions
- Increasing utilization of E-Prescribing

14.06 - Data Collection and Reporting

The QM Department collects data and analyzes MC performance for the following indicators:

- Well-child visits in the first 15 months of life
- Well-child visits for members age 3-6
- EPSDT participation rates
- Childhood immunization (for members 24 months old)
- Adolescent immunization
- Annual dental visits for members age 1-20
- Preventive Dental Care
- Dental Sealant Application
- Children's access to primary care providers
- Adolescent well-care visits
- Cervical cancer screening
- Adult access to preventive/ambulatory health services
- Mammograms
- Diabetes management
- Appropriate Asthma medication
- Chlamydia screening
- Prenatal care
- Postpartum services
- Hospital Readmissions
- PCP follow-up after discharge
- 7 and 30 days follow up after a BH Inpatient discharge
- ED Utilization
- Inpatient Utilization
- Diabetes, COPD and CHF Admissions
- Flu Shots

Clinical indicators are reviewed regularly to monitor progress. Findings and results of studies and surveys are shared with health professionals via newsletters.

GENERAL REQUIREMENTS FOR ALL PLANS

14.07 - Reports

The QM department has developed reports for health professionals on the following topics:

- **Well woman:** A quarterly report of members who need a mammogram, cervical cancer screening or chlamydia screening.
- **Diabetes:** A quarterly report of members diagnosed with diabetes and diabetes-related services rendered during the past 12 months.
- **Immunizations:** A monthly report listing members due for one or more immunizations.
- **Well Child:** A monthly report listing members due for a Well Child visit.
- **HEDIS Star:** A quarterly report listing MCA members in need of one or more of the following services:
 - Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis
 - Breast Cancer Screening
 - Controlling High Blood Pressure
 - Comprehensive Diabetes Care
 - Colorectal Cancer Screening
 - Osteoporosis Management in Women Who Had a Fracture

14.08 - Credentialing/Re-Credentialing

The Credentialing Committee (comprised of both network peer physicians and MC medical directors) reviews all credentialing information and forwards their recommendations to the CMO who presents the information to the Quality Management Oversight Committee and the MC's Board of Directors for a final decision. Providers have the following rights:

- To review their application and information obtained from outside sources, (e.g. state licensing agencies and malpractice carriers) except for references, recommendations or other peer-review protected information.
- To correct erroneous information submitted by another source. MC will notify credentialing applicants if information obtained from other sources (e.g. licensure boards, National Practitioner Data Bank, etc.) varies substantially from that provided by the applicant.

14.09 - Streamlining Process

MC is dedicated to improving and streamlining credentialing processes and timelines for those providers credentialed and re-credentialed directly through MC. In addition, contractual relationships have been developed to delegate credentialing and re-credentialing activities to approved, qualified outside entities throughout the state. This practice has been put into place to decrease the time spent completing multiple credentialing applications for providers belonging to one of these entities, and to ensure a complete and comprehensive network for MC members.

GENERAL REQUIREMENTS FOR ALL PLANS

Providers' credentialed/re-credentialed through a delegated entity must still be approved through the MC Board of Directors prior to providing health care services to members. Providers are re-credentialed every three years and must complete the required reappointment application. Updates of malpractice coverage, state licenses and Drug Enforcement Agency (DEA) certificates, if applicable, are also required. The MC Special Needs Unit (SNU) coordinates care and services with the carve-out programs for MC members enrolled in one or more of the following programs:

- AZ Department of Economic Security, Division of Developmental Disabilities.

MC performs the following activities:

- Assists in resolving coordination of benefit issues.
- Monitors timeliness of services delivered by MC providers.
- Provides information or clarification to parents/guardians and providers.
- Ensures services are provided by the appropriate resource – either MC or carve out program.
- Serve as the MC liaison for the state agencies listed above, and their contractors and DD services.

For members with a developmental disability, activities include coordination of benefits with DES/DDD and private insurance carriers; consultation with other MC departments to ensure that they receive medically necessary services; monitoring the timeliness of service delivery; providing information to members and their parents/guardians and providers; and coordinating with DES/DDD support managers regarding long term care and other services that members are also entitled to receive.

14.10 - Incident, Accident, Death Reporting Processes

The incident, accident, death reporting process is comprised of the following:

- Receipt of an incident, accident, death report form:
All reported events of incident, accident, death reports are submitted by providers into the AHCCCS Quality Management System (QMS) Web Portal system within 48 hours of the occurrence to MC.
- AHCCCS QMS is located the following link:
https://qmportal.azahcccs.gov/WF_Public_Default.aspx

Below is a list of all reportable events that pertain to enrolled members with an open episode of care (EOC), *but not limited to*:

- Deaths
- Medication Error(s)
- Abuse or Neglect Allegation made about/involving staff member(s)

GENERAL REQUIREMENTS FOR ALL PLANS

- Suicide Attempt
- Self-Inflicted Injury
- Injury Requiring Emergency Treatment
- Physical Injury that occurs because of a personal, chemical, or mechanical restraint
- Unauthorized absence from a licensed behavioral health facility, group home or HCTC of children or recipients under court ordered treatment
- Suspected or alleged criminal activity
- Discovery that a client, staff member, or employee has a communicable disease as listed in A.A.C. R9-21, Article 2
- Discrimination
- Exploitation
- Coercion
- Manipulation
- Retaliation for submitting complaint to Authorities
- Threat of discharge/transfer for punishment
- Treatment involving denial of food
- Treatment involving denial of opportunity to sleep
- Treatment involving denial of opportunity to use toilet
- Use of Restraint/Seclusion as retaliation
- Health Care-Acquired and Provider Preventable Conditions as described in the AHCCCS AMPM Chapter 900

Internal Review, Identification and Monitoring of AHCCCS QMS Web Portal System by MCAZ Quality Management:

The Quality Management Department is responsible for reviewing, identifying, and monitoring all reported events of incident, accident and death reporting. The process includes:

- Quality Management Consultant and/or Quality Management Manager reviews AHCCCS QMS web portal system daily for potential quality care of care (QOC) concerns and performs appropriate follow up with contracted providers through triage review and process.
- Incident, Accident, Death events that are identified as QOC concerns are handled and managed via the Quality of Care process. Please refer to the MC Policy 8000.62D QOC Reporting and Monitoring.
- As per AMPM Chapter 900, Policy 960, if an adverse action is taken with a provider for any reason including those related to quality of care concern, MC must report the adverse action to the AHCCCS Clinical Quality Management within 24 hours of the determination to take an adverse action as well as to the National Practitioner Data Bank

GENERAL REQUIREMENTS FOR ALL PLANS

- a) A QOC investigation is opened if the incident, accident, death event includes a reportable:
 - a. Death
 - b. Member Rights Violation
 - c. Safety/Risk Management
 - d. Medication Error
- b) A QOC investigation may also be opened if an incident, accident, death event presents a concern/issue that appears to have the potential of precipitating into one of the following categories:
 - a. Abuse
 - b. Availability, Accessibility, Adequacy
 - c. Denial, Decrease, or Discontinuation of a Covered Benefit(s)
 - d. Effectiveness/Appropriateness of Care
 - e. Hospital Acquired Conditions
- Incident, Accident, Death events that *are not* identified as a QOC concern and do not meet QOC criteria are closed out with no further action and documented as such within the AHCCCS QMS web portal system.

The Quality Management Department is responsible for producing trend reports from the AHCCCS Quality Management System (QMS) web portal data system and to track and evaluate providers, and:

- If significant negative trends are noted, the Quality Management Department may recommend the topic for one of its performance improvement activities to improve the process, and to make improvements that address other system issues raised in the resolution process. The case may also be reviewed by the Quality Management Committee
- All Incident, Accident, Death events are redacted in the AHCCCS QMS web portal system with an additional review and manual redaction by a QM designee to ensure all member information is protected. These IAD reports are then submitted weekly via the AHCCCS QMS web portal system to the Maricopa Human Rights Committee by COB every Friday.

Notifications**External**

- AHCCCS Quality Management Department is notified via the AHCCCS QMS web portal system of:
 - a) All Incident, Accident, Death event closures
 - b) All Incident, Accident, Death events that meet the QOC process criteria and are opened as a QOC

GENERAL REQUIREMENTS FOR ALL PLANS

- Any significant or egregious incident, accident, death events are reported to AHCCCS Quality Management Department on the same day of reported incident by the Quality Management Manager

Internal

- Any significant or egregious incident, accident, death events that are reported to the MC Chief Medical Officer, Quality Management Manager and Quality Management Administrator.

Reporting

- Maricopa Human Rights Committee weekly submission due on every Friday COB
- AHCCCS Quality Management weekly QOC report indicating which incident, accident, death events were opened as a quality of care concern

GENERAL REQUIREMENTS FOR ALL PLANS

MC CHAPTER 15 – PARTNERSHIP REQUIREMENTS WITH FAMILIES AND FAMILY-RUN ORGANIZATIONS

15.00 – Peer and Family Support Services

Peer and family services are a vital part of member- and family-centered care. When you put a member and their family at the center of their care, the individual's voice is strengthened, and recovery and resiliency can remain the primary focus for all involved in the care for loved ones experiencing mental illness.

Peer and family support services usually operate in conjunction with clinical services which amplify the benefits of treatment by engaging peers in services they might otherwise not accept, offering ongoing support and psychosocial rehabilitation, and encouraging peers to stay in treatment and services by sharing their stories of recovery.

Peer and family support services are a valuable addition to traditional care, and these services are known to contribute to improved outcomes in employment, education, housing stability, satisfaction, self-esteem, medication adherence, and decrease in the need for more costly services, such as hospitalizations. Peer-provided services help to foster recovery, increase treatment and service engagement, reduce acute care use, and improve quality of life.

Peer and family services are available to all Mercy RBHA Title 19 and Non-Title 19 members and their families within the clinic setting as well as at community-based service organizations. Based on member's choice and/or if peer and/or family support services is not available in the clinic where services are provided, a referral is needed prior to engaging in these supportive services.

15.01 – Incorporating Peer and Family Voice and Choice in Integrated Care Service Delivery *Advisory Councils*

All providers must establish and maintain an Advisory Council made up of individuals receiving services at that provider clinic, direct service staff, clinic leadership, and relevant community members/neighbors.

The purpose of the Advisory Council is to provide a formal structure and process for individuals receiving services and their family members or loved ones to participate in organizational decision making and to have regular dialogue with clinic leaders. The Council provides an opportunity for individuals and their family members, direct clinic staff and vested community members to participate and be involved in improving the delivery of services, improving the environment in which services are provided, and enhancing customer service.

GENERAL REQUIREMENTS FOR ALL PLANS

Leadership for the council members consists of a chair-member, a co-chair-member, and a meeting minute/note taker all of which should be individuals receiving services or family members/loved ones.

Advisory Councils will meet monthly for a minimum of one hour. The agenda must allot time for the members/family members or loved ones to voice their concerns and ideas regarding the clinic. This venue can be utilized for educational opportunities on access to services by inviting guest speakers from various providers.

Monthly meeting minutes need to be taken and posted in the clinic lobby for public consumption and comment as well as retained and distributed to Mercy RBHA, Office of Individual and Family Affairs (OIFA) representative along with agendas and sign-in sheets monthly.

Advisory Councils will be entrusted with the responsibility of reviewing member feedback and making recommendations for continuous improvement to the provider leadership. Provider leadership is expected to attend Advisory Council meetings as invited by the Council chair.

When applicable, the Mercy RBHA OIFA will assist the council to implement actions, solutions or requests developed at the meetings. OIFA will be available to the Advisory Councils for assistance, as well as participate in the meetings, when appropriate.

Peer, Youth and Family Engagement and Participation Committee Involvement and Participation

Mercy RBHA encourages all members and their families to become involved in a way that is comfortable to them and allows them to voice concerns, provide input, make recommendations, and participate in decision-making. All committee participants will be provided with a description of their rights, roles and responsibilities as described below.

Individual and Family Rights

- Participate in dialogue and discussions as an equal participant;
- Have input valued and respected by other committee member and participants;
- Receive information in a time frame that allows for the review of materials prior to the meeting;
- Receive adequate notice of scheduled meetings;
- Have questions answered in a respectful manner;
- Have opportunities to attend trainings on their roles and responsibilities, reviewing data, or other topics that will support their meaningful participation on the committee;
- Make recommendations that are equally considered by the committee;
- Participate in workgroups or subcommittees, as needed and appropriate;
- Participate equally in decision-making by the committee; and

GENERAL REQUIREMENTS FOR ALL PLANS

- Have access to a Mercy RBHA staff member to support their participation in the committee through coaching and technical assistance.

Peer, Youth and Family Roles

- Participate in the review of all quality improvement measures and performance indicators;
- Participate in the review of community facing educational and marketing materials;
- Participate in monitoring service delivery and development;
- Provide input on the quality of services provided to the community;
- Assist in identifying gaps in services;
- Identify community needs and work with committee members to develop recommendations to fill those needs;
- As a committee participant, submit to the Mercy RBHA Governance Committee recommendations regarding ways to improve the delivery of mental health and substance use services;
- Provide advice and consultation regarding development of new models of service delivery;
- Observe, report, and participate in strategic planning; and
- Share insights and information about their experiences in ways that others can learn from them.

Peer, Youth and Family Responsibilities

- Participate in scheduled trainings;
- Attend meetings;
- Inform the committee lead if unable to attend a meeting;
- Stay informed about issues impacting the behavioral health delivery system
- Review all materials presented within specified time frames;
- Provide thoughtful input;
- Work toward fulfilling the committee/workgroup's objectives;
- Carry out individual assignments within specified timeframes;
- Focus on the best interests of the behavioral health delivery system;
- Consult with consumers, providers and RBHA staff to develop a better understanding of differing viewpoints, as well as the potential impact of service proposals on the greater community;
- Deal with one another and the greater community in ways that respect the dignity and worth of all members; and
- Encourage communication that clarifies intent

GENERAL REQUIREMENTS FOR ALL PLANS

Engagement and Involvement of Members and Family Members in Service Planning and Delivery

To ensure the inclusion of peer and family members, Mercy RBHA's contracted service providers are responsible for carrying out the activities that comprise effective engagement and involvement of members and family members in service planning and service delivery. The contracted providers are responsible for facilitating the building of rapport and encouragement of individuals to include others, such as family members, relatives, and other natural supports in the process.

Behavioral health services will be done in an effective and recovery-oriented fashion and delivered through a strengths-based assessment and service planning approach. The model incorporates the concept of a "team", established for each member receiving behavioral health services.

For children, this team is the Child and Family Team (CFT) and for adults, this team is the Adult Recovery Team (ART). At a minimum, the functions of the Child and Family Team and Adult Recovery Team include initial and ongoing engagement of the member, family and others who are significant in meeting the behavioral health needs of the member, including their active participation in the decision-making process and involvement in treatment.

The team process emphasizes a family friendly, culturally sensitive and clinically sound model that focuses on identification of the member and family strengths. The process includes engagement and input from those members being served, as well as their family and significant others, and focuses on identifying the member's and team member's preferences.

Mercy RBHA requires the following from subcontractors and providers:

- The ability to welcome and engage family members in the member's service planning and service delivery as full partners in the planning, delivery and evaluation of services and supports;
- Demonstration of the ability to include family members viewpoint in the service planning and service delivery processes;
- Encourage and engage family members to participate, be active and respected as part of the member's team;
- During the assessment process, establish that the service assessment and service planning process is viewed as a partnership and is a team approach;
- During the Individual Service Plan (ISP) development, the assessor will identify the unique strengths, needs and preferences of the member, family/caregiver and identified team members. The needs (and associated services) identified in the ISP will be tailored to the unique strengths, values and beliefs of each individual member and their family, and will be updated as members progress toward recovery and their goals evolve;
 - All Individual Service Planning (ISP) and development with children is completed collaboratively with the child's parent and/or primary caregiver;

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- Development and prioritization of ISP goals are not focused solely on the child, but include the parent, caregiver and the needs of the family as a whole;
- All ISP should consider the inclusion of community and natural supports;
- Providers are required to adhere to [AHCCCS Clinical Guidance Tool Family and Youth Involvement in the Children's Behavioral Health System](#).
- Provide support to family members to assist in eliminating barriers preventing them from actively participating on the member's team, and;
- Establish a mechanism that will provide family support be accessible to families to help engage the family and to help the individual best utilize their natural support network;
- Establish partnerships with peer-run and family-run organizations to co-facilitate trainings on peer and family-professional partnerships, and;
- Partner with peer and family-run organizations in the delivery of training on peer-to-peer and family-to-family roles for Peer and Parent/Family Support Provider roles employed in the system.

Mercy RBHA requires providers to demonstrate documentary evidence to show participation of at least one peer, youth or family during the interview process when hiring for all direct services staff positions. Mercy RBHA requires affiliated RBHA providers to have at least one peer/recovery support specialist assigned on each adult recovery team.

GENERAL REQUIREMENTS FOR ALL PLANS

MC CHAPTER 16 – REFERRALS AND AUTHORIZATIONS**16.00 - Referral Overview**

It may be necessary for a MC member to be referred to another provider for medically necessary services that are beyond the scope of the member's PCP. For those services, providers only need to complete their own Referral Form and refer the member to the appropriate MC PHP. MC's website includes a provider search function for your convenience. More information is available in this Provider Manual under section **MC Chapter 4 – Provider Requirements, Section 4.40 – Mercy Care Web Portal** concerning prior authorizations.

There are two types of referrals:

- Participating providers (particularly the member's PCP) may refer members for specific covered services to other practitioners or medical specialists, allied healthcare professionals, medical facilities, or ancillary service providers.
- Member may self-refer to certain medical specialists for specific services, such as an OB/GYN.

Referrals must meet the following conditions:

- The referral must be requested by a participating provider and be in accordance with the requirements of the member's benefiting plan (covered benefit).
- The member must be enrolled in MC on the date of service(s) and eligible to receive the service.

If MC's network does not have a PHP to perform the requested services, members may be referred to out of network providers if:

- The services required are not available within the MC network.
- MC prior authorizes the services.

If out of network services are not prior authorized, the referring and servicing providers may be responsible for the cost of the service. The member may not be billed if the provider fails to follow MC's policies. Both referring and receiving providers must comply with MC policies, documents, and requirements that govern referrals (paper or electronic) including prior authorization. Failure to comply may result in delay in care for the member, a delay or denial of reimbursement or costs associated with the referral being changed to the referring provider. Referrals are a means of communication between two providers servicing the same member. Although MC encourages the use of a Referral Form, it is recognized that some providers use telephone calls and other types of communication to coordinate the member's medical care. This is acceptable to MC, if the communication between providers is documented and maintained in the members' medical records.

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16.01 - Referring Provider's Responsibilities

- Confirm that the required service is covered under the member's benefit plan prior to referring the member.
- Confirm that the receiving provider is contracted with MC.
- Obtain prior authorization for services that require prior authorization or are performed by a non-PHP.
- Complete a Referral Form and mail or fax the referral to the receiving provider.

16.02 - Receiving Provider's Responsibilities

PHPs may render services to members for services that do not require prior authorization and that the provider has received a completed MC referral form (or has documented the referral in the member's medical record). The provider rendering services based on the referral is responsible to:

- Schedule and deliver the medically necessary services in compliance with MC's requirements and standards related to appointment availability.
- Verify the member's enrollment and eligibility for the date of service. If the member is not enrolled with MC on the date of service, MC will not render payment regardless of referral or prior authorization status.
- Verify that the service is covered under the member's benefit plan.
- Verify that the prior authorization has been obtained, if applicable, and includes the prior authorization number on the claim when submitted for payment.
- Inform the referring provider of the consultation or service by sending a report and applicable medical records to allow the referring provider to continue the member's care.

16.03 - Period of Referral

Unless otherwise stated in a PHP's contract or MC documents, a referral is valid for the full extent of the member's care starting from the date it is signed and dated by the referring provider, if the member is enrolled and eligible with MC on the date of service.

16.04 - Maternity Referrals

Referrals to Maternity Care Health Practitioners may occur in two ways:

- A pregnant MC member may self-refer to any MC contracted Maternity Care Practitioner.
- The PCP may refer pregnant members to a MC contracted Maternity Care Practitioner.

At a minimum, Maternity Care Practitioners must adhere to the following guidelines:

- Coordinate the members maternity care needs until completion of the postpartum visits.
- Schedule a minimum of one postpartum visit at approximately six weeks postpartum.

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- When necessary, refer members to other practitioners in accordance with the MC referral policies and procedures.
- Schedule return visits for members with uncomplicated pregnancies consistent with the American College of Obstetrics and Gynecology standards:
 - Through twenty-eight weeks of gestation – every four weeks
 - Between twenty-nine- and thirty-six-weeks' gestation every two weeks
 - After the thirty sixth week – once a week
 - Schedule first-time appointments within the required time frames
 - Members in first trimester – within seven calendar days
 - Members in third trimester – within three calendar days
 - High-risk Members – within three calendar days of identification or immediately when an emergency condition exists.

16.05 - Ancillary Referrals

All practitioners and providers must use and/or refer to MC contracted ancillary providers.

16.06 - Member Self-Referrals

MC members can self-refer to participating providers for the following covered services:

- Family Planning Services
- OB Services
- GYN Services
- Dental Services for Members Under Age 21
- Vision services for Members Under Age 21
- Behavioral Health Services

When a member self refers for any of the above services, providers rendering services must adhere to the same referral requirements as described above.

16.07 - Prior Authorization

MC requires prior authorization for select acute outpatient services and planned hospital admissions. Prior authorization is not required for the following:

- Emergency services
- Prior authorization is no longer required for observation, due to the change in pricing at APR-DRG.
- Both participating and non-participating facility services for the following obstetrical services:
 - OB Observation
 - Vaginal Delivery if stay is no longer than 48 hours
 - Cesarean delivery if the stay is no longer than 96 hours

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Prior authorization guidelines are reviewed and updated regularly. To request an authorization, to find out what requires authorization, or check on the status of an authorization, please visit Mercy Care Web Portal. More information is available in this Provider Manual under section **MC Chapter 4 – Provider Requirements, Section 4.40 – Mercy Care Web Portal** concerning authorizations. You may also call our Prior Authorization department at 602-263-3000 or 800-624-3879 (toll-free).

Mercy Care has recently reduced the amount of services that require prior authorization. To review codes that require prior authorization, please click on the following links by line of business:

- **Mercy Care Prior Authorization Codes**
- **Mercy Care RBHA Prior Authorization Codes**
- **GMH/SU & Non-title Services Prior Authorization Codes**

In addition, we also provide a **Prior Authorization Code Changes – FAQ**. We are in the process of updating a centralized listing through our ProPat tool. In the meantime, you can use the attached listings.

16.08 - Types of Requests

- **Expedited Service Authorization Request:** A request for services in which either the requesting provider indicates, or the MC determines that following the standard timeframes for issuing an authorization decision could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. In these circumstances, the authorization decision must be expedited and must be made within 72 hours from the date of receipt of the service request. If the due date for an expedited authorization decision falls on a weekend (Saturday and Sunday) or legal holiday as defined by the State of Arizona, the expedited decision must be made on the day preceding the weekend or holiday.
- **Expedited Authorization Request Downgraded to a Standard Request:** When MC receives an expedited request for a service authorization and the requested service is not of an expedited medical nature, the MC will downgrade the expedited authorization request to a standard request.
- **Standard Service Authorization Request:** A request from the member, the representative, or a provider for a service for the member. The authorization decision must be made within 14 calendar days from the date of receipt of the service request.

16.09 – Medical Prior Authorization

The Prior Authorization team is responsible for processing prior authorization requests for non-emergency, elective procedures and services that are in our prior authorization code list, referenced above.

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16.10 – Complex Radiology Service Authorizations

eviCore healthcare administers prior authorization services for complex radiology services for MC. Services requiring authorization but performed without authorization may be denied for payment, and you may not seek reimbursement from members.

Prior authorization is required for the following complex radiology services:

- CT/CTA
- MRI/MRA
- PET

Services performed in conjunction with an inpatient stay, observation, or emergency room visit are not subject to authorization requirements.

To request an authorization from eviCore healthcare, please submit your request online, by phone or by fax to:

- Log onto the [eviCore healthcare Online Web Portal](#).
- Call eviCore healthcare at 888-693-3211.
- Fax an **eviCore healthcare Request Form** (available online at the eviCore healthcare Online Web Portal) to 888-693-3210.

For urgent requests: If services are required in less than 48 hours due to medically urgent conditions, please call eviCore healthcare's toll-free number for expedited authorization reviews. Be sure to tell the representative the authorization is for medically urgent care. eviCore healthcare recommends that ordering physicians secure authorizations and pass the authorization numbers to the rendering facilities at the time of scheduling. eviCore healthcare will communicate authorization decisions by fax to both the ordering physicians and requested facilities. Authorizations contain authorization numbers and one or more CPT codes specific to the services authorized. If the service requested is different than what is authorized, the rendering facility must contact eviCore healthcare for review and authorization prior to claim submission.

16.11 – Bariatric Surgery Approval Process

Bariatric surgery is covered by MC if there are evidence-based criteria to support the need for the surgery. The following information must be documented and met:

- Certificate of Seminar Attendance and class attendance.
- 2 years of medical records (must include documented weight history) and if possible a monthly summary.
- A BMI of 35 or greater, along with one comorbidity.

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- Six-month physician supervised diet. It must be consecutive and within the last two years. Each monthly visit must be documented and signed by the physician. For your convenience, MC has a **Bariatric Surgery Monthly Summary Form** on our [Forms](#) web page that must be filled out. This form is available under the Forms section of our website or by clicking on the link. Documentation includes:
 - The date the patient was seen
 - The patient's weight
 - Detailed documentation of the weight loss program the patient is following, including progress or non-progress
 - The patient's BMI
 - Exercise activity (increase/decrease). If there is an inability to exercise this must be documented as to why
 - A Food/Exercise journal must be reviewed on monthly visits with the PCP
 - Letter of recommendation from the Primary Care Physician documenting medical necessity.
 - One consultation of a Nutritionist or Dietician, as soon as possible.
 - Psychological Evaluations (including MMPI) are only necessary for a patient who has an established behavioral health diagnosis. It is recommended this be completed by the fourth month into the program. A behavioral health condition may be exacerbated or may interfere with the long-term management of the patient after the procedure.
 - Cardiac clearance and pulmonary clearance are recommended for patients. MC requires the actual test results and a letter stating that the patient is cleared for surgery by the Cardiologist and the Pulmonologist, respectively.

MC maintains a list of approved Bariatric Surgeons to conduct the surgery, Nutritionist/Dieticians to provide nutritional counseling, as well as contracted psychologists to provide evaluations for bariatric surgery (only if the patient has an existing behavioral health diagnosis). Please contact our prior authorization department to get a list.

Member steps for approval requirements for bariatric surgery are as follows:

- Attend Bariatric seminar of surgeon of choice
- Obtain a referral to a Bariatric surgeon.
- Start requirements with monthly documentation of diet/exercise with primary care doctor (six consecutive months).
- Obtain a referral to dietician/nutritionist (as soon as possible after seminar and consult with surgeon).
- Start food/exercise journal as soon as possible, documenting everything (and how much) the patient eats and drinks, daily. The amount of exercise and type must be tracked as well. Members should discuss with their PCP at their monthly visit and results should be documented in the PCP's notes. The PCP's notes are the notes reviewed by MC.

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- Fourth month into program, obtain referrals for clearances to the Psychologist (if needed based on an existing behavioral health diagnosis), Cardiology and Pulmonary physicians.
- Support groups are recommended (all surgeons have their own groups). Members will need to find their own transportation. MC will transport to first meeting only,
- The PCP writes all referrals.
- When all requirements are completed, the member will have documenting PCP send the six months of documentation, including clearances and past medical history to the bariatric surgeon.
- The process of getting the paperwork reviewed and signed by the surgeon to send to health plan may take several weeks.

16.12 - Pharmacy Prior Authorization

The Pharmacy Prior Authorization team is responsible for processing prior authorization requests for the following:

- Medications not included in the MC's PDL, also referred to as a formulary.
- Medications that require prior authorization.
- Step Therapy medications.
- Medications with Quantity Limits.

A team of registered pharmacists and certified pharmacy technicians authorize based on a set of pre-established clinical guidelines. Refer to **Chapter 14 – Pharmacy Management** in this Provider Manual for additional information.

16.13 - Nutritional Assessment and Nutritional Therapy

MC covers nutritional assessment and nutritional therapy for members over 21 on an enteral, parenteral or oral basis when determined medically necessary to provide either complete daily dietary requirements, or to supplement a member's daily nutritional and caloric intake.

The following requirements apply:

- Must be assessed at each visit.
- Members in need of nutritional assessment or nutritional therapy should be identified and referred to a registered dietician in MC's network.
- Members in need of nutritional supplements may be referred to Option 1 Nutrition Solutions, LLC, MC's contracted DME provider for these services.
- Nutritional therapy requires prior authorization and approval by MC. To determine prior authorization, MC requires the AHCCCS **Attachment C – Certificate of Medical Necessity for Commercial Oral Nutritional Supplements for Members 21 Years of Age or Greater – Initial or Ongoing Request** form, along with clinical notes, supporting documentation and evidence of required criteria as indicated in the Certificate of Medical Necessity be sent to Option 1 Nutrition Solutions, LLC. Their fax number is 480-883-1193. Option 1 will contact MC to request prior authorization.

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For detailed information regarding Nutritional Assessment and Nutritional Therapy, please refer to the

[AHCCCS Medical Policy Manual \(AMPM\), Chapter 300 - 310-GG Nutritional Assessments and Nutritional Therapy.](#)

16.14 – Metabolic Medical Foods

Members who have been diagnosed with the following genetic metabolic conditions and who need metabolic medical foods may receive services through their genetics provider. MC covers medical foods, within the limitations specified in the [AHCCCS Medical Policy Manual, \(AMPM\), Chapter 300 – 320-H Metabolic Medical Foods](#), for any member diagnosed with one of the following inherited metabolic conditions:

- Phenylketonuria
- Homocystinuria
- Maple Syrup Urine Disease
- Galactosemia (requires soy formula)
- Beta Keto-Thiolase Deficiency
- Citrullinemia
- Glutaric Acidemia Type I
- Methylcrotonyl CoA Carboxylase Deficiency
- Isovaleric Acidemia
- Methylmalonic Acidemia

16.15 - Extensions and Denials

If MC requires additional clinical documentation to decide on the prior authorization request, MC will extend the turnaround time for an additional fourteen (14) calendar days. MC will notify the provider and member of this extension and detail the request for additional documentation. If the requested supporting documentation is not received within the requested timeframe, MC may deny the request for prior authorization on the date that the timeframe expires.

16.16 - Prior Authorization and Referrals for Services

- **Laboratory Services and Referrals:** Prior authorization is NOT required for approved in office lab procedures that are on MC's in office labs code list. MC is contracted with Sonora Quest to provide laboratory services. Please refer to our Claims Processing Manual on our Claims Information web page under Chapter 2 – Professional Claim Types by Specialty, Section 2.0 – Laboratory for a listing of MC's in office labs code list.
- **Radiology Services Referrals:** Prior authorization IS required before referring members for certain radiology services. To request an authorization, find out what requires authorization or check on the status of an authorization, please visit Mercy Care Web Portal.
- **Infusion or Enteral Therapy Referrals:** Prior authorization is NOT required to refer members to a contracted infusion or enteral provider. However, any medically

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necessary services rendered by an infusion, enteral provider or through a home health agency must be prior authorized. All infusion medications must be processed through the MC PBM (Pharmacy Benefit Manager) pharmacy benefit. Referrals may be processed through the PBM. All enteral needs are processed through the nutritional therapy contracted provider for MC and comply with medical necessity criteria.

- **Durable Medical Equipment (DME) Referrals:** Prior authorization is NOT required to refer members to a contracted DME provider. However, certain services may require prior authorization, as indicated in the provider's contract.
- **DES/DDD Prior Authorization:** Prior authorization IS required. For members enrolled in the Department of Economic Security, Division of Developmental Disabilities (DES/DDD) health professionals must obtain prior authorization from MC by faxing your request to 602-431-7155. Final determination will be made by the DES/DDD medical director prior to providing sterilization procedures for members enrolled with DES/DDD, in addition to Aetna Medicaid Administrators LLC. Notification of approved requests will be faxed or mailed to the provider.

16.17 - Prior Authorization and Coordination of Benefits

If other insurance is the primary payer before MC, prior authorization of a service is not required, unless it is known that the service provided is not covered by the primary payer. If the service is not covered by the primary payer, the provider must follow MC's prior authorization rules.

16.18 - Prior Authorization Contacts**Inpatient Hospital and Hospice Services**

Fax: 800-217-9345

Pharmacy Prior Authorization

Fax: 800-854-7614 (Toll Free)

Behavioral Health

Fax: 1-855-825-3165

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MC CHAPTER 17 – BILLING ENCOUNTERS AND CLAIMS

17.00 - Billing Encounters and Claims Overview

The MC Claims department is responsible for claims, resubmissions, claims inquiry/research and provider encounter submissions to AHCCCS.

All providers who participate with MC must first register with AHCCCS to obtain an AHCCCS Provider Identification Number. Please contact AHCCCS directly for this number. Once you have obtained your 6-digit AHCCCS provider ID, notify Provider Relations.

Billing**17.01 - When to Bill a Member**

A member may be billed when the member knowingly receives non-covered services.

- Provider **MUST** notify the member in advance of the charges.
- Provider should have the member sign a statement agreeing to pay for the services and place the document in the member's medical record.

MC members may **NOT** be billed for covered services or for services not reimbursed due to the failure of the provider to comply with MC's prior authorization or billing requirements. Please refer to *Arizona Revised Statute A.R.S. §36-2903.01 (L) and Administrative Codes R9-22-702, R9-27-702, R9-28-702, R9-30-702 I and R9-31-702* for additional information. Arizona Administrative Code R9-22-702 states in part, "an AHCCCS registered provider shall not do either of the following, unless services are not covered or without first receiving verification from the Administration [AHCCCS] that the person was not an eligible person on the date of service:

1. Charge, submit a claim to, or demand or collect payment from a person claiming to be AHCCCS eligible; or
2. Refer or report a person claiming to be an eligible person to a collection agency or credit reporting agency"

MC members should not be billed or reported to a collection agency for any covered services your office provides.

Provider may **NOT** collect copayments, coinsurance or deductibles from members with other insurance, whether it is Medicare, a Medicare HMO or a commercial carrier. Providers must bill MC for these amounts and MC will coordinate benefits. Unless otherwise stated in contract, MC adjudicates payment using the lesser of methodology and members may not be billed for any remaining balances due to the lesser of methodology calculation.

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17.02 - Prior Period Coverage

On occasion, AHCCCS eligible members are enrolled retrospectively into MC. The retrospective enrollment is referred to as Prior Period of Coverage (PPC). Members may have received services during PPC and MC is responsible for payment of covered services that were received.

For services rendered to the member during PPC, the provider must submit PPC claims to MC for payment of covered benefits. The provider must promptly refund, in full, any payments made by the member for covered services during the PPC period.

While prior authorization is not required for PPC services, MC may, at its discretion, retroactively review medical records to determine medical necessity. If such services are deemed not medically necessary, MC reserves the right to recoup payment, in full, from the provider. The provider may not bill the member.

Encounters

17.03 - Encounter Overview

An encounter is a record of an episode of care indicating medically necessary services provided to an enrolled member. To comply with federal reporting requirements, AHCCCS requires the submission of claims and encounters for all services provided to enrolled members. Fines and penalties are levied against MC for failure to correctly report encounters in a timely manner. MC may pass along these financial sanctions to a provider that fails to comply with encounter submissions.

17.04 - When to File an Encounter

Encounters should be filed for **all** services provided, even those that are capitated. MC uses the encounter information to determine if care requirements have been met and establish rate adjustments.

17.05 - How to File an Encounter

To comply with federal reporting requirements, the AHCCCS Administration conducts program integrity studies on a random sample of members' medical records to compare recorded utilization information with submitted encounter data. The study evaluates the correctness or omission of encounter data. It is imperative that claims and encounters are submitted with correct procedure and diagnosis coding, and that the codes entered on the claim correspond to the actual services provided as evidenced in the member's medical record.

Services rendered must also coincide with the category of service listed on the provider record with AHCCCS. If services do not coincide, claims will be reversed, and monies recouped. If providers do not properly report all encounters, MC may be assessed monetary penalties for

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noncompliance with encounter submission standards. We may then pass these financial sanctions on to providers or terminate contracts with providers who are not complying with these standards.

Claims**17.06 - When to File a Claim**

All claims and encounters must be reported to MC, including prepaid services.

17.07 - Timely Filing of Claim Submissions

Unless a contract specifies otherwise, MC ensures that for each form type (Dental/Professional/Institutional) 95% of all clean claims are adjudicated within 30 days of receipt of the clean claim and 99% are adjudicated within 60 days of receipt of the clean claim.

MC shall not pay:

- Claims initially submitted more than six months after date of service for which payment is claimed or after the date that eligibility is posted, whichever date is later; or
- Claims that are submitted as clean claims more than 12 months after date of service for which payment is claimed or after the date that eligibility is posted, whichever date is later (A.R.S. §36-2904.G).

Regardless of any subcontract with MC, when one AHCCCS Contractor recoups a claim because the claim is the payment responsibility of another AHCCCS Contractor (responsible Contractor); the provider may file a claim for payment with the responsible Contractor. The provider must submit a clean claim to the responsible Contractor no later than:

- 60 days from the date of the recoupment,
- 12 months from the date of service, or
- 12 months from date that eligibility is posted, whichever date is later.

The responsible Contractor shall not deny a claim based on lack of timely filing if the provider submits the claim within the timeframes above.

Claim payment requirements pertain to both contracted and non-contracted providers.

17.08 - MC as Secondary Insurer

MC is the payer of last resort. It is critical that you identify any other available insurance coverage for the patient and bill the other insurance as primary. For example, if Medicare is primary and MC is secondary.

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- File an initial claim with MC if you have not received payment or denial from the other insurer before the expiration of your required filing limit. Make sure you are submitting timely to preserve your claim dispute rights.
- Upon the receipt of payment or denial by the other insurer, you should then submit your claim to MC, showing the other insurer payment amount or denial reason, if applicable, and enclosing a complete legible copy of the remittance advice or Explanation of Benefits (EOB) from the other insurer.
- When a member has other health insurance, such as Medicare, a Medicare HMO or a commercial carrier, MC will coordinate payment of benefits.
- In accordance with requirements of the Balanced Budget Act of 1997, MC will pay co-payments, deductibles and/or coinsurance for AHCCCS Covered Services up to the lower of either MC's fee schedule or the Medicare/other insurance allowed amount.

Claims should be initially submitted within 180 days from the date of service for a first submission to retain appeal rights, whether the other insurance explanation of benefits has been received or not.

Claims should be resubmitted within one year from the last date of service or 60 days from the date of the other insurance explanation of benefits, whichever is later, once the other insurance explanation of benefits is received.

17.09 - Dual Eligibility MCA Cost Sharing and Coordination of Benefits

Coordinating MCA Benefits with Mercy Care (except for Mercy Care RBHA)– For MCA members enrolled in both Mercy Care (either Mercy Care Complete Care, Mercy Care Long Term Care and Division of Developmental Disabilities lines of business) and MCA, any cost sharing responsibilities will be coordinated between the two payers. For the most part, providers only need to submit one claim to Mercy Care. Once the claim has been paid by Mercy Care Advantage, the claims payment information will cross over to Mercy Care and benefits will be automatically coordinated. There may be exceptions to this, which are covered in this chapter under the section titled **Instruction for Specific Claim Types**.

Coordinating MCA Benefits with Mercy Care RBHA – For MCA members enrolled in both Mercy Care RBHA and MCA, any cost sharing responsibilities will be coordinated between the two payers. Once the claim has been paid by Mercy Care Advantage, a remit will be sent to the provider. Mercy Care RBHA follows the CMS COBA process. Unfortunately, this may involve delays in getting the claims to cross-over to Mercy Care RBHA to coordinate benefits. To expedite claims payment, we recommend that the provider submit the MCA Explanation of Benefits, along with the claim, to Mercy Care RBHA. This will allow benefits to be coordinated quicker.

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As a reminder, Medicaid is the payer of last resort. It's very important to verify eligibility on all plans the member may be covered under to determine who the claim should be sent to and how the claim should coordinate.

17.10 - Injuries due to an Accident

In the event the member is being treated for injuries suffered in an accident, the date of the accident should be included on the claim for MC to investigate the possibility of recovery from any third-party liability source. This is particularly important in cases involving work-related injuries or injuries sustained as the result of a motor vehicle accident.

17.11 - How to File a Claim

- 1) Select the appropriate claim form (refer to table below).

<u>Service</u>	<u>Claim Form Type</u>
Medical and Professional Services	Form 1500 (02-12)
Family Planning Services – Medical	Form 1500 (02-12)
Family Planning Service – Hospital Inpatient	CMS UB-04 Form
Family Planning Service - Outpatient or Emergency Obstetrical Care	Form 1500 (02-12)
Obstetrical Care	Form 1500 (02-12)
Hospital Inpatient, Outpatient, Skilled Nursing Facility and Emergency Room Services	CMS UB-04 Form
General Dental Services for Mercy Care RBHA Only	ADA 2006 Claim Form (02/12)/837D
Dental Services that are Considered Medical Services (Oral Surgery, Anesthesia)	Form 1500 (02-12)

Instructions on how to fill out the each of the claim forms can be found in our Claims Processing Manual, available on our [Claims Information](#) web page or in the AHCCCS Fee For Service Manual, as follows:

- [Form 1500 \(02-12\) Completion Instructions](#)
- [UB-04 \(CMS 1450\) Form Completion Instructions](#)
- [ADA Dental Claim Form Completion Instructions](#)

- 2) Complete the claim form.

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- a) Claims must be legible and suitable for imaging and/or microfilming for permanent record retention. Complete ALL required fields and include additional documentation when necessary.
 - b) The claim form may be returned unprocessed (unaccepted) if illegible or poor-quality copies are submitted or required documentation is missing. This could result in the claim being denied for untimely filing.
- 3) Submit **original** copies of claims electronically or through the mail (do NOT fax or hand-deliver). To include supporting documentation, such as members' medical records, clearly label and send to the Claims department at the correct address.
- a) Electronic Clearing House - Providers who are contracted with MC can use electronic billing software. Electronic billing ensures faster processing and payment of claims, eliminates the cost of sending paper claims, allows tracking of each claim sent and minimizes clerical data entry errors. Additionally, a Level Two report is provided to your vendor, which is the only accepted proof of timely filing for electronic claims.
 - The EDI vendors that MC uses are as follows:
 - Change Healthcare
 - SPSI
 - SSI
 - Contact your software vendor directly for further questions about your electronic billing.
 - Contact your Network Relations Specialist/Consultant for more information about electronic billing.

Additional information can be attained by reviewing MC's **Claims Processing Manual** available on our [Claims Information](#) web page, **Chapter 1 – General Claims Processing Information, Section 1.3 – Electronic Tools and Mercy Care Web Portal**.

All electronic submission shall be submitted in compliance with applicable law including HIPAA regulations and MC policies and procedures.

b) Through the Mail

<u>Claim Address Table</u>		
<u>Claims</u>	<u>Mail To</u>	<u>Electronic Submission*</u>
<u>Medical</u>		
Mercy Care Complete Care and Mercy Care Long Term Care	Mercy Care Claims Department	Through Electronic Clearinghouse

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P.O. Box 52089
Phoenix, AZ 85072-2089

Mercy Care RBHA

Mercy Care RBHA
Claims Department
P.O. Box 64835
Phoenix, AZ 85082-4835

Through Electronic
Clearinghouse
Payer ID: 33628

Dental

**Mercy Care Complete Care and
Mercy Care Long Term Care**

DentaQuest of Arizona, LLC
Attention: Claims
P.O. Box 2906
Milwaukee, WI 53201-2906

Through DentaQuest
Electronic Clearinghouse

Mercy Care RBHA

Mercy Care RBHA
Dental Claims Department
P.O. Box 62978
Phoenix, AZ 85082-2978

Through Electronic
Clearinghouse
Payer ID: 33628

Refunds

For All Plans

Mercy Care
Attention: Finance Department
P.O. Box 90640
Phoenix, AZ 85066

N/A

17.12 - Correct Coding Initiative

MC and AHCCCS follow the same standards as Medicare's Correct Coding Initiative (CCI) policy and perform CCI edits and audits on claims for the same provider, same recipient, and same date of service. For more information on this initiative, please review the CMS website under [National Correct Coding Initiative Edits](#).

MC utilizes ClaimCheck as our comprehensive code auditing solution that will assist payers with proper reimbursement. Correct Coding Initiative guidelines will be followed in accordance with both AHCCCS and CMS, in addition to pertinent coding information received from other medical organizations or societies.

Clear Claim Connection is a web-based stand-alone code auditing reference tool designed to mirror MC's comprehensive code auditing solution through ClaimCheck. It enables MC to share with our providers the claim auditing rules and clinical rationale inherent in ClaimCheck.

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Providers will have access to Clear Claim Connection through MC's website through a secure login. Clear Claim Connection coding combinations can be used to review claim outcomes after a claim has been processed. Coding combinations may also be reviewed prior to submission of a claim so that the provider can view claim auditing rules and clinical rationale prior to submission of claims.

Further detail on how to use Clear Claim Connection can be found on the application itself by using the help link. Clear Claims Connection can be found after logging in to [Mercy Care Web Portal](#).

17.13 - Correct Coding

Correct coding means billing for a group of procedures with the appropriate comprehensive code. All services that are integral to a procedure are considered bundled into that procedure as components of the comprehensive code when those services:

- Represent the standard of care for the overall procedure, or
- Are necessary to accomplish the comprehensive procedure, or
- Do not represent a separately identifiable procedure unrelated to the comprehensive procedure.

17.14 - Incorrect Coding

Examples of **incorrect coding** include:

- "Unbundling" - Fragmenting one service into components and coding each as if it were a separate service.
- Billing separate codes for related services when one code includes all related services.
- Breaking out bilateral procedures when one code is appropriate.
- Down coding a service to use an additional code when one higher level, more comprehensive code is appropriate.

17.15 - Modifiers

Appropriate modifiers must be billed to reflect services provided and for claims to pay appropriately. MC can request copies of operative reports or office notes to verify services provided. Common modifier issue clarification is below:

Modifier 59 – Distinct Procedural Services - must be attached to a component code to indicate that the procedure was distinct or separate from other services performed on the same day and was not part of the comprehensive service. Medical records must reflect appropriate use of the modifier. Modifier 59 cannot be billed with evaluation and management codes (99201-99499) or radiation therapy codes (77261 -77499).

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Modifier 25 – Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service - must be attached to a component code to indicate that the procedure was distinct or separate from other services performed on the same day and was not part of the comprehensive service. Medical records must reflect appropriate use of the modifier. Modifier 25 is used with evaluation and management codes and cannot be billed with surgical codes.

Modifier 50 – Bilateral Procedure - If no code exists that identifies a bilateral service as bilateral, you may bill the component code with modifier 50. MC follows the same billing process as CMS and AHCCCS when billing for bilateral procedures. Services should be billed on one-line reporting one unit with a 50 modifier.

Modifier 57 – Decision for Surgery – must be attached to an Evaluation and Management code when a decision for surgery has been made. MC follows CMS guidelines regarding whether the Evaluation and Management will be payable based on the global surgical period. CMS guidelines found in the Medicare Claims Processing Manual, Chapter 12 – Physicians/Non-physician Practitioners indicate:

“Carriers pay for an evaluation and management service on the day of or on the day before a procedure with a 90-day global surgical period if the physician uses CPT modifier “-57” to indicate that the service resulted in the decision to perform the procedure. Carriers may not pay for an evaluation and management service billed with the CPT modifier “-57” if it was provided on the day of or the day before a procedure with a 0 or 10-day global surgical period.”

EP Modifier – Service provided as part of a Medicaid early periodic screening diagnosis and treatment [EPSDT] program – must be appended to CPT code 96110 to receive additional developmental screening tool payment. For additional information please refer to our **Claims Processing Manual** available on our [Claims Information](#) web page, **Chapter 3 – Early Periodic Screening and Developmental Testing (EPSDT)**, which is available on our website.

SL Modifier – State Supplied Vaccine – If a vaccine is provided through the VFC program, the SL modifier must be added to both the vaccine code and the vaccine administration code. For additional information please refer to our **Claims Processing Manual** available on our [Claims Information](#) web page, **Chapter 3 – Early Periodic Screening and Developmental Testing (EPSDT), Section 3.4 – Vaccines for Children Program**, which is available on our website.

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Please refer to your Current Procedural Terminology (CPT) manual for further detail on all modifier usage.

17.16 - Medical Claims Review

To ensure medical appropriateness and billing accuracy, any inpatient and outpatient outlier claims are sent for Medical Claims Review.

17.17 - Checking Status of Claims

Providers may check the status of a claim by accessing MC's secure website or by calling the Claims Inquiry Claims Research (CICR) department.

Online Status through MC's Secure Website

MC encourages providers to take advantage of using online status, as it is quick, convenient, can be used off-hours, and used to determine status for multiple claims. To register, go to [Mercy Care Web Portal](#) and Log In or contact your Network Relations Specialist/Consultant to establish a Login. More information is available in this Provider Manual under section **MC Chapter 4 – Provider Requirements, Section 4.40 – Mercy Care Web Portal**. The Mercy Care Web Portal is available 24 hours a day/7 days a week to providers. Using Mercy Care Web Portal will make better use of your time and allow us to focus on more complex claim questions for both you and other providers calling in.

Calling the Claims Inquiry Claims Research Department

Claim status calls are limited to 3-member status requests during our peak business hours (between 10:00 a.m. to 3:00 p.m.). Unlimited status requests will be answered during non-peak hours.

The Claims Inquiry department is also available to:

- Answer questions about claims.
- Assist in resolving problems or issues with a claim.
- Provide an explanation of the claim adjudication process.
- Help track the disposition of a claim.
- Correct errors in claims processing:
 - Excludes corrections to prior authorization numbers (providers must call the Prior Authorization department directly).
 - Excludes rebilling a claim (the entire claim must be resubmitted with corrections, see section **MC Chapter 15 – Billing Encounters and Claims, Section 15.19 - Claim Resubmission or Reconsideration**).

Please be prepared to give the service representative the following information:

- Provider name and AHCCCS provider number with applicable suffix if appropriate.

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- Member name and AHCCCS member identification number.
- Date of service.
- Claim number from the remittance advice on which you have received payment or denial of the claim.

17.18 - Payment of Claims

MC processes and records the payment of claims through a Remittance Advice. Providers may choose to receive checks through the mail or electronically. MC encourages providers to take advantage of receiving Electronic Remittance Advices (ERA), as you will receive much sooner than receiving through the mail, enabling you to post payments sooner. Please contact your Network Relations Specialist/Consultant for further information on how to receive ERA. Remittance Advice samples are available under the [Forms](#) section of the MC website. Links to those remits are available under the section **MC Chapter 15 – Billing Encounters and Claims, Section 15.30 - Provider Remittance Advice** in this Provider Manual.

Through **Electronic Funds Transfer (EFT)**, providers can direct funds to a designated bank account. MC encourages you to take advantage of EFT. Since EFT allows funds to be deposited directly into your bank account, you will receive payment much sooner than waiting for the mailed check. You may enroll in EFT by submitting an **Electronic Funds Transfer (EFT) Form** available on our [Forms](#) web page. Submit this form along with a voided check to process the request. Please allow at least 30 days for EFT implementation. Your Network Relations Specialist/Consultant will assist you with this.

Additional information can be attained by accessing the **Claim Processing Manual** available on our [Claims Information](#) web page, **Chapter 1 – General Claims Processing Information, Section 1.3 – Electronic Tools and Mercy Care Web Portal** on MC's website.

17.19 - Claim Resubmission or Reconsideration

Providers have 12 months from the date of service to request a resubmission or reconsideration of a claim. A request for review or reconsideration of a claim does not constitute a claim dispute.

Providers may resubmit a claim that:

- Was originally denied because of missing documentation, incorrect coding, etc.
- Was incorrectly paid or denied because of processing errors.

When filing resubmissions or reconsiderations, please include the following information:

- Use the **Resubmission Form** located under the [Forms](#) section of MC's website.
- An updated copy of the claim. All lines **must** be rebilled or a copy of the original claim (reprint or copy is acceptable).

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- A copy of the remittance advice on which the claim was denied or incorrectly paid.
- Any additional documentation required.
- A brief note describing requested correction.
- Clearly label as “Resubmission” or “Reconsideration” at the top of the claim in black ink and mail to appropriate claims address as indicated in ***Claim Address Table***.

Resubmissions and reconsiderations can be submitted electronically, however, we are unable to accept electronic attachments at this time.

If billing a resubmission electronically, you must submit with:

- **Professional Claims** - A status indicator of 7 in the submission form location and the Original Claim ID field need to be filled out.
- **Facilities** – In the Bill Type field, the last number of the 3-digit code should be a 7.

If you need to submit attachments to your resubmission claims, please submit by paper, as we currently do not accept attachments. This is currently under testing and we will let you know when it is available.

When submitting paper resubmissions, failure to mail and accurately label the resubmission or reconsideration to the correct address will cause the claim to deny as a duplicate.

17.20 - Overpayments

Under Section 6402 of the Patient Protection and Affordable Care Act it states:

“Section 6402 of the Patient Protection and Affordable Care Act (PPACA) amends the Social Security Act (SSA) to include a variety of Medicare and Medicaid program integrity provisions that enhance the federal government’s ability to discover and prosecute provider fraud, waste, and abuse. Among the provisions that may have a significant impact on States are newly imposed requirements for health care providers to report any overpayments from Medicaid and Medicare.

Under a new Section 1128J(d) of the SSA, any provider of services or supplies under Medicaid or Medicare must report and return “overpayments,” which the statute defines as “any funds that a person receives or retains under either program “to which the person, after applicable reconciliation, was not entitled[.]” A “person” is defined as “a provider of services, supplier, Medicaid managed care organization..., Medicare Advantage organization..., or [Medicare Part D Prescription Drug Plan] sponsor[.]” PPACA § 6402(a). It does not include a beneficiary.

The overpayment must be returned within 60 days from the date the overpayment was

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“identified,” or by the date any corresponding cost report was due, whichever is later. This provision of the law became effective May 22, 2010.

To properly return an overpayment, the individual who has received an overpayment must:

return the payment to the Secretary of the Department of Health and Human Services (Secretary), the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address; and notify the Secretary, State, intermediary, carrier, or contractor to whom the overpayment was returned the reason for the overpayment in writing.

Failure to return an overpayment has severe consequences. *If an overpayment is retained beyond the 60-day deadline, PPACA Section 6402 makes clear that it will be considered an “obligation” under the FCA. As amended by the Fraud Enforcement Recovery Act of 2009 (FERA), the FCA subjects a person to a fine and treble damages if he or she knowingly conceals or knowingly and improperly avoids or decreases an “obligation” to pay money to the federal government. PPACA treats Medicaid and Medicare overpayments alike in stating that failing to refund an overpayment will be considered an “obligation” under the FCA.”*

Whether an overpayment is identified directly by the provider or an overpayment request letter is sent to the provider by MC, the refund along with any supporting documentation should be sent to:

Mercy Care
Attention: Finance Department
P.O. Box 90640
Phoenix, AZ 85066

Supporting documentation must include:

- The overpayment claim number(s); and/or
- The remittance advice specific to the overpayment.

Instruction for Specific Claim Types

17.21 - MC General Claims Payment Information

MC claims are always paid in accordance with the terms outlined in the PHP's contract. Prior authorized services from Non-PHPs will be paid in accordance with AHCCCS processing rules.

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17.22 – Inpatient Claims

MC processes inpatient claims at APR-DRG in accordance with AHCCCS requirements. Please refer to our **Claims Processing Manual** available on our [Claims Information](#) web page, **Chapter 4 – Inpatient Claims** for additional detail.

17.23 – Federally Qualified Health Centers (FQHCs)

Special billing rules apply to FQHCs. Please refer to our **Claims Processing Manual** available on our [Claims Information](#) web page, **Chapter 5 – Federally Qualified Health Centers (FQHC) Prospective Payment System (PPS) Processing** for additional detail on how these claims should be billed.

17.24 - Skilled Nursing Facilities (SNFs)***Acute Care Skilled Nursing Facility Stay***

Providers submitting claims for SNFs should use the [CMS UB-04 Form](#). Please refer to our **Claims Processing Manual** available on our [Claims Information](#) web page, **Chapter 6 – Skilled Nursing Facility Claims** for additional detail on how these claims should be billed.

Long Term Care Skilled Nursing Facility Stay

Therapy (occupational, physical, or speech) services performed in a SNF for Subacute Care Levels II and III (Codes 193 and 194) are included in the per diem. The SNF may be reimbursed for therapy services for the Custodial Level (codes 0081, 0082 and 0083) of stay and all other levels. The therapy services must be billed on the UB-04 along with the Custodial Level.

<u>Care Level</u>	<u>Codes</u>	<u>Therapy Service Coverage</u>
Subacute Care Levels II and III	0193, 0194	Included in the SNF per diem
Custodial Level	0081, 0082, 0083	SNF may be reimbursed if billed separately and authorized

ALTCS recipients are required to contribute toward the cost of their care. This is called Share of Cost (SOC). When a recipient's eligibility for ALTCS is approved, a notice is generated which identifies the amount of SOC the recipient owes. SOC change notices are sent to nursing facilities for any change that might occur to the SOC amount due. The identified SOC provided by AHCCCS is deducted from the payment owed for the claim. If a patient transfers from one facility to another in a month's time and the total SOC could not be applied to the first facility, the remainder will be carried over to the second facility's claim.

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Customized Durable Medical Equipment (DME), including customized wheelchairs and specialty beds such as Clinitron bed, may be covered by Medicaid in a SNF when prior authorized. Alternating pressure mattresses and pumps are included in the per diem.

Bariatric products and/or services are covered by Medicaid if they are authorized and it is not a Bariatric Level of stay. All other ancillary services are included in the SNF per diem. Some services can be paid under Medicare Part B.

Ancillary Service

Customized DME (including customized Wheelchairs and specialty beds)
Alternating pressure mattresses and pumps
Bariatric products and/or services

All other Ancillary Services

Coverage

May be covered when prior authorized

Included in the SNF per diem

Covered if authorized and it is not a Bariatric level of care

Included in the SNF per diem

If a member has MCA as primary coverage, providers must bill in accordance with standard Medicare RUGS billing requirement rules for MCA. The coordinating claim on the Medicaid side will require separate billing in accordance with the provider contract. This is one of the few situations where billing requirements differ on the MCA side versus the MCLTC side.

Please refer to the **Claims Processing Manual**, available on our [Claims Information](#) web page, **Chapter 6 – Skilled Nursing Facility Claims** on MCLTC's website.

17.25 - Dental Claims

Services provided by an anesthesiologist or medically related oral surgery procedure should be submitted on [Form 1500 \(02/12\)](#). Please refer to our **Claims Processing Manual** available on our [Claims Information](#) web page, **Chapter 2 – Professional Claims by Specialty, Section 2.11 – Dental Claims**, as well as **Section 2.12 – Oral Surgery Claims** on MC's website for additional claims information.

17.26 – Durable Medical Equipment (DME)

MC covers reasonable and medically necessary durable medical equipment (DME) when ordered by a primary care provider or a practitioner within certain limits based on member age and eligibility. Durable Medical Equipment (DME) may be purchased or rented. Total expense of the rental must not exceed the purchase price of the item.

All Customized Wheelchairs, Customized Hospital Beds and Augmentative Communication Devices must be provided within 90 days from when MCCC receives the initial request for authorization to the delivery of the equipment from the provider.

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Providers are expected to coordinate with MC on monthly reporting, which is required by AHCCCS. This reporting measures both MC's and vendors' performance on insuring that the member receives the services timely.

17.27 - Family Planning Claims

- Claims for medical services will only be accepted on [Form 1500 \(02/12\)](#).
- Inpatient hospitalizations, outpatient surgery and emergency department facility claims should be filed on [CMS UB-04 Form](#).
- Please refer to our **Claims Processing Manual** available on our [Claims Information](#) web page, **Chapter 2 – Professional Claim Types by Specialty, Section 2.14 – Family Planning Claims** for additional billing information.
- Family Planning services may be billed with other services on the same claim. When billed on the same claim though, a provider will receive two remits, one for family planning services and one for non-family planning services, as these services are paid out of separate funds.
- Family Planning claims may be submitted electronically.

Providers must submit the following information:

- AHCCCS Provider ID number.
- Family planning service diagnosis (all claims **must** have).
- Explanation of Benefits from other insurance (including Medicare).
- Correctly signed and dated sterilization consent forms.
- The 30-day waiting period can be waived for emergent or medically indicated reasons.
- Operative reports for surgical procedures.
- Use HCPCS “J” codes, and provide the drug administered, NDC code and the dosage for injected substances.
- Payment for IUDs requires a copy of the invoice to establish cost to the provider.
- Anesthesia claims require an ASA code for surgery with the appropriate time reflected in minutes.
- For Family Planning Services Extension Program members, X-ray and lab charges will be paid only if they are related to family planning. There must be a Family Planning Service diagnosis.
- A separate claim must be submitted for each date of service.

Members may request services, such as infertility evaluations and abortions, from providers, whether they are registered with AHCCCS, but must sign a release form stating that they understand the service is not covered and that the member is responsible for payment of these services.

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If you have authorization or claims questions related to family planning, please call:

Aetna Medicaid Administrators LLC

602-798-2745: Phoenix

888-836-8147: Outside Phoenix

17.28 - Complete Obstetrical Care Package

Reimbursement for obstetrical care is dependent upon the provider's contract with MC. Please refer to your contract for further detail. Providers are expected to bill for obstetrical care according to the terms of their contract and should file claims using a [Form 1500 \(02/12\)](#).

Fee for Service

For additional information regarding fee for service billing, please refer to our **Claims Processing Manual** available on our [Claims Information](#) web page, **Chapter 2 – Professional Claim Types by Specialty, Section 2.5 – Obstetrical Billing**. It is important to note that providers must bill all pre-natal and post-partum visits when submitting a finalized claim. This information is required per AHCCCS guidelines to increase the data available for calculating Performance Measures as well as to provide an opportunity to improve care, services and outcomes for members. Most providers are currently contracted on a fee for service basis and are paid in accordance with CPT Guidelines.

Global Case Rate

Providers contracted at a global case rate are reimbursed as follows:

Services Included in the Package

- Initial and subsequent prenatal visits, including early, periodic, screening, diagnosis and treatment services (EPSDT - see below) for patients less than 21 years of age
- Treatment of pregnancy related conditions, including hypertension and gestational diabetes
- Treatment of urinary tract infections and pelvic infections
- Routine labs and blood draws
- In-hospital management of threatened premature labor
- In-hospital management of hyperemesis gravidarum
- External cephalic version performed in hospital
- Induction of labor by prostaglandins and/or oxytocin and/or combined
- Amnioinfusion
- Trial of vaginal birth after a cesarean (VBAC)
- Delivery by any method, including cesarean section
- Episiotomy and repair, including 4th degree lacerations
- All routine post partum care, including follow-up visit

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- Any management that would ordinarily be considered part of OB care.

Services will not be separately reimbursed if billed separately.

If a provider does not complete all the services in the Global Obstetrical Care Package, this may result in a lesser payment or potential recoupment of payments made.

Services Not Included in the Package

- Amniocentesis
- Obstetrical Ultrasonography
- Non-stress and contraction stress tests
- Coloscopy and/or biopsy for accepted indication
- Return to operating or delivery room for postpartum hemorrhage/curettage
- Non-obstetrical related medical care
- Cerclage.

Separate reimbursement will be provided, if medically necessary.

17.29 - Trimester of Entry into Prenatal Care

Claims for obstetrical services are submitted on [Form 1500 \(02-12\)](#). Health providers must bill in accordance with our **Claims Processing Manual** available on our [Claims Information](#) web page, **Chapter 2 – Professional Claim Types by Specialty, Section 2.5 – Obstetrical Billing**.

While the goals of early entry into prenatal care and regular care during pregnancy have not changed, HEDIS guidelines will be followed to determine trimester of entry into prenatal care. Entry into prenatal care and the number of prenatal visits is measured and monitored by MCCC and AHCCCS as part of the Quality Management Program.

17.30 - Provider Remittance Advice

MCCC generates checks weekly. Claims processed during a payment cycle will appear on a remittance advice (“remit”) as paid, denied or reversed. Adjustments to incorrectly paid claims may reduce the check amount or cause a check not to be issued. Please review each remit carefully and compare to prior remits to ensure proper tracking and posting of adjustments. We recommend that you keep all remittance advices and use the information to post payments and reversals and make corrections for any claims requiring resubmission. Call your Network Relations Specialist/Consultant if you are interested in receiving electronic remittance advices.

The Provider Remittance Advice (remit) is the notification to the provider of the claims processed during the payment cycle. A separate remit is provided for each line of business in which the provider participates.

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Information provided on the remit includes:

- The Summary Box found at the top right of the first page of the remit summarizes the amounts processed for this payment cycle.
- The Remit Date represents the end of the payment cycle.
- The Beginning Balance represents any funds still owed to MCCC for previous overpayments not yet recouped or funds advanced.
- The Processed Amount is the total of the amount processed for each claim represented on the remit.
- The Discount Penalty is the amount deducted from, or added to, the processed amount due to late or early payment depending on the terms of the provider contract.
- The Net Amount is the sum of the Processed Amount and the Discount/Penalty.
- The Refund Amount represents funds that the provider has returned to MCCC due to overpayment. These are listed to identify claims that have been reversed. The reversed amounts are included in the Processed Amount above. Claims that have refunds applied are noted with a Claim Status of REVERSED in the claim detail header with a non-zero Refund Amount listed.
- The Amount Paid is the total of the Net Amount, plus the Refund Amount, minus the Amount Recouped.
- The Ending Balance represents any funds still owed to MCCC after this payment cycle. This will result in a negative Amount Paid.
- The Check # and Check Amount are listed if there is a check associated with the remit. If payment is made electronically then the EFT Reference # and EFT Amount are listed along with the last four digits of the bank account, the funds were transferred. There are separate checks and remits for each line of business in which the provider participates.
- The Benefit Plan refers to the line of business applicable for this remit. TIN refers to the tax identification number.
- The Claim Header area of the remit lists information pertinent to the entire claim. This includes:
 - Member/Patient Name
 - ID
 - Birth Date
 - Account Number,
 - Authorization ID, if Obtained
 - Provider Name,
 - Claim Status,
 - Claim Number
 - Refund Amount, if Applicable

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- The Claim Totals are totals of the amounts listed for each line item of that claim.
- The Code/Description area lists the processing messages for the claim.
- The Remit Totals are the total amounts of all claims processed during this payment cycle.
- The Message at the end of the remit contains claims inquiry and resubmission information as well as grievance rights information.

The following Remittance Advice samples are available under the [Forms](#) section on MC's website:

- **Mercy Care Complete Care Remit Format for Check**
- **Mercy Care Complete Care Remit Format for EFT**
- **Mercy Care Long Term Care Remit Format for Check**
- **Mercy Care Long Term Care Remit Format for EFT**
- **Mercy Care RBHA Remit Format for Check**
- **Mercy Care RBHA Remit Format for EFT**
- **Aetna FPS Remit Format for Check**
- **Aetna FPS Remit Format for EFT**

More information is available in this Provider Manual under section **MC Chapter 4 – Provider Requirements, Section 4.40 – Mercy Care Web Portal** regarding Remittance Advice Search.

An electronic version of the Remittance Advice can be attained. To qualify for an Electronic Remittance Advice (ERA), you must currently submit claims through EDI and receive payment for claim by EFT. You must also have the ability to receive ERA through an 835 file. We encourage our providers to take advantage of EDI, EFT, and ERA, as it shortens the turnaround time for you to receive payment and reconcile your outstanding accounts. Please contact your Network Relations Specialist/Consultant to assist you with this process.

17.31 – Program Integrity

Criteria Use in Program Integrity Reviews

The criteria include timeliness, correctness, and omission of encounters, in addition to encountering for services not documented in the medical record, incorrectly documented in the medical record or insufficiently documented in the medical record. These criteria are defined as follows:

- **Timeliness** - The time elapsed between the date of service and the date that the encounter is received;
- **Correctness** - A correct encounter contains a complete and accurate description of a covered behavioral health service provided to a member. Correctness errors frequently identified include, but are not limited to, invalid procedure or revenue codes and ICD-10

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- diagnoses not reported to the correct level of specificity; and
- Omission - Provider documentation shows a service was provided, however, an encounter was not submitted.
- Documentation Issues - A description of adequate documentation is referenced in [MC Chapter 4 – Provider Requirements, Section 4.16 – Member’s Medical Records](#).

In addition, assessment compliance will be monitored by Mercy RBHA in accordance with [RBHA Chapter 4 – General Mental Health/Substance Use \(GMHSU\), Section 4.04 - Assessment and Service Planning](#).

Mercy RBHA conducts program integrity audits studies with all contracted providers. The program integrity audits studies help ensure that covered healthcare services are appropriately documented and billed/encountered and that they support the identification of opportunities for improvement in billing practices.

Mercy RBHA will establish a review schedule with providers and provide advance notice of the program integrity audit. Reviews may be conducted on site or applicable documentation may be requested for submission to Mercy RBHA. The purpose of the program integrity audit is to confirm that covered services are encountered correctly and completely and on a timely basis. Providers should take special care to ensure that valid procedure and revenue codes are utilized and that the coding of diagnoses reflects the correct level of specificity.

Provider Responsibilities

Behavioral health providers must deliver covered services in accordance with the [AHCCCS Covered Behavioral Health Services Guide](#). Healthcare providers must document adequate information in the clinical record and submit encounters in accordance with [MC Chapter 15 - Submitting Claims and Encounters to Mercy RBHA](#). Any program integrity findings that indicate suspected fraud and/or program abuse must be reported to the AHCCCS Office of Inspector General as required. A determination of overpayment as the result of a program integrity audit will result in a recovery of the related funds/voiding of related encounters as required.

Program Integrity Findings

Mercy RBHA will report the program integrity findings to the provider.

Prepayment Review Process

Mercy RBHA may determine that a prepayment review is necessary based on findings resulting from Program Integrity Reviews, other audit processes or data mining activities. This is not an audit process, but simply a mechanism to ensure clean claiming is occurring.

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During the prepayment review process, samples of claims will be selected for review which may or may not require the submission of medical records. Any claims selected for prepayment review will be temporarily pended for further research. Once research has been completed, the pended claims will be released either for payment or denial.

- Providers will be given 3 business days to submit any requested medical records for review.
- Claims payments or denials will occur within 7 days of completion of the review.
- Mercy RBHA will have up to 30 days to complete review of the claims pended for prepayment review.
- The prepayment review process will have a prescribed review period, such as 60 or 90 days. At that time, Mercy RBHA will determine the need for a new prepayment review process or other actions. Providers may be released from prepayment review at that time.

AHCCCS Encounter Validation

AHCCCS performs periodic encounter validation studies. All AHCCCS contractors and subcontractors are contractually required to participate in this process. In addition, the encounter validation studies enable AHCCCS to monitor and improve the quality of encounter data.

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MC CHAPTER 18 – FRAUD, WASTE AND ABUSE

18.00 - Fraud and Abuse Overview

MC supports efforts to detect, prevent and report fraud and abuse within the Medicaid system. These efforts are consistent with our mission to provide care to the poor and those with special needs while exercising sound fiscal responsibility. Management of limited resources is a key part of this responsibility.

Fraudulent activity hurts everyone. We hope you will join us in our efforts to ensure that tax dollars spent for health care are spent responsibly and used to provide necessary care for as many members as possible.

Examples of actions that are reportable to the state's investigative agencies include:

- Physical or sexual abuse of members.
- Improper billing and coding of claims.
- Pass through billing.
- Billing for services not rendered.
- Raising fees for Medicaid patients to allowable amounts if these fees are not billed to other patients.
- Unbundling and up coding may be construed as fraud if a pattern is found to exist.

In addition, member fraud is also reportable, and examples include:

- Use of another member's identification to obtain services.
- Fraudulent application for eligibility.
- Sale of durable medical equipment while on loan to members.
- Prescription fraud.

MC is required to report cases of suspected fraud or abuse to the AHCCCS Office of Inspector General. Other agencies may be involved in cases of criminal activity or abuse. The AHCCCS Office of Inspector General is responsible for determining if suspected fraud or abuse cases warrant referral to the State Attorney General's office. The AHCCCS Office of Inspector General has the authority to levy civil monetary penalties, issue recoupment letters, and utilize other types of sanctions if fraud, waste or abuse is substantiated.

Anyone who suspects member or provider fraud, or abuse may report it either to the MC hotline number at 800-810-6544 or directly to the State hotline at:

- In Maricopa County: 602-417-4045
- Outside of Maricopa County: 888-ITS-NOT-OK or 888-487-6686.

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AHCCCS has published to its website an e-learning seminar entitled "Fraud Awareness for Providers" that discusses provider and member fraud. This seminar is available at the following website under the tab marked **Fraud Awareness for Providers**:

<https://azahcccs.gov/Fraud/Providers/>

MC would like to inform you of this valuable seminar's availability and would like to encourage our providers and their office staff to review/listen to this short seminar for additional information regarding fraud awareness.

Per the AHCCCS website, the chief goal of the AHCCCS Office of Inspector General is to ensure that AHCCCS (Medicaid) funds are used effectively, efficiently, and in compliance with applicable state and federal laws and policies. Every dollar lost to the misuse of AHCCCS benefits is one less dollar available to fund programs which provide essential medical services for Arizona residents. The Office of Inspector General audits and investigates providers and members who are suspected of defrauding the AHCCCS program, recovers overpayments, issues administrative sanctions, and refers cases of suspected fraud for criminal prosecution. You are encouraged to immediately report matters involving fraud, waste and abuse.

18.01 - Deficit Reduction Act and False Claims Act Compliance Requirements

Each Provider Agreement requires all providers to adhere to Deficit Reduction Act (DRA) requirements. The DRA requires that any entity (which receives or makes payments, under a state plan approved under Title XIX or under any waiver of such plan, totaling at least \$5 million annually) must establish written policies for its employees, management, contractors and agents regarding the False Claims Act (FCA). The FCA applies to claims presented for payment by federal health care programs. The FCA allows private persons to bring a civil action against those who knowingly submit false claims upon the government.

Activities for which one may be liable under the FCA:

- Knowingly presenting to an officer or employee of the United States government a false or fraudulent claim for payment or approval.
- Knowingly making, using, or causing a false record or statement to get a false or fraudulent claim paid or approved by the government.
- Conspiring to defraud the government by getting false or fraudulent claims allowed or paid.
- Having possession, custody, or control of property or money used, or to be used by the government and, intending to defraud the government by willfully concealing property, delivering, or causing to be delivered less property than the amount for which the person receives.

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- Authorizing to make or deliver a document, certifying receipt of property used by the government and intending to defraud the government and making or delivering a receipt without completely knowing that the information on the receipt is true;
- Knowingly buying, or receiving as a pledge of an obligation or debt, public property from an officer or employee of the government, or a member of the Armed Forces, who lawfully may not sell or pledge the property; or
 - Knowingly making, using or causing to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the government.
 - The definition of “knowing” and “knowingly” as it relates to the FCA includes actual knowledge of the information, acting in deliberate ignorance of the truth or falsity of the information, and/or acting in reckless disregard of the truth or falsity of the information. Proof of specific intent to “defraud” is not required for reporting potential violations of the law.

18.02 - False Claims Training Requirements

As required by MC’s contract with AHCCCS Administration, providers must train their staff on the following:

- The administrative remedies for false claims and statements.
- Any state laws relating to civil or criminal penalties for false claims and statements.
- The whistleblower (or relater) protections under such laws.

18.03 - Administrative Remedies for False Claims and Statements

The United States Government (Government) has administrative remedies available to it in cases that have resulted in FCA violations. The administrative remedy for violating the FCA is three times the dollar amount that the government is defrauded and civil penalties of \$5,500 to \$11,000 for each false claim by the party responsible for the claim. If there is a recovery in the case brought under the FCA, the person suing (relater) may receive a percentage of the recovery against the party that had responsibility for the false claim. For the party that had responsibility for the false claim, the government may seek to exclude it from future participation in federally funded health care programs or impose integrity obligations against it.

18.04 - State Laws Relating to Civil or Criminal Penalties or False Claims and Statements

To prevent and detect fraud, waste, and abuse, many states have enacted laws like the FCA but with state-specific requirements, including administrative remedies and relater rights. Those laws generally prohibit the same types of false or fraudulent claims for payments for health care related goods or services as are addressed by the federal FCA. For further information on specific state law requirements, contact MC’s Compliance Office.

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Additional information on the Deficit Reduction Act and False Claims Act is available on the following websites:

- **Deficit Reduction Act – Public Law 109-171**
- **Arizona Revised Statutes (ARS):**
 - ARS 13-1802: Theft
 - ARS 13-2002: Forgery
 - ARS 13-2310: Fraudulent schemes and artifices
 - ARS 13-2311: Fraudulent schemes and practices; willful concealment
 - ARS 36-2918: Duty to report fraud
 - AAC R9-22-1101, et seq.: Civil Monetary Penalties and Assessments

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MC CHAPTER 19 – WORKFORCE DEVELOPMENT**19.00 – General Information**

This chapter applies to AHCCCS Complete Care (ACC), ALTCS/EPD, DES/DDD (DDD), and RBHA contracted providers. The purpose of this chapter is to describe provider requirements, expectations and recommendations in developing the workforce. Initiatives in this chapter align with AHCCCS Workforce Development Policy [ACOM 407](#).

Definitions:

Workforce Development Alliance is organized by the Workforce Development (WFD) department at AHCCCS and includes members from Relias Learning, Arizona Association of Health Plans (AzAHP), Arizona Complete Health, Banner University Family Care, Care 1st, Magellan Complete Care, Mercy Care, Steward Health Choice Arizona and United Healthcare Community Plan.

Workforce Development (WFD) is an approach to improving healthcare outcomes of our members by enhancing the training, skills and competency of our workforce. It is a collaborative effort between all departments to set goals and initiatives to improve the workforce to provide better member services and care.

Competency is defined as a person's ability or capacity to successfully perform job duties. Competency encompasses more than merely training our workforce and includes specific behavioral indicators that are demonstrated and observed.

19.01 – Contract Requirements

Mercy Care's Workforce Development (WFD) department implements, monitors, and regulates Provider WFD activities and requirements listed in this chapter. In addition, Mercy Care evaluates the impact of the WFD requirements and activities to support Providers in developing a qualified, knowledgeable and competent workforce.

- The Mercy Care Provider Relations Department works in conjunction with WFD to provide initial and on-going development opportunities for contracted Provider agencies. Please contact their team directly for additional information.

Mercy Care believes that we ensure the provision of high-quality services by fostering collaboration, respect for differences, preferences, language and other cultural needs within the communities we serve. We believe that culturally and linguistically-responsive programs that promote building on people's strengths and values while reducing the effects of traumatic and other adverse experiences achieve positive health outcomes and create welcoming environments.

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With the above stated, we ensure that all course content is culturally appropriate, has a trauma informed approach and is developed using adult-learning principles and guidelines. Additionally, it is aligned with company guidelines and WFD industry standards, the Substance Abuse and Mental Health Services Administration (SAMHSA) core competencies for WFD, federal and state requirements and the requirements of the following agencies, entities and legal agreements:

- Centers for Medicare and Medicaid Services (CMS)
- Culturally and Linguistic Appropriate Services (CLAS) Standards
- Arizona Health Care Cost Containment System (AHCCCS)
- Arnold v. ADHS and JK v. Humble settlement agreements
- Maricopa County Superior Court

ALTCS/EPD

Mercy Care will promote optional WFD initiatives with ALTCS/EPD Providers that support the growth of business practices, improve member outcomes and increase the competency of the workforce.

DES (DDD)

DES (DDD) providers fall under ALTCS/EPD and/or ACC Contracts.

Physical Health ACC

Various trainings will be made available through the Mercy Care website to improve member outcomes and improve the competency of the workforce.

Behavioral Health ACC and RBHA (All Staff)

Workforce Development Plan (WFDP)

AHCCCS, in collaboration with Arizona Complete Health, Banner University Family Care, Care 1st, Magellan Complete Care, Mercy Care, Steward Health Choice Arizona, and United Healthcare Community Plan, requires that all Behavioral Health AHCCCS Complete Care (ACC) and Regional Behavioral Health Authority (RBHA) contracted provider agencies, complete a biannual Workforce Development Plan (WFDP). A WFDP Template is provided for this deliverable by MC to providers. Due dates for these plans will be determined by the Workforce Development Alliance and communicated to Providers.

Exceptions to the above include: Individual practitioners, hospitals, transportation, housing, and prevention agencies.

Relias Learning

All AHCCCS Complete Care (ACC)/ Regional Behavioral Health Authority (RBHA) Behavioral Health (BH) providers must have access to Relias Learning. This is the Learning Management

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System use by the ACC/RBHA Plans and their contracted BH providers through the Arizona Association of Health Plans (AzAHP). Agencies must manage and maintain their Relias Learning portal. This includes activating and deactivating users as well as enrollment and disenrollment of courses/events.

All contracted Mercy Care BH Providers must be set up to use Relias Learning to report all training activities for their staff to include but not limited to:

- Attendance, course completion and training content for:
 - Technology based/Online Courses
 - Web Conferences
 - Live Training, Seminars, Conferences and/or Events

Requesting Relias Access for newly contracted Providers:

1. Mercy Care's Provider Relations Representative makes a request, for Relias access, through the Mercy Care Workforce Development Department (WFD@MercyCareAZ.org). The request should include the following information:
 - a. Provider Agency Name
 - b. Contract Start Date
 - c. Address
 - d. Key WFD Contact
 - Name
 - Phone Number
 - Email Address
 - e. Contract Type (ACC/RBHA)
 - f. Provider Type (GMH/SU, Children's, SMI, Integrated Health Home, etc.)
 - g. Number of Users (# employees at the agency who need Relias access)
 - h. List of Health Plans provider is contracted with (if known)
2. The Mercy Care Workforce Development Administrator notifies the AzAHP Administrator that a contracted Provider is requesting a Relias Sub-Portal and provides the information outlined above in items "a-h."
3. The AzAHP Administrator submits request to Relias Client Success Manager.
4. The Relias Client Success Manager will notify the Relias Account Owner.
5. The Relias Account Owner sets up an account in Salesforce under AzAHP Enterprise and issues a one-time implementation fee agreement of \$1,500 directly to the provider*.
 - a. BH provider agencies with 20 or more users will be required to purchase access to Relias Learning for a one-time fee of \$1500 for full-site privileges. A full-site is defined as a site in which the agency may have full control of course customizations and competency development.
 - b. Provider agencies with 19 or fewer users will be added to AzAHP Relias Small Provider Portal at no cost with limited-site privileges. A limited-site is defined as one

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- in which the courses and competencies are set-up according to the standard of the plan with no customization or course development provided.
- c. Provider agencies that expand to 20 or more users will be required to purchase full-site privileges to Relias Learning immediately upon expansion.
6. Provider signs agreement and remits payment to Relias when invoiced.
7. Following Relias Legal and Finance Approval - Relias Professional Services sets up a sub-portal in the AzAHP Enterprise and provides administrator training to the appropriate Provider contact.

**Fee is subject to change if a Provider requires additional work beyond a standard sub-portal implementation.*

Required Training

Mercy Care ACC/RBHA providers must ensure that all staff who work in programs that support, oversee, or are paid by the Health Plan contract have access to Relias and are enrolled in the AzAHP Training Plans listed below. (This includes, but is not limited to, full time/part time, direct care, clinical, administrative and support staff).

Exceptions:

- Any staff member(s) hired for temporary services working less than 90 days is required to complete applicable training at the discretion of the provider.
- Any staff member(s) hired as an intern or Independent Contractor (IC) is required to complete applicable training at the discretion of the provider.

AzAHP Core Training Plan (First 90 Days)

- Welcome to Relias
- AzAHP – Limited English Proficiency (LEP)
- AzAHP – AHCCCS 101
- AzAHP – Quality of Care Concern
- AzAHP – Client Rights, Grievances and Appeals
- AzAHP – Culturally and Linguistically Appropriate Services (CLAS) Standards
- Corporate Compliance: The Basics
- Cultural Diversity
- Customer Service
- HIPAA Overview
- Integrating Primary Care with Behavioral Health
- Law, Ethics and Standards of Care in Behavioral Health
- Medicare and Medicaid Fraud and Abuse Preventions

GENERAL REQUIREMENTS FOR ALL PLANS

AzAHP – Core Training (Annual)

- AzAHP – Quality of Care Concern
- AzAHP – Cultural and Linguistically Appropriate Services (CLS) Standards
- Corporate Compliance: The Basics
- Cultural Diversity (course will be rotated annually with alternate)
- HIPAA Overview
- Law, Ethics and Standards of Care in Behavioral Health
- Medicare and Medicaid Fraud and Abuse Prevention

Required Training: ACC and RBHA (Program Specific)

Additional course requirements and competencies are listed below as relevant to each staff member's job duties, scope of work and responsibilities. Providers may decide to assign additional courses or competencies based upon individual needs and initiatives.

ACT/FACT Teams

All new team members (inclusive of Psychiatrist and RN's) receive standardized training in Evidence-Based Practices for 16 hours (at least a 2-day workshop or equivalent within two months of hiring. Existing team members receive annual refresher training of at least 8 hours (1-day workshop or equivalent). Providers will track this metric and must include training on the below topics in the total hour requirement for EBP however, training should not be solely limited to the following topics:

- Assertive Community Treatment
- Family Psychoeducation
- Integrated Dual Disorders Treatment
- Illness Management and Recovery
- Trauma Informed Care
- Permanent Supportive Housing
- Supported Employment
- Motivational Interviewing

Children's System of Care

- Birth to 5
 - Staff members completing Birth to 5 assessments are required to have training in this area prior to using the assessment tool with members. On-going competency assessments are also required to evaluate a staff member's knowledge and skills.
- Child and Adolescent Service Intensity Instrument (CASII)

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- Staff members completing CASII assessments are required to have training in this prior to using the assessment tool with members. On-going competency assessments are also required to evaluate a staff member's knowledge and skills.
- Child and Family Team (CFT)
 - Staff members who facilitate Child and Family Team meetings are required to complete this course within 90-days of the staff member's hire date. Please refer to the [AHCCCS Child and Family Team Practice Tool](#).
- Early Childhood Service Intensity Instrument (ECSII)
 - Staff members completing ECSII who are employed with an agency receiving funding through Targeted Investment are required to complete this course prior to using the assessment tool with members.
- High Needs Case Manager
 - Staff members holding this position within your organization are expected to have training and competency assessments in the following areas: Stakeholders, Advanced CFT and Transition Age Youth.
- Unique Needs of Children Involved with DCS
 - Providers servicing children and families involved with Department of Child Safety (DCS) are required to complete this course within 90-days of the staff member's hire date.

Community Service Agencies

Community Service Agencies (CSAs) must submit documentation as part of the initial and annual CSA application indicating that all direct service staff and volunteers have completed training specific to CSAs prior to providing services to members. For a complete description of all required training specific to CSAs, see the [AMPM Policy 961-C – Community Service Agencies](#).

General Mental Health/Substance Use (GMH/SU)

- American Society of Addiction Medicine (ASAM)
 - Staff members completing assessments of substance use disorders and subsequent levels of care, are required to complete ASAM Criteria training. This course is required prior to a staff member using the assessment tool with members and annually thereafter. The assessment used should be consistent with the most recent edition American Society of Addiction Medicine (ASAM) Criteria.

Please Note: The initial course must be an ASAM specific class. The annual requirement may be met by completing any approved substance use/abuse course.

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- Mercy - Substance Abuse Block Grant (SABG) and Governor's Office Substance Use Disorder Services (GO SUDS)
 - Mercy Care's expectation is that all contracted general mental health/substance use providers are knowledgeable about the Substance Abuse Block Grant (SABG). This includes requiring all employees who are member-facing to take the online RELIAS training (within 90-days of employment and annually thereafter).

Integrated Health Homes (IHH) and Virtual Health Homes (VHH)

- Mercy - Connecting Minds (Sessions 1-4)
 - All Integrated Health Homes (IHHs) must have (at a minimum) one Master Facilitator in the Connecting Minds training curriculum. All staff (administrative staff, clinical, care managers, allied health, supervisors, etc.) working with an IHH must complete all four modules of the Connecting Minds curriculum within eight (8) months of hire within an IHH. (75% of staff need to be trained in this, per integrated care plan with AHCCCS).
- Mercy - Health Coaching Concepts (Modules 0-8)
 - All Integrated Health Homes (IHHs) must have (at a minimum) one Master Facilitator in the Health Coaching Concepts training curriculum. All staff (administrative staff, clinical, care managers, allied health, supervisors, etc.) working with an IHH must complete all 8 modules of the Health Coaching Concepts curriculum within eight (8) months of hire within an IHH. (75% of staff need to be trained in this, per integrated care plan with AHCCCS).

Please Note: Certified Facilitators for the above courses are required to record completions for their staff using the Mercy Care course modules in Relias.

Residential Care (24hr care facilities)

- Crisis Prevention/de-escalation training is required for all member facing staff prior to serving members and annually thereafter.
- For facilities where restraints are approved, a nationally approved restraint training is required initially and annually for all member facing staff. This curriculum should include non-verbal, verbal and physical de-escalation techniques.

Seriously Mentally Ill (SMI) Clinics

- **Special Assistance**
 - All SMI clinics must have (at a minimum) one Master Facilitator in the Special Assistance training curriculum. Staff members completing Special Assistance assessments for SMI members are required to complete this course prior to completing an assessment with members and annually thereafter. The initial course must be completed in person using the Mercy Care approved training

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curriculum. The annual course may be completed using the online Relias version of the course or alternate approved course.

Division of Licensing Services (DLS) Required Training

It is the provider's responsibility to be aware of all training requirements that must be completed and documented in accordance with all additional licensing or accrediting licensing agencies, i.e., [Bureau of Medical Facilities Licensing \(BMFL\)](#) / [Bureau of Residential Facilities Licensing \(BRFL\)](#), Joint Commission, grant requirements and other entities, as applicable.

Training Expectations for Clinical and Recovery Practice Protocols

Under the direction of the AHCCCS Chief Medical Officer, the Department publishes national practice guidelines and clinical guidance documents to assist Mercy Care Providers. These can be found on the AHCCCS website under the [AHCCCS Behavioral Health System Practice Tools](#) web page.

Additional Expectations

Specific situations may necessitate the need for additional trainings. For example, quality improvement initiatives that may require focused training efforts and/or new regulations that impact the public healthcare system (e.g., the Balanced Budget Act (BBA), Medicaid Modernization Act (MMA), the Affordable Care Act (ACA) and Deficit Reduction Act (DRA)). Additional trainings may be required, as determined by geographic service area identified needs. The data that can be collected from providers includes, but is not limited to:

- Case file reviews
- Utilization management
- System of care data
- Court system data
- Information needed to serve specific populations

MASTER Facilitator

All AHCCCS Complete Care (ACC)/ Regional Behavioral Health Authority (RBHA) Behavioral Health (BH) providers, contracted with Mercy Care, who have 50 or more staff members, must have at least 1 individual at their agency complete the Mercy Care - Facilitator Workshop.

- Exemptions may be granted for staff who hold a degree in Education, Instructional Design or Facilitation and/or have taught courses at a collegiate level (years of experience would not be a qualifier). If you believe you/your employee(s) might qualify, please email: WFD@MercyCareAZ.org

About the Course: The Facilitator Workshop takes place over three (3) consecutive days. Using the ADDIE model for Instructional Design, participants will learn to develop and deliver course content. This course is beneficial for all skill levels as it will teach participants new skills or

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challenge them to refine skills that they already possess. The objectives for the training are demonstrated through development and delivery of course content in a 10-minute presentation that is implemented 2 times during the workshop.

Objectives:

- Apply adult learning models and theories throughout the design and instruction process
- Perform efficient learning analysis
- Design performance-based learning objectives
- Develop instructional components that enable knowledge transfer
- Implement facilitation strategies to increase participant engagement and manage diverse classroom behaviors
- Demonstrate effective use of assessment and Evaluation techniques to elicit feedback

Benefits to completing this course: Anyone who completes this 3-day workshop will be qualified to complete any/all upcoming MASTER Facilitator courses as a MASTER Facilitator. MASTER Facilitators are certified to conduct Train-the-Trainer courses with employees at their agency in specific course content, provided by Mercy Care.

AHCCCS/Mercy RBHA Ownership of any intellectual property

This serves as disclosure of ownership of any intellectual property created or disclosed during the service contract such as educational materials created for classroom training and/or learning programs.

All material published by MC in any medium is protected by copyright. Participants in Mercy Care's MASTER Facilitator programs have a license to use the curriculum, including supplemental materials, modifications and derivative works, (the "Licensed Materials") without limitation, for training to the participant's internal staff only. The Licensed Materials shall be used in the form provided to participant without alteration, including MC branding and copyrights. The Licensed Material shall be used solely for educational, non-commercial, not-for-profit purposes, and consistent with the purpose of the training.

Exceptions:

- Cases in which the production of such materials is part of sponsored programs;
- Cases in which the production of such materials is part of a Mercy Care paid subscription to online learning content;
- Cases in which substantial University resources were used in creating educational materials; and
- Cases which are specifically commissioned by contracted vendors or done as part of an explicitly designated assignment other than normal contactor educational pursuits.

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Supplemental Provider Training and Education

Providers have access to technical assistance and additional training to improve skill development as well as continued education opportunities. The provider may select from additional training courses through a variety of ways, including e-learning, webinars, on-line tools and instructor lead training. All courses developed by Mercy Care are delivered using a trauma informed approach in a culturally competent manner.

Workforce Development Consultation

Mercy Care employs WFD Consultants as key personnel and points of contact to implement and oversee compliance and competency initiatives. Each Provider will be assigned their own WFD Consultant. These individuals are available to assist your agency with:

- Technical Assistance
- Course Development
- Competency Consultation
- Collaboration Initiatives

On-Site Training Requests

All requests will be reviewed and responded to within 5-7 business days.

- Submit On-site request to WFD@MercyCareAZ.org
 - The form is located on the Mercy Care website
- On-site training can only be provided if a minimum of 10 individuals are registered for the training. Requests for less than 10 individuals will not be scheduled.
- The procedure for cancelling an on-site training request hosted by Mercy Care is as follows:
 - A provider must notify Mercy Care WFD (WFD@MercyCareAZ.org) at minimum 48 hours before the scheduled on-site training activity. In the event the Provider has not canceled within this timeframe, the opportunity to gain on-site training in the future could be limited.

For additional WFD requests or general questions please contact Mercy Care's WFD department by e-mailing WFD@MercyCareAZ.org.

Relias Learning Assistance

For technical assistance with the functionality of your Relias Learning portal, please contact Relias directly at: 1800-381-2312 or online via [Relias Connect](#).



Mercy Care Complete Care



Visit: www.MercyCareAZ.org

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MCCC CHAPTER 1 – MERCY CARE COMPLETE CARE OVERVIEW

1.00 – Mercy Care Complete Care Overview

Mercy Care Complete Care (herein MCCC), as part of MC, is a not-for-profit partnership sponsored by Dignity Health and Ascension Care Management. MCCC is committed to promoting and facilitating quality health care services with special concern for the values upheld in Catholic social teaching, and preference for the poor and persons with special needs. Aetna Medicaid Administrators, LLC administers MCCC for Dignity Health and Ascension Care Management.

MCCC is a managed care organization that provides health care services to people in Arizona's Medicaid program. MCCC has held a pre-paid capitated contract with the AHCCCS Administration since 1985. MCCC provides services to the Arizona Medicaid populations including:

- **AHCCCS Complete Care:** Members select the managed care plan to administer their benefits. MCCC is contracted in Maricopa, Pinal and Gila Counties to provide covered services to enrolled members and integrates both their behavioral health and physical health needs.
- **Children's Rehabilitative Services (CRS):** Arizona's Children's Rehabilitative Services (CRS) program provides medical and behavioral health care, treatment, and related support services to Arizona Health Care Cost Containment System (AHCCCS) members who meet the eligibility criteria and completed the application to be enrolled in the CRS program and have been determined eligible.
- **Division of Developmental Disabilities Long Term Care program:** Members are enrolled through the Arizona Department of Economic Security/Division of Developmental Disabilities (DDD). DDD is a Medicaid program administered by AHCCCS through the Department of Economic Security (DES). MCCC is contracted with DDD to provide acute care services. DDD members are located in the following counties:
 - Cochise
 - Gila
 - Graham
 - Greenlee
 - La Paz
 - Maricopa
 - Pima
 - Pinal
 - Santa Cruz
 - Yuma
- **General Mental Health and Substance Use (GMH/SU):** General Mental Health and Substance Use (GMH/SU) services are provided to adult members age 18 and older who have been determined to have an illness in this category. These individuals do not have

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a serious mental illness. General mental health disorders may include, but are not limited to, anxiety or depression. Substance use services are also provided for members using one or more substances, or have a dependency on a substance that causes harm to themselves or others. Additionally, services are also available for members dealing with both a general mental health concerns and a substance use at the same time known as co-occurring disorders.

- **KidsCare:** AHCCCS offers health insurance through KidsCare for eligible children (under age 19) who are not eligible for other AHCCCS health insurance. For those who qualify, there are monthly premiums. Please review the KidsCare webpage on the AHCCCS website for additional information.

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MCCC CHAPTER 2 – COVERED AND NON-COVERED SERVICES

2.00 – Coverage Criteria

Except for emergency care, all covered services must be medically necessary and provided by a primary care provider or other qualified provider. Benefit limits apply.

Each line of business has specific covered and non-covered services. Participating providers are required to administer covered and non-covered services to members in accordance with the terms of their contract and member's benefit package.

2.01 - Covered Services

Covered Services for all members include:

- Hospital care;
- Doctor office visits, including specialist visits;
- Health risk assessments and screenings for members age 21 years of age and over;
- Laboratory, radiology and medical imaging;
- Durable medical equipment and supplies'
- Medications on MCCC's list of covered medicines. Members with Medicare will receive their medications through Medicare Part D;
- Emergency care;
- Care to stabilize you after an emergency;
- Home health services (such as nursing and home health aide);
- Nursing home, when used instead of hospitalization, up to 90 days a year;
- Inpatient rehabilitation services, including occupational, speech and physical therapy;
- Respiratory therapy;
- Outpatient Rehabilitation services, including occupational, speech, physical and respiratory therapy (limitations apply) for patients older than age 21
- Routine immunizations;
- AHCCCS-approved organ and tissue transplants and related prescriptions (limitations apply);
- Dialysis;
- Foot and ankle services;
- Maternity care (prenatal, labor and delivery, postpartum);
- Family planning services;
- Behavioral health services;

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- Medically necessary and emergency transportation. Providers may arrange medically necessary non-emergent transportation for MCCC members by calling Member Services at 602-263-3000 or 800-624-3879;
- Medical foods;
- Emergency eye exam and lens post cataract surgery;
- Urgent care;
- Hospice;
- Wellness exams and preventative screenings; and
- Incontinence briefs to avoid or prevent skin breakdown, with limitations.

Additional covered services for children (under age 21):

- Identification, evaluation and rehabilitation of hearing loss;
- Medically necessary personal care. This may include help with bathing, toileting, dressing, walking and other activities that the member is unable to do for medical reasons;
- Routine preventive dental services, including oral health screenings, cleanings, fluoride treatments, dental sealant, oral hygiene education, X-rays, fillings, extractions and other therapeutic and medically necessary procedures;
- Vision services, including exams and prescriptive lenses (a limited selection of lenses and frames are covered);
- Outpatient speech, occupational and physical therapy;
- Chiropractic services;
- Conscious sedation;
- Adaptive aids (DD members only);
- Medically necessary practitioner visits to member's home (DD members only);
- Incontinence briefs, with limitations; and
- Acute services for DDD Members enrolled in CR.

Additional services for Qualified Medicare Beneficiaries (QMB):

- Chiropractic services;
- Outpatient occupational therapy; and
- Any services covered by Medicare but not by AHCCCS.

Limited and Excluded Services

The following services are not covered for adults 21 years and older. (If a member is a Qualified Medicare Beneficiary, we will continue to pay their Medicare deductible and coinsurance for these services.)

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BENEFIT/SERVICE	SERVICE DESCRIPTION	SERVICE EXCLUSIONS OR LIMITATIONS
Percussive vests	This vest is placed on a person's chest and shakes to loosen mucous.	AHCCCS will not pay for percussive vests. Supplies, equipment maintenance (care of the vest) and repair of the vest will be paid for.
Bone-anchored hearing aid	A hearing aid that is put on a person's bone near the ear by surgery. This is to carry sound.	AHCCCS will not pay for Bone-Anchored Hearing Aid (BAHA). Supplies, equipment maintenance (care of the hearing aid) and repair of any parts will be paid for.
Cochlear implant	A small device that is put in a person's ear by surgery to help you hear better.	AHCCCS will not pay for cochlear implants. Supplies, equipment maintenance (care of the implant) and repair of any parts will be paid for.
Lower limb microprocessor controlled joint/prosthetic	A device that replaces a missing part of the body and uses a computer to help with the moving of the joint.	AHCCCS will not pay for a lower limb (leg, knee or foot) prosthetic that includes a microprocessor (computer chip) that controls the joint.
Emergency dental service	Emergency treatment for pain, infection, swelling and/or injury	Emergency dental services are covered for members under the age of 21. Covered emergency dental services for members 21 years of age and older are limited to problem focused exam, required X-rays, jaw fractures, biopsies and medically necessary anesthesia.
Transplants	A transplant is when an organ or blood cells are moved from one person to another.	Approval is based on the medical need and if the transplant is on the "covered" list. Only transplants listed by AHCCCS as covered will be paid for.
Occupational and Physical Therapy	Exercises taught or provided by a physical therapist to make you stronger or help improve movement	<p>Outpatient Occupational Therapy services are covered for members under the age of 21, when medically necessary.</p> <p>Outpatient Occupational Therapy services are covered for members, 21 years of age and older as follows:</p> <ul style="list-style-type: none"> • 15 OT visits per benefit year for restoring a skill or level of function and maintaining that skill or level of function once restored, and • 15 OT visits per benefit year for acquiring a new skill or a new level of function and maintaining that skill or level of function

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once acquired.

Outpatient physical therapy visits are limited to 15 habilitate / 15 rehabilitative for a total of 30 visits for the continued care for one diagnosis per contract year (10/1– 9/30). For dual eligible members, the health plan is responsible for paying the Medicare cost of share limited to 15 habilitate/15 rehabilitative for a total of 30 visits for the continued care for one diagnosis per contract year (10/1– 09/30).

Orthotic Devices

Orthotic devices for members under the age of 21 are provided when prescribed by the member's primary care provider, attending physician or practitioner.

Orthotics devices for members who are 21 years of age and older:

MCCC covers orthotic devices for members who are 21 years of age and older when the orthotic is medically necessary as the preferred treatment based on Medicare Guidelines, along with the following criteria:

- The orthotic costs less than all other treatments and surgical procedures to treat the same condition; and
- The orthotic is ordered by a physician or primary care practitioner (nurse practitioner or physician assistant).

Repairs or Adjustments of Purchased Equipment:

Reasonable repairs or adjustments of purchased equipment are covered for all members over and under the age of 21 to make the equipment serviceable and/or when the repair cost is less than renting or purchasing another unit. The component will be replaced if at the time authorization is sought and documentation is provided to establish that the component is not operating effectively.

2.02 – Non-Covered Services

Non-covered services include:

- Services from a provider who is NOT contracted with MCCC (unless prior approved by the Health Plan)
- Cosmetic services or items;
- Personal care items such as combs, razors, soap etc.;

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- Any service that needs prior authorization that was not prior authorized;
- Services or items given free of charge, or for which charges are not usually made;
- Services of special duty nurses, unless medically necessary and prior authorized;
- Physical therapy that is not medically necessary;
- Routine circumcisions;
- Services that are determined to be experimental by the health plan medical director;
- Abortions and abortion counseling, unless medically necessary, pregnancy is the result of rape or incest, or if physical illness related to the pregnancy endangers the health of the mother;
- Health services if you are in prison or in a facility for the treatment of tuberculosis;
- Experimental organ transplants, unless approved by AHCCCS;
- Sex change operations;
- Reversal of voluntary sterilization;
- Medications and supplies without a prescription;
- Treatment to straighten teeth, unless medically necessary and approved by MCCC;
- Prescriptions not on our list of covered medications, unless approved by MCCC;
- Physical exams for qualifying for employment or sports activities;

Other Services that are Not Covered for Adults (age 21 and over)

- Hearing aids, including bone-anchored hearing aids.
- Cochlear implants;
- Microprocessor controlled lower limbs and microprocessor-controlled joints for lower limbs;
- Percussive vests;
- Routine eye examinations for prescriptive lenses or glasses;
- Routine dental services and emergency dental services, unless related to the treatment of a medical condition such as acute pain, infection, or fracture of the jaw;
- Chiropractic services (except for Medicare QMB members);
- Outpatient speech therapy (except for Medicare QMB members).

PLAN SPECIFIC TERMS**MCCC CHAPTER 3 – BEHAVIORAL HEALTH****3.00 - Behavioral Health Overview**

Comprehensive mental health and substance abuse (behavioral health) services are available to MCCC members. A direct referral for a behavioral health evaluation can be made by any health care professional in coordination with the member's assigned PCP and care manager. MCCC members may also self-refer for a behavioral health evaluation. The level and type of behavioral health services will be provided based upon a member's strengths and needs and will respect a member's culture. Behavioral health services include:

- Behavior management (personal care, family support/home care training, peer support)
- Behavioral health care management services
- Behavioral health nursing services
- Emergency behavioral healthcare
- Emergency and non-emergency transportation
- Evaluation and assessment
- Individual, group and family therapy and counseling
- Inpatient hospital services
- Non-hospital inpatient psychiatric facilities services (Level I residential treatment centers and sub-Acute facilities)
- Lab and radiology services for psychotropic medication regulation and diagnosis
- Opioid Agonist treatment
- Partial care (supervised, therapeutic and medical day programs)
- Psychological rehabilitation (living skills training; health promotion; supportive employment services)
- Psychotropic medication
- Psychotropic medication adjustment and monitoring
- Respite care (with limitations)
- Rural substance abuse transitional agency services
- Screening
- Home Care Training to Home Care Client

3.01 - Behavioral Health Provider Types

Several main provider types typically provide behavioral health services for MCCC members. These may include, but are not limited to, the following licensed agencies or individuals:

- Outpatient behavioral health clinics
- Psychiatrists
- Psychologists
- Certified psychiatric nurse practitioners
- Licensed clinical social workers
- Licensed professional counselors
- Licensed associate counselors

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- Licensed marriage and family therapists
- Licensed substance abuse counselors
- Residential treatment facilities
- Behavioral health group homes, Levels II and III.
- Partial hospital programs
- Substance abuse programs

3.02 - Alternative Living Arrangements

MCCC also includes the following alternative living arrangements:

- **Behavioral Health Level II and III** – these settings provide behavioral health treatment with 24-hour supervision. Services may include on site medical services and intensive behavioral health treatment programs.
- **Traumatic Brain Injury Treatment Facility** – this setting provides treatment and services for people with traumatic brain injuries.
- **DDD Group Homes** – these settings provide behavioral health treatment with 24-hour supervision.

3.03 - Emergency Services

MCCC covers behavioral health emergency services for MCCC members. If a member is experiencing a behavioral health crisis, please contact the MCCC Behavioral Health Hotline at 800-876-5835.

During a member's behavioral health emergency, the MCCC Behavioral Health Hotline clinician may dispatch a behavioral health mobile crisis team to the site of the member to de-escalate the situation and evaluate the member for behavioral health services. All medically necessary services are covered by MCCC.

3.04 - Behavioral Health Consults

Behavioral Health consults are required by AHCCCS on all MCCC members who receive behavioral health services. Behavioral Health Consults are done between an MCCC care manager and a behavioral health care manager reviewing the behavioral health provider's progress notes and treatment plan to determine continued medical necessity of the services. Per AHCCCS guidelines, the following items are required for the Behavioral Health Consultations Process:

- Consults must take place quarterly for long term care members that are receiving behavioral health services and 30 days after a referral for behavioral health services is made.
- Behavioral health consultations must be reviewed face-to-face with, and the outcome signed by, a Master's Level Behavioral Health Clinician.

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MCCC behavioral health prescriber will send a letter to the member's PCP regarding the member's treatment and psychotropic medication regime.

3.05 - Behavioral Health Screening

- Members should be screened by their PCP for behavioral health needs during routine or preventive visits.
- Behavioral health screening by PCPs is required at each EPSDT visit for members under age 21

3.06 - Behavioral Health Appointment Standards

MCCC routinely monitors providers for compliance with appointment standards. The minimum standard requirements are:

- Urgent - Within 24 hours of referral.
- Routine - within 30 days of referral.

3.07 - Behavioral Health Provider Coordination of Care Responsibilities

It is critical that a strong communication link be maintained with behavioral health providers including:

- PCPs and other interested parties such as CPS (if the guardian and MCCC have the paper work)
- Public Fiduciary Department (if documentation is provided identifying the Public Fiduciary Department as the member's guardian)
- Veterans Office (when guardian)
- Children's schools (participation in the ISP with parental or guardian consent)
- The court system (when completing paper work for all court ordered treatments or evaluations)
- Other providers not described above

Information can be shared with the other party that is necessary for the member's treatment. This process begins once a member is identified as meeting medical necessity for seeing a behavioral health provider by the behavioral health coordinator. Information can be shared with other parties with written permission from the member or the member's guardian.

3.08 - PCP Coordination of Care

The PCP will be informed of the member's behavioral health provider so that communication may be established. It is very important that PCPs develop a strong communication link with the behavioral health provider. PCPs are expected to exchange any relevant information such as medical history, current medications, diagnosis and treatment within 10 business days of receiving the request from the behavioral health provider.

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Where there has been a change in a member's health status identified by a medical provider, there should be coordination of care with the behavioral health provider within a timely manner. The update should include but is not limited to; diagnosis of chronic conditions, support for the petitioning process, and all medication prescribed.

The PCP should also document, and initial signifying review receipt of information received from a behavioral health provider who is treating the member. All efforts to coordinate on care on behalf of the member should be documented in the member's medical record.

3.09 – General and Informed Consent

Each member has the right to participate in decisions regarding his or her behavioral health care, including the right to refuse treatment. It is important for members seeking behavioral health services to agree to those services and be made aware of the service options and alternatives available to them as well as specific risks and benefits associated with these services.

General Consent is a one-time agreement to receive certain services, including but not limited to behavioral health services that is usually obtained from a member during the intake process at the initial appointment, and is always obtained prior to the provision of any behavioral health services. General consent must be obtained from a member's behavioral health recipient's or legal guardian's signature.

Informed Consent is an agreement to receive behavioral health services before the provision of a specific treatment that has associated risks and benefits. Informed consent is required to be obtained from a member or legal guardian prior to the provision of the following services and procedures:

- Complementary and Alternative Medicine (CAM),
- Psychotropic medications,
- Electro-Convulsive Therapy (ECT),
- Use of telemedicine,
- Application for a voluntary evaluation,
- Research,
- Admission for medical detoxification, an inpatient facility or a residential program (for members determined to have a Serious Mental Illness), and
- Procedures or services with known substantial risks or side effects

MCCC recognizes two primary types of consent for behavioral health services: general consent and informed consent.

Prior to obtaining informed consent, an appropriate behavioral health representative, as identified in R9-21-206.01(c), must present the facts necessary for a member to make an

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informed decision regarding whether to agree to the specific treatment and/or procedures. Documentation that the required information was given, and that the member agrees or does not agree to the specific treatment, must be included in the comprehensive clinical record, as well as the member/ guardian's signature when required.

In addition to general and informed consent for treatment, state statute (A.R.S. §15-104) requires written consent from a child's parent or legal guardian for any behavioral health survey, analysis, or evaluation conducted about a school-based prevention program.

The intent of this section is to describe the requirements for reviewing and obtaining general, and informed consent, for members receiving services within the behavioral health system, as well as consent for any behavioral health survey or evaluation in connection with an AHCCCS school-based prevention program.

General Requirements

- Any member aged 18 years and older, in need of behavioral health services must give voluntary general consent to treatment, demonstrated by the member's or legal guardian's signature on a general consent form, before receiving behavioral health services.
- For members under the age of 18, the parent, legal guardian, or a lawfully authorized custodial agency (including foster care givers A.R.S. 8.514.05(C)) must give general consent to treatment, demonstrated by the parent, legal guardian, or a lawfully authorized custodial agency representative's signature on a general consent form prior to the delivery of behavioral health services.
- Any member aged 18 years and older or the member's legal guardian, or in the case of members under the age of 18, the parent, legal guardian or a lawfully authorized custodial agency, after being fully informed of the consequences, benefits and risks of treatment, has the right not to consent to receive behavioral health services.
- Any member aged 18 years and older or the member's legal guardian, or in the case of members under the age of 18, the parent, legal guardian or a lawfully authorized custodial agency has the right to refuse medications unless specifically required by a court order or in an emergency.
- Providers treating members in an emergency are not required to obtain general consent prior to the provision of emergency services. Providers treating members pursuant to court order must obtain consent, as applicable, in accordance with A.R.S. Title 36, Chapter 5.
- All evidence of informed consent and general consent to treatment must be documented in the comprehensive clinical record per the **AHCCCS AMPM Policy 940**.
- Contractors and TRBHAs must develop and make available to providers policies and procedures that include any additional information or forms.
- A foster parent, group home staff, foster home staff, relative, or other person or agency in whose care a child is currently placed may give consent for:
 - Evaluation and treatment for emergency conditions that are not life threatening, and

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- Routine medical and dental treatment and procedures, including Early Periodic Screening Diagnosis and Treatment (EPSDT) services, and services by health care providers to relieve pain or treat symptoms of common childhood illnesses or conditions (A.R.S. §8-514.05(C)).
- To ensure timely delivery of services, consent for intake and routine behavioral health services may be obtained from either the foster caregiver or the Department of Child Safety Specialist (DCSS) whomever is available to do so immediately upon request (A.R.S. § 8-514.05(C)).
- Foster or kinship caregivers can consent to evaluation and treatment for routine medical and dental treatment and procedures, including behavioral health services. Examples of behavioral health services in which foster, or kinship can consent to include:
 - Assessment and service planning,
 - Counseling and therapy,
 - Rehabilitation services,
 - Medical Services,
 - Psychiatric evaluation,
 - Psychotropic medication,
 - Laboratory services,
 - Support Services,
 - Care Management,
 - Personal Care Services,
 - Family Support,
 - Peer Support,
 - Respite,
 - Sign Language or Oral Interpretive Services,
 - Transportation,
 - Crisis Intervention Services,
 - Behavioral Health Day Programs.
- A foster parent, group home staff, foster home staff, relative, or other person or agency in whose care a child is currently placed shall not consent to:
 - General Anesthesia,
 - Surgery,
 - Testing for the presence of the human immunodeficiency virus,
 - Blood transfusions,
 - Abortions.
- Foster or kinship caregivers may not consent to terminate behavioral health treatment. The termination of behavioral health treatment requires Department of Child Safety (DCS) consultation and agreement.
- If the foster or kinship caregiver disagrees on the behavioral health treatment being recommended through the Child and Family Team (CFT), the CFT including the foster or kinship caregiver and DCS case worker should reconvene and discuss the recommended

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treatment plan. Only DCS can refuse consent to medically recommended behavioral health treatment.

General Consent

Administrative functions associated with a member's enrollment do not require consent, but before any services are provided, general consent must be obtained.

MCCC will make available to providers any form used to obtain general consent to treatment.

Informed Consent

- In all cases where informed consent is required by this policy, informed consent must include at a minimum:
 - The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions,
 - Information about the member's diagnosis and the proposed treatment, including the intended outcome, nature and all available procedures involved in the proposed treatment,
 - The risks, including any side effects, of the proposed treatment, as well as the risks of not proceeding,
 - The alternatives to the proposed treatment, particularly alternatives offering less risk or other adverse effects,
 - That any consent given may be withheld or withdrawn in writing or orally at any time. When this occurs, the provider must document the member's choice in the medical record;
 - The potential consequences of revoking the informed consent to treatment, and
- A description of any clinical indications that might require suspension or termination of the proposed treatment. Documenting Informed Consent:
 - Members, or if applicable the member's parent, guardian or custodian, shall give informed consent for treatment by signing and dating an acknowledgment that he or she has received the information and gives informed consent for the proposed treatment.
 - When informed consent is given by a third party, the identity of the third party and the legal capability to provide consent on behalf of the member, must be established. If the informed consent is for psychotropic medication or telemedicine and the member, or if applicable, the member's guardian refuses to sign an acknowledgment and gives verbal informed consent, the medical practitioner shall document in the member's record that the information was given, the member refused to sign an acknowledgment and that the member gives informed consent to use psychotropic medication or telemedicine.
- When providing information that forms the basis of an informed consent decision for the circumstances identified above, the information must be:

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- Presented in a manner that is understandable and culturally appropriate to the member, parent, legal guardian or an appropriate court; and
- Presented by a credentialed behavioral health medical practitioner or a registered nurse with at least one year of behavioral health experience. It is preferred that the prescribing clinician provide information forming the basis of an informed consent decision. In specific situations in which it is not possible or practicable, information may be provided by another credentialed behavioral health medical practitioner or registered nurse with at least one year of behavioral health experience.
- Psychotropic Medications, Complementary and Alternative Treatment and Telemedicine:
 - Unless treatments and procedures are court ordered, providers must obtain written informed consent, and if written consent is not obtainable, providers must obtain oral informed consent. If oral informed consent is obtained instead of written consent from the member, parent or legal guardian, it must be documented in written fashion. Informed consent is required in the following circumstances:
 - Prior to the initiation of any psychotropic medication or initiation of Complementary and Alternative Treatment (CAM) (see [AMPM Policy 310-V](#)). The use of [AMPM Exhibit 310-V, Attachment A](#), Informed Consent/Assent for Psychotropic Medication Treatment Form is recommended as a tool to review and document informed consent for psychotropic medications, and
 - Prior to the delivery of behavioral health services through telemedicine.
 - Electro-Convulsive Therapy (ECT), research activities, voluntary evaluation and procedures or services with known substantial risks or side effects.
 - Written informed consent must be obtained from the member, parent or legal guardian, unless treatments and procedures are under court order, in the following circumstances:
 - Before the provision of (ECT),
 - Prior to the involvement of the member in research activities,
 - Prior to the provision of a voluntary evaluation for a member. The use of AMPM Exhibit 320-Q-1, Application for Voluntary Evaluation is required for members determined to have a Serious Mental Illness and is recommended as a tool to review and document informed consent for voluntary evaluation of all other populations, and
 - Prior to the delivery of any other procedure or service with known substantial risks or side effects.
- Written informed consent must be obtained from the member, legal guardian or an appropriate court prior to the member's admission to any medical detoxification, inpatient facility or residential program operated by a behavioral health provider.
- If informed consent is revoked, treatment must be promptly discontinued, except in cases in which abrupt discontinuation of treatment may pose an imminent risk to the member. In such cases, treatment may be phased out to avoid any harmful effects.
- Informed Consent for Telemedicine:

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- Before a health care provider delivers health care via telemedicine, verbal or written informed consent from the member or their health care decision maker must be obtained. Refer to the AHCCCS AMPM Policy 320-I for additional detail.
- Informed consent may be provided by the behavioral health medical practitioner or registered nurse with at least one year of behavioral health experience. When providing informed consent, it must be communicated in a manner that the member and/or legal guardian can understand and comprehend.
- Exceptions to this consent requirement include:
 - If the telemedicine interaction does not take place in the physical presence of the member;
 - In an emergency in which the member or the member's health care decision maker is unable to give informed consent; or
 - To the transmission of diagnostic images to a health care provider serving as a consultant or the reporting of diagnostic test results by that consultant.

Special Requirements for Children

- In accordance with A.R.S. §36-2272, except as otherwise provided by law or a court order, no person, corporation, association, organization or state-supported institution, or any individual employed by any of these entities, may procure, solicit to perform, arrange for the performance of or perform mental health screening in a nonclinical setting or mental health treatment on a minor without first obtaining consent of a parent or a legal custodian of the minor child. If the parental consent is given through telemedicine, the health professional must verify the parent's identity at the site where the consent is given. This section does not apply when an emergency exists that requires a person to perform mental health screening or provide mental health treatment to prevent serious injury to or save the life of a minor child.
- Non-Emergency Situations
 - In cases where the parent is unavailable to provide general or informed consent and the child is being supervised by a caregiver who is not the child's legal guardian (e.g., grandparent) and does not have power of attorney, general and informed consent must be obtained from one of the following:
 - Lawfully authorized legal guardian,
 - Foster parent, group home staff or another person with whom the DCS has placed the child, or
 - Government agency authorized by the court.
- If someone other than the child's parent intends to provide general and, when applicable, informed consent to treatment, the following documentation must be obtained and filed in the child's comprehensive clinical record:

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INDIVIDUAL/ENTITY	DOCUMENTATION
Legal guardian	Copy of court order assigning custody
Relatives	Copy of power of attorney document
Another person/agency	Copy of court order assigning custody
DCS Placements (for children removed from the home by DCS), such as: <ul style="list-style-type: none"> • Foster parents • Group home staff • Foster home staff • Relatives • Other person/agency in whose care DCS has placed the child 	None required (see note)

NOTE: If behavioral health providers doubt whether the individual bringing the child in for services is a person/agency representative in whose care DCS has placed the child, the provider may ask to review verification, such as documentation given to the individual by DCS indicating that the individual is an authorized DCS placement. If the individual does not have this documentation, then the provider may also contact the child's DCS case worker to verify the individual's identity.

- For any child who has been removed from the home by DCS, the foster parent, group home staff, foster home staff, relative or other person or agency in whose care the child is currently placed may give consent for the following behavioral health services:
 - Evaluation and treatment for emergency conditions that are not life threatening, and
 - Routine medical and dental treatment and procedures, including early periodic screening, diagnosis and treatment services, and services by health care providers to relieve pain or treat symptoms of common childhood illnesses or conditions (including behavioral health services and psychotropic medications).
 - Any minor who has entered into a lawful contract of marriage, whether that marriage has been dissolved subsequently, any emancipated youth or any homeless minor may provide general and, when applicable, informed consent to treatment without parental consent (A.R.S. §44-132).
- Emergency Situations
 - In emergencies involving a child in need of immediate hospitalization or medical attention, general and, when applicable, informed consent to treatment is not required.

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- Any child, 12 years of age or older, who is determined upon diagnosis of a licensed physician, to be under the influence of a dangerous drug or narcotic, not including alcohol, may be considered an emergency and can receive behavioral health care as needed for the treatment of the condition without general and, when applicable, informed consent to treatment.

At times, involuntary treatment can be necessary to protect safety and meet needs when a member, due to mental disorder, is unwilling or unable to consent to necessary treatment. In this case, a court order may serve as the legal basis to proceed with treatment. However, capacity to give informed consent is situational, not global, as a member may be willing and able to give informed consent for aspects of treatment even when not able to give general consent. Members should be assessed for capacity to give informed consent for specific treatment and such consent obtained if the member is willing and able, even though the member remains under court order.

Consent for Behavioral Health Survey or Evaluation for School-Based Prevention Programs

- Written consent must be obtained from a child's parent or legal guardian for any behavioral health survey, analysis, or evaluation conducted about a school-based prevention program administered by AHCCCS.
- AMPM Exhibit 320-Q-2, Substance Abuse Prevention Program and Evaluation Consent must be used to gain parental consent for evaluation of school-based prevention programs. Providers may use an alternative consent form only with the prior written approval of AHCCCS. The consent must satisfy all the following requirements:
 - Contain language that clearly explains the nature of the screening program and when and where the screening will take place;
 - Be signed by the child's parent or legal guardian; and
 - Provide notice that a copy of the actual survey, analysis, or evaluation questions to be asked of the student is available for inspection upon request by the parent or legal guardian.
- 3. Completion of AMPM Exhibit 320-Q-2, Substance Abuse Prevention Program and Evaluation Consent applies solely to consent for a survey, analysis, or evaluation only, and does not constitute consent for participation in the program itself.

3.10 - Family Involvement

Family involvement in a member's treatment is an important aspect in recovery. Studies have shown members who have family involved in their treatment tend to recover quicker, have less dependence on outside agencies, and tend to rely less on emergency resources. Family is defined as any person related to the member biologically or appointed (step-parent, guardian, and/or power of attorney). Treatment includes treatment planning, participation in counseling or psychiatric sessions, providing transportation or social support to the member. Information

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can be shared with other parties with written permission from the member or the member's guardian.

3.11 - Members with Diabetes and the Arizona State Hospital

- Members with diabetes who are admitted to the Arizona State Hospital (herein AzSH) for behavioral health services will receive training to use a glucometer and testing supplies during their stay at AzSH.
- Upon discharge from AzSH, PCPs must ensure these members are issued the same brand and model of glucometer and supplies that they were trained to use during their AzSH admission.
- MCCC's behavioral health coordinator will notify the PCP of the member's discharge from AzSH and provide information on the brand and model of equipment and supplies that should be continued to be prescribed.
- The MCCC behavioral health coordinator will work with AzSH to ensure the member has enough testing supplies to last until an office visit can be scheduled with the provider.
- In the event the member's mental status renders them incapable or unwilling to manage their medical condition and that condition requires skilled medical care, the MCCC behavioral health coordinator will work with AzSH and the PCP to obtain an appropriate placement for additional outpatient services.
- For re-authorization for continued behavioral health services, contact the member's care manager and fax the Behavioral Health Treatment Plan and progress notes requesting continued authorization. Be sure to include the services to be delivered, frequency of services to be delivered and duration of services provided.
- ALWAYS verify member eligibility prior to the provision of services.

3.12 – Pre-Petition Screening, Court Ordered Evaluation and Court Ordered Treatment

At times, it may be necessary to initiate civil commitment proceedings to ensure the safety of a person, or the safety of other persons, due to a member's mental disorder when that member is unable or unwilling to participate in treatment. In Arizona, state law permits any responsible person to apply for pre-petition screening when another member may be, because of a mental disorder:

- **A danger to self (DTS);**
- **A danger to others (DTO);**
- **Persistently or acutely disabled (PAD); or**
- **Gravely disabled (GD).**

If the person who is the subject of a court ordered commitment proceeding is subject to the jurisdiction of an Indian tribe rather than the state, the laws of that tribe, rather than state law, will govern the commitment process.

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Pre-petition screening includes an examination of the person's mental status and/or other relevant circumstances by a designated screening agency. Upon review of the application, examination of the person and review of other pertinent information, a licensed screening agency's medical director or designee will determine if the person meets criteria for DTS, DTO, PAD, or GD because of a mental disorder.

If the pre-petition screening indicates that the person may be DTS, DTO, PAD, or GD, the screening agency will file an application for a court ordered evaluation. Based on the immediate safety of the member or others, an emergency admission for evaluation may be necessary. Otherwise, an evaluation will be arranged for the person by a designated evaluation agency within timeframes specified by state law.

Based on the court ordered evaluation, the evaluating agency may petition for court ordered treatment on behalf of the member. A hearing, with the member and his/her legal representative and the physician(s) treating the member, will be conducted to determine whether the member will be released and/or whether the agency will petition the court for court ordered treatment. For the court to order ongoing treatment, the person must be determined, because of the evaluation, to be DTS, DTO, PAD, or GD. Court Ordered Treatment (COT) may include a combination of inpatient and outpatient treatment. Inpatient treatment days are limited contingent on the member's designation as DTS, DTO, PAD, or GD. Members identified as:

- DTS may be ordered up to 90 inpatient days per year;
- DTO and PAD may be ordered up to 180 inpatient days per year; and
- GD may be ordered up to 365 inpatient days per year.

If the court orders a combination of inpatient and outpatient treatment, a mental health agency will be identified by the court to supervise the person's outpatient treatment. Before the court can order a mental health agency to supervise the person's outpatient treatment, the agency medical director must agree and accept responsibility by submitting a written treatment plan to the court.

At every stage of the pre-petition screening, court ordered evaluation, and court ordered treatment process, a person will be provided an opportunity to change his/her status to voluntary. Under voluntary status, the person is no longer considered to be at risk for DTS/DTO and agrees in writing to receive a voluntary evaluation.

County agencies and MCCC contracted agencies responsible for pre-petition screening and court ordered evaluations must use the following forms prescribed in **9 A.A.C. 21, Article 5** for persons determined to have a Serious Mental Illness; agencies may also use the following forms AHCCCS Forms found under the [AHCCCS Medical Policy Manual, Section 320-U](#), for all other populations:

- **Application for Involuntary Evaluation**

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- **Application for Voluntary Evaluation**
- **Application for Emergency Admission for Evaluation**
- **Petition for Court Ordered Evaluation**
- **Petition for Court Ordered Treatment Gravely Disabled Person**
- **Affidavit**
- **Special Treatment Plan for Forced Administration of Medications**

In addition to court ordered treatment as a result of civil action, an individual may be ordered by a court for evaluation and/or treatment upon: 1) conviction of a domestic violence offense; or 2) upon being charged with a crime when it is determined that the individual is court ordered to treatment, or programs, as a result of being charged with a crime and appears to be an “alcoholic”.

Licensing Requirements

Behavioral health providers who are licensed by the Arizona Department of Health Services/Division of Public Health Licensing Services as a court ordered evaluation or court ordered treatment agency must adhere to ADHS licensing requirements.

Pre-Petition Screening

PINAL COUNTY

Pinal County contracts with Horizon Health and Wellness and CPR to complete Pre-Petition Screening within Pinal County. These services can be accessed by calling Nursewise at 1-866-495-6735.

GILA COUNTY

In Gila County, Community Bridges Inc. is the designated screening agency; however other behavioral health agencies may be granted permission upon request to the Gila County Attorney's Office. Community Bridges, Inc. can be contacted at 1-877-931-9142.

MARICOPA COUNTY

There is an intergovernmental agreement between Maricopa County and AHCCCS for the management, provision of, and payment for Pre-Petition Screening and Court Ordered Evaluation. AHCCCS in turn contracts with MCCC for these pre-petition screening and court ordered evaluation functions. MCCC is required to coordinate provision of behavioral health services with the member's contractor responsible for the provision of behavioral health services.

The pre-petition screening includes an examination of the member's mental status and/or other relevant circumstances by a designated screening agency. The designated screening agency must follow these procedures:

- The pre-petition screening agency must help, if needed, to the applicant in the preparation of the application for court ordered evaluation (see Application for

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Involuntary Evaluation).

- Any behavioral health provider that receives an application for court ordered evaluation (see Application for Involuntary Evaluation) must immediately refer the applicant for pre-petition screening and petitioning for court ordered evaluation to the designated pre-petition screening agency or county facility.

Filing of Non-Emergent Petitions

This provides instruction to the Care Manager and Pre-Petition Team relative to AAC and ARC requirements, not intended to be instructive to provider/community members.

Non-emergent Process

For behavioral health members receiving MCCC Clinic Services, the following steps will be completed by the Clinical Team.

- For all other residents of Maricopa County (not enrolled with a MCCC Clinic), the pre-petition team will complete these steps for petitions for COE. Any responsible individual may apply for a COE of a member who is alleged to be, because of a mental disorder, a danger to self or to other, persistently or acutely disabled, or gravely disabled and who is unwilling or unable to undergo a voluntary evaluation.
- For Maricopa County residents not enrolled with a MCCC Clinic, an applicant contacts the MCCC Customer Service Line at 800-564-5465 or the Crisis Response Network Crisis Line 800-631-1314 and requests a PAD or GD petition application be completed on an identified member in the community. An applicant can also go in person to UPC, RRC, or CPEC to begin the non-emergent process. The Pre-Petition team shall receive the referral and will contact the applicant to assist the applicant in completion of the **Application for Involuntary Evaluation** when a non-emergency COE is requested. All other steps, when applicable, will be the same as for MCCC Clinic enrolled behavioral health members.
- For MCCC Clinic enrolled behavioral health members, the Clinical Team shall assist the applicant in the completion of the application and evaluation when a non-emergency COE is requested. If at any time during the process the behavioral health member is determined to be in imminent danger of harming self or others, UPC, RRC, or CPEC will be contacted for assistance in evaluation and possible application for an emergency admission.
- For all MCCC Clinic enrolled or non-enrolled members, pre-petition screening must be attempted within forty-eight (48) hours, excluding weekends and holidays, of completion of the application. Pre-petition screening process includes informing the individual that an application for evaluation (**Application for Involuntary Evaluation**) has been completed, explaining the individual's rights to voluntary evaluation, reviewing the allegations, and completing a mental status examination. The **Pre-Petition Screening Report** is a detailed report of the information obtained during the assessment. This report must be completed by someone other than the applicant. If the member does consent to a voluntary evaluation the **Application for Voluntary**

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Evaluation shall be used.

- During the pre-petition screening, at least three attempts to contact the behavioral health member should be completed. If attempts at contacting the behavioral health member are unsuccessful and screening is not possible, screening staff will review this information with a physician. The screening agency shall prepare a report giving reasons why the screening was not possible, including opinions/conclusions of staff members who attempted to conduct pre- petition screening.
- If the behavioral health member does not consent to a voluntary outpatient evaluation or voluntary inpatient evaluation or when a voluntary evaluation is not appropriate as determined by the evaluating psychiatrist, the involuntary process shall continue.
- The Clinical Team or Pre-Petition Team will staff the application for involuntary evaluation (**Application for Involuntary Evaluation** and **Pre-Petition Screening Report**) with a psychiatrist. The psychiatrist need never have met the person to decide regarding whether to move forward with a Petition for COE. The psychiatrist will:
 - Review the application, pre-petition screening report, and any other collateral information made available as part of the pre-petition screening to determine if it indicates that there is reasonable cause to believe the allegations of the applicant for the COE.
 - Prepare a Petition for COE and file the petition if the psychiatrist determines that the member, due to a mental disorder, which may include a primary diagnosis of dementia and other cognitive disorders, is DTS, DTO, PAD or GD. The **Petition for Court Ordered Evaluation** documents pertinent information for COE;
 - If the psychiatrist determines that there is reasonable cause to believe that the member, without immediate hospitalization, is likely to harm him/her or others, the psychiatrist must coordinate with the UPC, RRC-W or CPEC and ensure completion of the **Application for Emergency Admission for Evaluation** and take all reasonable steps to procure hospitalization on an emergency basis.
- Pre-petition screens, application, and petition for Inpatient or Outpatient Court Ordered Evaluation can be filed on a non-emergent basis at the MIHS Desert Vista Campus Legal Office, 570 West Brown Road, Mesa, AZ 85201, and 480-344-2000. This involves all Persistently or Acutely Disabled (PAD) and Gravely Disabled (GD) petitions. Danger to Self (DTS) and Danger to Others (DTO) petitions that do not require immediate intervention can also be filed on a non-emergent basis. Please use the following forms for filing the non-emergent petition: **Petition for Court Ordered Evaluation** and **Application for Involuntary Evaluation**.
- Eight copies and the original Petition for Court Ordered Evaluation, Application for Involuntary Evaluation, Pre-Petition Screening Report and the Police Mental Health Detention Information Sheet, must be submitted by the behavioral health member's Care Manager or the pre-petition team to the Legal Department at Maricopa Integrated Health System (MIHS) Desert Vista Campus for review by the County Attorney, preparation of the Detention Order, and filing with the Superior Court. These documents must be filed within 24 hours of completion, excluding weekends and

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holidays.

- Once the petition is filed with the court, the Legal Department at MIHS Desert Vista Campus Delivers the Detention Order to the Police Department to have the behavioral health member brought to the UPC, RRC or CPEC for evaluation. NOTE: The **Petition for Court Ordered Evaluation** and **Police Mental Health Detention Information Sheet** expire 14 days from the date the judge signs off on the order for COE.
- One of the eight copies of petition documents shall be stored by the behavioral health member's Case Manager or the pre-petition team in a secure place (such as a locked file cabinet) to ensure the behavioral health member's confidentiality. A petition for involuntary evaluation may not be stored in the medical record if the behavioral health member has not been court ordered to receive treatment.

Emergent Filing

In cases where it is determined that there is reasonable cause to believe that the member is in such a condition that without immediate hospitalization he/she is likely to harm himself/herself or others, an application for emergency admission can be filed. Only applications indicating Danger to Self and/or Danger to Others can be filed on an emergent basis and shall be filed at the Urgent Psychiatric Care (UPC), 1201 S 7th Ave; Suite #150, Phoenix, AZ 85007; 602-416-7600; Response Recovery Center- (RRC, 11361 N. 99th Ave Suite 402, Peoria AZ 85345, 602-636-4605; or Community Psychiatric Emergency Center (CPEC), 358 E. Javelina, Mesa, AZ 85210, 480-507-3180. MCCC contracts with the UPC, RCC, and CPEC to assist the applicant in preparing the **Application for Emergency Admission for Evaluation** when an emergent evaluation is requested and can also assist when an Application for Court Ordered Evaluation on a non-emergent basis is needed due to the person not meeting criteria for an emergency admission.

Emergent process

The applicant is a person who has, based on personal observation, knowledge of the behavioral health member's behavior that is danger to self or danger to others. The applicant shall complete the **Application for Emergency Admission for Evaluation** with assistance of UPC/RRC/CPEC staff and include:

- The applicant must have seen or witnessed the behavior or evidence of mental disorder.
- The applicant, as a direct observer of dangerous behavior, may be called to testify in court if the application results in a petition for COE.
- Upon receipt of the Application for Emergency Admission for Emergency Evaluation (MH-104) the UPC, RRC or CPEC admitting officer will begin the assessment process to determine if enough evidence exists for an emergency admission for evaluation. If there is enough evidence to support the emergency admission for evaluation and the member does not require medical care beyond the capacity of UPC, RRC or CPEC, then the UPC, RRC or CPEC staff will immediately coordinate with local law enforcement for the detention of the member and transportation to UPC, RRC or CPEC.
- If the Application for Emergency Admission for Evaluation is accepted by the UPC, RRC

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or CPEC admitting officer and the member requires a level of medical support not available at the UPC, RRC or CPEC, then within 24 hours the UPC, RRC or CPEC admitting officer will coordinate admission to the MIHS Psychiatric Annex. If admission to the MIHS Psychiatric Annex cannot be completed within 24 hours of the Application for Emergency Admission for Evaluation being accepted by the UPC, RRC or CPEC admitting officer, then the Mercy RBHA Medical Director must be notified.

- An **Application for Emergency Admission for Evaluation** may be discussed by telephone with a UPC, RRC or CPEC admitting officer, the referring physician, and a police officer to facilitate transport of the member to be evaluated at a UPC, RRC or CPEC.
- A member proposed for emergency admission for evaluation may be apprehended and transported to the UPC, RRC or CPEC by police officials through a written **Application for Emergency Admission for Evaluation** faxed by the UPC, RRC or CPEC admitting officer to the police.
- A 23-Hour Emergency Admission for Evaluation begins at the time the behavioral health member is detained involuntarily by the Admitting Officer at UPC, RRC or CPEC who determines there is reasonable cause to believe that the member, as a result of a mental disorder, is a DTS or DTO and that during the time necessary to complete prescreening procedures the member is likely, without immediate hospitalization, to suffer harm or cause harm to others.
- During the emergency admission period of up to 23 hours the following will occur:
 - The behavioral health member's ability to consent to voluntary treatment will be assessed.
 - The behavioral health member shall be offered and receive treatment to which he/she may consent. Otherwise, other than calming talk or listening, the only treatment administered involuntarily will be for the safety of the individual or others, i.e. seclusion/restraint or pharmacological restraint in accordance with A.R.S. §36-513.
 - UPC/RRC/CPEC may contact the County Attorney prior to filing a petition if it alleges that a member is DTO.
 - If the behavioral health member is determined to require a court ordered evaluation, then the petition for COE will be filed with the court within 24 hours of admission (not including weekends or court holidays). If the behavioral health member does not meet the criteria for an application for emergency admission but is determined to meet criteria for PAD and/or GD, UPC, RRC-W or CPEC will notify and offer to assist the applicant of the non-emergent process.

Court Ordered Evaluation

If the pre-petition screening indicates that the member may be DTS, DTO, PAD, or GD, the screening agency will file an application for a court ordered evaluation. The procedures for court ordered evaluations are outlined below:

MCCC and its subcontracted behavioral health provider must follow these procedures:

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- A member being evaluated on an inpatient basis must be released within seventy-two hours (not including weekends or court holidays) if further evaluation is not appropriate, unless the member makes application for further care and treatment on a voluntary basis;
- A member who is determined to be DTO, DTS, PAD, or GD because of a mental disorder must have a petition for court ordered treatment prepared, signed and filed by Mercy RBHA's medical director or designee; and
- Title XIX/XXI funds must not be used to reimburse court ordered evaluation services.

MCCC encourages the utilization of outpatient evaluation on a voluntary or involuntary basis. MCCC is not be responsible to pay for the costs associated with Court Ordered Evaluation outside of the limited "medication only" benefit package available for Non-Title XIX members determined to have SMI, unless other prior payment arrangements have been made with another entity (e.g. county, hospital, provider).

Court Ordered Outpatient Evaluation

- After the pre-petition screening, if the member is refusing a voluntary evaluation and the psychiatrist determines the member is safe to go through an Outpatient Court Ordered Evaluation, then the Case Manager or pre-petition team will deliver the original Application for Involuntary Evaluation, **Pre-Petition Screening Report**, and **Petition for Court Ordered Evaluation** to the Legal Department at Maricopa Integrated Health System(MIHS) Desert Vista Campus for review by the County Attorney, preparation of the service order, and filing with the Superior Court.
- Once the petition is filed with the court, the Legal Department at MIHS Desert Vista delivers the service order to the police department to have the member served legal notice of the date/time/location of the outpatient evaluation. One of the eight copies of the petition documents shall be stored by the member's Care Manager or PAD team in a secure place (such as a locked file cabinet) to ensure the behavioral health member's confidentiality. A petition for involuntary evaluation may not be stored in the medical record if the behavioral health member has not been court ordered to receive treatment.
- The MIHS Legal Department will arrange for an outpatient Court Ordered Evaluation and notify the Case Manager or Pre-Petition Team of the date and time of the evaluation.
- If the Outpatient COE is scheduled to take place at Desert Vista, the Case Manager will arrange for transportation for the member to and from the Outpatient COE and will provide any documents requested by the psychiatrists conducting the evaluation. If the member is not enrolled at an SMI Clinic, the MCCC Court Liaison will assist the member in arranging transportation.
- If the two evaluating psychiatrists do not believe that the member needs COT, then the MIHS Legal Department will forward the physicians' affidavits to the Care Manager or Pre-Petition Team with an explanation that the member has been determined not to need COT.

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- If the two evaluating psychiatrists completing the Outpatient Court Ordered Evaluation determine the member needs COT, then the two physician's **Affidavit and social work** report will be delivered to the MIHS Legal Department within 1 business day of the evaluation. The MCCC Court Liaison will then file a Petition for Court Ordered Treatment with the Maricopa County Superior Court within 2 business days.

Voluntary Evaluation

Any MCCC contracted behavioral health provider that receives an application for voluntary evaluation must immediately refer the member to the facility responsible for voluntary evaluations.

Voluntary Inpatient or Outpatient Evaluation

- If the individual agrees to a voluntary evaluation, complete the **Application for Voluntary Evaluation** and review with a psychiatrist.
- If the psychiatrist determines that a voluntary evaluation is appropriate, then a decision as to whether the evaluation is to take place on an inpatient or outpatient basis will be made by the psychiatrist.
- If the psychiatrist determines an inpatient voluntary evaluation is necessary, the Care Manager or PAD Team is to arrange for a voluntary admission to UPC, RRC, or CPEC, for the evaluation to take place, assist the member in signing in and deliver the original notarized **Application for Voluntary Evaluation** to the UPC, RRC, or CPEC Coordinator.
- If the psychiatrist determines an outpatient voluntary evaluation is acceptable, then the Case Manager or PAD Team will deliver the original, notarized **Application for Voluntary Evaluation** to the MIHS Legal Department. An outpatient evaluation will then be scheduled at Desert Vista Hospital and the Case Manager or PAD Team will be responsible for notifying the member of the date and time of the evaluation, provide transportation to and from the evaluation, and provide any documentation requested by the physician's conducting the evaluation.
- The voluntary outpatient or inpatient assessment must include evaluation by two psychiatrists and the involvement of either two social workers, or one social worker and one psychologist, who shall complete the outpatient treatment plan. The voluntary psychiatric evaluation shall include determination regarding the existence of a mental disorder, and whether, because of a mental disorder, the individual meets one or more of the standards. The psychiatric evaluation must also include treatment recommendations. The psychiatrists completing the outpatient psychiatric evaluations will submit a written affidavit to the MIHS Legal Department regarding their findings.
- If the psychiatrists do not believe that the member needs COT, then the MIHS Legal Department will forward the physicians' affidavits to the Care Manager or PAD Team with an explanation that the member has been determined not to need COT.
- If the psychiatrists completing the voluntary inpatient evaluation or voluntary outpatient evaluation determine the member needs COT, then the two physician's **Affidavit** and a social work report will be delivered to the MIHS Legal Department within

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1 business day of the evaluation. The MCCC contracted behavioral health provider must follow these procedures:

- The evaluation agency must obtain the individual's informed consent prior to the evaluation (see **Application for Voluntary Evaluation** and provide evaluation at a scheduled time and place within five days of the notice that the member will voluntarily receive an evaluation;
- For inpatient evaluations, the evaluation agency must complete evaluations in less than seventy-two hours of receiving notice that the member will voluntarily receive an evaluation; and
- If a behavioral health provider conducts a voluntary evaluation service as described in this chapter, the comprehensive clinical record must include:
 - A copy of the **Application for Voluntary Evaluation**;
 - A completed informed consent form; and
 - A written statement of the member's present medical condition.

MCCC contracts with Maricopa Integrated Health Systems for inpatient Court Ordered Evaluations and Outpatient Court Ordered Evaluations when the county does not contract with MCCC for court ordered evaluations.

Court Ordered Treatment Following Civil Proceedings under A.R.S. Title 36

Based on the court ordered evaluation, the evaluating agency may petition for court-ordered treatment. The behavioral health provider must follow these procedures:

- Upon determination that an individual is DTS, DTO, GD, or PAD, and if no alternatives to court ordered treatment exist, the medical director of the agency that provided the court ordered evaluation must file a petition for court ordered treatment (see **Petition for Court Ordered Treatment**);
- Any behavioral health provider filing a petition for court ordered treatment must do so in consultation with the member's clinical team prior to filing the petition;
- The petition must be accompanied by the affidavits of the two physicians who conducted the examinations during the evaluation period and by the affidavit of the applicant for the evaluation (see **Affidavit** and attached addenda);
- A copy of the petition, in cases of grave disability, must be mailed to the public fiduciary in the county of the patient's residence, or the county in which the patient was found before evaluation, and to any member nominated as guardian or conservator; and
- A copy of all petitions must be mailed to the superintendent of the Arizona State Hospital.

Responsibility of the Outpatient Agency Appointed to Supervise and Administer the Court Order for Treatment

For ACC members on COT, the Outpatient Agency appointed by the court to supervise and administer COT is responsible to file status reports as ordered by the court. These are typically

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ordered at 45 days, 180 days, and 305 days after COT start date. Status review hearings where a team member must appear may also be ordered by the court.

The Outpatient Agency will schedule members on COT to see a Behavioral Health Medical Professional (BMHP) at least once every 30 days. If a member does not attend a scheduled appointment, the clinical team will attempt to locate the member and re-schedule the appointment within one (1) business day. If the member cannot be engaged, then clinical team will discuss options for engagement and options for amending the COT to bring the member to inpatient or sub-acute facility for assessment.

Members placed on COT after finding of Not Competent/Not Restorable in a Criminal Matter (Rule 11 COT)

Members placed on COT after having been found not competent and not restorable (Rule 11) require special treatment and tracking by the Outpatient Agency. ARS §36-544 requires the Outpatient Agency to file a notice with the court and prosecuting attorney within five (5) days of a members unauthorized absence from treatment and request the court toll (suspend) the treatment order for the period of time the patient is absent. “Unauthorized absence” means:

- The member is absent from an inpatient treatment facility without authorization; or
- The member is no longer living in a placement or residence specified by the treatment plan and has left without authorization; or
- The member left or failed to return **to the county or state without authorization.**

Additionally, the statute requires the Outpatient Agency to:

- Use information and other resources available to the agency to facilitate efforts to locate and return the patient to treatment.
- File a status report every sixty (60) days specifying the information and resources used to facilitate the member’s return to treatment; and
- Notify the court of the patient’s return to treatment.

After 180 days, the Outpatient Agency may petition the court to terminate the order for treatment. The court may either terminate the treatment order or require additional outreach.

If a Notice of Noncompliance appears in the Court Order for Treatment or Minute Entry, the Outpatient Agency must report any noncompliance with the treatment order.

If the medical director intends to release a patient from a Rule 11 COT prior to the expiration of the COT, he/she must provide at least a ten (10) day notice to the court, prosecuting attorney, and any relative or victim of the patient who filed a demand for notice.

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If the medical director decides not to renew a Rule 11 COT or the Application for Renewal was not filed on time, at least a ten (10) day notice of the pending expiration date of COT shall be provided to the court and prosecuting agency.

Judicial Review and COT Renewal Timelines/Forms

Judicial Review

Pursuant to ARS§36-546 each member Court Ordered Treatment must be provided with a Notice of the Right to Judicial Review 60 days after the start of COT and every 60 days thereafter. Any member of the clinical team can provide this notice and must document in a progress note the date and time notice was provided. The notice of right to judicial review can be completed verbally and/or with a form developed by the provider for this purpose. If the member does request Judicial Review, below is the timeline and paperwork that will need to be submitted:

- Member signs request for Judicial Review which is then signed by a member of the clinical team and notarized. The member does not need to make this request in person. Request for Judicial Review can be made on the phone and staff person receiving the phone call will complete the Request for Judicial Review form on behalf of the member and note that the request was made by phone on the form and also in a progress note in the medical record.
- The Psychiatric Report for Judicial Review must be completed by a psychiatrist signed and notarized, and filed with the court within 72 hours (not including weekends or court holidays) of the request for judicial review (please also note that the date of the MD signature MUST match the date of the notarization or it will be rejected).
- The original Request for Judicial Review and Psychiatric Report for Judicial Review must be filed with the court within 72 hours of the Request for Judicial Review.
- If the court orders a full hearing for the Judicial Review the medical director of the treating agency shall provide the member's attorney with a copy of the member's medical records at least 24hr prior to the hearing.

Application for COT Renewal

All renewal paperwork must be submitted to the provider agency court coordinator **NO LATER** than 45 days prior to the expiration of COT. If the Final Status Report states that renewal is requested, the following paperwork will need to be submitted:

- A Final Status Report stating that renewal is requested and can be signed by a psychiatrist or Nurse Practitioner.
- Psychiatric Report for Annual Review of COT must be completed by a psychiatrist, signed and notarized (please note that the date of the psychiatrist's signature MUST match the date of the notarization or it will be rejected).
- **ORIGINAL** Psychiatric Report for Annual Review of COT must be delivered to the provider agency court coordinator as copies cannot be filed with the court.

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- Two witness statements for those who will be attending a hearing if one should be set. (The witness statements aren't notarized so these can be scanned and emailed, preferably at the same time.)

**Please note that both psych reports must be completed by a MD. A NP or PA CANNOT complete these, nor is co-signing permitted.*

Members who are Title XIX/XXI Eligible and/or Determined to have Serious Mental Illness (SMI)

When a member referred for court ordered treatment is Title XIX/XXI eligible and/or determined or suspected to have a Serious Mental Illness, MCCC will:

- Conduct an evaluation to determine if the member has a Serious Mental Illness in accordance with **MCCC Chapter 3 – Behavioral Health, Section 3.14 – SMI Eligibility Determination**, and conduct a behavioral health assessment to identify the member's service needs in conjunction with the member's clinical team, as described in **MC Chapter 10 – Behavioral Health Assessments and Treatment/Service Planning**.
- Provide necessary court ordered treatment and other covered behavioral health services in accordance with the member
- Member's needs, as determined by the member's clinical team, the behavioral health member, family members, and other involved parties and
- Perform, either directly or by contract, all treatment required by A.R.S. Title 36, Chapter 5, Article 5 and 9 A.A.C. 21, Article 5.

Transfer from one behavioral health provider to another

A member ordered by the court to undergo treatment can be transferred from one behavioral health provider to another behavioral health provider if:

- The member does not have a court appointed guardian;
- The medical director of the receiving behavioral health provider accepts the transfer; and
- The consent of the court for the transfer is obtained as necessary.
- In order to coordinate a transfer of a member under court ordered treatment to ALTCS or another RBHA, the behavioral health member's clinical team will coordinate with the MCCC Court Advocacy Department at contractingdepartment@MercyCareAZ.org.
- In order to coordinate a transfer of a member under COT from one SMI Clinic to another, the behavioral health member's current psychiatrist will discuss the transfer with the receiving psychiatrists. If both SMI Clinics agree that the transfer is appropriate, the receiving psychiatrist will then provide a Letter of Intent to Treat to the SMI Clinic Court Coordinator of the sending SMI Clinic. The SMI Clinic Court Coordinator will then prepare a motion to transfer treatment provider, review with SMI Clinic attorney, and file with the court. The member's care will not be transitioned to the receiving SMI Clinic until the new treatment provider is reflected on the COT.

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Court Ordered Treatment for Members Charged with or Convicted of a Crime

MCCC providers may be responsible for providing evaluation and/or treatment services when an individual has been ordered by a court due to:

- Conviction of a domestic violence offense; or
- Upon being charged with a crime when it is determined that the individual is court ordered to treatment, or programs, as a result of being charged with a crime and appears to be an “alcoholic.”

Domestic Violence Offender Treatment

Domestic violence offender treatment may be ordered by a court when an individual is convicted of a misdemeanor domestic violence offense. Although the order may indicate that the domestic violence (DV) offender treatment is the financial responsibility of the offender under **A.R.S. §13-3601.01**, Mercy RBHA will cover DV services with Title XIX/XXI funds when the member is Title XIX/XXI eligible, the service is medically necessary, required prior authorization is obtained if necessary, and/or the service is provided by an in-network provider. For Non-TXIX/XXI eligible member’s court ordered for DV treatment, the individual can be billed for the DV services.

Court ordered substance abuse evaluation and treatment

Substance abuse evaluation and/or treatment (i.e., DUI services) ordered by a court under **A.R.S. §36-2027** is the financial responsibility of the county, city, town or charter city whose court issued the order for evaluation and/or treatment. Accordingly, if MCCC receives a claim for such services, the claim will be denied with instructions to the provider to bill the responsible county, city or town.

Court Ordered Treatment for American Indian Tribal Members in Arizona

Arizona tribes are sovereign nations, and tribal courts have jurisdiction over their members residing on reservation. Tribal court jurisdiction, however, does not extend to tribal members residing off the reservation or to state court ordered evaluation or treatment ordered because of a behavioral health crisis occurring off reservation.

Although some Arizona tribes have adopted procedures in their tribal codes, which are similar to Arizona law for court ordered evaluation and treatment, each tribe has its own laws which must be followed for the tribal court process. Tribal court ordered treatment for American Indian tribal members in Arizona is initiated by tribal behavioral health staff, the tribal prosecutor or other member authorized under tribal laws. In accordance with tribal codes, tribal members who may be a danger to themselves or others and in need of treatment due to a mental health disorder are evaluated and recommendations are provided to the tribal judge for a determination of whether court ordered treatment is necessary. Tribal court orders specify the type of treatment needed.

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Additional information on the history of the tribal court process, legal documents and forms as well as contact information for the tribes, MCCC liaison(s), and tribal court representatives can be found on the AHCCCS web page titled, [Tribal Court Procedures for Involuntary Commitment - Information Center](#).

Since many tribes do not have treatment facilities on reservation to provide the treatment ordered by the tribal court, tribes may need to secure treatment off reservation for tribal members. To secure court ordered treatment off reservation, the court order must be “recognized” or transferred to the jurisdiction of the state.

The process for establishing a tribal court order for treatment under the jurisdiction of the state is a process of recognition, or “domestication” of the tribal court order (see **A.R.S. §12-136**). Once this process occurs, the state recognized tribal court order is enforceable off reservation. The state recognition process is not a rehearing of the facts or findings of the tribal court. Treatment facilities, including the Arizona State Hospital, must provide treatment, as identified by the tribe and recognized by the state. [A.R.S. §12-136 Domestication or Recognition of Tribal Court Order](#) is a flow chart demonstrating the communication between tribal and state entities.

MCCC providers must comply with state recognized tribal court orders for Title XIX/XXI and Non-Title XIX SMI members. When tribal providers are also involved in the care and treatment of court ordered tribal members, Mercy and its providers must involve tribal providers to ensure the coordination and continuity of care of the members for the duration of court ordered treatment and when members are transitioned to services on the reservation, as applicable.

This process must run concurrently with the tribal staff’s initiation of the tribal court ordered process in an effort to communicate and ensure clinical coordination with the MCCC. This clinical communication and coordination with the MCCC is necessary to assure continuity of care and to avoid delays in admission to an appropriate facility for treatment upon state/county court recognition of the tribal court order. The Arizona State Hospital should be the last placement alternative considered and used in this process

A.R.S. §36-540(B) states, “The Court shall consider all available and appropriate alternatives for the treatment and care of the patient. The Court shall order the least restrictive treatment alternative available.” MCCC will partner with American Indian tribes and tribal courts in their geographic service areas to collaborate in finding appropriate treatment settings for American Indians in need of behavioral health services.

Due to the options American Indians have regarding their health care, including behavioral health services, payment of behavioral health services for AHCCCS eligible American Indians may be covered through a T/RBHA, RBHA or IHS/638 provider (see [Behavioral Health Services](#))

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[Payment Responsibilities](#) on the [AHCCCS Tribal Court Procedures for Involuntary Commitment](#) web page for a diagram of these different payment structures).

3.13 - Behavioral Health Treatment Plans and Daily Documentation

Behavioral Health Treatment Plan

A Behavioral Health Treatment Plan must be developed and reviewed/updated annually on each MCCC member, and as needed should a change in the member's condition require a modification to the treatment plan. The treatment plan should include strengths, measurable goals and presenting behavioral issues. For the behavioral issues, list recommended behavioral interventions to be utilized. Amended/renewed plans should indicate goals achieved or barriers interfering with success and recommendations to address this.

Daily Documentation

Daily documentation is required to reflect MCCC member's behaviors and issues that occur. This should include frequency of behaviors, frequency and type of staff interventions required throughout the day, and the member's level of responsiveness to interventions/redirections.

3.14 – SMI Eligibility Determination

General Requirements

This chapter applies to:

- Members who are referred for, request or have been determined to need an eligibility determination for Serious Mental Illness (SMI);
- Members who are enrolled as a member determined to have a SMI for whom a review of the determination is indicated; and
- MCCC, subcontracted providers and the MCCC designee.

A qualified assessor must complete all SMI evaluations. If the qualified assessor is a Behavioral Health Technician the evaluation must be reviewed, approved, and signed by a Behavioral Health Professional.

All members must be evaluated for SMI eligibility by a qualified assessor, and have an SMI eligibility determination made by the Crisis Response Network, if the member:

- Requests an SMI determination;
- A guardian/legal representative who is authorized to consent to inpatient treatment makes a request on behalf of the member;
- An Arizona Superior Court issues an order instructing that a member is to undergo a SMI evaluation/determination; or
- Has both a qualifying SMI diagnosis and functional impairment because of the qualifying diagnosis.

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The SMI eligibility determination record must include all of the documentation that was considered during the review including, but not limited to current and/or historical treatment records. The record may be maintained in either hardcopy or electronic format. MCCC will develop and make available to providers any requirements or guidance on SMI eligibility determination record location and/or maintenance.

Computation of time is as follows:

- Evaluation date with a qualified clinician = day zero (0), regardless of time of the evaluation.
- Determination due date = Three (3) business days from day zero (0), excluding weekends and holiday.
- The final determination is required three (3) business days from day 0, not 3 business days from the date of submission to MCCC or designee. Providers that contract with MCCC must submit the SMI evaluation to the designees as soon as practicable, but no later than 11:59 p.m. on the next business day following the evaluation. **MCCC or designee will have at least two (2) business days to complete the SMI determination.**

Completion Process of Initial SMI Eligibility Determination

Upon receipt of a referral for, a request, or identification of the need for an SMI determination, the behavioral health provider or designated Department of Corrections' staff member will schedule an appointment for an initial meeting with the member and a qualified assessor. This shall occur no later than 7 days after receiving the request or referral.

During the initial meeting with the member by a qualified assessor, the assessor must:

- Make a clinical assessment whether the member is competent enough to participate in an assessment;
- Obtain general consent from the member or, if applicable, the member's guardian to conduct an assessment; and
- Provide to the member and, if applicable, the member's guardian, the information required in **R9-21-301(D) (2)**, a client rights brochure, and the appeal notice required by **R9-21- 401(B)**.

If during the initial meeting with the member the assessor is unable to obtain sufficient information to determine whether the applicant is SMI, the assessor must:

- Request the additional information in order to make a determination of whether the member is SMI and obtain an authorization for the release of information, if applicable
- Initiate an assessment including completion of the [AHCCCS Medical Policy Manual 320-P Serious Mental Illness Determination](#).

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Criteria for SMI Eligibility Determination

The determination of SMI requires both a qualifying SMI diagnosis and functional impairment as a result of the qualifying diagnosis.

Functional Criteria for SMI Determination

To meet the functional criteria for SMI, a member must have, as a result of a qualifying SMI diagnosis, dysfunction in at least one of the following four domains, as described below, for most of the past twelve months or for most of the past six months with an expected continued duration of at least six months:

- **Inability to live in an independent or family setting without supervision** – Neglect or disruption of ability to attend to basic needs. Needs assistance in caring for self. Unable to care for self in safe or sanitary manner. Housing, food and clothing must be provided or arranged for by others. Unable to attend to the majority of basic needs of hygiene, grooming, nutrition, medical and dental care. Unwilling to seek prenatal care or necessary medical/dental care for serious medical or dental conditions. Refuses treatment for life threatening illnesses because of behavioral health disorder.
- **A risk of serious harm to self or others** – Seriously disruptive to family and/or community. Pervasively or imminently dangerous to self or others' bodily safety. Regularly engages in assaultive behavior. Has been arrested, incarcerated, hospitalized or at risk of confinement because of dangerous behavior. Persistently neglectful or abusive towards others in the member's care. Severe disruption of daily life due to frequent thoughts of death, suicide, or self-harm, often with behavioral intent and/or plan. Affective disruption causes significant damage to the member's education, livelihood, career, or personal relationships.
- **Dysfunction in role performance** – Frequently disruptive or in trouble at work or at school. Frequently terminated from work or suspended/expelled from school. Major disruption of role functioning. Requires structured or supervised work or school setting. Performance significantly below expectation for cognitive/developmental level. Unable to work, attend school, or meet other developmentally appropriate responsibilities; or
- **Risk of Deterioration** – A qualifying diagnosis with probable chronic, relapsing and remitting course. Co-morbidities (like mental retardation, substance dependence, personality disorders, etc.). Persistent or chronic factors such as social isolation, poverty, extreme chronic stressors (life-threatening or debilitating medical illnesses, victimization, etc.). Other (past psychiatric history; gains in functioning have not solidified or are a result of current compliance only; court-committed; care is complicated and requires multiple providers; etc.).

The following reasons shall not be sufficient in and of themselves for denial of SMI eligibility:

- An inability to obtain existing records or information
- Lack of a face-to-face psychiatric or psychological evaluation

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Member with Co-occurring Substance Abuse

For members who have a qualifying SMI diagnosis and co-occurring substance abuse, for purposes of SMI determination, presumption of functional impairment is as follows:

- For psychotic diagnoses (i.e., bipolar I disorder with psychotic features, delusional disorder, major depression, recurrent, severe, with psychotic features, schizophrenia, schizoaffective disorder and psychotic disorder NOS) functional impairment is presumed to be due to the qualifying psychiatric diagnosis;
- For other major mental disorders (i.e., bipolar disorders, major depression and obsessive compulsive disorder), functional impairment is presumed to be due to the psychiatric diagnosis, unless:
 - The severity, frequency, duration or characteristics of symptoms contributing to the functional impairment cannot be attributed to the qualifying mental health diagnosis; or
 - The assessor can demonstrate, based on a historical or prospective period of treatment, that the functional impairment is present only when the member is abusing substances or experiencing symptoms of withdrawal from substances.
- For all other mental disorders not covered above, functional impairment is presumed to be due to the co-occurring substance use unless:
 - The symptoms contributing to the functional impairment cannot be attributed to the substance abuse disorder; or
 - The functional impairment is present during a period of cessation of the co-occurring substance use of at least thirty (30) days; or
 - The functional impairment is present during a period of at least ninety (90) days of reduced use unlikely to cause the symptoms or level of dysfunction.

SMI Eligibility Determination for Inmates in the Department of Corrections (DOC)

An SMI eligibility designation/determination is done for purposes of determining eligibility for community-based behavioral health services. The Arizona Department of Health Services recognizes the importance of evaluating and determining the SMI eligibility for inmates in the Department of Corrections (DOC) with impending release dates in order to appropriately coordinate care between the DOC and the community based behavioral health system.

Inmates of DOC **pending release within 6 months**, who have been screened or appear to meet the diagnostic and functional criteria, **will now be permitted to be referred** for an SMI eligibility evaluation and determination. Inmates of DOC whose release date exceeds 6 months are not eligible to be referred for an SMI eligibility evaluation and determination.

SMI Eligibility Determination for Children Transitioning into the Adult System

When the adolescent reaches the **age of 17.5** and the Child and Family Team (CFT) believes that the youth may meet eligibility criteria as an adult with a Serious Mental Illness (SMI), the T/RBHA and their subcontracted providers must ensure the young adult receives an eligibility determination as outlined in the [AHCCCS Medical Policy Manual 320-P Serious Mental Illness Determination](#).

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If the youth is determined eligible, or likely to be determined eligible for services as a member with a Serious Mental Illness, the adult behavioral health services care manager is then contacted to join the CFT and participate in the transition planning process. **After obtaining permission from the parent/guardian, it is the responsibility of the children's behavioral health service provider to contact and invite the adult behavioral health services care manager to upcoming planning meetings.** Additionally, the children's provider must track and report the following information to MCCC, CFT transition date (date the adult and children's provider attended a CFT) and adult intake date. When more than one T/RBHA and/or behavioral health service provider agency is involved, the responsibility for collaboration lies with the agency that is directly responsible for service planning and delivery.

If the young adult is not eligible for services as a member with a Serious Mental Illness, it is the responsibility of the children's behavioral health provider, through the CFT, to coordinate transition planning with the adult GMH/SU provider. The importance of securing representation from the adult service provider in this process cannot be overstated, regardless of the member's identified behavioral health category assignment (SMI, General Mental Health, Substance Abuse). The children's behavioral health provider should be persistent in its efforts to make this occur.

For additional guidance regarding the Transition to Adulthood Process for youth determined SMI prior to turning 18, see [AHCCCS Clinical Guidance Tool Transition to Adulthood Practice Protocol](#).

Completion Process of Final SMI Eligibility Determination

The licensed psychiatrist, psychologist, or nurse practitioner designated by Crisis Response Network must make a final determination as to whether the member meets the eligibility requirements for SMI status based on:

- A face-to-face assessment or reviewing a face-to-face assessment by a qualified assessor
- A review of current and historical information, if any, obtained orally or in writing by the assessor from collateral sources, and/or present or previous treating clinicians

The following must occur if the designated reviewing psychiatrist, psychologist, or nurse practitioner has not conducted a face-to-face assessment and has a disagreement with the current evaluating or treating qualified behavioral health professional or behavioral health technician (that cannot be resolved by oral or written communication):

- **Disagreement regarding diagnosis:** Determination that the member does not meet eligibility requirements for SMI status must be based on a face to face diagnostic evaluation conducted by a designated psychiatrist, psychologist, or nurse practitioner. The resolution of (specific reasons for) the disagreement shall be documented in the member's comprehensive clinical record.
- **Disagreement regarding functional impairment:** Determination that the member does

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not meet eligibility requirements must be based upon a face-to-face functional evaluation conducted by a designated psychiatrist, psychologist, or nurse practitioner. The psychiatrist, psychologist, or nurse practitioner shall document the specific reason(s) for the disagreement in the member's comprehensive clinical record.

If there is sufficient information to determine SMI eligibility, the member shall be provided written notice of the SMI eligibility determination within three (3) business days of the initial meeting with the qualified assessor.

Issues Preventing Timely Completion of SMI Eligibility Determination

The time to initiate or complete the SMI eligibility determination may be extended no more than 20 days if the member agrees to the extension and:

- There is substantial difficulty in scheduling a meeting at which all necessary participants can attend
- The member fails to keep an appointment for assessment, evaluation or any other necessary meeting
- The member is capable of, but temporarily refuses to cooperate in the preparation of the completion of an assessment or evaluation
- The member or the member's guardian and/or designated representative requests an extension of time
- Additional documentation has been requested, but has not yet been received
- There is insufficient functional or diagnostic information¹ to determine SMI eligibility within the required time periods.

Crisis Response Network

Crisis Response Network must:

- Document the reasons for the delay in the member's eligibility determination record when there is an administrative or other emergency that will delay the determination of SMI status
- Not use the delay as a waiting period before determining SMI status or as a reason for determining that the member does not meet the criteria for SMI eligibility (because the determination was not made within the time standards).

Situations in which Extension is due to Insufficient Information

- The Crisis Response Network shall request and obtain the additional documentation needed e.g., current and/or past medical records) and/or perform or obtain any necessary psychiatric or psychological evaluations

¹ Insufficient diagnostic information shall be understood to mean that the information available to the reviewer is suggestive of two or more equally likely working diagnoses, only one of which qualifies as SMI, and an additional piece of existing historical information or a face-to-face psychiatric evaluation is likely to support one diagnosis more than the other(s).

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- The designated reviewing psychiatrist, psychologist, or nurse practitioner must communicate with the member's current treating clinician, if any, prior to the determination of SMI, if there is insufficient information to determine the member's level of functioning
- SMI eligibility must be determined within three days of obtaining sufficient information, but no later than the end date of the extension

If the member refuses to grant an extension, SMI eligibility must be determined based on the available information. If SMI eligibility is denied, the member will be notified of his/her appeal rights and the option to reapply).

If the evaluation or information cannot be obtained within the required time period because of the need for a period of observation or abstinence from substance use in order to establish a qualifying mental health diagnosis, the member shall be notified that the determination may, with the agreement of the member, be extended for up to 90 (calendar) days.

Notification of SMI Eligibility Determination

If the eligibility determination results in approval of SMI status, the SMI status must be reported to the member in writing, including notice of his/her right to appeal the decision.

If the eligibility determination results in a denial of SMI status, the Crisis Response Network shall include in the notice above:

- The reason for denial of SMI eligibility (**Serious Mental Illness Determination**)
- The right to appeal
- The statement that Title XIX/XXI eligible members will continue to receive needed Title XIX/XXI covered services. In such cases, the member's behavioral health category assignment must be assigned based on criteria.

Re-enrollment or Transfer

If the member's status is SMI at disenrollment, or upon transfer from another T/RBHA, the member's status shall continue as SMI upon re-enrollment, opening of a new episode of care, or transfer.

Review of SMI Eligibility Determination

A review of SMI eligibility made by Crisis Response Network for individuals currently enrolled as a member with a SMI may be initiated by MCCC or behavioral health provider:

- As part of an instituted, periodic review of all members determined to have a SMI
- When there has been a clinical assessment that supports that the member no longer meets the functional and/or diagnostic criteria
- An individual currently enrolled as a member with a SMI, or their legally authorized representative, upon their request

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A review of the determination may not be requested by MCCC or behavioral health provider within six months from the date an individual has been determined SMI eligible.

If, as a result of such review, the member is determined to no longer meet the diagnosis and functional requirements for SMI status, MCCC must ensure that:

- Services are continued depending on Title XIX/XXI eligibility, or other MCCC service priorities.
- Written notice of the determination made on review with the right to appeal is provided to the affected member with an effective date of 30 days after the date the written notice is issued.

Verification of SMI Eligibility Determinations

When a T/RBHA or its contracted providers are required to verify SMI Eligibility for individuals who have previously been determined SMI, but cannot locate the member's original SMI determination documentation, or when the SMI determination is outdated (more than 10 years old as required by AHCCCS for eligibility/enrollment for benefits), **Serious Mental Illness Determination Verification** must be completed.

- The form does not replace Serious Mental Illness Determination, but enables the MCCC and providers to "verify" a member's current SMI eligibility.

The form must be completed by a licensed psychiatrist, psychologist, or nurse practitioner, and then submitted to MCCC for approval. MCCC is responsible for monitoring and validating the forms. MCCC must keep copies of the validated Serious Mental Illness Determination Verification form in the member's record.

SMI Decertification

There are two established methods for removing a SMI designation, one clinical and the other an administrative option, as follows:

1. SMI Clinical Decertification

- A member who has a SMI designation or a member working with an individual from the member's clinical team may request a SMI Clinical Decertification. A SMI Clinical Decertification is a determination that a member who has a SMI designation no longer meets SMI criteria. If, as a result of a review, the member is determined to no longer meet the diagnostic and/or functional requirements for SMI status:
 - The Determining Entity shall ensure that written notice of the determination and the right to appeal is provided to the affected member with an effective date of 30 days after the date the written notice is issued.
 - MCCC must ensure that services are continued in the event an appeal is filed timely, and that services are appropriately transitioned as part of the discharge planning process.

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2. SMI Administrative Decertification

- A member who has a SMI designation may request a SMI Administrative Decertification if the member has not received behavioral health services for a period of two or more years.
 - Upon receipt of a request for Administrative Decertification, MCCC shall direct the member to contact AHCCCS DHCM Customer Service.
 - AHCCCS will evaluate the member's request and review data sources to determine the last date the member received a behavioral health service. AHCCCS will inform the member of changes that may result with the removal of the member's SMI designation. Based upon review, the following will occur:
 - In the event the member has not received a behavioral health service within the previous two years, the member will be provided with AMPM Exhibit 320-P-3. This form must be completed by the member and returned to AHCCCS.
 - In the event the review finds that the member has received behavioral health services within the prior two year period, the member will be notified that they may seek decertification of their SMI status through the Clinical Decertification process.

SMI Clinic Transfer Protocol

- Once CRN determines the SMI decertification, CRN sends an email to the SMI clinic indicating the specific member status of decertification.
- As soon as the SMI clinic receives notification that a member has completed and been approved for SMI decertification, the SMI clinic will immediately begin working with the member in order to determine where the member wants to transfer their services.
- The SMI clinic must complete appropriate coordination between a GMH/SU provider(s) or BHMP/PCP of the member's choice in order to eliminate any gaps in care for the member.
- The transferring of services from the SMI clinic to the GMH/SU provider(s) or alternative BHMP/ PCP must be completed in less than thirty (30) days from the time the SMI clinic is notified the member is determined to no longer meet SMI criteria.
- All coordination must be appropriately documented in the member's medical record.
- It is the sending provider's responsibility to gather a release of information from the member and transfer all applicable records to the receiving provider.
- If a member is not currently receiving services from an SMI clinic but is T19, the SMI clinic that the member was paneled to under the Navigator level of care is responsible for completing the transfer of the member.
- If a member does not want to transfer to a GMH/SU provider or BHMP/PCP or refuses to sign a release of information for a receiving provider, the SMI clinic will complete appropriate outreach and engagement which requires two outreach attempts.

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- The SMI clinic will offer the member the opportunity to obtain their medical records (see **MC Chapter 4 – Provider Requirements, Section 4.16 – Member’s Medical Records**) if the member declines further assistance with the transfer process.
- If the member is unable to be contacted or declines obtaining their records, the SMI clinic must retain the original or copies of the member’s medical records for at least six (6) years after the last date the member receives medical or health care services from the provider.

MCCC Transfer Protocol

MCCC member transition process, in coordination with Arizona Health Care Cost Containment System (AHCCCS), helps to ensure that members’ healthcare continues without interruption or delay when there is a change of health plans. When an individual has been approved for SMI decertification, MCCC, as the relinquishing Contractor, will complete and transmit the Enrollment Transition Information (ETI) form to the appropriate parties no later than 10 business days from receipt of AHCCCS notification. MCCC’s transition coordinator will also notify the receiving health plan’s transition coordinator to ensure that the member’s services are appropriately transferred.

Paneling of Members with GMH/SU

All members enrolled in MCCC and Non-Title XIX SMI eligibility plans are paneled to an Assigned Behavioral Health Clinic (ABHC) once behavioral health services are initiated within identified paneling organizations. Members will be re-paneled, as appropriate, to paneling organizations that are the primary catalyst of behavior health services. Members entering behavioral health services via emergency and/or crisis services will be paneled according to member preference and geographical location. If member preference is unavailable, the member is paneled to an ABHC based on geographic proximity. Paneling to an ABHC is aligned to member eligibility. Members are not paneled to an ABHC during gaps in enrollment or while eligible in a plan other than Integrated or Non-Title XIX SMI.

Paneling of Members with SMI

All members enrolled in MCCC and Non-Title XIX SMI eligibility plans are paneled to an Assigned Behavioral Health Clinic (ABHC). MCCC panels newly enrolled members to an ABHC based on member preference. If member preference is unavailable, the member is paneled to an ABHC based on geographic proximity. Paneling to an ABHC is aligned to member eligibility. Members are not paneled to an ABHC during gaps in enrollment or while eligible in a plan other than Integrated or Non-Title XIX SMI.

There are numerous scenarios where members determined with SMI may be enrolled in a plan other than Integrated or Non-Title XIX SMI.

- **Native American** – Native American members have choice and may opt-out of enrollment in an integrated plan.

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- **Opt-Out Request** – A member determined SMI, who is currently enrolled in a RBHA, may opt out of receiving physical health services from the RBHA and be transferred to an Acute Care Contractor for his/her physical health services if one or more of the applicable opt out criteria are satisfied. Members who meet the opt-out criteria will continue to receive behavioral health services through Mercy Maricopa.
- **Recent Determination** – There is a 14-day transitional period for a change in health plan for Medicaid members determined with SMI.

In addition to being paneled to an ABHC, members receiving services through Assertive Community Treatment (ACT) teams must be paneled to an ACT Team. MCCC does not panel newly enrolled members to ACT teams.

SMI clinics and ACT teams are required to manage their panels through the Member Paneling tool available in Provider Intake on the Medicaid Web Portal. Panel changes submitted through the Member Paneling tool are processed nightly and loaded directly into the Mercy Maricopa provider information systems. Specific instructions on utilization of the **Provider Intake Member Paneling Tool** are available under the [Reference Material and Guides](#) of our website.

IHH Health Homes, SMI clinics and ACT teams that fail to manage their panels are subject to corrective action, loss or reduction of incentives and sanctions.

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MCCC CHAPTER 4 – GENERAL MENTAL HEALTH/SUBSTANCE USE (GMH/SU)

4.00 – About General Mental Health/Substance Use (GMH/SU)

MCCC's integrated system joins both physical and behavioral health services together to treat all aspects of our members' health care needs under one plan. MCCC encourages more coordination between providers within the same network which can mean better health outcomes for our members.

4.01 – Funding***Special Populations***

MCCC receives some funding for behavioral health services through the Federal Substance Abuse Block Grant (SABG). SABG funds are used to provide substance use services for Non-Title XIX/XXI eligible members. As a condition of receiving this funding, certain populations are identified as priorities for the timely receipt of designated behavioral health services. Currently, not all network contracted providers receive SABG Block Grant funding. Providers who do receive these funds must follow the requirements found in this chapter. For all other contracted behavioral health providers that do not currently receive these funds, the following expectations do not apply.

Substance Abuse Block Grant (SABG) Populations

The following populations are prioritized and covered under the Substance Abuse Block Grant (SABG) funding:

- First:** Pregnant females who use drugs by injection;
- Then:** Pregnant females who use substances;
- Then:** Teenagers who use substances;
- Then:** Other injection drug users;
- Then:** Substance-using females with dependent children, including those attempting to regain custody of their children; and
- Finally:** All other members in need of substance use treatment.

Response Times for Designated Behavioral Health Services under the Substance Abuse Block Grant (SABG) (based on available funding)

- **WHEN:** Behavioral health services provided within a timeframe indicated by clinical need, but no later than 48 hours from the referral/initial request for services.
- **WHAT:** Any needed covered behavioral health service, including admission to a residential program if clinically indicated. If a residential program is temporarily unavailable, an attempt shall be made to place the member within another provider agency facility, including those in other geographic service areas. If capacity still does not exist, the member shall be placed on an actively managed wait list and interim services must be provided until the individual is admitted. Interim services include: counseling/education about HIV and Tuberculosis (include the risks of transmission), the

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risks of needle sharing and referral for HIV and TB treatment services if necessary, counseling on the effects of alcohol/drug use on the fetus and referral for prenatal care.

- **WHO:** Pregnant women/teenagers referred for substance use treatment (includes pregnant injection drug users and pregnant substance users) and Substance-using females with dependent children, including those attempting to regain custody of their children.
- **WHEN:** Behavioral health services provided within a timeframe indicated by clinical need but no later than 14 days following the initial request for services/referral. All subsequent behavioral health services must be provided within timeframes according to the needs of the member.
- **WHAT:** Includes any needed covered behavioral health services. Admit to a clinically appropriate substance use treatment program (can be residential or outpatient based on the member's clinical needs); if unavailable, interim services must be offered to the member. Interim services shall minimally include education/interventions about HIV and tuberculosis and the risks of needle sharing and must be offered within 48 hours of the request for treatment.
- **WHO:** All other injection drug users.

4.02 – Referral and Intake Process

Behavioral Health Referral and Intake Process

To facilitate a member's access to behavioral health services in a timely manner, MCCC maintains an effective process for the referral and intake for behavioral health services that includes:

- Communicating to potential referral sources the process for making referrals (e.g., centralized intake at MCCC, identification of providers accepting referrals);
- Collecting enough basic information about the member to determine the urgency of the situation and subsequently scheduling the initial assessment within the required timeframes and with an appropriate provider;
- Adopting a welcoming and engaging manner with the member and/or member's legal guardian/family member;
- Ensuring that intake interviews are culturally appropriate and delivered by providers that are respectful and responsive to the member's cultural needs;
- Keeping information or documents gathered in the referral process confidential and protected in accordance with applicable federal and state statutes, regulations and policies;
- Informing, as appropriate, the referral source about the final disposition of the referral; and
- Conducting intake interviews that ensure the accurate collection of all the required information and ensure members who have difficulty communicating because of a disability or who require language services are afforded appropriate accommodations to assist them in fully expressing their needs.

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Responding to Referrals

Follow-Up

When a request for behavioral health services is initiated but the member does not appear for the initial appointment, the provider must attempt to contact the member and implement engagement activities consistent with **MCCC Chapter 4 – General Mental Health/Substance Use, Section 4.03 – Outreach, Engagement, Reengagement and Closure**.

MCCC or provider will also attempt to notify the entity that made the referral.

Documenting and Tracking Referrals

MCCC or subcontracted provider will document and track all referrals for behavioral health services including, at a minimum, the following information:

- Member's name and, if available, AHCCCS identification number;
- Name and affiliation of referral source;
- Date of birth;
- Type of referral (immediate, urgent, routine);
- Date and time the referral was received;
- If applicable, date and location of first available appointment and, if different, date and location of actual scheduled; and
- Final disposition of the referral.

Intake

Behavioral health providers must conduct intake interviews in an efficient and effective manner that is both "member friendly" and ensures the accurate collection of all the required information necessary for enrollment into the system or for collection of information for AHCCCS eligible individuals who are already enrolled. The intake process must:

- Be flexible in terms of when and how the intake occurs. For example, to best meet the needs of the member seeking services, the intake might be conducted over the telephone prior to the visit, at the initial appointment prior to the assessment and/or as part of the assessment; and
- Make use of readily available information (e.g., referral form, AHCCCS eligibility screens, Department of Child Safety related documentation) to minimize any duplication in the information solicited from the member and his/her family.

During the intake, the behavioral health provider will collect, review and disseminate certain information to members seeking behavioral health services. Examples can include:

- The collection of contact information, insurance information, the reason why the member is seeking services and information on any accommodations the member may require to effectively participate in treatment services (i.e., need for oral interpretation or sign language services, consent forms in large font, etc.).
- The collection of required demographic information and completion of client demographic information sheet, including the behavioral health member's

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- primary/preferred language;
- The completion of any applicable authorizations for the release of information to other parties;
- The dissemination of a Member Handbook to the member;
- The review and completion of a general consent to treatment;
- The collection of financial information, including the identification of third-party payers and information necessary to screen and apply for AHCCCS health insurance, when necessary;
- Advising Non-Title XIX/XXI members determined to have a Serious Mental Illness (SMI) that they may be assessed a co-.
- The review and dissemination of MCCC's Notice of Privacy Practices (NPP) and the AHCCCS HIPAA Notice of Privacy Practices (NPP) located at; and
- The review of the member's rights and responsibilities as a member of behavioral health services, including an explanation of the appeal process.

The member and/or family members may complete some of the paperwork associated with the intake, if acceptable to the member and/or family members.

Behavioral health providers conducting intakes must be appropriately trained, approach the member and family in an engaging manner, and possess a clear understanding of the information that needs to be collected.

Integrated Care Specific Referral and Intake Guidelines

It may be necessary for a MCCC member to be referred to another provider for medically necessary services that are beyond the scope of the member's PCP. For those services, providers only need to complete the **Specialist Referral Form** available on our [Forms Library](#) web page and refer the member to the appropriate MCCC Participating Health Provider (PHP). MCCC's website includes a provider search function for your convenience.

There are two types of referrals:

- Participating providers (particularly the member's PCP) may refer members for specific covered services to other practitioners or medical specialists, allied healthcare professionals, medical facilities, or ancillary service providers.
- Member may self-refer to certain specialists for specific services, such as an OB/GYN or substance use treatment.

Referrals must meet the following conditions:

- The referral must be requested by a participating provider and be in accordance with the requirements of the member's benefit plan (covered benefit).
- The member must be enrolled in MCCC on the date of service (s) and eligible to receive the service.
- If MCCC's network does not have a provider to perform the requested services,

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members may be referred to out of network providers if:

- The services required are not available within the MCCC's network.
- MCCC prior authorizes the services.

If out of network services are not prior authorized, the referring and servicing providers may be responsible for the cost of the service. The member may not be billed if the provider fails to follow MCCC's policies. Both referring and receiving providers must comply with MCCC policies, documents, and requirements that govern referrals (paper or electronic) including prior authorization. Failure to comply may result in delay in care for the member, a delay or denial of reimbursement or costs associated with the referral being charged to the referring provider.

Referrals are a means of communication between two providers servicing the same member. Although MCCC encourages the use of its referral form, it is recognized that some providers use telephone calls and other types of communication to coordinate the member's medical care. This is acceptable to MCCC if the communication between providers is documented and maintained in the member's medical records.

Referring Provider's Responsibilities

- Confirm that the required service is covered under the member's benefit plan prior to referring the member.
- Confirm that the receiving provider is contracted with MCCC.
- Obtain prior authorization for services that require prior authorization or are performed by a non-PHP.
- Complete a Specialist Referral Form available on our [Forms Library](#) web page and mail or fax the referral to the receiving provider.

Receiving Provider's Responsibilities

PHPs may render services to members for services that do not require prior authorization and that the provider has received a completed referral form (or has documented the referral in the member's medical record). The provider rendering services based on the referral is responsible to:

- Schedule and deliver the medically necessary services in compliance with MCCC's requirements and standards related to appointment availability.
- Verify the member's enrollment and eligibility for the date of service. If the member is not enrolled with MCCC on the date of service, MCCC will not render payment regardless of referral or prior authorization status.
- Verify that the service is covered under the member's benefit plan.
- Verify that the prior authorization has been obtained, if applicable, and includes the prior authorization number on the claim when submitted for payment.
- Inform the referring provider of the consultation or service by sending a report and applicable medical records to allow the referring provider to continue the member's care.

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Period of Referral

Unless otherwise stated in a provider's contract or MCCC documents, a referral is valid for the full extent of the member's care starting from the date it is signed and dated by the referring provider, if the member is enrolled and eligible with MCCC on the date of service.

Maternity Referrals

Referrals to Maternity Care Health Practitioners may occur in two ways:

- A pregnant MCCC member may self-refer to any MCCC contracted Maternity Care Practitioner.
- The PCP may refer pregnant members to a MCCC contracted Maternity Care Practitioner.

At a minimum, Maternity Care Practitioners must adhere to the following guidelines:

- Coordinate the members maternity care needs until completion of the postpartum visits.
- Schedule a minimum of one postpartum visit at approximately six weeks postpartum.
- When necessary, refer members to other practitioners in accordance with the MCCC referral policies and procedures.
- Schedule return visits for members with uncomplicated pregnancies consistent with the American College of Obstetrics and Gynecology standards:
 - Through twenty-eight weeks of gestation – every four weeks.
 - Between twenty-nine- and thirty-six-weeks gestation every two weeks.
 - After the thirty sixth week – once a week.
 - Schedule first-time appointments within the required time frames.
 - Members in first trimester – within seven calendar days.
 - Members in third trimester – within three calendar days.
 - High-risk Members – within three calendar days of identification or immediately when an emergency condition exists.

Ancillary Referrals

All practitioners and providers must use and/or refer to MCCC contracted ancillary providers.

Member Self-Referrals

MCCC members can self-refer to participating providers for the following covered services:

- Family Planning Services
- OB/GYN Services
- Dental Services for Members Ages 18 through 20 years old.
- Vision services for Members Ages 18 through 20 years old.
- Behavioral Health Services for Members 18 years of age and older.

4.03 – Outreach, Engagement, Reengagement and Closure

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Outreach

The behavioral health system must provide outreach activities to inform the public of the benefits and availability of behavioral health services and how to access them. MCCC will disseminate information to the general public, other human service providers, school administrators and teachers and other interested parties regarding the behavioral health services that are available to eligible members.

Outreach activities conducted by MCCC may include, but are not limited to:

- Participation in local health fairs or health promotion activities
- Involvement with local schools
- Routine contact with AHCCCS Health Plan behavioral health coordinators and/or primary care providers
- Development of homeless outreach programs
- Development of outreach programs to members who are at risk, are identified as a group with high incidence or prevalence of behavioral health issues or are underserved
- Publication and distribution of informational materials
- Liaison activities with local and county jails, county detention facilities, and local and county DCS offices and programs
- Routine interaction with agencies that have contact with substance abusing pregnant females
- Development and implementation of outreach programs that identify members with co-morbid medical and behavioral health disorders and those who have been determined to have a Serious Mental Illness (SMI) within MCCC's geographic service area, including members who reside in jails, homeless shelters, county detention facilities or other settings
- Provision of information to mental health advocacy organizations
- Development and coordination of outreach programs to Native American tribes in Arizona to provide services for tribal members

Engagement

MCCC or their subcontracted providers will actively engage the following in the treatment planning process:

- The member and/or member's legal guardian
- The member's family/significant others, if applicable and amenable to the member
- Other agencies/providers as applicable

Behavioral health providers must provide services in a culturally competent manner in accordance with MCCC's Cultural Competency Plan. Additionally, behavioral health providers must:

- Provide a courteous, welcoming environment that provides members with the opportunity to explore, identify and achieve their personal goals

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- Engage members in an empathic, hopeful and welcoming manner during all contacts
- Provide culturally relevant care that addresses and respects language, customs, and values and is responsive to the member's unique family, culture, traditions, strengths, age and gender
- Provide an environment that in which members from diverse cultural backgrounds feel comfortable discussing their cultural health beliefs and practices in the context of negotiating treatment options
- Provide care by communicating to members in their preferred language and ensuring that they understand all clinical and administrative information (see **MC Chapter 4 – Provider Requirements, Section 4.24 – Cultural Competency, Health Literacy and Linguistic Services**)
- Be aware of and seek to gain an understanding of members with varying disabilities and characteristics
- Display sensitivity to, and respect for, various cultural influences and backgrounds (e.g., ethnic, racial, gender, sexual orientation, socio-economic class, and veteran status)
- Establish an empathic service relationship in which the member experiences the hope of recovery and is considered to have the potential to achieve recovery while developing hopeful and realistic expectations
- Demonstrate the ability to welcome the member, and/or the member's legal guardian, the member's family members, others involved in the member's treatment and other service providers as collaborators in the treatment planning and implementation process
- Demonstrate the desire and ability to include the member's and/or legal guardian's viewpoint and to regularly validate the daily courage needed to recover from persistent and relapsing disorders
- Assist in establishing and maintaining the member's motivation for recovery
- Provide information on available services and assist the member and/or the member's legal guardian, the member's family, and the entire clinical team in identifying services that help meet the member's goals
- Provide the member with choice when selecting a provider and the services they participate in

Reengagement

For Children and GMH/SU members, the reengagement policy is as follows:

Behavioral health providers must attempt to re-engage members in an episode of care that have withdrawn from participation in the treatment process prior to the successful completion of treatment, refused services or failed to appear for a scheduled service. All attempts to reengage members who have withdrawn from treatment, refused services or failed to appear for a scheduled service must be documented in the comprehensive clinical record. The behavioral health provider must attempt to reengage the member with a minimum of three (3) separate outreach attempts by:

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- Communicating in the member's preferred language
- Contacting the member or the member's legal guardian by telephone, at times when the member may reasonably be expected to be available (e.g., after work or school)
- Whenever possible, contacting the member or the member's legal guardian (if applicable) face-to-face, if telephone contact is insufficient to locate the member or determine acuity and risk
- Sending a letter to the current or most recent address requesting contact once three (3) separate outreach attempts at personal contact are unsuccessful, except when a letter is contraindicated due to safety concerns (e.g., domestic violence) or confidentiality issues. The provider will note safety or confidentiality concerns in the progress notes section of the clinical record and include a copy of the letter sent in the comprehensive clinical record

For children in the custody of DCS or adopted children, contact the DCS Specialist or the DCS Supervisor to inform them of the need for assistance in re-engaging the member and the DCS out-of-home placement (e.g., foster home, kinship or group home). If unsuccessful, contact the MCCC Child Welfare Single Point of Contact at DCS@MercyCareAZ.org to assist with re-engagement. For CMDP Youth who have been in services less than one year and all re-engagement attempts have been unsuccessful, please contact the MCCC Child Welfare Single Point of Contact at DCS@MercyCareAZ.org.

For children and GMH/SU members, if the member had a hospitalization during the review period, the discharge policy is as follows:

- BHMP appointment must be scheduled within 5 business days following discharge.
Please Note: If the child is receiving care management services only from a High Needs Care Management provider, there must be evidence of the High Needs Care Manager (HNCM) coordinating with the Qualified Service Provider (QSP) providing medication monitoring services to set up a BHMP appointment within the required timeframe.
- Behavioral Health providers must have telephonic or face to face contact with the member within 24 business hours of crisis episode or discharge.
- A face to face visit must be completed within 5 business days following discharge.
- Telephonic contact must be made each week for 4 weeks following discharge (weekly contact is monitored by 7-day intervals).
- For children in the custody of DCS and adopted children, the QSP must collaborate with DCS to ensure an appropriate alternative placement for the member to be discharged when:
 - It is unsafe for the member to return to the out-of-home placement or adoptive family, and/or
 - It is unsafe for the out-of-home placement or adoptive family for the member to return.

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MCCC behavioral health providers are expected to:

- Involve the member, their parent/guardian, their families, or significant others in transition or aftercare planning;
 - For extenuating circumstances involving crisis calls, follow up within 24 hours and if the member is unreachable, initiate a welfare check that could include utilizing law enforcement services, family members and significant others as designated by the member;
 - Commence discharge planning at the time of intake;
 - Within 24 hours of notification of admission and after the initial concurrent review, the clinical team contacts the inpatient social worker to schedule discharge planning staffing;
 - Within 72 hours of notification of admission and after the initial concurrent review has occurred, the clinical team coordinates with a MCCC Care Coordinator to provide an initial discharge plan;
 - Involve the member, parent/guardian, and/or family members in the selection of aftercare providers and appointment times, and make sure that aftercare appointments meet established access standards;
 - Formalize discharge planning in writing with a discharge summary and follow up actions clearly indicated with scheduled aftercare appointments;
 - Ensure members have enough medications or a prescription to last until the follow-up BHP appointment. This includes coordination with the inpatient treating physician and may include prior authorization requests to the MCCC;
 - Within 72 hours of discharge, a BHMP completes a face-to-face comprehensive evaluation of the member and addresses any medication and/or treatment issues;
 - Implement a multi-disciplinary team approach which includes the following:
 - A home visit within 5 days of discharge to identify environmental issues that may need interventions to prevent hospital readmission.
 - Weekly face-to-face contact after discharge for at least four consecutive weeks intended to identify causes, which led to the hospitalization and assess the member's ability to engage in their own wellness and transition successfully to community care. *
 - A Clinical Team Nurse will schedule an appointment within 10 days of discharge to ensure behavioral health members understand medications; dosages, side effects and any medication changes post discharge. **
 - 30-day post discharge face to face to formally review the discharge transition to determine if the member is at risk for readmission; assess the level of care needed; and develop a written action plan to maintain independence in the community.
- *The face to face, weekly, requirement is enough, if the member is going into residential treatment, following discharge and the clinical and discharge team indicates that weekly face to face contact does not need to occur. This decision

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must be documented in either the hospital discharge plan and/or discharge staffing note.

- ** The children's provider may not employ a RN, if that is the case, it is enough if there is evidence in the BHMP note ensuring the member/guardian understands medications; dosages, side effects and any medication changes post discharge.

For members receiving General Mental Health/Substance Use services, behavioral health providers must also document activities in the clinical record related to coordination of care upon admission and with discharge planning, and conduct follow-up activities to maintain engagement including:

- Discharge from inpatient services in accordance with the discharge plan within 7 days of discharge upon notification;
- Involved in a behavioral health crisis within timeframes based upon the member's clinical needs, but no later than 7 days upon notification;
- Ensure members have enough medications or a prescription to last until the follow-up BHMP appointment, as applicable and upon notification. This includes coordination with the inpatient treating physician;
- Refusing prescribed psychotropic medications within timeframes based upon the member's clinical needs and individual history;
- Involve the member, their parent/guardian, their families, or significant others in transition or aftercare planning; and
- Released from local and county jails and detention facilities within 7 days upon notification.

Additionally, for members to be released from these settings, behavioral health providers must help establish priority prescribing clinician appointments, as applicable, to ensure client stabilization, medication adherence, and to avoid re-hospitalization.

Should members receiving GMH/SU services with recurrent hospitalizations meet specific criteria as being at 'high risk', additional navigator assistance services may be available through specifically funded providers through the Comprehensive Community Health Program. Navigators assist members with engagement and coordination of care.

Ending an Episode of Care for Member in Behavioral Health System

Under certain circumstances, it may be appropriate or necessary to dis-enroll a member or end an episode of care from services after reengagement efforts described in **Reengagement** have been expended except for members designated as SMI, TXIX or Non-Title XIX. Ending the episode of care can occur due to clinical or administrative factors involving the enrolled member. The episode of care can be ended for both Non-Title XIX and Title XIX individuals, but Title XIX eligible individuals no longer in an episode of care for behavioral health services remain enrolled with AHCCCS. When a member is dis-enrolled or has an episode of care ended, notice and appeal requirements may apply.

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For children in the custody of DCS who have been enrolled with a Qualified Service Provider (QSP) for less than 12 months, the QSP must elevate closure reasons of 'Treatment Completed', 'Lack of Contact', or 'Declined Further Services' to the MCCC Child Welfare Single Point of Contact at DCS@MercyCareAZ.org prior to ending the Episode of Care.

Clinical Factors

Treatment Completed:

A member's episode of care must be ended upon completion of treatment. A Non-Title XIX member would also be dis-enrolled at treatment completion. Prior to ending the episode of care or dis-enrolling a member following the completion of treatment, the behavioral health provider and the member or the member's legal guardian must mutually agree that behavioral health services are no longer needed.

Further Treatment Declined:

A member's episode of care must be ended if the member or the member's legal guardian decides to refuse ongoing behavioral health services. A Non-Title XIX member would also be dis-enrolled from services except for members designated as SMI, TXIX or nontitle XIX. Prior to ending the episode of care or dis-enrolling a member for declining further treatment or moving a member to a Patient Navigator, the behavioral health provider must ensure the following:

- All applicable and required reengagement activities described in *Reengagement* have been conducted and clearly documented in the member's comprehensive clinical record; and
- The member does not meet clinical standards for initiating the pre-petition screening or petition or petition for treatment process.
- Upon receiving a request from a DCS Specialist or representative for a child in the custody of DCS to discontinue services and/or dis-enroll a foster child, the behavioral health provider will conduct a Child Family Team (CFT) meeting to determine if this is clinically sound. If the child has been enrolled with the QSP for less than 12 months, the QSP must elevate the request to decline further treatment to MCCC Child Welfare Single Point of Contact at DCS@MercyCareAZ.org.

Lack of Contact:

A member's episode of care may be ended if MCCC or behavioral health provider is unable to locate or contact the member after ensuring that all applicable and required re-engagement activities described in *Reengagement* have been conducted.

A Non-Title XIX individual would also be dis-enrolled from services.

Administrative Factors:

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Eligibility/Entitlement Information Changes Including:

- Loss of Title XIX/XXI eligibility, if other funding is not available to continue services; and
- Members who become or are enrolled as elderly or physically disabled (EPD) under the Arizona Long Term Care System (ALTCS) must be dis-enrolled after ensuring appropriate coordination and continuity of care with the ALTCS program contractor. (Not applicable for developmentally delayed ALTCS members ALTCS/DD whose behavioral health treatment is provided through the T/RBHA system.)

Behavioral health providers may dis-enroll Non-Title XIX/XXI eligible members for non-payment of assessed co-payments per **MC Chapter 4 – Provider Requirements, Section 4.29 -**

Copayments under the following conditions:

- The member is not eligible as a member determined to have a Serious Mental Illness (SMI); and
- Attempts at reasonable options to resolve the situation, (e.g., informal discussions) do not result in resolution. All efforts to resolve the issue must be documented in the member's comprehensive clinical record, in accordance with **MC Chapter 4 – Provider Requirements, Section 4.29 – Copayments**.

Out-of-State Relocations:

A member's episode of care must be ended for a member who relocates out-of-state after appropriate transition of care. A Non-Title XIX individual would also be dis-enrolled. This does not apply to members placed out-of-state for purposes of providing behavioral health treatment.

Inter-T/RBHA Transfers:

A member who relocates to another T/RBHA and requires ongoing behavioral health services must be closed from one T/RBHA and transferred to the new T/RBHA. Services must be transitioned.

Children in the Custody of DCS:

Inter-RBHA transfers are not to be initiated if an AHCCCS-eligible child is in the custody of DCS, remains with the same court of jurisdiction and moves to a different county due to the location of an out-of-home placement (e.g., foster home, kinship or group home).

Arizona Department of Corrections Confinements:

A member age 18 or older must be dis-enrolled upon acknowledgement that the member has been placed in the long-term control and custody of a correctional facility.

Children Held at County Detention Facilities:

A child who was served by MCCC prior to detainment in a county detention facility will remain in an active episode of care if the child remains Title XIX/XXI eligible. MCCC and contracted providers must check the AHCCCS Pre-paid Medical Management Information System (PMMIS)

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to ensure Title XIX/XXI eligibility prior to the delivery of each behavioral health service to a child who is held in a county detention facility.

Inmates of Public Institutions:

AHCCCS has implemented an electronic inmate of public institution notification system developed by the AHCCCS Division of Member Services (DMS). If a member is eligible for AHCCCS covered services during the service delivery period, MCCC is obligated to cover the services regardless of the perception of the member's legal status.

For AHCCCS to monitor any change in a member's legal status, and to determine eligibility, providers need to notify AHCCCS via e-mail if they become aware that an AHCCCS eligible member is incarcerated. AHCCCS has established email addresses for this purpose. Please note that there are two separate e-mail addresses based on the member's age. For children less than 18 years of age, please use DMSJUVENILEincarceration@azahcccs.gov. For adults age 18 years and older, please use DMSADULTincarceration@azahcccs.gov.

Notifications must include the following member information:

- **AHCCCS ID;**
- **Name;**
- **Date of Birth;**
- **Incarceration date; and**
- **Name of public institution where incarcerated.**

Please note that providers **do not** need to report members incarcerated with the Arizona Department of Corrections.

Deceased Members:

A member's episode of care must be ended following acknowledgement that the member is deceased, effective on the date of the death. The Non-Title XIX individual would be dis-enrolled from the system.

Crisis Episodes:

For members who are enrolled because of a crisis episode, the member's episode of care would end if the following conditions have been met:

- The behavioral health provider conducts all applicable and required reengagement activities and such attempts are unsuccessful; or
- The behavioral health provider and the member or the member's legal guardian mutually agrees that ongoing behavioral health services are not needed; a Non-Title XIX individual would be dis-enrolled from the system.

One-Time Consultations:

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For members who are in the system for a one-time consultation, the member's episode of care may be ended if the behavioral health provider and the member or the member's legal guardian mutually agrees that ongoing behavioral health services are not needed. The Non-Title XIX individual would also be dis-enrolled.

Serving Members Previously Enrolled in Behavioral Health System

Some members who have ended their episode of care or were dis-enrolled may need to re-enter the behavioral health system. The process used is based on the length of time that a member has been out of the behavioral health system.

For members not receiving services for less than one year:

- If the member has not received a behavioral health assessment in the last year, conduct a new behavioral health assessment and revise the member's service plan as needed. If the member has received a behavioral health assessment in the last year and there has not been a significant change in the member's behavioral health condition, behavioral health providers may utilize the most current assessment. Review the most recent service plan (developed within the last year) with the member, and if needed, coordinate the development of a revised service plan with the member's clinical team.
- If the member presents at a different T/RBHA or provider, obtain new general and informed consent to.
- If the member presents at a different T/RBHA or provider, obtain new authorizations to disclose confidential information, as applicable.

For members not receiving services for one year or longer:

- Conduct a new intake, behavioral health assessment and service plan.
- Continue the member's SMI status if the member was previously determined to have a Serious Mental Illness (SMI)
- Obtain new general and informed consent to treatment.
- Obtain new authorizations to disclose confidential information, as applicable.

4.04 – Serious Mental Illness Determination

General Requirements

This section applies to:

- Members who are referred for, request or have been determined to need an eligibility determination for Serious Mental Illness (SMI);
- Members who are enrolled as a member determined to have a SMI for whom a review of the determination is indicated; and
- MCCC, subcontracted providers and the MCCC designee.

A qualified assessor must complete all SMI evaluations. If the qualified assessor is a Behavioral Health Technician the evaluation must be reviewed, approved, and signed by a Behavioral Health Professional.

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All members must be evaluated for SMI eligibility by a qualified assessor, and have an SMI eligibility determination made by the Crisis Response Network, if the member:

- Requests an SMI determination;
- A guardian/legal representative who is authorized to consent to inpatient treatment makes a request on behalf of the member;
- An Arizona Superior Court issues an order instructing that a member is to undergo a SMI evaluation/determination; or
- Has both a qualifying SMI diagnosis and functional impairment because of the qualifying diagnosis.

The SMI eligibility determination record must include all the documentation that was considered during the review including, but not limited to current and/or historical treatment records. The record may be maintained in either hardcopy or electronic format. MCCC will develop and make available to providers any requirements or guidance on SMI eligibility determination record location and/or maintenance.

Computation of time is as follows:

- Evaluation date with a qualified clinician = day zero (0), regardless of time of the evaluation.
- Determination due date = Three (3) business days from day zero (0), excluding weekends and holiday.
- The final determination is required three (3) business days from day 0, not 3 business days from the date of submission to MCCC or designee. Providers that contract with MCCC must submit the SMI evaluation to the designees as soon as practicable, but no later than 11:59 p.m. on the next business day following the evaluation. MCCC or designee will have at least two (2) business days to complete the SMI determination.

Completion Process of Initial SMI Eligibility Determination

Upon receipt of a referral for, a request, or identification of the need for an SMI determination, the behavioral health provider or designated Department of Corrections' staff member will schedule an appointment for an initial meeting with the member and a qualified assessor. This shall occur no later than 7 days after receiving the request or referral.

During the initial meeting with the member by a qualified assessor, the assessor must:

- Make a clinical assessment whether the member is competent enough to participate in an assessment;
- Obtain general consent from the member or, if applicable, the member's guardian to conduct an assessment; and
- Provide to the member and, if applicable, the member's guardian, the information required in **R9-21-301(D) (2)**, a client rights brochure, and the appeal notice required by **R9-21- 401(B)**.

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If, during the initial meeting with the member, the assessor is unable to obtain enough information to determine whether the applicant is SMI, the assessor must:

- Request the additional information to decide of whether the member is SMI and obtain an authorization for the release of information, if applicable; and
- Initiate an assessment including completion of the **Serious Mental Illness Determination**.

Criteria for SMI Eligibility Determination

The determination of SMI requires both a qualifying SMI diagnosis and functional impairment because of the qualifying diagnosis.

Functional Criteria for SMI Determination

To meet the functional criteria for SMI, a member must have, because of a qualifying SMI diagnosis, dysfunction in at least one of the following four domains, as described below, for most of the past twelve months or for most of the past six months with an expected continued duration of at least six months:

- **Inability to live in an independent or family setting without supervision** – Neglect or disruption of ability to attend to basic needs. Needs assistance in caring for self. Unable to care for self in safe or sanitary manner. Housing, food and clothing must be provided or arranged for by others. Unable to attend to most basic needs of hygiene, grooming, nutrition, medical and dental care. Unwilling to seek prenatal care or necessary medical/dental care for serious medical or dental conditions. Refuses treatment for life threatening illnesses because of behavioral health disorder.
- **A risk of serious harm to self or others** – Seriously disruptive to family and/or community. Pervasively or imminently dangerous to self or others' bodily safety. Regularly engages in assaultive behavior. Has been arrested, incarcerated, hospitalized or at risk of confinement because of dangerous behavior. Persistently neglectful or abusive towards others in the member's care. Severe disruption of daily life due to frequent thoughts of death, suicide, or self-harm, often with behavioral intent and/or plan. Affective disruption causes significant damage to the member's education, livelihood, career, or personal relationships.
- **Dysfunction in role performance** – Frequently disruptive or in trouble at work or at school. Frequently terminated from work or suspended/expelled from school. Major disruption of role functioning. Requires structured or supervised work or school setting. Performance significantly below expectation for cognitive/developmental level. Unable to work, attend school, or meet other developmentally appropriate responsibilities; or
- **Risk of Deterioration** – A qualifying diagnosis with probable chronic, relapsing and remitting course. Co-morbidities (like mental retardation, substance dependence, personality disorders, etc.). Persistent or chronic factors such as social isolation, poverty, extreme chronic stressors (life-threatening or debilitating medical illnesses, victimization, etc.). Other (past psychiatric history; gains in functioning have not

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solidified or are a result of current compliance only; court-committed; care is complicated and requires multiple providers; etc.).

The following reasons shall not be enough in and of themselves for denial of SMI eligibility:

- An inability to obtain existing records or information; or
- Lack of a face-to-face psychiatric or psychological evaluation.

Member with Co-Occurring Substance Use

For members who have a qualifying SMI diagnosis and co-occurring substance use, for purposes of SMI determination, presumption of functional impairment is as follows:

- For psychotic diagnoses (bipolar I disorder with psychotic features, delusional disorder, major depression, recurrent, severe, with psychotic features, schizophrenia, schizoaffective disorder and psychotic disorder NOS) functional impairment is presumed to be due to the qualifying psychiatric diagnosis;
- For other major mental disorders (bipolar disorders, major depression and obsessive-compulsive disorder), functional impairment is presumed to be due to the psychiatric diagnosis, unless:
 - The severity, frequency, duration or characteristics of symptoms contributing to the functional impairment cannot be attributed to the qualifying mental health diagnosis; or
 - The assessor can demonstrate, based on a historical or prospective period of treatment, that the functional impairment is present only when the member is abusing substances or experiencing symptoms of withdrawal from substances.
- For all other mental disorders not covered above, functional impairment is presumed to be due to the co-occurring substance use unless:
 - The symptoms contributing to the functional impairment cannot be attributed to the substance use disorder; or
 - The functional impairment is present during a period of cessation of the co-occurring substance use of at least thirty (30) days; or
 - The functional impairment is present during a period of at least ninety (90) days of reduced use unlikely to cause the symptoms or level of dysfunction.

SMI Eligibility Determination for Inmates in the Department of Correction (DOC)

An SMI eligibility designation/determination is done for purposes of determining eligibility for community-based behavioral health services. The Arizona Department of Health Services recognizes the importance of evaluating and determining the SMI eligibility for inmates in the Department of Corrections (DOC) with impending release dates to appropriately coordinate care between the DOC and the community based behavioral health system. Inmates of DOC **pending release within 6 months**, who have been screened or appear to meet the diagnostic and functional criteria, **will now be permitted to be referred** for an SMI eligibility evaluation and determination. Inmates of DOC whose release date exceeds 6 months are not eligible to be referred for an SMI eligibility evaluation and determination.

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SMI Eligibility Determination for Children Transitioning into the Adult System

When the adolescent reaches the **age of 17.5** and the Child and Family Team (CFT) believes that the youth may meet eligibility criteria as an adult with a Serious Mental Illness (SMI), the T/RBHA and their subcontracted providers must ensure the young adult receives an eligibility determination as outlined in the [AHCCCS Medical Policy Manual 320-P Serious Mental Illness Determination](#).

If the youth is determined eligible, or likely to be determined eligible for services as a member with a Serious Mental Illness, the adult behavioral health services care manager is then contacted to join the CFT and participate in the transition planning process. **After obtaining permission from the parent/guardian, it is the responsibility of the children's behavioral health service provider to contact and invite the adult behavioral health services care manager to upcoming planning meetings.** Additionally, the children's provider must track and report the following information to MCCC, CFT transition date (date the adult and children's provider attended a CFT) and adult intake date. When more than one T/RBHA and/or behavioral health service provider agency is involved, the responsibility for collaboration lies with the agency that is directly responsible for service planning and delivery.

If the young adult is not eligible for services as a member with a Serious Mental Illness, it is the responsibility of the children's behavioral health provider, through the CFT, to coordinate transition planning with the adult GMH/SU provider. The importance of securing representation from the adult service provider in this process cannot be overstated, regardless of the member's identified behavioral health category assignment (SMI, General Mental Health, Substance Use). The children's behavioral health provider should be persistent in its efforts to make this occur.

For additional guidance regarding the Transition to Adulthood Process for youth determined SMI prior to turning 18, see [AHCCCS Clinical Guidance Tool Transition to Adulthood Practice Protocol](#).

Completion Process of Final SMI Eligibility Determination

The licensed psychiatrist, psychologist, or nurse practitioner designated by Crisis Response Network must make a final determination as to whether the member meets the eligibility requirements for SMI status based on:

- A face-to-face assessment or reviewing a face-to-face assessment by a qualified assessor; and
- A review of current and historical information, if any, obtained orally or in writing by the assessor from collateral sources, and/or present or previous treating clinicians.

The following must occur if the designated reviewing psychiatrist, psychologist, or nurse practitioner has not conducted a face-to-face assessment and has a disagreement with the

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current evaluating or treating qualified behavioral health professional or behavioral health technician (that cannot be resolved by oral or written communication):

- Disagreement regarding diagnosis: Determination that the member does not meet eligibility requirements for SMI status must be based on a face to face diagnostic evaluation conducted by a designated psychiatrist, psychologist, or nurse practitioner. The resolution of (specific reasons for) the disagreement shall be documented in the member's comprehensive clinical record.
- Disagreement regarding functional impairment: Determination that the member does not meet eligibility requirements must be based upon a face-to-face functional evaluation conducted by a designated psychiatrist, psychologist, or nurse practitioner. The psychiatrist, psychologist, or nurse practitioner shall document the specific reason(s) for the disagreement in the member's comprehensive clinical record.

If there is enough information to determine SMI eligibility, the member shall be provided written notice of the SMI eligibility determination within three (3) business days of the initial meeting with the qualified assessor.

Issues Preventing Timely Completion of SMI Eligibility Determination

The time to initiate or complete the SMI eligibility determination may be extended no more than 20 days if the member agrees to the extension and:

- There is substantial difficulty in scheduling a meeting at which all necessary participants can attend;
- The member fails to keep an appointment for assessment, evaluation or any other necessary meeting;
- The member is capable of, but temporarily refuses to cooperate in the preparation of the completion of an assessment or evaluation;
- The member or the member's guardian and/or designated representative requests an extension of time;
- Additional documentation has been requested, but has not yet been received; or
- There is insufficient functional or diagnostic information to determine SMI eligibility within the required time periods.

Crisis Response Network must:

- Document the reasons for the delay in the member's eligibility determination record when there is an administrative or other emergency that will delay the determination of SMI status; and
- Not use the delay as a waiting period before determining SMI status or as a reason for determining that the member does not meet the criteria for SMI eligibility (because the determination was not made within the time standards).

Situations in which Extension is due to Insufficient Information:

- The Crisis Response Network shall request and obtain the additional documentation

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needed e.g., current and/or past medical records) and/or perform or obtain any necessary psychiatric or psychological evaluations;

- The designated reviewing psychiatrist, psychologist, or nurse practitioner must communicate with the member's current treating clinician, if any, prior to the determination of SMI, if there is insufficient information to determine the member's level of functioning; and
- SMI eligibility must be determined within three days of obtaining enough information, but no later than the end date of the extension.

If the member refuses to grant an extension, SMI eligibility must be determined based on the available information. If SMI eligibility is denied, the member will be notified of his/her appeal rights and the option to reapply).

If the evaluation or information cannot be obtained within the required time because of the need for a period of observation or abstinence from substance use to establish a qualifying mental health diagnosis the member shall be notified that the determination may, with the agreement of the member, be extended for up to 90 (calendar) days.

Notification of SMI Eligibility Determination

If the eligibility determination results in approval of SMI status, the SMI status must be reported to the member in writing, including notice of his/her right to appeal the decision.

If the eligibility determination results in a denial of SMI status, the Crisis Response Network shall include in the notice above:

- The reason for denial of SMI eligibility (**Serious Mental Illness Determination**);
- The right to appeal; and
- The statement that Title XIX/XXI eligible members will continue to receive needed Title XIX/XXI covered services.

Re-Enrollment or Transfer

If the member's status is SMI at disenrollment, or upon transfer from another T/RBHA, the member's status shall continue as SMI upon re-enrollment, opening of a new episode of care, or transfer.

Review of SMI Eligibility Determination

A review of SMI eligibility made by Crisis Response Network for individuals currently enrolled as a member with a SMI may be initiated by MCCC or behavioral health provider:

- As part of an instituted, periodic review of all members determined to have a SMI; or
- When there has been a clinical assessment that supports that the member no longer meets the functional and/or diagnostic criteria.
- An individual currently enrolled as a member with a SMI, or their legally authorized representative, upon their request.

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A review of the determination may not be requested by MCCC or behavioral health provider within six months from the date an individual has been determined SMI eligible.

If, because of such review, the member is determined to no longer meet the diagnosis and functional requirements for SMI status, MCCC must ensure that:

- Services are continued depending on Title XIX/XXI eligibility, MCCC service priorities and any other requirements.
- Written notice of the determination made on review with the right to appeal is provided to the affected member with an effective date of 30 days after the date the written notice is issued.

Verification of SMI Eligibility Determinations

When a T/RBHA or its contracted providers are required to verify SMI Eligibility for individuals who have previously been determined SMI, but cannot locate the member's original SMI determination documentation, or when the SMI determination is outdated (more than 10 years old as required by AHCCCS for eligibility/enrollment for benefits), **Serious Mental Illness Determination Verification** must be completed.

- The form does not replace Serious Mental Illness Determination but enables the MCCC and providers to "verify" a member's current SMI eligibility.

The form must be completed by a licensed psychiatrist, psychologist, or nurse practitioner, and then submitted to MCCC for approval. MCCC is responsible for monitoring and validating the forms. MCCC must keep copies of the validated Serious Mental Illness Determination Verification form in the member's record.

4.05 - Special Populations

MCCC receives Federal grants and State appropriations to deliver behavioral health services to special populations in addition to Federal Medicaid (Title XIX) and the State Children's Health Insurance Program (Title XXI) funding. The grants are awarded by a Federal agency and made available to AHCCCS. AHCCCS then disburses the funding throughout Arizona for the delivery of covered behavioral health services in accordance with the requirements of the fund source.

Substance Abuse Block Grant (SABG)

The SABG supports primary prevention services and treatment services for member with substance use disorders. It is used to plan, implement and evaluate activities to prevent and treat substance use. Grant funds are also used to provide early intervention services for HIV and tuberculosis disease in high-risk substance users. This section is intended to present an overview of the major Federal grants that provide AHCCCS and the public behavioral health system with funding to deliver services to member who may otherwise not be eligible for covered behavioral health services.

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Coverage and Prioritization

SABG funds are used to ensure access to treatment and long-term recovery support services for (in order of priority):

- Pregnant women/teenagers who use drugs by injection;
- Pregnant women/teenagers who use substances;
- Other member who use drugs by injection;
- Substance using women and teenagers with dependent children and their families, including females who are attempting to regain custody of their children; and
- All other clients with a substance use disorder, regardless of gender or route of use, (as funding is available).

Members must indicate active substance use within the previous 12-month period to be eligible for SABG funded services.

Choice of Substance Use Providers

Members receiving substance use treatment services under the SABG have the right to receive services from a provider to whose religious character they do not object.

Behavioral health subcontractors providing substance use services under the SABG must notify members of this right using the [AHCCCS AMPM Manual, Policy 320-T, Exhibit 320-T-9, Notification to Individuals Receiving Substance Use Services](#). Members must document that the member has received notice in the member's comprehensive clinical record.

If a member objects to the religious character of a behavioral health provider, the provider must refer the member to an alternative provider within 7 days, or earlier when clinically indicated, after the date of the objection. Upon making such a referral, providers must notify MCCC of the referral and ensure that the member contacts the alternative provider.

Upon making a referral, the provider will notify MCCC's General Mental Health/Substance Use Administrator by calling 800-564-5465.

Available Services

The following services must be made available to Substance Abuse Block Grant (SABG) special populations, as clinically identified and appropriate: Behavioral health providers must provide specialized, gender-specific treatment and recovery support services for females who are pregnant or have dependent children and their families in outpatient/residential treatment settings. Services are also provided to mothers who are attempting to regain custody of their children. Services must treat the family as a unit. As needed, providers must admit both mothers and their dependent children into treatment. The following services are provided or arranged as needed:

- Referral for primary medical care for pregnant females
- Referral for primary pediatric care for children

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- Gender-specific substance use treatment
- Therapeutic interventions for dependent children

MCCC is required to ensure the following issues do not pose barriers to access to obtaining substance use treatment:

- Child care
- Care management
- Transportation

MCCC is required to publicize the availability of gender-based substance use treatment services for females who are pregnant or have dependent children. Publicizing will include at a minimum the posting of fliers at each site notifying the right of pregnant females and females with dependent children to receive substance use treatment services at no cost.

Subcontracted providers must notify MCCC if, based on moral or religious grounds, the provider elects to not provide or reimburse for a covered service.

Providers may call MCCC 800-564-5465 with questions regarding specialty program services for women and children.

Interim Services for Pregnant Women/Injection Drug Users (Non-Title XIX/XXI only)

The purpose of interim services is to reduce the adverse health effects of substance use, promote the health of the individual, and reduce the risk of transmission of disease. Provision of interim services must be documented in the client's chart as well as reported to MCCC through the online waitlist. Interim services are available for Non-Title XIX/XXI priority populations who are maintained on an actively managed wait list. Title XIX/XXI eligible members who also meet a priority population type may not be placed on a wait list (see **MCCC Chapter 3 – Behavioral Health, Section 3.06 – Behavioral Health Appointment Standards**). The minimum required interim services include education that covers:

- Prevention of and types of behaviors which increase the risk of contracting HIV, Hepatitis C and other sexually transmitted diseases;
- Effects of substance use on fetal development;
- Risk assessment/screening;
- Referrals for HIV, Hepatitis C, and tuberculosis screening and services; and
- Referrals for primary and prenatal medical care.

SABG Reporting Requirements

Providers must promptly submit information for Priority Population Members (Pregnant Women, Women with Dependent Children and Intravenous Drug Users) who are waiting for placement in a Residential Treatment Center, to the MCCC SABG Waitlist System, or in a different format upon written approval by MCCC.

- Title XIX/XXI members may not be added to the wait list.

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- Priority Population Members must be added to the wait list if MCCC or its providers are not able to place the member in a Residential Treatment Center within the timeframes prescribed.
 - For pregnant females the requirement is within 48 hours, for women with dependent children the requirement is within 5 calendar days, and for all IVDUs the requirement is within 14 calendar days.
- Non-Title XIX/XXI members may be added to the waitlist if there are no available services.

Other SABG Requirements

MCCC is required to designate:

- A lead substance use treatment coordinator who will be responsible for ensuring MCCC compliance with all SABG requirements;
- A women's treatment coordinator;
- An opiate treatment coordinator
- A prevention services administrator; and
- An HIV early intervention services coordinator

HIV Early Intervention Services

Because members with substance use disorders are considered at high risk for contracting HIV-related illness, the SABG requires HIV intervention services to reduce the risk of transmission of this disease.

In Maricopa County, Terros, Inc., provides HIV early intervention services at substance use programs, care management sites for the seriously mentally ill, and community events, and operates a drop-in center. To contact this program, please call 602-685-6000.

Eligibility for HIV Early Intervention Services

- **Services are provided exclusively to populations with substance use disorders.**
- **HIV services may not be provided to incarcerated populations.**

Requirements for Providers Offering HIV Early Intervention Services

HIV early intervention service providers who accept funding under the Substance Abuse Block Grant (SABG) must provide HIV testing services.

Behavioral health providers must administer HIV testing services in accordance with the Clinical Laboratory Improvement Amendments (CLIA) requirements, which requires that any agency that performs HIV testing must register with CMS to obtain CLIA certification. However, agencies may apply for a CLIA Certificate of Waiver which exempts them from regulatory oversight if they meet certain federal statutory requirements. Many of the Rapid HIV tests are waived. Available for your review is a complete list of waived Rapid HIV tests listed on the CDC

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website under [Rapid HIV tests suitable for use in non-clinical settings \(CLIA Waived\)](#). Waived rapid HIV tests can be used at many clinical and non-clinical testing sites, including community and outreach settings. Any agency that is performing waived rapid HIV tests is considered a clinical laboratory.

Any provider planning to perform waived rapid HIV tests must develop a quality assurance plan, designed to ensure any HIV testing will be performed accurately. (Please click to see the [Centers for Disease Control Quality Assurance Guidelines](#).)

HIV Education and Pre/Post-test Counseling: The HIV Prevention Counseling training provided through MCCC must be completed by MCCC HIV Coordinators, provider staff and provider supervisors whose duties are relevant to HIV services. Staff must successfully complete the training with a passing grade prior to performing HIV testing.

MCCC HIV Coordinators and provider staff delivering HIV Early Intervention Services for the Substance Abuse Block Grant (SABG) must attend an HIV Early Intervention Services Webinar issued by MCCC on an annual basis, or as indicated by AHCCCS. The Webinar will be recorded and made available by MCCC. New staff assigned to duties pertaining to HIV services must view the Webinar as part of their required training prior to delivering any HIV Early Intervention Services reimbursed by the SABG.

HIV early intervention service providers cannot provide HIV testing until they receive a written HIV test order from a licensed medical doctor, in accordance with **A.R.S. §36-470**. HIV rapid testing kits must be obtained from the Office of Tobacco and Chronic Disease.

HIV early intervention service providers must actively participate in regional community planning groups to ensure coordination of HIV services.

Reporting Requirements for HIV Early Intervention Services

For every occurrence in which an oral swab rapid test provides a reactive result, a confirmatory blood test must be conducted, and the blood sample sent to the Arizona State Lab for confirmatory testing. Therefore, each provider who conducts rapid testing must have capacity to collect blood for confirmatory testing whenever rapid testing is conducted.

The number of the confirmatory lab slip will be retained and recorded by the provider. This same number will be used for reporting in the Luther database. The HIV Early Intervention service provider must establish a Memorandum of Understanding (MOU) with their local County Health Department to define how data and information will be shared.

Providers must use the Luther database to submit HIV testing data after each test administered.

Monitoring Requirements for HIV Early Intervention Services

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MCCC is required to collect monthly progress reports from subcontracted providers and submit quarterly progress reports to AHCCCS.

Site visits to providers offering HIV Early Intervention Services must be conducted bi-annually. The AHCCCS HIV Coordinator, MCCC HIV Coordinator, provider staff and supervisors relevant to HIV services must be in attendance during staff visits. A budget review and description/justification for use of funding must be made available by the provider as part of the site visit.

Minimum Performance Expectations

MCCC is expected to administer a minimum of 1 test per \$600 in HIV funding.

Delivery Considerations Services to Substance Abuse Block Grant (SABG) Populations

SABG treatment services must be designed to support the long-term treatment and substance-free recovery needs of eligible members. Specific requirements apply regarding preferential access to services and the timeliness of responding to a member's identified needs. Providers funded with SABG funding must coordinate non-emergency transportation to covered SABG services.

Restrictions use of Substance Abuse Block Grant (SABG)

The State shall not expend SABG Block Grant funds on the following activities:

- To provide inpatient hospital services, except for detox services;
- To make cash payments to intended members of health services;
- To purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;
- To satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds (Maintenance of Effort);
- To provide financial assistance to any entity other than a public or nonprofit private entity;
- To provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs, unless the Surgeon General of the Public Health Service determines that a demonstration needle exchange program would be effective in reducing drug use and the risk that the public will become infected with the etiologic agent for AIDS;
- To pay the salary of an individual through a grant or other extramural mechanism at a rate in excess of [Executive Level I of the Executive Salary Schedule](#) for the award year; and
- To purchase treatment services in penal or correctional institutions of the State of Arizona.

Room and Board (H0046-SE) services funded by the Substance Abuse Block Grant (SABG) are limited to children/adolescents with a Substance Use Disorder (SUD), and adult priority

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population members (pregnant females, females with dependent children, and intravenous drug users with a SUD).

Mental Health Block Grant (MHBG)

The MHBG provides funds to establish or expand an organized community-based system of care for providing Non-Title XIX mental health services to children with serious emotional disturbances (SED) and adults with serious mental illness (SMI). These funds are used to:

- Carry out the State plan contained in the application;
- Evaluate programs and services, and;
- Conduct planning, administration, and educational activities related to the provision of services.

Coverage and Prioritization

The MHBG provides Non-Title XIX/XXI behavioral health services to adults with SMI and children with SED.

The MHBG must be used:

- To ensure access to a comprehensive system of care, including employment, housing, care management, rehabilitation, dental, and health services, as well as mental health services and supports;
- To promote participation by consumer/survivors and their families in planning and implementing services and programs, as well as in evaluating State mental health systems;
- To ensure access for underserved populations, including people who are homeless, residents of rural areas, and older adults;
- To promote recovery and community integration for adults with SMI and children with SED;
- To provide for a system of integrated services to include:
 - Social services;
 - Educational services;
 - Juvenile justice services;
 - Substance use services;
 - Health and behavioral health services; and
- To provide for training of providers of emergency health services regarding behavioral health.
- To provide for a system of integrated services to include:
 - Social services;
 - Educational services;
 - Juvenile justice services;
 - Substance use services;
 - Health and behavioral health services; and
 - To provide for training of providers of emergency health services regarding

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behavioral health.

Restrictions on Use of MHBG Funds

The State shall not expend MHBG funds on the following activities:

- To provide inpatient hospital services; except for detox services
- To make cash payments to intended members of health services;
- To purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;
- To satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds (Maintenance of Effort);
- To provide financial assistance to any entity other than a public or nonprofit private entity;
- To provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs, unless the Surgeon General of the Public Health Service determines that a demonstration needle exchange program would be effective in reducing drug use and the risk that the public will become infected with the etiologic agent for AIDS;
- To pay the salary of an individual through a grant or other extramural mechanism at a rate in excess of [Executive Level I of the Executive Salary Schedule](#) for the award year; and
- To purchase treatment services in penal or correctional institutions of the State of Arizona Room and Board services funded by the MHBG are limited to children with SED.

Room and Board services funded by the MHBG are limited to children with SED.

4.06 – Crisis Intervention Services

Crisis intervention services are provided to a member for stabilizing or preventing a sudden, unanticipated, or potentially dangerous behavioral health condition, episode or behavior. Crisis intervention services are provided in a variety of settings, such as hospital emergency departments, face-to-face at a member's home, over the telephone or in the community. These intensive and time limited services may include screening, (e.g., triage and arranging for the provision of additional crisis services) assessing, evaluating or counseling to stabilize the situation, medication stabilization and monitoring, observation and/or follow-up to ensure stabilization, and/or other therapeutic and supportive services to prevent, reduce or eliminate a crisis.

General Requirements

To meet the needs of individuals in communities throughout Arizona, MCCC will ensure that the following crisis services are available:

- Telephone Crisis Intervention Services:
 - Telephone crisis intervention and NurseLine services, including a toll-free number, available 24 hours per day, seven days a week: 602-222-9444; toll free 800-631-1314; or TTY/TTD toll free 800-327-9254.

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- Answer calls within three (3) telephone rings (equivalent to 18 seconds), with a call abandonment rate of less than three (3%) percent.
 - Offer interpretation or language translation services to members who do not speak or understand English and for the deaf and hard of hearing.
- Mobile Crisis Intervention Services
 - Mobile crisis intervention services available 24 hours per day, seven days a week;
 - Mobile crisis teams will respond within one (1) hour to a psychiatric crisis in the community.
 - If a two-member team responds, one member may be a Behavioral Health Technician, including a peer or family member, provided he/she has supervision and training as currently required for all mobile team members.
- 23-hour crisis observation/stabilization services, including detoxification services.
- Up to 72 hours of additional crisis stabilization as funding is available for mental health and substance use related services.
- Work collaboratively with local emergency departments and first responders.

Psychiatric and Substance Use Emergencies for Child and Adolescent

St. Luke's Behavioral Health Center (child and adolescent services only)
1800 E. Van Buren St.
Phoenix, AZ 85006
Phone: 602-251-8535

Psychiatric Emergencies for Adults

Community Bridges- Community Psychiatric Emergency Center
358 E. Javelina Ave.
Mesa, AZ 85210
Phone: 877-931-9142

Connections AZ Urgent Psychiatric Care Center (UPC)
1201 S. 7th Ave., #150
Phoenix, AZ 85007
Phone: 602-416-7600

Recovery Response Center (formerly Recovery Innovations Psychiatric Recovery Center (META) West (PRC-West))
11361 N 99th Ave., Ste. 402
Peoria, AZ 85345
Phone: 602-650-1212, then press 2

Substance Use Emergencies for Adults

Community Bridges Central City Addiction Recovery Center (CCARC)
2770 E. Van Buren St.

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Phoenix, AZ 85008
Phone: 877-931-9142

Community Bridges East Valley Addiction Recovery Center (EVARC)
506 S. Bellview
Mesa, AZ 85204
Phone: 877-931-9142

Up to 72 hours of additional crisis stabilization as funding is available for mental health and substance use related services at an inpatient psychiatric acute or sub-acute facility.

Management of Crisis Services

While MCCC must provide a standard set of crisis services to ensure the availability of these services throughout the state, MCCC will also be able to meet the specific needs of communities located within their service area. MCCC will utilize the following in managing crisis services:

- Allocate and manage funding to maintain the availability of required crisis services for the entire fiscal year;
- Work collaboratively with local hospital-based emergency departments to determine whether a MCCC-funded crisis provider should be deployed to such locations for crisis intervention services;
- Work collaboratively with local inpatient hospitals to determine whether and for how many hours such locations are used for crisis observation/stabilization services; and
- When Non-Title XIX/XXI eligible individuals are receiving crisis services and require medication, MCCC will use the generic medication formulary identified in the Non-Title XIX SMI benefit.

Whenever possible, Crisis Services are to be delivered within the community at the least restrictive level of care available.

General Mental Health/Substance Use (GMH/SU) Member Contact in Sub-Acute and Inpatient Facilities

Upon finding out that a client has been admitted to an inpatient level of care:

- Behavioral health providers must attempt to speak with the sub-acute or inpatient provider daily.
- Behavioral health providers must actively participate in the client's discharge planning and should make plans for follow up activities once the client is discharged (actual discharge planning should begin to occur at the time of admission).

Behavioral health providers must also document activities in the clinical record and conduct follow-up activities to maintain engagement within the following timeframes:

- Community Based MCCC Contracted Behavioral Health Providers must have

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- telephonic or face to face contact with member within 24 hours of crisis episode or discharge.
- Member to see prescriber within 7 days of discharge.

4.07 – Training Requirements

MCCC leadership's expectation is that all contracted General Mental Health/Substance Use providers are knowledgeable about the Substance Abuse Block Grant (SABG). This includes providers having SABG posters and materials available in waiting areas, and to be able to speak to uninsured and underinsured individuals who may need treatment or providing a referral for treatment.

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MCCC CHAPTER 5 – DENTAL AND VISION SERVICES

5.00 - Dental Overview

Dentaquest

Effective January 1, 2015, DentaQuest will administer dental benefits for MCCC. DentaQuest has administrative oversight for the following responsibilities:

- Credentialing
- Patient Management
- Prior Authorization
- Claims
- Customer Service Calls from Providers
- Appeals

MCCC will administer the following for our members:

- Grievances
- Customer Service Calls from Members

Claims with dates of service on or after January 1, 2015 need to be sent to DentaQuest at the following claims address:

DentaQuest of Arizona, LLC – Attention: Claims
P.O. Box 2906
Milwaukee, WI 53201-2906

For electronic claims submissions, DentaQuest works directly with the following Clearinghouses:

Change Healthcare (888-255-7293)
Tesla (800-724-7420)
EDI Health Group (800- 576-6412)
Secure EDI (877-466-9656)
Mercury Data Exchange (866-633-1090)

You can contact your software vendor to make certain that they have DentaQuest listed as the payer and claim mailing address on your electronic claim. Your software vendor will be able to provide you with any information you may need to ensure that submitted claims are forwarded to DentaQuest. DentaQuest's Payer ID is CX014.

If you have additional questions regarding your claims for DentaQuest, you may contact them directly at 844-234-9831. They will be happy to assist you.

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You may also utilize their Interactive Voice Response (IVR) system 24 hours a day, 7 days a week that provides up-to-date information regarding member eligibility, claim status, and much more. Benefits associated with this program and more detailed information regarding DentaQuest can be found in their Office Reference Manual on-line at www.dentaquestgov.com.

5.01 – Dental Covered Services

Dental Screening/Dental Treatment for children under 21

More information regarding Dental Screening/Dental Treatment for children under 21 is available under the **Chapter 100 – Mercy Care Provider Manual - Chapter 5 – Early and Periodic Screening, Diagnostic and Treatment (EPSDT)**, under Section 5.13 – Dental Screening and Referrals.

The following dental services/dental treatments are covered for children under age 21:

- oral health screenings
- cleanings
- fluoride treatments
- dental sealant
- oral hygiene education
- x-rays
- fillings
- extractions
- other therapeutic and medically necessary procedures
- routine dental services

Two (2) routine preventive dental visits are covered per year. Visits to the dentist must take place within six months and one day after the previous visit. The first dental visit should take place by one year of age. Members under 21 years of age do not need a referral for dental care.

Benefits covered for children under age 21 are in accordance with AHCCCS' [Exhibit 431, Attachment A - AHCCCS Dental Periodicity Table](#). Benefits are also outlined in the DentaQuest Office Manual available at www.dentaquestgov.com.

Mercy Care assigns all members under 21 years of age to a dental home. A dental home is where the member and a dentist work together to best meet dental health needs. Having a dental home builds trust between the member and the dentist. It is a place where the member can get regular, ongoing care, not just a place to go when there is a dental problem. A “dental home” may be an office or facility where all dental services are provided in one place. Members can choose or change their assigned dental provider.

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Emergency Dental Services for Members 21 Years of Age and Older

Members 21 years of age or older have a \$1,000 annual emergency dental benefit per health plan year. The annual benefit plan year runs from October 1 - September 30. A dental emergency is an acute disorder of oral health resulting in severe pain and/or infection because of pathology or trauma.

Emergency dental services* include:

- Emergency oral diagnostic examination (limited oral examination - problem focused);
- Radiographs and laboratory services limited to the symptomatic teeth;
- Composite resin due to recent tooth fracture for anterior teeth;
- Prefabricated crowns, to eliminate pain due to recent tooth fracture only;
- Recementation of clinically sound inlays, onlays, crowns, and fixed bridges;
- Pulp cap, direct or indirect plus filling;
- Root canals and vital pulpotomies when indicated for the treatment of acute infection or to eliminate pain;
- Apicoectomy performed as a separate procedure, for treatment of acute infection or to eliminate pain, with favorable prognosis;
- Immediate and palliative procedures, including extractions if medically necessary, for relief of pain associated with an oral or maxillofacial condition;
- Tooth reimplantation of accidentally avulsed or displaced anterior tooth, with favorable prognosis;
- Temporary restoration which provides palliative/sedative care (limited to the tooth receiving emergency treatment);
- Initial treatment for acute infection, including, but not limited to, periapical and periodontal infections and abscesses by appropriate methods;
- Preoperative procedures and anesthesia appropriate for optimal patient management; and
- Cast crowns limited to the restoration of root canal treated teeth only.

*Emergency dental services do not require prior authorization.

Dental services that are **not** covered:

- Diagnosis and treatment of TMJ - except to reduce trauma
- Maxillofacial dental services that are not needed to reduce trauma
- Routine restorative procedures and routine root canal therapy
- Bridgework to replace missing teeth
- Dentures

Covered dental services not subject to the \$1,000 emergency dental limit include:

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- Extraction of teeth in preparation for radiation treatment of cancer of the jaw, neck or head.
- Members who require medically necessary dental services before getting a covered organ or issue transplant**:
 - Treatment for oral infections
 - Treatment of oral disease, including dental cleanings, treatment of periodontal disease, medically necessary extractions and simple restorations.

**These services are covered only after a transplant evaluation determines that the member is a candidate for organ or tissue transplantation.

Anesthesia related to the emergency dental services also falls under the annual \$1,000 benefit.

Emergency dental codes are covered only if they meet the criteria of emergent treatment per AHCCCS policy. For additional detail regarding this benefit, we are including the following links to the AHCCCS Medical Policy Manual:

- [Dental Services for Members 21 Years of Age and Older](#)
- [Arizona Long Term Care System Adult Dental Services](#)

The list of codes that are included in the dental emergency benefit are below:

D0140	D2390	D2933	D3347	D7250	D7440	D7560
D0191	D2740	D2940	D3348	D7251	D7441	D7970
D0220	D2750	D2950	D3410	D7260	D7450	D7971
D0230	D2751	D2952	D3421	D7261	D7451	D7972
D0270	D2752	D2954	D3425	D7270	D7460	D7980
D0272	D2790	D3110	D3426	D7285	D7461	D7981
D0273	D2791	D3120	D3430	D7286	D7465	D7982
D0274	D2792	D3220	D7111	D7310	D7510	D7983
D0277	D2794	D3221	D7140	D7311	D7511	D7999
D0330	D2910	D3310	D7210	D7320	D7520	D9223
D2330	D2915	D3320	D7220	D7321	D7521	D9230
D2331	D2920	D3330	D7230	D7410	D7530	D9243
D2332	D2931	D3331	D7240	D7411	D7540	D9248
D2335	D2932	D3346	D7241	D7415	D7550	

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5.01 – Vision Services

Vision Overview

MCCC covers eye and optometric services provided by qualified eye/optometry professionals within certain limits based on member age and eligibility:

- Emergency eye care, which meets the definition of an emergency medical condition, is covered for all members.
- For members who are 21 years of age or older, treatment of medical conditions of the eye, excluding eye examinations for prescriptive lenses and the provision of prescriptive lenses, are covered.
- Vision examinations and the provision of prescriptive lenses are covered for members under the EPSDT and for adults when medically necessary following cataract removal.
- Cataract removal is covered for all eligible members under certain conditions. For more information, please review the [AHCCCS Medical Policy Manual, Chapter 300](#).

Coverage for Children (Under Age 21)

- Medically necessary emergency eye care, vision examinations, prescriptive lenses and treatments for conditions of the eye.
- PCPs are required to provide initial vision screening in their office as part of the EPSDT program.
- Members under age 21 with vision screening of 20/60 or greater should be referred to the contracted vision provider for further examination and possible provision of glasses.
- Replacement of lost or broken glasses is a covered benefit.
- Contact lenses are not a covered benefit.

Nationwide Referral Instructions

Nationwide is MCCC's contracted vendor for all vision services, including diabetic retinopathy exams. Members requiring vision services should be referred by the PCP's office to a Nationwide provider listed on MCCC's website. The member may call Nationwide directly to schedule an appointment.

Coverage for Adults (21 years and older)

- Emergency care for eye conditions when the eye condition meets the definition of an emergency medical condition; for cataract removal and/or medically necessary vision examinations; and for prescriptive lenses if required following cataract removal.
- Routine eye exams and glasses are not a covered service for adults.
- Adults 21 years of age and older should be referred to Nationwide for the diagnosis and treatment of eye diseases as well.

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Dental and Vision Community Resources for Adults

AHCCCS benefits do not include routine dental and vision services for adults. However, there are community resources available to help members obtain routine dental and vision care. For more information, call MCCC's Member Services at 602-263-3000 or 800-624-3879 (toll-free).

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MCCC CHAPTER 6 – GRIEVANCES, APPEALS AND CLAIMS DISPUTES

6.00 - Grievances

MCCC's Grievance System includes a process for enrollee grievances, enrollee appeals, provider claim disputes and access to the State Fair Hearing system.

A Grievance is described as any written or verbal expression of dissatisfaction over anything that does not involve appealing a decision, such as a denial or discontinuance of services or benefits. Grievances may be filed by a member or provider authorized in writing to act on the member's behalf. A grievance may be submitted orally or in writing to any MCCC staff person. Grievances include, but are not limited to, issues regarding:

- Quality of care or services
- Accessibility or availability of services
- Interpersonal relationships (e.g. rudeness of a provider or employee, cultural barriers or insensitivity)
- Claims or billing
- Failure to respect a member's rights

To file a grievance, members and/or providers filing on behalf of a member, should contact Member Services by phone at 602-263-3000, Toll -Free at 800-634-3879, or in writing at:

Mercy Care
Member Services Department
4755 S. 44th Place
Phoenix, AZ 85040

MCCC will respond and resolve member grievances at the time of the initial call, if possible, or within 90 days if further investigation is needed. If resolution to the grievance is not favorable to the member or representative, MCCC will also provide written information to both members and providers, regarding the Grievance and Appeal System requirements. This includes:

- The right to a state fair hearing, the method for obtaining a state fair hearing
- The Rules that govern representation at the hearing
- The right to file grievances, appeals and claim disputes
- The requirements and timeframes for filing grievances, appeals and claims disputes
- The availability of assistance in the filing process, the toll-free numbers that the member can use to file a grievance or appeal by phone
- That benefits will continue when required by the member in an appeal or a state fair hearing request concerning certain actions which are timely filed
- That the member may be required to pay the cost of services furnished during the appeal/hearing process if the final decision is averse to the member, and

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- That a provider may file an appeal on behalf of a member with the member's written consent

If the grievance involves a quality of care concern, it will be forwarded to MCCC's Quality Management Department for further review. The concern will be investigated, and the member and/or the member's representative will be notified in writing within 90 days of the results of the investigation.

6.01 - Provider Claim Disputes

A claim dispute is a dispute involving the payment of a claim, denial of a claim, imposition of a sanction or reinsurance. A provider may file a claim dispute based on:

- Claim Denial
- Recoupment
- Dissatisfaction with Claims Payment

Before a provider initiates a claims dispute, the following needs to occur:

- The claim dispute process should only be used after other attempts to resolve the matter have failed.
- The provider should contact MCCC Claims and/or Provider Relations to seek additional information prior to initiating a claim dispute.
- The provider must follow all applicable laws, policies and contractual requirements when filing.
- According to the Arizona Revised Statute, Arizona Administrative Code and AHCCCS guidelines, all claim disputes related to a claim for system covered services must be filed in writing and received by the administration or the prepaid capitated provider or program contractor:
 - Within 12 months after the date of service.
 - Within 12 months after the date that eligibility is posted.
 - Or within 60 days after the date of the denial of a timely claim submission, whichever is later.

You may submit your claim dispute in writing through the mail or send electronically to us through fax. Not only do we now have the ability to receive disputes by fax, but we can also respond back to our providers via fax, allowing you to receive faster decisions. If you choose to send via fax, please fax your disputes to **602 351-2300**.

Written claim disputes must be submitted to the MCCC Appeals Department. Please include all supporting documentation with the initial claim dispute submission. The claim dispute must specifically state the factual and legal basis for the relief requested, along with copies of any supporting documentation, such as remittance advice(s), medical records or claims. Failure to specifically state the factual and legal basis may result in denial of the claim dispute.

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MCCC will acknowledge a claim dispute request within five (5) business days after receipt. If a provider does not receive an acknowledgement letter within five (5) business days, the provider must contact the Appeals Department. Once received, the claim dispute will be reviewed, and a decision will be rendered within 30 days after receipt. MCCC may request an extension of up to 45 days, if necessary. If you are submitting via mail, the claim dispute, including all supporting documentation, should be sent to:

Mercy Care
Appeals Department
4755 S. 44th Place
Phoenix, AZ 85040

If a provider disagrees with the MCCC Notice of Decision, the provider may request a State Fair Hearing. The request for State Fair Hearing must be filed in writing no later than 30 days after receipt of the Notice of Decision. Please clearly state "State Fair Hearing Request" on your correspondence. All State Fair Hearing Requests must be sent in writing to the follow address:

Mercy Care
Appeals Department
Attention: Hearing Coordinator
4755 S. 44th Place
Phoenix, AZ 85040

6.02 - Appeals

An appeal is a request for review of an action by an enrollee (member) or their authorized representative, such as a provider. An appeal can be filed for various reasons including the denial or limited authorization of a requested service, the type or level of service, or for the reduction, suspension or termination of a previously authorized service. An authorized representative acting on behalf of the member, with the member's written consent, may file an appeal or request a State Fair Hearing on behalf of a member.

Standard Appeals - An appeal must be filed either orally or in writing with MCCC within 60 days after the date of the Notice of Adverse Benefit Determination. A provider may assist a member in filing an appeal. MCCC does not restrict or prohibit a provider from advocating on behalf of a member.

Standard Appeal Resolution - MCCC will resolve the appeal and mail the written Notice of Appeal Resolution to the member within 30 days after the day MCCC receives the appeal.

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Expedited Appeals - If a provider believes that the time for a standard resolution appeal could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function, the provider can submit a request for an Expedited Appeal, with the member's written consent, along with supporting documentation to MCCC. MCCC will acknowledge an expedited appeal within one working day of receipt.

Expedited Appeal Resolution - MCCC will resolve the appeal and mail a written Notice of Appeal Resolution to the member within 3 working days after MCCC receives the Expedited Appeal. MCCC will also make reasonable efforts to provide prompt oral notification to the member. This timeframe may be extended if MCCC needs additional information and the extension is in the best interest of the member. If the request for an Expedited Appeal is denied, MCCC will decide the appeal within the standard timeframe (30 days from the day MCCC receives the Expedited Appeal).

Each appeal should be filed separately. To file an appeal, please submit in writing, along with all substantiating documentation to:

Mercy Care
Appeals Department
4755 S. 44th Place
Phoenix, AZ 85040
602-351-2300 (FAX)

A member may also file an Appeal orally by contacting:

Mercy Care
Appeals Department
Phone: 602-453-6098
Toll Free: 800-624-3879

An authorized representative, including a provider, acting on behalf of the member, with the member's written consent, may request a State Fair Hearing on behalf of the member. The request for State Fair Hearing must be in writing, submitted to and received by MCCC, no later than 30 days after the date the member receives the Notice of Appeal Resolution.

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All State Fair Hearing Requests must be sent in writing to the follow address:

Mercy Care
Appeals Department
Attention: Hearing Coordinator
4755 S. 44th Place
Phoenix, AZ 85040
602-351-2300 (fax)



Mercy Care Long Term Care



Visit: www.MercyCareAZ.org

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MCLTC CHAPTER 1 – MERCY CARE LONG TERM CARE OVERVIEW

1.00 – Mercy Care Long Term Care Overview

Mercy Care Long Term Care (herein MCLTC), as part of MC, is a not-for-profit partnership sponsored by Dignity Health and Ascension Care Management. MCLTC is committed to promoting and facilitating quality health care services with special concern for the values upheld in Catholic social teaching, and preference for the poor and persons with special needs. Aetna Medicaid Administrators, LLC administers MCLTC for Dignity Health and Ascension Care Management.

MCLTC is a managed care organization that provides health care services to people in Arizona's Medicaid program. MCLTC has held a pre-paid capitated contract with the AHCCCS Administration since 1985. MCLTC provides services to the Arizona Medicaid populations including:

- **Arizona Long Term Care System (herein ALTCS):** AHCCCS offers services for individuals who require nursing home or in-home care and integrates both their behavior health and physical health needs. These services are offered through the *Arizona Long Term Care System (ALTCS)*. This program is intended for individuals who are age 65 or older, blind or have a disability (at any age) and need ongoing services at a nursing facility level of care. Those who qualify do not have to reside in a nursing home. Many ALTCS members live in their own homes or an assisted living facility and receive needed in-home services. ALTCS members are located in the following counties:
 - Maricopa
 - Gila
 - Pima
 - Pinal
- **Children's Rehabilitative Services (CRS):** Arizona's Children's Rehabilitative Services (CRS) program provides medical and behavioral health care, treatment, and related support services to Arizona Health Care Cost Containment System (AHCCCS) members who meet the eligibility criteria and completed the application to be enrolled in the CRS program and have been determined eligible.
- **Division of Developmental Disabilities Long Term Care program:** Members are enrolled through the Arizona Department of Economic Security/Division of Developmental Disabilities (DDD). DDD is a Medicaid program administered by AHCCCS through the Department of Economic Security (DES). MCLTC is contracted with DDD to provide acute care services. DDD members are located in the following counties:
 - Cochise
 - Gila
 - Graham
 - Greenlee
 - La Paz

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- Maricopa
- Pima
- Pinal
- Santa Cruz
- Yuma

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MCLTC CHAPTER 2 – NETWORK PROVIDER SERVICE DELIVERY REQUIREMENTS

2.00 – MCLTC Overview

The MCLTC program includes additional requirements and benefits compared to the Mercy Care (herein MC) Acute line of business. MCLTC members are eligible for:

- Home and Community Based Services
- Alternative Residential Settings
- Residential Skilled Nursing Facilities (SNF) – For additional information please review our Claims Processing Manual on our [Claims Information](#) web page under **Chapter 6 - Skilled Nursing Facility Claims**.

Below is a list of services specific to the MCLTC program:

[MCLTC Services Table](#)

<u>Type of Service</u>	<u>Description</u>
Adult Day Health Care	Health care and personal services as part of an adult day center. This may include meals, health checks and therapies.
Alternative Residential Facilities	Services provided to residents in a facility that provides assistance with activities of daily living.
Attendant Care Services	A trained person from a certified caregiver agency provides services in the member's home such as personal care, housekeeping and meal preparation.
Emergency Alert System	Equipment that provides 24-hour access to emergency help.
Habilitation	This service provides training in independent living skills.
Home Delivered Meals	Healthy meals are prepared and brought to a member's home.
Home Health Service	This service provides nursing, home health aide, and therapy in the member's home.
Homemaker	This service is designed to assist with household jobs like cleaning, shopping or running errands.

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Home Modification	This service makes adaptive changes to the home to increase the member's independence.
Hospice Care	Services that help members who need health care and emotional support during the final stages of life.
Nursing Facility	Nursing facilities provide room, board and nursing services for members who need these services all the time.
Personal Care	This service offers help with eating, bathing and dressing.
Private Duty Nursing	Nursing services for members who need more individual and continuous care.
Respite	This service provides personal care to provide a member's family and caregiver support. This service can be provided in the member's home, assisted living facility or skilled nursing home.
Self-Directed Attendant Care	This program is for members who want to be in charge of their attendant caregiver service. Members using this service will hire/fire, train, and be in charge of their own caregivers. Members have more control in this program. They can hire anyone that has the basic skills needed, give work and make schedules within the weekly service hours chosen by MCLTC care manager.
Spouse Attendant Care	A spouse can become a member's paid attendant caregiver while s/he is living at home. State guidelines must be followed, so please speak to a MCLTC care manager regarding Spouse Attendant Care.

2.01 – MCLTC Program Contractor Changes

MCLTC has a transition coordinator to assist with all program contractor changes. All MCLTC members have the option of changing program contractors during their annual enrollment choice month. AHCCCS sends a packet of information to each member prior to their annual enrollment choice about how to change program contractors and the dates by which their choice must be communicated to AHCCCS. Members may also change program contractors at other times if the circumstance meets AHCCCS criteria such as:

- moving to another county
- moving to another program contractor to maintain continuity of medical care, or
- residing in a facility that no longer contracts with their current program contractor.

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In these situations the member's care manager will put together a packet of information and the transition coordinator will send it to the requested program contractor. If the requested program contractor grants the request, a transition date is determined and AHCCCS is notified and makes the change.

2.02 - Home and Community Based Services (HCBS)

All Home and Community Based providers who provide attendant care, housekeeping, personal care, and respite care are required by AHCCCS to complete a monthly MCLTC Provider Non-Provision of Services Log for critical services. Your Network Relations Specialist/Consultant is available for initial and ongoing training.

A gap in critical services is defined as the difference between the number of hours of home care worker critical services scheduled in each member's HCBS care plan and the hours of scheduled type of critical service that are actually delivered to the member.

Critical services received in the member's home are inclusive of tasks such as bathing, toileting, dressing, feeding, transferring to or from bed or wheelchair, and assistance with similar daily activities. Types of critical services include:

- Attendant care, including spouse attendant care
- Personal Care
- Homemaker
- In-home respite

Please refer to [Chapter 1200, Arizona Long Term Care System Services and Settings for Members Who Are Elderly and/or have Physical Disabilities and/or have Developmental Disabilities](#) in the AHCCCS Medical Policy Manual (AMPM) for additional Home and Community Based Services information.

2.03 - Agency with Choice Providers

The following provisions apply to all Agency with Choice Providers:

An authorized representative of the Provider must sign a Member's Service Plan if present at the service plan meeting. Regardless of whether Provider signs the Service Plan, by acceptance of this Agreement, Provider agrees to its roles and responsibilities in implementing the Service Plan, which it will perform in accordance with the terms of the Service Plan, this Agreement and applicable law.

2.04 - Attendant Care Services - Interruption in Service

There may be times where an interruption in service may occur due to an unplanned hospital admission for the member. While services may have been authorized for attendant care during

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this time, attendant care agencies should not be billing for any days that fall between the admission date and the discharge date or any day during which services were not provided.

Example:

Member is authorized to receive 40 hours of attendant care per week over a 5 day period. The member is receiving 8 hours of care a day.

The member is admitted into the hospital on January 1, 2010 and is discharged from the hospital on January 3, 2010. There should be no billable hours for January 2, 2010, as no services were provided on that date since the member was hospital confined for a full 24 hours.

Caregivers would not be able or allowed to claim time with the member on the example above, since no services could be performed on January 2, 2010 by the attendant care agency. This is also true for Personal Care, Homemaker, and Respite Services as well.

Each attendant care agency will be responsible for following this process. If any hours are submitted when a member has been hospitalized for the full 24 hours, the attendant care agency will be required to pay back any monies paid by MCLTC. In accordance with AHCCCS requirements, MCLTC will be conducting periodic audits to verify this is not occurring.

2.05 - Attendant Care Modifiers

AHCCCS requires the use of specific codes/modifiers for attendant care as follows:

Attendant Care:

Non-Family: S5125-No modifier
Family Non-Resident: S5125-U4
Family Resident: S5125-U5
Spouse: S5125-U3

Agency with Choice

Non-Family: S5125-U7
Family Non-Resident: S5125-U4U7
Family Resident: S5125-U5U7
Spouse: S5125-U3U7

Self-Directed Attendant Care

Non-Family: S5125-U2
Family Non-Resident: S5125-U2U4
Family Resident: S5125-U2U5

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Skilled Self-Directed Attendant Care**Non-Family: S5125-U6****Family Non-Resident: S5125-U6U4****Family Resident: S5125-U6U5*****Example:***

During a six month time frame the member is receiving 20 hours per week of Family Non-Resident attendant care and 10 hours per week of Non-Family attendant care for a total of 30 hours per week.

The attendant care agency needs to pay attention to how many units are allotted for each of these two specific care categories. Billing with incorrect modifiers and units could result in claims being pended and denied for no units available. The attendant care agency must bill in accordance with the authorized services and units.

If there is a change in care during the authorized time period, i.e. the Non Family attendant care worker starts to work more than 10 hours per week (on a consistent basis), the attendant care agency must contact the MCLTC care manager in order to correct the authorization and adjust the units to reflect the change in care. If this happens for only one occurrence, the agency does not need to contact the care manager, but if a major change is needed to the original authorization, the attendant care agency would need to work with the MCLTC care manager to correct the authorization. This will alleviate potential claims from pending or being denied.

2.06 – Attendant Care Out of Area Care

For members wishing to take vacations or otherwise leave the area temporarily, MCLTC would like to address the issue of paid Attendant Care Caregivers providing services outside of Maricopa and Pima Counties. MCLTC does not authorize services at a specific location provided the member resides in Maricopa or Pima County. Services are authorized to the requesting attendant care agency based on the member's evaluation by Care Management. It is up to the individual agency to decide their policy regarding out-of-county care with paid caregivers. This includes family attendants. MCLTC does not recognize any difference between family attendants and non-family attendants. Both are paid employees of the agency and all Department of Labor regulations apply to them equally.

If your agency does decide to allow out-of-county services please keep a few key points in mind:

- How will your agency ensure the safety of the member?
- How will your agency deal with a gap in coverage and provide a replacement caregiver if needed?

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- How will your agency ensure that the authorized care has actually been provided by the paid caregiver?
- This could also affect your workers compensation and raise other legal concerns. If this is in question your organization should seek qualified legal advice.

If an agency decides not to allow out-of-county services, MCLTC will respect that decision and it will not affect your relationship with MCLTC in any way.

If an agency does decide to allow out-of-county services, each occurrence will need to be reviewed by the member's Care Manager to ensure continuity of care and correct services are provided prior to the planned departure.

2.07 – Direct Care Worker Database

AHCCCS maintains an online database which tracks the testing records of Direct Care Workers (DCWs) serving Arizona Long Term Care System members living in their own homes. DCW and DCW Trainer testing records are portable or transferrable from one employer to another.

The online database serves as an administrative support tool for DCW agencies and Approved Direct Care Worker Training and Testing Programs (Approved Programs). Per AHCCCS:

- DCW agencies will use the online database to manage a list of employees and search for testing records of prospective/new employees.
- Approved Programs will use the online database to manage a list of trainers and to input DCW or DCW Trainer testing records.

Please refer to the following to the [Welcome to the AHCCCS DCW and DCW Trainer Testing Records Online Database](#) for further information.

Effective October 1, 2018, PHPs must develop policies and procedures for, and begin conducting background checks of Direct Care Workers (DCWs), that comply with the following standards:

- At the time of hire/initial contract and every three years thereafter, conduct a nationwide criminal background check that accounts for criminal convictions in Arizona.
- At the time of hire/initial contract and every year thereafter, conduct a search of the Arizona Adult Protective Services Registry.
- Prohibit a DCW from providing services to ALTCS members if the background check results contains:
 - Convictions for any of the offenses listed in A.R.S. §41-1758.03(B) or (C), or
 - Any substantiated report of abuse, neglect or exploitation of vulnerable adults listed on the Adult Protective Services Registry pursuant to A.R.S. §46-459.
- Upon hire/initial contract and annually thereafter, obtain a notarized attestation from the DCW that he/she is not:
 - Subject to registration as a sex offender in Arizona or any other jurisdiction,
 - Awaiting trial on or been convicted of committing or attempting, soliciting,

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facilitating or conspiring to commit any criminal offense listed in A.R.S. §41-1758.03(B) or (C), or any similar offense in another state or jurisdiction.

- Require DCWs to report immediately to the agency if a law enforcement entity has charged the DCW with any crime listed in A.R.S. §41-1758.03(B) or (C).
- Require DCWs to report immediately to the agency if Adult Protective Services has alleged that the DCW abused, neglected or exploited a vulnerable adult.
- Agencies may choose to allow exceptions to the background requirements for DCWs providing services to family members only. If the agency allows a DCW to provide services under this exception, the agency shall:
 - Notify the ALTCS member in writing that the DCW does not meet the background check standards and therefore otherwise would not normally be allowed to provide services, and
 - Obtain consent from the ALTCS member to allow the DCW to provide services despite the findings of the background check.
- Agencies are prohibited from allowing exceptions to the Adult Protective Services Registry screening requirements for DCWs providing services to family members only.

PHPs are required to comply with Fingerprint Clearance Card requirements outlined in A.R.S. Title 41, Chapter 12, Article 3.1. Providers may use a DCW's Fingerprint Clearance Card as evidence of complying with the criminal background check required by this Policy; however, the agency must still comply with the obligation to check the Arizona Adult Protective Services Registry. DCWs are prohibited from providing services to ALTCS members if the DCW is precluded from receiving a Fingerprint Clearance Card or has a substantiated report of abuse, neglect or exploitation of vulnerable adults listed on the Adult Protective Services Registry pursuant to A.R.S. §46-459.

2.08 – Non-Provision of Service Log (NPS)

The Non-Provision of Service Log includes information to identify differences between the numbers of hours the home care worker for critical services were scheduled to provide and the actual number of hours delivered to the member. Providers are required to complete the Non-Provision of Service log each month even if there are no non-provisions of service for the month. The NPS log must be completed by the fifth business day of each month. The provider must complete the notification via the MCLTC Provider Non-Provision of Service Log (NPS) located on the MCLTC secure website, Mercy Care Web Portal.

Telephone accessibility standards also apply. After-hour phone audits may be conducted by MCLTC to assure providers have 24-hour coverage available for unforeseen gaps in service. Please note that the AHCCCS standard is to allow HBCS providers 15 minutes to return a call addressing a gap in service. To allow an agency more than 15 minutes to return a phone call when a gap in service is being reported would make it exceptionally difficult for the service to be filled within the two (2) hour requirement.

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2.09 - Prior Period Coverage for Home and Community Based Services (HCBS)

“Prior Period Coverage” for an HCBS member refers to HCBS in place prior to enrollment with MCLTC (during the Prior Period Coverage period). Services were previously provided by another AHCCCS plan.

Prior Period eligibility dates are determined by AHCCCS. The MCLTC care manager will perform a retrospective assessment to determine the medical necessity of services, along with determination that the services previously delivered were provided by a registered AHCCCS provider in the most cost effective manner.

If the MCLTC care manager determines that the services are covered, reimbursement will be made to the provider.

2.10 - Care Manager Responsibilities

Each MCLTC member is assigned to a care manager. The care manager is responsible for working with the member’s PCP to coordinate and authorize the provision of medically necessary services for the member. The care manager is also the member’s advocate and works to facilitate the member’s care.

The MCLTC care manager authorizes medically necessary services, providing information about room and board to providers and members, and assisting members with coordination of appropriate services.

The MCLTC care manager is the primary point of contact for providers when there are issues or questions about a member. Providers must also contact the MCLTC care manager whenever there are changes in a member’s health status.

2.11 - Service Authorizations

The following table illustrates Acute and HCBS services provided to MCLTC members that require PCP orders and/or authorization by the program contractor.

NOTE: The MCLTC care manager only authorizes long term care services, not medical services. Medical service authorization procedures are outlined in [MC Chapter 14 – Referrals and Authorizations](#).

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MCLTC Service Authorization Table

<u>Service</u>	<u>PCP Orders</u>	<u>Program Contractor Authorization</u>
Acute Hospital Admission (Non-Medicare Admission)	X	X
Adult Day Health Services		X
Assisted Living Facility		X
Attendant Care		X
Behavioral Health Services		X
DME/Medical Supplies	X	X
Emergency Alert	X	X
Habilitation		X
Home Delivered Meals		X
Home Health Agency	X	X
Home Modifications	X	X
Homemaker Services		X
Hospice Services (HCBS and Institutional – Non-Medicare)	X	X
ICF/MR	N/A	N/A
Medical Care Acute Services	X	X
Nursing Facility Services	X	X
Personal Care		X
Respite Care (In-Home)		X
Respite Care (Institutional)	X	X

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Therapies	X	X
Transportation		X

2.12 – MCLTC Alternative Residential Settings

MCLTC offers different types of medically necessary alternative residential settings for eligible members. These different types of settings provide supervisory services, personal care or direct care, and are delivered by licensed or certified facilities. Members are required to pay room and board fees in these settings. The MCLTC care manager will assess the member's need for the appropriate type of setting.

MCLTC Service Types

<u>Setting</u>	<u>Description</u>
Adult Foster Care	This setting includes up to 4 residents. The owner of the home must live in the home and provide the care.
Adult Therapeutic Home Care	Provides behavioral health and ancillary services for a minimum of 1 and a maximum of 3 people.
Child Therapeutic Home Care	Provides services by homes licensed with DES as a professional foster care home.
Assisted Living Home	This setting provides care and supervision for up to 10 people.
Assisted Living Center	This setting provides resident rooms or residential units and services to 11 or more residents. Three meals are provided in the main dining hall. Personal care and medication monitoring is provided as needed.

2.13 - Provider Requirements for Assisted Living Facilities

Assisted Living Home and Assisted Living Center Requirements

- The provider of an Assisted Living Facility must collect room and board fees from the member. Room and board is the amount the MCLTC member pays each month for the cost of food and/or shelter.
- MCLTC does not pay the member's room and board cost when the member is in an alternative setting. MCLTC's room and board agreement identifies the level of payment

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for the setting, placement date, and room and board amount the member must pay and is determined by the MCLTC care manager at the time of placement.

- The room and board agreement is used for all alternative settings. The amount of room and board will periodically change based on a member's income.
- The Room and Board Agreement form is completed at least once a year or more often if there are changes in income.
- Payment issued to the provider is always the contracted amount minus the member's room and board.
- For Adult Foster Care, Foundation for Senior Living is billed for all Adult Foster Care services provided in Maricopa County. For all other alternative living arrangement settings, MCLTC should be billed directly.
- PHP shall notify MCLTC in writing immediately if a change in location of the Assisted Living Home or Assisted Living Center is being considered. MCLTC Care Management will communicate with members and their representatives to determine whether or not a location change is in their best interest.
- PHP will notify MCLTC in writing immediately if an ownership change is being considered. MCLTC will decide if a contract with the new owner will be offered. In order to be considered for a contract, a new owner must be licensed by Arizona Department of Health Services (ADHS), have an AHCCCS Provider Identification number and have proof of required liability insurance.
- PHP shall maintain in full force and effect and be covered at all times throughout the term of their MCLTC contract by (a) professional liability (malpractice) insurance which covers all acts of omissions of PHP in providing or arranging for Covered Assisted Living Home Services under their MCLTC contract, and (b) general liability insurance. The terms and limits of such insurance coverage shall be subject to MCLTC approval; provided, however PHP shall maintain in full force and effect and be covered at all times throughout the term of this Agreement by (a) professional liability (malpractice) insurance which covers all acts and omissions of PHP in providing or arranging for covered services under their MCLTC contract, and (b) general liability insurance. The general liability policy shall have limits of liability of not less than One Million Dollars (\$1,000,000) per occurrence, and an annual aggregate of Two Million Dollars (\$2,000,000). Failure to secure and maintain such professional liability and general liability insurance coverage shall constitute a material breach of PHP's contract with MCLTC.
- PHP must ensure Mercy Care staff has immediate access to the member and member's records at all times.

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Assisted Living Home Requirements

- PHP must obtain written authorization from the MCLTC care manager who is the sole authorizing agent for placement and level of care prior to admission. Covered Assisted Living Home services not prior authorized will not be reimbursed.
- PHP shall maintain member case records with information that includes, but is not limited to:
 - Member's name and MCLTC identification number;
 - Member's relative name(s) address(es) and phone number(s);
 - Emergency contact name and phone number
 - Member's primary care provider address and phone number;
 - Member's current medications and pharmacy phone number; and
 - Member's guardian, grantee of power of attorney, or healthcare decision maker, as applicable.
- PHP shall maintain policies and procedures specific to the management and organization of PHP, which include but are not limited to an admission agreement; personnel policies and staffing ratios; house standards; medication dispensing and home furnishings and repairs. PHP shall submit copies of policies and procedures to MCLTC (i) annually, (ii) as developed, and (iii) as the policies and procedures are revised.
- All deposits paid prior to MCLTC enrollment date must be refunded to the member or member's power of attorney designee **immediately**.
- If the member is eligible for Prior Period Coverage (PPC), PHP is encouraged to bill MCLTC for this prior period time and refund the member the MCLTC rates for this prior period time.
- All private agreements with members cease on the effective enrollment date of the member with MCLTC. Following MCLTC enrollment, the MCLTC contract and the MCLTC Room & Board Placement Agreement should control. All private and previous agreements with an MCLTC member are null and void.
- PHP shall not charge members for any item(s) or service(s) which are covered under their MCLTC contract or the AHCCCS Medical Policy Manual.
- PHP shall arrange for or provide recreational and social activities on a regular basis designed to maintain or improve skills to members.
- PHP will report to MCLTC care manager all member emergency room visits, hospitalizations, observation bed admissions and expirations within twenty-four (24) hours of the occurrence.
- PHP must provide shampoo, hand soap, toilet paper, laundry detergent, gloves, wipes, chux, or any other personal care items for each resident.

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Assisted Living Center Requirements

- PHP shall ensure that each new PHP staff completes an orientation within ten (10) days from the date of employment which includes, but is not limited to, orientation to the characteristics and needs of Assisted Living Center members; promotion of member dignity, independence, self-determination, privacy, choice and rights; and instruction on the development and implementation of treatment plans.
- PHP shall ensure that each staff member completes a minimum of six (6) hours of ongoing training every twelve (12) months and includes but is not limited to promoting dignity, independence, self-determination, privacy, choice and rights; fire, safety and emergency procedures; and assistance in self-administration of medications.
- PHP must obtain written authorization from the MCLTC. Care Management is the sole authorizing agent for placement and level of care of MCLTC members in an Assisted Living Center, Behavioral Health Assisted Living or in an Assisted Living Alzheimer's Unit.
- Upon admission, there must be documentation/evidence that the member is free from infectious tuberculosis. Annual testing is to be completed and documented in the member's medical record.
- PHP will report to MCLTC care manager all member emergency room visits, hospitalizations, observation bed admissions and expirations within twenty-four (24) hours of the occurrence.
- There must always be staff member(s) on duty who speak and read English (fluently), twenty-four (24) hours per day, three hundred sixty five (365) days per year.
- PHP must provide shampoo, hand soap, toilet paper, laundry detergent, gloves, wipes, chux, or any other personal care items for each resident.
- One (1) staff member certified in CPR must be on duty at all times.
- All deposits paid prior to MCLTC enrollment date must be refunded to the member or member's power of attorney designee **immediately**.
- If the member is eligible for Prior Period Coverage (PPC), PHP is encouraged to bill MCLTC for this prior period of time and to refund the member the MCLTC rates for this time frame.
- All private agreements with members cease on the effective enrollment date of the member with MCLTC. Following MCLTC enrollment, the MCLTC contract and the MCLTC Room & Board Placement Agreement should control. All private and previous agreements with an MCLTC member are null and void.
- PHP shall maintain member case records with information that includes, but is not limited to:
 - Member's name and MCLTC identification number;
 - Member's relative name(s) address(es) and phone number(s);

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- Emergency contact name and phone number
- Member's primary care provider address and phone number;
- Member's current medications and pharmacy phone number; and
- Member's guardian, grantee of power of attorney, or healthcare decision maker, as applicable
- PHP shall maintain policies and procedures required by applicable law which are specific to the management and organization of PHP, which include, but are not limited to admission agreements, personnel policies and staffing ratios, house standards, medication dispensing, and home furnishings and repairs. PHP shall submit copies of its policies and procedures to MCLTC:
 - Upon request
 - When new policies and procedures are implemented
 - When existing policies and procedures are revised by PHP.
- PHP shall maintain policies and procedures specific to a member's personal needs allowance according to applicable law; PHP shall submit such policies to MCLTC upon request.
- PHP shall not charge members for any item(s) or service(s) which are covered under their MCLTC contract or the AHCCCS Medical Policy Manual.
- PHP shall collect the room and board amount determined by the MCLTC care manager from the member.
- PHP shall maintain in full force and effect and be covered at all times throughout the term of their MCLTC contract by (a) professional liability (malpractice) insurance which covers all acts of omissions of PHP in providing or arranging for covered Assisted Living Home Services under their MCLTC contract, and (b) general liability insurance. The terms and limits of such insurance coverage shall be subject to MCLTC approval; provided, however PHP shall maintain in full force and effect and be covered at all times throughout the term of their contract by (a) professional liability (malpractice) insurance which covers all acts and omissions of PHP in providing or arranging for covered services under their MCLTC contract, and (b) general liability insurance. The general liability policy shall have limits of liability of not less than One Million Dollars (\$1,000,000) per occurrence, and an annual aggregate of Two Million Dollars (\$2,000,000). Failure to secure and maintain such professional liability and general liability insurance coverage shall constitute a material breach of PHP's contract with MCLTC.

Additional Requirements for Covered Behavioral Health Assisted Living Center

- PHP must meet minimum staffing ratios of 3.3 hours per patient day (this staffing does not include maintenance, clerical, or administrative staff).
- PHP must meet minimum training hours for new staff six (6) of didactic in-service training in behavioral health topics and ongoing monthly training for all direct care staff.

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- PHP shall provide members with recreational and social activities on a daily basis designed to maintain or improve physical and social interaction.
- PHP shall provide service including, but not limited to psychosocial rehabilitation; skills training and development; and assist member on a daily basis to carry out specified goals and objectives as prescribed in the member's treatment plan.
- PHP shall provide a designated unit secured by locked or electronically controlled doors (a wander guard-type system alone does not meet this requirement) for locked Behavioral Health Assisted Living Unit.
- PHP shall maintain in full force and effect and be covered at all times throughout the term of their MCLTC contract by (a) professional liability (malpractice) insurance which covers all acts of omissions of PHP in providing or arranging for Covered Assisted Living Home Services under their MCLTC contract, and (b) general liability insurance. The terms and limits of such insurance coverage shall be subject to MCLTC approval; provided, however PHP shall maintain in full force and effect and be covered at all times throughout the term of this Agreement by (a) professional liability (malpractice) insurance which covers all acts and omissions of PHP in providing or arranging for covered services under their MCLTC contract, and (b) general liability insurance. The general liability policy shall have limits of liability of not less than One Million Dollars (\$1,000,000) per occurrence, and an annual aggregate of Two Million Dollars (\$2,000,000). Failure to secure and maintain such professional liability and general liability insurance coverage shall constitute a material breach of PHP's contract with MCLTC.

Additional Requirements for Assisted Living Alzheimer's Units

- PHP shall provide a designated unit secured by locked or electronically controlled doors (a wander guard-type system alone does not meet this requirement).
- PHP shall be staffed with the following ratios: (these staffing ratios exclude facility directors, administrative, clerical and maintenance staff).
 - One (1) staff to ten (10) members from 6:00 am – 2:00 pm
 - One (1) staff to ten (10) members from 2:00 pm – 10:00 pm
 - One (1) staff to twenty (20) members from 10:00 pm – 6:00 am

Example: If PHP has thirty-eight (38) members, PHP is required to have three (3) full time staff and then the fourth (4th) staff would be required to work 6 hours and 40 minutes of the 8 hour shift during the hours of 6:00 am to 10:00 pm.
- All staff newly assigned to work on the unit must receive two (2) hours of in-service training prior to actually providing care to members with dementia. Training must include, but is not be limited to:
 - Understanding members with dementia; and
 - How to work with members with dementia.
- All staff on the unit must attend a minimum of one (1) hour every month of in-service education addressing the special needs of members with dementia such as those with

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Alzheimer's disease and related disorders. Training must take place and be documented within thirty (30) days.

- Off-site in service education may be included to meet this requirement.
- Topics for in-service sessions are to include, but are not limited to:
 - Charting and documentation;
 - Understanding persons with dementia;
 - How to work with persons with dementia;
 - Providing services to members based on individual needs;
 - How to maximize independence for persons with dementia;
 - Member rights;
 - Appropriate verbal and non-verbal interaction with members;
 - Pharmacological and physical restraints and their use;
 - Facility protocol to manage/locate members who wander;
 - Activities of daily living as part of the activity program;
 - Fall prevention;
 - Cultural diversity; and
 - Using hospice for members with advanced dementia.
- PHP must have activity staff programming ten (10) hours a week. PHP must offer activities that are appropriate for persons with dementia seven (7) days a week.
- PHP must have buildings and furnishings that are designed for the member's safety.
- PHP facilities must be designed to maximize comfort for the member's physical environment, personal and shared space, demonstrate a balance of sensory stimuli that are calming and soothing; and other sensory stimuli that are pleasantly stimulating and engaging.
- PHP shall maintain in full force and effect and be covered at all times throughout the term of their MCLTC contract by (a) professional liability (malpractice) insurance which covers all acts of omissions of PHP in providing or arranging for Covered Assisted Living Home Services under their MCLTC contract, and (b) general liability insurance. The terms and limits of such insurance coverage shall be subject to MCLTC approval; provided, however PHP shall maintain in full force and effect and be covered at all times throughout the term of this Agreement by (a) professional liability (malpractice) insurance which covers all acts and omissions of PHP in providing or arranging for covered services under their MCLTC contract, and (b) general liability insurance. The general liability policy shall have limits of liability of not less than One Million Dollars (\$1,000,000) per occurrence, and an annual aggregate of Two Million Dollars (\$2,000,000). Failure to secure and maintain such professional liability and general liability insurance coverage shall constitute a material breach of PHP's contract with MCLTC.

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2.14 - Provider Requirements for Adult Foster Care Home

- For Adult Foster Care Homes in Maricopa County, Foundation for Senior Living is billed for all Adult Foster Care services.
- PHP must obtain written authorization from the MCLTC care manager who is the sole authorizing agent for placement and level of care prior to admission. Covered Assisted Living Home services not prior authorized will not be reimbursed.
- PHP must provide shampoo, hand soap, toilet paper, laundry detergent, gloves, wipes, chux, or any other personal care items for each resident.
- All deposits paid prior to MCLTC enrollment date must be refunded to the member or member's power of attorney designee **immediately**.
- If the member is eligible for Prior Period Coverage (PPC), PHP is encourage to bill MCLTC for this prior period time and to refund the member the MCLTC rates for this prior period time.
- All private agreements with members cease on the effective enrollment date of the member with MCLTC. Following MCLTC enrollment, the MCLTC contract and the MCLTC Room and Board Placement Agreement should control. All private and previous agreements with an MCLTC member are null and void.
- PHP shall notify MCLTC in writing within five (5) business days of PHP changes that include, but are not limited to a change in location, services, licensing, or ownership.
- Referrals for specific covered Adult Foster Care services must be initiated and obtained by the member's primary care provider and/or the MCLTC care manager. Services not authorized by MCLTC will not be reimbursed.
- PHP shall maintain member case records with information that includes at a minimum the following:
 - Member's name and ALTCS identification number;
 - Member's relative(s) name(s), address(es), and phone number(s);
 - Member's emergency contact(s) name(s), address(es) and phone number(s);
 - Member's primary care provider address and phone number;
 - Member's current medications and pharmacy phone number;
 - Member's guardian, grantee of power of attorney, or healthcare decision maker, as applicable.
- PHP shall maintain policies and procedures specific to advanced directives according to applicable law and MCLTC Policies. PHP must also provide education to PHP staff and subcontractors regarding advance directives.
- PHP shall maintain policies and procedures required by applicable law specific to the management and organization of PHP, which includes, but is not limited to an admission agreement; personnel policies and staffing ratios; house standards; medication dispensing; and home furnishings and repairs. PHP must submit copies of policies and procedures to MCLTC upon request.
- PHP shall not charge Members for any item(s) or service(s) which are covered under this Agreement by AHCCCS or Medicare.

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- PHP shall maintain policies and procedures specific to Member's personal needs according to applicable law and submit them to MCLTC upon request.
- Nursing care services may be provided by PHP if such PHP is a nurse licensed by the State of Arizona to provide covered Adult Foster Care Services according to applicable law. PHP shall keep a record of nursing services rendered and obtain prior authorization according to MCLTC Policy and Provider Manual.
- PHP shall arrange for or provide recreational and social activities on a regular basis designed to maintain or improve skills to members.
- PHP will report to MCLTC care manager all member emergency room visits, hospitalizations, observation bed admissions and expirations within twenty-four (24) hours of the occurrence.
- PHP shall maintain in full force and effect and be covered at all times throughout the term of their MCLTC contract by (a) professional liability (malpractice) insurance which covers all acts of omissions of PHP in providing or arranging for Covered Assisted Living Home Services under their MCLTC contract, and (b) general liability insurance. The terms and limits of such insurance coverage shall be subject to MCLTC approval; provided, however PHP shall maintain in full force and effect and be covered at all times throughout the term of this Agreement by (a) professional liability (malpractice) insurance which covers all acts and omissions of PHP in providing or arranging for covered services under their MCLTC contract, and (b) general liability insurance. The general liability policy shall have limits of liability of not less than One Million Dollars (\$1,000,000) per occurrence, and an annual aggregate of Two Million Dollars (\$2,000,000). Failure to secure and maintain such professional liability and general liability insurance coverage shall constitute a material breach of PHP's contract with MCLTC.
- PHP must ensure Mercy Care staff has immediate access to the member and member's records at all times.

2.15 - Provider Requirements for Skilled Nursing Facilities (SNFs)

Skilled Nursing Facilities (SNFs) provide services to members that need consistent care, but do not have the need to be hospitalized or require daily care from a physician. Many SNFs provide additional services or other levels of care to meet the special needs of members. SNFs are responsible for making sure that members residing in their facility are seen by their PCP in accordance with the following intervals:

- For initial admissions to a nursing facility, members must be seen once every 30 days for the first 90 days, and at least once every 60 days thereafter.
- Members that become eligible while residing in a SNF must be seen within the first 30 days of becoming eligible, and at least once every 60 days thereafter.

Additional nursing facility visits are provided as medically necessary and appropriate.

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Providers may also refer to MCLTC's **Claims Processing Manual** available on our [Claims Information](#) web page under **Chapter 6 – Skilled Nursing Facility Claims**. The **Claims Processing Manual** includes helpful information regarding the following:

- Billable Days
- Share of Cost
- Patient Trust Accounts
- Behavioral Health Services
- Therapy Authorizations
- Claims
- Claims Payment and Submission
- Discharge from a SNF
- Information and Services offered by MCLTC for SNF
- Provider Claim Disputes and Member Appeals

Covered services delivered to eligible members in accordance with a PHP's contract include the following:

- MCLTC is not responsible to pay for any otherwise covered services rendered to MCLTC members prior to the date the MCLTC member becomes enrolled by the State Agency with MCLTC (except with respect to certain newborns pursuant to the State Agency regulations) or after the MCLTC member loses eligibility or otherwise is dis-enrolled from MCLTC.
- The per diem payment for ALTCS members includes over-the-counter medications. The PHP must use MCLTC contracted pharmacies and durable medical equipment companies for non-Medicare and MCA enrollees who are on a custodial stay in the facility.
- MCLTC should be billed for co-payments for MCLTC members who have Fee for Service Medicare and a Prescription Drug Program or who are on a Medicare Advantage Program, which is not MCA.
- Mercy Care shall reimburse PHP for covered therapy services on a fee for service basis. Mercy Care will update internal payment systems in response to additions, deletions and changes of this nature.

Levels of Care

The appropriate level of care will be determined by the MCLTC care manager, utilizing the AHCCCS/ALTCS Uniform Assessment Guidelines.

In the event PHP disagrees with the level of care authorized, the PHP may request an administrative review by MCLTC. In the event PHP disagrees with the decision following the administrative review, PHP may request a second administrative review. The second review request must be made in writing to the MCLTC care management supervisor within thirty (30)

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days of the determination of the first administrative review. In the event the original level of care is upheld, the decision is final and not subject to further review by MCLTC. In the event the original level of care is overturned during the administrative review process, CMCLTC will adjust the level of care in accordance with the date of the PHP's initial level of care notification.

Levels of care are listed in the table below:

<u>Level of Care</u>	<u>Revenue Codes</u>
Sub-Acute Care Level III	0193
Sub-Acute Care Level IV (Ventilator care)	0194
Custodial Level I	0081
Custodial Level II	0082
Custodial Level III	0083
Hospital Bed Hold	185
Therapeutic Bed Hold	183

- Level of care changes authorized by MCLTC will be effective on the day of evaluation. Level of care changes may be retroactive to the date of phone or fax notification to the Nursing Facility, but not prior to the date of notification.
- Covered Therapy Services are not included in the MCLTC member per diem rate, except where specified. PHP shall arrange or provide covered therapy services, for MCLTC members residing in its facility. For additional information regarding referrals and authorizations, please refer to **MC Chapter 14 – Referrals and Authorizations** in this provider manual.

Requirements for Specialty Rates

Custodial levels of care are determined according to the AHCCCS Universal Assessment Tool for Acuity Determinations.

These levels are NOT for placements that are Medicare funded by MCA. RUG rates are used for MCA members whose care meets the Medicare criteria for RUG rates.

PHPs providing specialty levels of care must meet the requirements identified below, in accordance with their contract:

Sub-Acute

Level III - Intensive Sub-Acute. This includes any combination of the following:

- complex wound care/decubitus
- total parenteral nutrition or tracheotomy care
- or any therapy up to 3 hours per day (PT/OT/ST)

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An RN charge nurse is required to be on the station where Level III members are located 24 hours a day. This level of care is authorized by the MCLTC concurrent review nurse.

Daily documentation in the medical chart of continued need for sub-acute level of care is required.

PHP must notify MCLTC staff within 24 hours of when a member no longer requires sub-acute level of care services.

High Respiratory

- Ensure that all respiratory therapy personnel must be licensed by the State of Arizona.
- Strive to utilize regularly designated nursing and respiratory staff for the care of members in need of respiratory services. If nursing pool must be used, ensure that these temporary personnel have training in respiratory care and the ability to manage equipment currently in use in the facility.
- Maintain a 1:5 ratio of Therapist/Technician to MCLTC members in need of respiratory services for each eight (8) hour shift.
- Provide oversight by a licensed pulmonologist.
- Designate one (1) Registered Respiratory Therapist (RPT) as the Respiratory Director, who will be in charge of all respiratory duties and who will work no less than (40) hours per week.
- Designate one (1) Registered Nurse for each (8) hour shift who will be in charge of all nursing duties for members requiring respiratory services for that period of time.
- Individuals admitted for respiratory services may be weaning from a ventilator, require multiple respiratory treatments, or have a tracheostomy requiring frequent respiratory therapy monitoring.

Ventilator

- Ensure that all respiratory therapy personnel are licensed by the State of Arizona.
- Strive to utilize regularly designated nursing and respiratory staff for the care of members in need of respiratory services. If nursing pool must be used, ensure that these temporary personnel have training in respiratory care and the ability to manage equipment currently in use in the facility.
- Maintain a 1:5 ratio of Therapist/Technician to MCLTC member in need of respiratory services for each eight (8) hour shift.
- Provide oversight by a licensed pulmonologist.
- Designate one (1) Registered Respiratory Therapist (RPT) as the Respiratory Director who will be in charge of all respiratory duties and who will work no less than (40) hours per week.

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- Designate one (1) Registered Nurse for each (8) hour shift who will be in charge of all nursing duties for Members requiring respiratory services for that period of time.
- Provide care for members who are on a ventilator.
- Provide care for members on BiPap with a back-up breath rate.
- Maintain respiratory therapy notes of member's condition, including daily documentation of heart rate, breathe sounds and any medical condition, during and after respiratory procedures, including response to treatment and how many hours of ventilator usage each day.
- Notify the MCLTC care manager or Concurrent Review Nurse within 24 hours of the initiation of ventilator/BiPap treatment and/or ventilator weaning.
- Provide the services of a licensed pulmonologist who will:
 - Conduct a physical examination and complete medical history as it pertains to ventilator services on each newly admitted MCLTC ventilator dependent member within seven (7) days of admittance, when ordered by the MCLTCPCP.
 - Perform routine on-site visits which include evaluation for potential weaning and appropriate diagnosis and treatment on each MCLTC ventilator dependent member when ordered by the MCLTCPCP.
 - Re-evaluate, at least annually, each MCLTC ventilator dependent member to review continued prospects of weaning the member from dependency on the ventilator.
 - Visit and evaluate MCLTC ventilator dependent members at least every thirty (30) days.
 - Ensure that appropriate discharge orders accompany member when leaving the ventilator unit including a discharge summary from the ventilator unit which includes input from the nursing facility pulmonologist and a plan for any on-going treatments, including respiratory treatments.
 - Provide education and training for ventilator dependent members and their families when appropriate to increase member's functioning and self-sufficiency.
 - Evaluate member's ability to provide self-care and/or family's ability to care for the member.
 - Provide on-going nursing and therapy consultation and training to promote the development of the member's ability to provide self-care and the family's ability to care for the member.
 - Provide training on maintenance of equipment and nursing care to members who are discharging home.
 - Maintain adequate documentation that reflects the member's/family's ability to provide care.
 - Coordinate with MCLTC care manager or Concurrent Review Nurse regarding DME, supplies, home nursing and other follow-up care that may

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be needed for members who are discharging to the community.

Staff Assisted Dialysis

- In order to qualify for staff assisted dialysis level of care, members must be unable to attend outpatient dialysis due to their medical condition.
- PHP must provide medical documentation to the MCLTC care manager substantiating need for staff assisted dialysis in lieu of outpatient dialysis prior to admission to the facility at the staff assisted dialysis level of care.
- Perform dialysis treatment as ordered by a nephrologist.
- Evaluate and monitor the member's condition on an on-going basis.
- Inform the member's PCP and nephrologist of relevant diagnostic study results within 72 hours of receipt of results; and report adverse results within 24 hours of receipt of results.
- Administer medications and perform other treatments/diagnostic studies as ordered by the nephrologist.
- Provide all services, supplies, items and equipment and ESRD related laboratory tests covered under the composite/service rates necessary to perform dialysis treatments.
- Approval of requests to provide staff assisted dialysis services beyond the initially authorized time frame is dependent on PHP's submission of medical documentation supporting member's need for ongoing staff assisted dialysis.

Wandering Dementia Program

- Provide a safe and secure nursing home environment for MCLTC members who have been assessed by the MCLTC care manager as needing this environment due to exhibition of problematic wandering to a degree that endangers the member and other nursing home residents and who cannot be safely managed in a traditional nursing home unit.
- Provide secure living area indoors and outdoors by means of locks (a wander guard type system alone will not meet this requirement) and/or electronically controlled access. Secured areas will be large enough to permit members space to walk, while remaining in sight of the nursing station. Mirrors or video monitors may be used to assist visual supervision of members.
- Provide dining area on the secured unit or nearby with staffing to supervise members going to and returning from meals. If possible, the dining area will be separate from that of the other units in the facility. If not possible, meals for the unit will be scheduled at different times than those of the other units.
- Maintain a 3.0 NHPPD (Nursing Hours per Patient Day) minimum staffing level on the unit.
- All staff newly assigned to work on the unit will receive two (2) hours of in-service training prior to working with the dementia members. The subjects will include understanding members with dementia and how to provide care to members with

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dementia.

- All staff on the unit will attend a minimum of one (1) hour every month of in-service education addressing the special needs of dementia members such as those with Alzheimer's disease and related disorders and how to provide care for them.
- The unit will have an activity program which offers activities that are appropriate for persons with dementia, including at least one planned activity per day in the Wandering Unit.
- Develop a facility protocol to manage wandering members which includes:
- Identify potential wanderers to all staff to enable recognition of members who may be found off the wandering unit.
- Compile a file of member photographs that can be used to identify members to police in the event a resident elopes from the facility.
- Develop an intercom code or other procedure to alert all staff when a member is temporarily off the wandering unit.
- Assign responsibility to each employee for an area of the facility to search in the event of an alert for a wandering member.
- In the event of complete but unsuccessful search for a wandering member, notify police and MCLTC care manager no later than 30 minutes from the time the Member was identified as missing from the unit.

Bariatric

Bariatric services are reserved for individuals that have a very poor prognosis for weight loss. These members will typically exhibit a body mass index (BMI) that is severe enough to make care difficult due to the individual's inability to change position, ambulate, or transfer without hands on assistance from three or more nursing home staff. Additional care requirements specifically related to the member's morbid obesity must be evident in the facility documentation prior to approval of a bariatric level of care.

- The facility will be required to provide medical documentation supporting the need for a bariatric level of care to the MCLTC care manager prior to admission and prior to continued authorization.
- Documentation of care planning and ongoing efforts to affect member weight loss must be provided to the MCLTC care manager prior to continued authorization for this level of care.
- PHP shall provide the following:
 - Additional nutritional counseling to assist member with appropriate caloric needs.
 - Physical, occupational or restorative therapies tailored to the member.
 - Demonstrate an ongoing multidisciplinary approach to weight loss.

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- Provide all services, medications, supplies and bariatric equipment necessary including a bariatric bed to maintain the member at the bariatric level of care (excludes customized DME).

Hospital Bed Hold

Bed holds require authorization by MCLTC staff. PHP must notify the MCLTC care manager within 24 hour of hospital admission if there is a request for a hospital bed hold. There are a maximum of twelve (12) days that may be authorized per member, per contract year (October 1- September 30).

Therapeutic Bed Hold

Bed holds require authorization by MCLTC staff. There are a maximum of nine (9) days that may be authorized per member, per contract year (October 1- September 30).

Respite

Respite placement in a nursing facility is authorized by MCLTC staff according to AHCCCS requirements. The purpose is to provide an interval of rest and/or relief to a family member or other unpaid person caring for the member, and to improve the emotional and mental well-being of the member. There is a maximum of 25 respite days per contract year (October 1-September 30) provided member has not used respite in any other setting during the contract year.

Requirements for All Behavioral Health Specialty Placements

Provider shall provide all of the following Behavioral Health Services:

- Psychiatric nursing care services
- Rehabilitative services
- Restorative services
- Overall management and evaluation of a member's care plan
- Observation and assessment of a member's changing condition
- Attendants for off-site appointments
- One-on-one services for short durations

Mercy Care Behavioral Health Care Manager and the Behavioral Health Program Team, which shall include the member, the member's authorized representative, the Clinical Program Director, Unit Coordinator, and other nursing home clinical staff involved in the member's clinical care will reassess all members placed on the Behavioral Health High Acuity Unit monthly and report to MCLTC all changes to the member's needs, ensuring that placement on the unit remains appropriate.

PHP shall provide a minimum of forty (40) hours of on-the-job training for new staff in the Behavioral Health High Acuity Unit covering the services provided on the unit. During

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the didactic in-service requirements during which the new staff observes and participates, new staff is not to be left alone or responsible for direct member care.

PHP shall provide a secure outdoor area separate from any outdoor area utilized by other facility residents. The outdoor area for the covered behavioral health program services must be available to members twenty-four (24) hours per day, must have *secured* gates and have a fence no less than six (6) feet high, and be designed in such a manner as to ensure the staff's ability to directly observe and supervise members at all times.

PHP shall comply with MCLTC documentation requirements that include but are not limited to:

- The development of a behavioral treatment plan for each member;
- Charting of all behavior related to the behavioral treatment plan *daily, and*
- Maintain a system to track the increase and decrease of targeted behaviors.

PHP shall provide the foregoing documentation upon request from MCLTC.

Behavioral Health High Acuity

In addition to the above requirements, PHPs must meet the requirements for Behavioral Health High Acuity, as follows:

- 7.66 nursing hours per patient day (NHPPD), including 1.66 NHPPD of Registered Nursing (RN) or Licensed Practical Nursing (LPN), and 6.00 NHPPD of Certified Nursing Assistants (CNA). These hours are to be dedicated exclusively to residents of the Behavioral Health High Acuity Unit.
- Assuming a full census, the Behavioral Health High Acuity Unit shall be staffed with two licensed nurses throughout the day and evening shifts (6:00 a.m. to 10:30 p.m.) for a total of sixteen (16) hours, and one (1) licensed nurse on the night shift (10:00 p.m. to 6:30 a.m.).
- For all persons (including MCLTC members and non-members) the Behavioral Health High Acuity Unit shall be staffed with the ratio of CNAs to residents as follows:
 - Day Shift: 1 CNA to 2 residents
 - PM Shift: 1 CNA to 2 residents
 - Night Shift: 1 CNA to 4 residents

Behavioral Health Standard Rate

In addition to the above requirements, PHPs must meet the requirements for Behavioral Health Standard Rate as follows:

- PHP shall maintain the following staffing ratio:
 - 5.45 Nursing Hours Per Patient Day (NHPPD), including 0.40 NHPPD Registered Nurse (RN) Program Coordinator
 - 1.20 NHPPD Licensed Practical Nurse (LPN)
 - 0.25 NHPPD Activity Program Staff
 - 3.60 NHPPD paraprofessional therapeutic assistants

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CNA Staff Ratio

Day Shift: 1 CNA to 4 residents

PM Shift: 1 CNA to 4 residents

Night Shift: 1 CNA to 6 residents

These hours are to be dedicated exclusively to the members in the Behavior Unit and shall be maintained at the same rate for all members including those who are not on MCLTC.

Behavioral Health Step-Down

In addition to the above requirements, PHPs must meet the requirements for Behavioral Health Step-Down Rate as follows:

- PHP shall maintain 3.00 Nursing Hours per Patient Day (NHPPD) minimum staffing, including 1.0 NHPPD Licensed Nurses, and 2.0 NHPPD Certified Nursing Assistants. These hours shall be dedicated exclusively to the Step-Down Unit. This staffing shall be maintained at the same rate for non-MCLTC residents who are placed on the Step-Down Unit.
- A Unit Coordinator must work exclusively on the Step-Down Unit seven (7) days per week, eight (8) hours per day. The Licensed Nurse Unit Coordinator's hours must not be counted in the 3.0 NHPPD.

CNA Staff Ratio:

Day Shift: 1 CNA to 6 residents

PM Shift: 1 CNA to 6 residents

Night Shift: 1 CNA to 8 residents

Behavioral Health Troublesome

In addition to the above requirements, PHPs must meet the requirements for Behavioral Health Troublesome Rate as follows:

- Ensure that all new staff will receive a minimum of six (6) hours of didactic in-service training prior to working on the unit. Training shall include, but not be limited to the following:
 - Charting and documentation
 - Appropriate verbal and non-verbal interaction with members
 - Psychotropic medication management
 - Behavior management
 - Activities of daily living as part of the specialized activity programming

CNA staffing ratio:

Day Shift: 1 CNA to 6 residents

PM Shift: 1 CNA to 6 residents

Night Shift: 1 CNA to 8 residents

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2.16 - Contract Terminations – Nursing Facilities and Alternative Residential Settings

The below process defines the relationship between MCLTC, a Nursing Facility (NF) and/or an Alternative Residential Setting (ARS) following the termination of a contract between these entities, regardless of which entity terminates the contract or the reason for contract termination. The following process delineates how MCLTC, NF and/or ARS will collaborate to provide for the needs of the members residing in the facility at the time of contract termination.

Member/Resident Options when a NF and/or ARS Contract is Terminated

Affected members residing in a NF and/or ARS at the time of a contract termination may continue to reside in that facility until their open enrollment period, at which time they must either choose an available Contractor that is contracted with the facility, or move to a setting that is contracted with their current Contractor.

A meeting between the Contractor, NF and/or ARS and AHCCCS will be held prior to the effective date of the contract termination to plan all aspects related to the change in contract status and impact on members and representatives.

MCLTC in collaboration with the NF and/or ARS and AHCCCS must develop a member/representative communication plan. The purpose of the communication plan is to provide affected or impacted members and/or their representatives with consistent information regarding the contract termination. The Contractor must receive approval of their member/representative communication plan from the Division of Health Care Management Operations Unit. The plan must be submitted to AHCCCS within five business days of the termination decision. All member communications must be consistent with guidelines found in the AHCCCS ACOM Policy 404.

Reimbursement

▪ Nursing Facilities

MCLTC shall reimburse the NF at the previously contracted rates or the AHCCCS fee for service schedule rates, whichever are greater. Should AHCCCS increase its fee schedule, MCLTC shall reimburse the NF at the greater of the increased AHCCCS fee for service schedule rates or MCLTC's previously contracted rates. Should AHCCCS reduce its fee schedule, LCT shall reduce its previously contracted rates by the same percentage, and pay the greater of the adjusted rates.

If MCLTC had in place a provision for subacute, specialty care or add-on rates at the time of the contract termination, then MCLTC shall apply those rates. Should AHCCCS adjust its fee schedule, then MCLTC will adjust its subacute or add-on rate(s) by the average adjustment to the NF fee schedule rates.

▪ Alternative Residential Settings

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MCLTC shall reimburse the ARS at the previously contracted rate. Should AHCCCS adjust its HCBS Fee Schedule rates, MCMCLTC will adjust its ARS rates by the average percentage that the HCBS Fee Schedule rates are adjusted.

Quality of Care

In the event that MCLTC or other entity, such as Arizona Department of Health Services (ADHS) Licensure or AHCCCS identify instances where the overall quality of care delivered by an NF or ARS places residents in immediate jeopardy, the Contractor will inform members/representatives of the problems and offer members alternative placement. Members may have the option to continue to reside in the NF or ARS.

In some cases, ADHS or AHCCCS may require that MCLTC find new placements for members. In such cases, the Contractor shall work with the members/representative to identify an appropriate placement that meets the needs of the member. AHCCCS may require MCLTC increase monitoring of facilities identified as having health or safety issues until AHCCCS is assured that the issues have been resolved or members have been transitioned to a placement setting that can meet their needs.

In the event of a bankruptcy or foreclosure order of an NF or ARS, MCLTC must notify AHCCCS of the situation. In these instances, MCLTC should review the financial, health and safety status prior to placing a member in a placement owned by the same entity. In the event that MCLTC identifies a member specific quality of care concern, MCLTC shall identify that to the NF or ARS for resolution. MCLTC shall also report to external entities, and to AHCCCS as required by the AHCCCS AMPM Chapter 900.

Admissions/Discharges/Readmissions

- NFs or ARSs are not required to accept new admissions of members who are enrolled with a non-contracted Contractor.
- NFs are required to otherwise follow admission, readmission, transfer, and discharge rights as per 42 CFR 438.12.
- The Contractor may authorize bedhold days up to the allowed limit (Short Term Hospitalization Leave – 12 days and Therapeutic – nine days) as required by Chapter 100 of the AHCCCS AMPM.

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MCLTC CHAPTER 3 – COVERED SERVICES

3.00 – Coverage Criteria

With the exception of emergency care, all covered services must be medically necessary and provided by a primary care provider or other qualified providers. Benefit limits apply.

Each line of business has specific covered and non-covered services. Participating providers are required to administer covered and non-covered services to members in accordance with the terms of their contract and member's benefit package.

3.01 - Covered Services

Long term care covered services and benefits:

- Nursing home care
- Home and Community Based Services
 - Adult day health care
 - Attendant care (includes spouse attendant care and self-directed care)
 - Community transitional service
 - Habilitation (includes day treatment and training)
 - Home delivered meals
 - Home health services
 - Homemaker services
 - Home modifications
 - Hospice
 - Personal care services
 - Respite and group respite care
- Alternative residential settings
 - Adult foster care
 - Adult and child developmental home
 - Assisted living home
 - Assisted living center
 - Behavioral health facility
 - Substance abuse transitional facility
 - Therapeutic home care - adult and child
 - Traumatic brain injury home

Medical covered services and benefits:

- Audiology services, including evaluation and treatment of hearing loss
- Behavioral health services and settings
- Breast reconstruction after a mastectomy
- Care to stabilize you after an emergency
- Diabetes care including A1C and LDL screenings, and eye exam for diabetes-related care

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- Doctor office visits, including specialists and primary care providers
- Durable medical equipment such as crutches, walkers, wheelchairs and blood glucose monitors
- Emergency medical care
- Family planning services such as contraceptives and testing for sexually transmitted infections
- Foot and ankle services such as treatment for foot pain or preventative diabetic foot care
- Health risk assessments and screening such as blood pressure testing, mammography and colon cancer screenings
- Hospital care, including inpatient medical care, observation and outpatient medical care
- Incontinence briefs to avoid or prevent skin breakdown, with limitations
- Kidney dialysis
- Laboratory and X-rays, including blood work
- Limited vision services, for members over 21 years of age, including: emergency eye care and some medically necessary vision services such as cataract removal
- Maternity care (prenatal, labor and delivery, postpartum)
- Medical foods, with limitations
- Medical supplies such as catheters and oxygen
- Medically necessary transportation to and from required medical services; emergency transportation
- Medications on MCLTC's list of covered medicines - members with Medicare will receive their medications from Medicare Part D
- Nutritional assessments, including evaluation and dietary recommendations
- Orthotics to support or brace weak joints or muscles
- Outpatient surgery and anesthesia
- Prescriptive lenses after cataract surgery
- Rehabilitation services, including occupational, speech, physical and respiratory therapy (limitations apply) for patients older than age 21
- Routine immunizations, such as flu shots
- Treatment of sexually transmitted diseases
- Urgent care services – when you need care today, or within the next couple of days
- Wellness exams and preventative screenings

Additional covered services for children (under age 21):

- Dental homes are covered for members under 21 years of age. A “dental home” is an office or facility where all dental services are provided in one location.
- Two (2) routine and preventive dental visits are covered per year for members under the age of 21.
- Visits to the dentist must take place within six (6) months and one (1) day after the previous visit. Services include: oral health screenings, cleanings, fluoride treatments, dental sealants, oral hygiene education, X-rays, fillings, extractions and other medically necessary procedures and therapeutic and emergency dental services.

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- Routine and emergency vision services are covered for members under 21. Vision services include exams and prescriptive lenses.
- EPSDT visits (same as wellness visits) includes checkups and immunizations (shots). See section on EPSDT/ Children's Services.
- Chiropractic services
- Conscious sedation
- Incontinence briefs, with limitations
- Additional services for Qualified Medicare Beneficiaries (QMBs)
- Any service covered by Medicare but not by AHCCCS

Limited and excluded benefits/services: for members 21 years or older:

The following services are not covered for adults 21 years and older. (If a member is a Qualified Medicare Beneficiary, we will continue to pay their Medicare deductible and coinsurance for these services.)

Benefit/service	Service Description	Service exclusions or limitations
Chiropractic services	Hands on therapy for spinal manipulation or adjustment	Excluded except for QMB members
Percussive vests	This vest is placed on a person's chest and shakes to loosen mucous.	AHCCCS will not pay for percussive vests. Supplies, equipment maintenance (care of the vest) and repair of the vest will be paid for.
Bone-anchored hearing aid	A hearing aid that is put on a person's bone near the ear by surgery. This is to carry sound.	AHCCCS will not pay for Bone-Anchored Hearing AID (BAHA). Supplies, equipment maintenance (care if the hearing aid) and repair of any parts will be paid for.
Cochlear implant	A small device that is put in a person's ear by surgery to help he/ she hear better.	AHCCCS will not pay for cochlear implants. Supplies, equipment maintenance (care of the implant) and repair of any parts will be paid for.
Lower limb microprocessor controlled joint/prosthetic	A device that replaces a missing part of the body and uses a computer to help with the moving of the joint.	AHCCCS will not pay for a lower limb (leg, knee or foot) prosthetic that includes a microprocessor (computer chip) that controls the joint.

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Dental and emergency dental service	Emergency services are those times that you need care immediately like a bad infection in your mouth or pain in your teeth or jaw.	There is limited coverage for dental services for members with cancer of the jaw, neck or head and for members who are pre-transplant candidates. Coverage for emergency dental services for members 21 years of age or older is limited to services that physicians are generally competent to perform. Exclusions include services such as dental cleanings, routine dental exams, dental restorations and root canals. Diagnosis and treatment of TMJ is not covered except for reduction of trauma.
Transplants	A transplant is defined as the transfer of an organ or blood cells from one person to another.	Approval is based on the medical need and if the transplant is on the “covered” list. Only transplants listed by AHCCCS as covered will be paid for.
Occupational, Physical and Speech Therapies	Exercises taught or provided by a physical therapist to make you stronger or help improve movement.	Coverage for out-patient physical therapy visits is limited to 15 visits to re-learn a skill and 15 visits to learn a new skill per contract year (October 1 - September 30). Coverage for members who have Medicare is limited to payment of copays for 15 visits. Members who have Medicare should contact the health plan for help in determining coverage.
Respite care	Respite care is offered as a temporary break for caregivers to take time for themselves.	The number of respite hours available to adults and children receiving ALTCS benefits or behavioral health services is 600 hours within a 12-month period. The 12 months will run from October 1 through September 30 of the next year.

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3.02 – Non-Covered Services

- Services from a provider who is NOT contracted with MCLTC (unless prior approved by MCLTC)
- Cosmetic services or items
- Personal care items such as combs, razors, soap etc.
- Any service that needs prior authorization that was not prior authorized
- Services or items given free of charge, or for which charges are not usually made
- Services of special duty nurses, unless medically necessary and prior authorized
- Physical therapy that is not medically necessary
- Routine circumcisions
- Services that are determined to be experimental by the health plan medical director
- Abortions and abortion counseling, unless medically necessary, pregnancy is the result of rape or incest, or if physical illness related to the pregnancy endangers the health of the mother
- Health services if you are in prison or in a facility for the treatment of tuberculosis
- Experimental organ transplants, unless approved by AHCCCS
- Sex change operations
- Reversal of voluntary sterilization
- Medications and supplies without a prescription
- Treatment to straighten teeth, unless medically necessary and approved by MCLTC
- Prescriptions not on MCLTC's list of covered medications, unless approved by MCLTC
- Diapers solely for personal hygiene
- Physical exams for the purpose of qualifying for employment or sports activities

Other Services that are Not Covered for Adults (age 21 and over):

- Hearing aids, including bone-anchored hearing aids
- Cochlear implants
- Microprocessor controlled lower limbs and microprocessor controlled joints for lower limbs
- Percussive vests
- Routine eye examinations for prescriptive lenses or glasses
- Chiropractic services (except for Medicare QMB members)
- Outpatient speech therapy (except for Medicare QMB members)

PLAN SPECIFIC TERMS**MCLTC CHAPTER 4 – BEHAVIORAL HEALTH****4.00 - Behavioral Health Overview**

Comprehensive mental health and substance abuse (behavioral health) services are available to MCLTC members. A direct referral for a behavioral health evaluation can be made by any health care professional in coordination with the member's assigned PCP and care manager. MCLTC members may also self-refer for a behavioral health evaluation. The level and type of behavioral health services will be provided based upon a member's strengths and needs and will respect a member's culture. Behavioral health services include:

- Behavior management (personal care, family support/home care training, peer support)
- Behavioral health care management services
- Behavioral health nursing services
- Emergency behavioral healthcare
- Emergency and non-emergency transportation
- Evaluation and assessment
- Individual, group and family therapy and counseling
- Inpatient hospital services
- Non-hospital inpatient psychiatric facilities services (Level I residential treatment centers and sub-Acute facilities)
- Lab and radiology services for psychotropic medication regulation and diagnosis
- Opioid Agonist treatment
- Partial care (supervised, therapeutic and medical day programs)
- Psychological rehabilitation (living skills training; health promotion; supportive employment services)
- Psychotropic medication
- Psychotropic medication adjustment and monitoring
- Respite care (with limitations)
- Rural substance abuse transitional agency services
- Screening
- Home Care Training to Home Care Client

4.01 - Behavioral Health Provider Types

Several main provider types typically provide behavioral health services for MCLTC members. These may include, but are not limited to, the following licensed agencies or individuals:

- Outpatient behavioral health clinics
- Psychiatrists
- Psychologists
- Certified psychiatric nurse practitioners
- Licensed clinical social workers
- Licensed professional counselors
- Licensed marriage and family therapists

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- Licensed substance abuse counselors
- Residential treatment facilities
- Behavioral health group homes, Levels II and III.
- Partial hospital programs
- Substance abuse programs

4.02 - Alternative Living Arrangements

MCLTC also includes the following alternative living arrangements:

- **Behavioral Health Level II and III** – these settings provide behavioral health treatment with 24-hour supervision. Services may include on site medical services and intensive behavioral health treatment programs.
- **Traumatic Brain Injury Treatment Facility** – this setting provides treatment and services for people with traumatic brain injuries.
- **DDD Group Homes** – these settings provide behavioral health treatment with 24-hour supervision.

4.03 - Emergency Services

MCLTC covers behavioral health emergency services for MCLTC members. If a member is experiencing a behavioral health crisis, please contact the **MCLTC Behavioral Health Hotline at 800-876-5835**.

During a member's behavioral health emergency, the MCLTC Behavioral Health Hotline clinician may dispatch a behavioral health mobile crisis team to the site of the member to de-escalate the situation and evaluate the member for behavioral health services. All medically necessary services are covered by MCLTC.

4.04 - Behavioral Health Consults

Behavioral Health consults are required by AHCCCS on all MCLTC members who receive behavioral health services. Behavioral Health Consults are done between an MCLTC care manager and a behavioral health care manager reviewing the behavioral health provider's progress notes and treatment plan to determine continued medical necessity of the services. Per AHCCCS guidelines, the following items are required for the Behavioral Health Consultations Process:

- Consults must take place quarterly for long term care members that are receiving behavioral health services and 30 days after a referral for behavioral health services is made.
- Behavioral health consultations must be reviewed face-to-face with, and the outcome signed by, a Masters Level Behavioral Health Clinician.

MCLTC behavioral health prescriber will send a letter to the member's PCP regarding the member's treatment and psychotropic medication regime.

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4.05 - Behavioral Health Screening

- Members should be screened by their PCP for behavioral health needs during routine or preventive visits.
- Behavioral health screening by PCPs is required at each EPSDT visit for members under age 21

4.06 - Behavioral Health Appointment Standards

MCLTC routinely monitors providers for compliance with appointment standards. The minimum standard requirements are:

- Emergency - Within 24 hours of referral.
- Routine - within 30 days of referral.

4.07 - Behavioral Health Provider Coordination of Care Responsibilities

It is critical that a strong communication link be maintained with behavioral health providers including:

- PCPs and other interested parties such as CPS (if the guardian and MCLTC has the paper work)
- Public Fiduciary Department (if documentation is provided identifying the Public Fiduciary Department as the member's guardian)
- Veterans Office (when guardian)
- Children's schools (participation in the ISP with parental or guardian consent)
- The court system (when completing paper work for all court ordered treatments or evaluations)
- Other providers not described above

Information can be shared with the other party that is necessary for the member's treatment. This process begins once a member is identified as meeting medical necessity for seeing a behavioral health provider by the behavioral health coordinator. Information can be shared with other parties with written permission from the member or the member's guardian.

4.08 - PCP Coordination of Care

The PCP will be informed of the member's behavioral health provider so that communication may be established. It is very important that PCPs develop a strong communication link with the behavioral health provider. PCPs are expected to exchange any relevant information such as medical history, current medications, diagnosis and treatment within 10 business days of receiving the request from the behavioral health provider.

Where there has been a change in a member's health status identified by a medical provider, there should be coordination of care with the behavioral health provider within a timely

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manner. The update should include but is not limited to; diagnosis of chronic conditions, support for the petitioning process, and all medication prescribed.

The PCP should also document and initial signifying review receipt of information received from a behavioral health provider who is treating the member. All efforts to coordinate on care on behalf of the member should be documented in the member's medical record.

4.09 - Prior Authorization Requirements and Process

MCLTC requires notification for outpatient behavioral health services.

To provide notification:

- Contact the member's Care Manager prior to delivery of services.
- Explain to the Care Manager the type of services to be delivered, frequency of services to be delivered, and duration of services provided.

The following behavioral health form is available on our [Forms](#) web page:

- **Long Term Care Behavioral Health Authorization Renewal Form**

4.10 – General and Informed Consent

Each member has the right to participate in decisions regarding his or her behavioral health care, including the right to refuse treatment. It is important for members seeking behavioral health services to agree to those services and be made aware of the service options and alternatives available to them as well as specific risks and benefits associated with these services.

General Consent is a one-time agreement to receive certain services, including but not limited to behavioral health services that is usually obtained from a member during the intake process at the initial appointment, and is always obtained prior to the provision of any behavioral health services. General consent must be obtained from a member's behavioral health recipient's or legal guardian's signature.

Informed Consent is an agreement to receive behavioral health services before the provision of a specific treatment that has associated risks and benefits. Informed consent is required to be obtained from a member or legal guardian prior to the provision of the following services and procedures:

- Complementary and Alternative Medicine (CAM),
- Psychotropic medications,
- Electro-Convulsive Therapy (ECT),
- Use of telemedicine,
- Application for a voluntary evaluation,
- Research,

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- Admission for medical detoxification, an inpatient facility or a residential program (for members determined to have a Serious Mental Illness), and
- Procedures or services with known substantial risks or side effects

MCLTC recognizes two primary types of consent for behavioral health services: general consent and informed consent.

Prior to obtaining informed consent, an appropriate behavioral health representative, as identified in R9-21-206.01(c), must present the facts necessary for a member to make an informed decision regarding whether to agree to the specific treatment and/or procedures. Documentation that the required information was given, and that the member agrees or does not agree to the specific treatment, must be included in the comprehensive clinical record, as well as the member/ guardian's signature when required.

In addition to general and informed consent for treatment, state statute (A.R.S. §15-104) requires written consent from a child's parent or legal guardian for any behavioral health survey, analysis, or evaluation conducted in reference to a school based prevention program.

The intent of this section is to describe the requirements for reviewing and obtaining general, and informed consent, for members receiving services within the behavioral health system, as well as consent for any behavioral health survey or evaluation in connection with an AHCCCS school-based prevention program.

General Requirements

- Any member, aged 18 years and older, in need of behavioral health services must give voluntary general consent to treatment, demonstrated by the member's or legal guardian's signature on a general consent form, before receiving behavioral health services.
- For members under the age of 18, the parent, legal guardian, or a lawfully authorized custodial agency (including foster care givers A.R.S. 8.514.05(C)) must give general consent to treatment, demonstrated by the parent, legal guardian, or a lawfully authorized custodial agency representative's signature on a general consent form prior to the delivery of behavioral health services.
- Any member aged 18 years and older or the member's legal guardian, or in the case of members under the age of 18, the parent, legal guardian or a lawfully authorized custodial agency, after being fully informed of the consequences, benefits and risks of treatment, has the right not to consent to receive behavioral health services.
- Any member aged 18 years and older or the member's legal guardian, or in the case of members under the age of 18, the parent, legal guardian or a lawfully authorized custodial agency has the right to refuse medications unless specifically required by a court order or in an emergency situation.

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- Providers treating members in an emergency are not required to obtain general consent prior to the provision of emergency services. Providers treating members pursuant to court order must obtain consent, as applicable, in accordance with A.R.S. Title 36, Chapter 5.
- All evidence of informed consent and general consent to treatment must be documented in the comprehensive clinical record per the AHCCCS AMPM Policy 940.
- Contractors and T/RBHAs must develop and make available to providers policies and procedures that include any additional information or forms.
- A foster parent, group home staff, foster home staff, relative, or other person or agency in whose care a child is currently placed may give consent for:
 - Evaluation and treatment for emergency conditions that are not life threatening, and
 - Routine medical and dental treatment and procedures, including Early Periodic Screening Diagnosis and Treatment (EPSDT) services, and services by health care providers to relieve pain or treat symptoms of common childhood illnesses or conditions (A.R.S. §8-514.05(C)).
- To ensure timely delivery of services, consent for intake and routine behavioral health services may be obtained from either the foster caregiver or the Department of Child Safety Specialist (DCSS) whomever is available to do so immediately upon request (A.R.S. § 8-514.05(C)).
- Foster or kinship caregivers can consent to evaluation and treatment for routine medical and dental treatment and procedures, including behavioral health services. Examples of behavioral health services in which foster or kinship can consent to include:
 - Assessment and service planning,
 - Counseling and therapy,
 - Rehabilitation services,
 - Medical Services,
 - Psychiatric evaluation,
 - Psychotropic medication,
 - Laboratory services,
 - Support Services,
 - Care Management,
 - Personal Care Services,
 - Family Support,
 - Peer Support,
 - Respite,
 - Sign Language or Oral Interpretive Services,
 - Transportation,
 - Crisis Intervention Services,
 - Behavioral Health Day Programs.
- A foster parent, group home staff, foster home staff, relative, or other person or agency in whose care a child is currently placed shall not consent to:
 - General Anesthesia,
 - Surgery,

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- Testing for the presence of the human immunodeficiency virus,
 - Blood transfusions,
 - Abortions.
- Foster or kinship caregivers may not consent to terminate behavioral health treatment. The termination of behavioral health treatment requires Department of Child Safety (DCS) consultation and agreement.
- If the foster or kinship caregiver disagrees on the behavioral health treatment being recommended through the Child and Family Team (CFT), the CFT including the foster or kinship caregiver and DCS case worker should reconvene and discuss the recommended treatment plan. Only DCS can refuse consent to medically recommended behavioral health treatment.

General Consent

Administrative functions associated with a member's enrollment do not require consent, but before any services are provided, general consent must be obtained.

MCLTC will make available to providers any form used to obtain general consent to treatment.

Informed Consent

- In all cases where informed consent is required by this policy, informed consent must include at a minimum:
 - The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions,
 - Information about the member's diagnosis and the proposed treatment, including the intended outcome, nature and all available procedures involved in the proposed treatment,
 - The risks, including any side effects, of the proposed treatment, as well as the risks of not proceeding,
 - The alternatives to the proposed treatment, particularly alternatives offering less risk or other adverse effects,
 - That any consent given may be withheld or withdrawn in writing or orally at any time. When this occurs the provider must document the member's choice in the medical record;
 - The potential consequences of revoking the informed consent to treatment, and
- A description of any clinical indications that might require suspension or termination of the proposed treatment. Documenting Informed Consent:
 - Members, or if applicable the member's parent, guardian or custodian, shall give informed consent for treatment by signing and dating an acknowledgment that he or she has received the information and gives informed consent for the proposed treatment.

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- When informed consent is given by a third party, the identity of the third party and the legal capability to provide consent on behalf of the member, must be established. If the informed consent is for psychotropic medication or telemedicine and the member, or if applicable, the member's guardian refuses to sign an acknowledgment and gives verbal informed consent, the medical practitioner shall document in the member's record that the information was given, the member refused to sign an acknowledgment and that the member gives informed consent to use psychotropic medication or telemedicine.
- When providing information that forms the basis of an informed consent decision for the circumstances identified above, the information must be:
 - Presented in a manner that is understandable and culturally appropriate to the member, parent, legal guardian or an appropriate court; and
 - Presented by a credentialed behavioral health medical practitioner or a registered nurse with at least one year of behavioral health experience. It is preferred that the prescribing clinician provide information forming the basis of an informed consent decision. In specific situations in which it is not possible or practicable, information may be provided by another credentialed behavioral health medical practitioner or registered nurse with at least one year of behavioral health experience.
- Psychotropic Medications, Complementary and Alternative Treatment and Telemedicine:
 - Unless treatments and procedures are court ordered, providers must obtain written informed consent, and if written consent is not obtainable, providers must obtain oral informed consent. If oral informed consent is obtained instead of written consent from the member, parent or legal guardian, it must be documented in written fashion. Informed consent is required in the following circumstances:
 - Prior to the initiation of any psychotropic medication or initiation of Complementary and Alternative Treatment (CAM) (see AMPM Policy 310-V). The use of AMPM Exhibit 310-V-1, Informed Consent/Assent for Psychotropic Medication Treatment Form is recommended as a tool to review and document informed consent for psychotropic medications, and
 - Prior to the delivery of behavioral health services through telemedicine.
 - Electro-Convulsive Therapy (ECT), research activities, voluntary evaluation and procedures or services with known substantial risks or side effects.
 - Written informed consent must be obtained from the member, parent or legal guardian, unless treatments and procedures are under court order, in the following circumstances:
 - Before the provision of (ECT),
 - Prior to the involvement of the member in research activities,
 - Prior to the provision of a voluntary evaluation for a member. The use of AMPM Exhibit 320-Q-1, Application for Voluntary Evaluation is required for members determined to have a Serious Mental Illness and is recommended as a tool to review and document informed consent for voluntary evaluation of all other populations, and

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- Prior to the delivery of any other procedure or service with known substantial risks or side effects.
- Written informed consent must be obtained from the member, legal guardian or an appropriate court prior to the member's admission to any medical detoxification, inpatient facility or residential program operated by a behavioral health provider.
- If informed consent is revoked, treatment must be promptly discontinued, except in cases in which abrupt discontinuation of treatment may pose an imminent risk to the member. In such cases, treatment may be phased out to avoid any harmful effects.
- Informed Consent for Telemedicine:
 - Before a health care provider delivers health care via telemedicine, verbal or written informed consent from the member or their health care decision maker must be obtained. Refer to the AHCCCS AMPM Policy 320-I for additional detail.
 - Informed consent may be provided by the behavioral health medical practitioner or registered nurse with at least one year of behavioral health experience. When providing informed consent it must be communicated in a manner that the member and/or legal guardian can understand and comprehend.
 - Exceptions to this consent requirement include:
 - If the telemedicine interaction does not take place in the physical presence of the member;
 - In an emergency situation in which the member or the member's health care decision maker is unable to give informed consent; or
 - To the transmission of diagnostic images to a health care provider serving as a consultant or the reporting of diagnostic test results by that consultant.

Special Requirements for Children

- In accordance with A.R.S. §36-2272, except as otherwise provided by law or a court order, no person, corporation, association, organization or state-supported institution, or any individual employed by any of these entities, may procure, solicit to perform, arrange for the performance of or perform mental health screening in a nonclinical setting or mental health treatment on a minor without first obtaining consent of a parent or a legal custodian of the minor child. If the parental consent is given through telemedicine, the health professional must verify the parent's identity at the site where the consent is given. This section does not apply when an emergency exists that requires a person to perform mental health screening or provide mental health treatment to prevent serious injury to or save the life of a minor child.
- Non-Emergency Situations
 - In cases where the parent is unavailable to provide general or informed consent and the child is being supervised by a caregiver who is not the child's legal guardian (e.g., grandparent) and does not have power of attorney, general and informed consent must be obtained from one of the following:
 - Lawfully authorized legal guardian,

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- Foster parent, group home staff or other person with whom the DCS has placed the child, or
 - Government agency authorized by the court.
- If someone other than the child's parent intends to provide general and, when applicable, informed consent to treatment, the following documentation must be obtained and filed in the child's comprehensive clinical record:

INDIVIDUAL/ENTITY	DOCUMENTATION
Legal guardian	Copy of court order assigning custody
Relatives	Copy of power of attorney document
Other person/agency	Copy of court order assigning custody
DCS Placements (for children removed from the home by DCS), such as: <ul style="list-style-type: none"> • Foster parents • Group home staff • Foster home staff • Relatives • Other person/agency in whose care DCS has placed the child 	None required (see note)

NOTE: If behavioral health providers doubt whether the individual bringing the child in for services is a person/agency representative in whose care DCS has placed the child, the provider may ask to review verification, such as documentation given to the individual by DCS indicating that the individual is an authorized DCS placement. If the individual does not have this documentation, then the provider may also contact the child's DCS case worker to verify the individual's identity.

- For any child who has been removed from the home by DCS, the foster parent, group home staff, foster home staff, relative or other person or agency in whose care the child is currently placed may give consent for the following behavioral health services:
- Evaluation and treatment for emergency conditions that are not life threatening, and
 - Routine medical and dental treatment and procedures, including early periodic screening, diagnosis and treatment services, and services by health care providers to relieve pain or treat symptoms of common childhood illnesses or conditions (including behavioral health services and psychotropic medications).

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- Any minor who has entered into a lawful contract of marriage, whether or not that marriage has been dissolved subsequently, any emancipated youth or any homeless minor may provide general and, when applicable, informed consent to treatment without parental consent (A.R.S. §44-132).
- Emergency Situations
 - In emergencies involving a child in need of immediate hospitalization or medical attention, general and, when applicable, informed consent to treatment is not required.
 - Any child, 12 years of age or older, who is determined upon diagnosis of a licensed physician, to be under the influence of a dangerous drug or narcotic, not including alcohol, may be considered an emergency situation and can receive behavioral health care as needed for the treatment of the condition without general and, when applicable, informed consent to treatment.

At times, involuntary treatment can be necessary to protect safety and meet needs when a member, due to mental disorder, is unwilling or unable to consent to necessary treatment. In this case, a court order may serve as the legal basis to proceed with treatment. However, capacity to give informed consent is situational, not global, as a member may be willing and able to give informed consent for aspects of treatment even when not able to give general consent. Members should be assessed for capacity to give informed consent for specific treatment and such consent obtained if the member is willing and able, even though the member remains under court order.

Consent for Behavioral Health Survey or Evaluation for School-Based Prevention Programs

- Written consent must be obtained from a child's parent or legal guardian for any behavioral health survey, analysis, or evaluation conducted in reference to a school-based prevention program administered by AHCCCS.
- AMPM Exhibit 320-Q-2, Substance Abuse Prevention Program and Evaluation Consent must be used to gain parental consent for evaluation of school based prevention programs. Providers may use an alternative consent form only with the prior written approval of AHCCCS. The consent must satisfy all of the following requirements:
 - Contain language that clearly explains the nature of the screening program and when and where the screening will take place;
 - Be signed by the child's parent or legal guardian; and
 - Provide notice that a copy of the actual survey, analysis, or evaluation questions to be asked of the student is available for inspection upon request by the parent or legal guardian.
- 3. Completion of AMPM Exhibit 320-Q-2, Substance Abuse Prevention Program and Evaluation Consent applies solely to consent for a survey, analysis, or evaluation only, and does not constitute consent for participation in the program itself.

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4.11 - Family Involvement

Family involvement in a member's treatment is an important aspect in recovery. Studies have shown members who have family involved in their treatment tend to recover quicker, have less dependence on outside agencies, and tend to rely less on emergency resources. Family is defined as any person related to the member biologically or appointed (step-parent, guardian, and/or power of attorney). Treatment includes treatment planning, participation in counseling or psychiatric sessions, providing transportation or social support to the member. Information can be shared with other parties with written permission from the member or the member's guardian.

4.12 - Members with Diabetes and the Arizona State Hospital

- Members with diabetes who are admitted to the Arizona State Hospital (herein AzSH) for behavioral health services will receive training to use a glucometer and testing supplies during their stay at AzSH.
- Upon discharge from AzSH, PCPs must ensure these members are issued the same brand and model of glucometer and supplies that they were trained to use during their AzSH admission.
- MCLTC's behavioral health coordinator will notify the PCP of the member's discharge from AzSH and provide information on the brand and model of equipment and supplies that should be continued to be prescribed.
- The MCLTC behavioral health coordinator will work with AzSH to ensure the member has sufficient testing supplies to last until an office visit can be scheduled with the provider.
- In the event the member's mental status renders them incapable or unwilling to manage their medical condition and that condition requires skilled medical care, the MCLTC behavioral health coordinator will work with AzSH and the PCP to obtain an appropriate placement for additional outpatient services.
- For re-authorization for continued behavioral health services, contact the member's care manager and fax the Behavioral Health Treatment Plan and progress notes requesting continued authorization. Be sure to include the services to be delivered, frequency of services to be delivered and duration of services provided.
- ALWAYS verify member eligibility prior to the provision of services.

4.13 - Court Ordered Treatment and Petition Process

At times, it may be necessary to initiate civil commitment proceedings to ensure the safety of a person, or the safety of other persons, due to a member's mental disorder when that member is unable or unwilling to participate in treatment. In Arizona, state law permits any responsible person to submit an application for pre-petition screening when another member may be, as a result of a mental disorder:

- **A danger to self (DTS);**

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- **A danger to others (DTO);**
- **Persistently or acutely disabled (PAD); or**
- **Gravely disabled (GD).**

If the person who is the subject of a court ordered commitment proceeding is subject to the jurisdiction of an Indian tribe rather than the state, the laws of that tribe, rather than state law, will govern the commitment process.

Pre-petition screening includes an examination of the person's mental status and/or other relevant circumstances by a designated screening agency. Upon review of the application, examination of the person and review of other pertinent information, a licensed screening agency's medical director or designee will determine if the person meets criteria for DTS, DTO, PAD, or GD as a result of a mental disorder.

If the pre-petition screening indicates that the person may be DTS, DTO, PAD, or GD, the screening agency will file an application for a court-ordered evaluation. Based on the immediate safety of the member or others, an emergency admission for evaluation may be necessary. Otherwise, an evaluation will be arranged for the person by a designated evaluation agency within timeframes specified by state law.

Based on the court-ordered evaluation, the evaluating agency may petition for court-ordered treatment on behalf of the member. A hearing, with the member and his/her legal representative and the physician(s) treating the member, will be conducted to determine whether the member will be released and/or whether the agency will petition the court for court-ordered treatment. For the court to order ongoing treatment, the person must be determined, as a result of the evaluation, to be DTS, DTO, PAD, or GD. Court-Ordered Treatment (COT) may include a combination of inpatient and outpatient treatment. Inpatient treatment days are limited contingent on the member's designation as DTS, DTO, PAD, or GD. Members identified as:

- DTS may be ordered up to 90 inpatient days per year;
- DTO and PAD may be ordered up to 180 inpatient days per year; and
- GD may be ordered up to 365 inpatient days per year.

If the court orders a combination of inpatient and outpatient treatment, a mental health agency will be identified by the court to supervise the person's outpatient treatment. Before the court can order a mental health agency to supervise the person's outpatient treatment, the agency medical director must agree and accept responsibility by submitting a written treatment plan to the court.

At every stage of the pre-petition screening, court-ordered evaluation, and court-ordered treatment process, a person will be provided an opportunity to change his/her status to

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voluntary. Under voluntary status, the person is no longer considered to be at risk for DTS/DTO and agrees in writing to receive a voluntary evaluation.

County agencies and MCLTC contracted agencies responsible for pre-petition screening and court-ordered evaluations must use the following forms prescribed in **9 A.A.C. 21, Article 5** for persons determined to have a Serious Mental Illness; agencies may also use the following forms AHCCCS Forms found under the [AHCCCS Medical Policy Manual, Section 320-U](#), for all other populations:

- **Application for Involuntary Evaluation**
- **Application for Voluntary Evaluation**
- **Application for Emergency Admission for Evaluation**
- **Petition for Court-Ordered Evaluation**
- **Petition for Court-Ordered Treatment Gravely Disabled Person**
- **Affidavit**
- **Special Treatment Plan for Forced Administration of Medications**

In addition to court ordered treatment as a result of civil action, an individual may be ordered by a court for evaluation and/or treatment upon: 1) conviction of a domestic violence offense; or 2) upon being charged with a crime when it is determined that the individual is court ordered to treatment, or programs, as a result of being charged with a crime and appears to be an “alcoholic”.

Licensing Requirements

Behavioral health providers who are licensed by the Arizona Department of Health Services/Division of Public Health Licensing Services as a court-ordered evaluation or court-ordered treatment agency must adhere to ADHS licensing requirements.

Pre-Petition Screening

MARICOPA COUNTY

There is an intergovernmental agreement between Maricopa County and AHCCCS for the management, provision of, and payment for Pre-Petition Screening and Court Ordered Evaluation. AHCCCS in turn contracts with MCLTC for these pre-petition screening and court ordered evaluation functions. MCLTC is required to coordinate provision of behavioral health services with the member’s contractor responsible for the provision of behavioral health services.

The pre-petition screening includes an examination of the member’s mental status and/or other relevant circumstances by a designated screening agency. The designated screening agency must follow these procedures:

- The pre-petition screening agency must offer assistance, if needed, to the applicant in the preparation of the application for court-ordered evaluation (see Application for Involuntary Evaluation).

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- Any behavioral health provider that receives an application for court-ordered evaluation (see Application for Involuntary Evaluation) must immediately refer the applicant for pre-petition screening and petitioning for court-ordered evaluation to the designated pre-petition screening agency or county facility.

PIMA COUNTY

Emergent Petition

Only persons who, as a direct result of a mental disorder, display behaviors that are DTS or DTO, and the person is likely, without immediate hospitalization, to suffer serious physical harm or serious illness, or is likely to inflict serious physical harm upon another person, is appropriate for an emergency petition that precludes the use of the pre-petition non-emergent screening process.

The Emergent Petition can be initiated by police, crisis teams, family members, or anyone who has directly witnessed the alleged behavior(s). In addition, there must be two witnesses available to verify the member's behavior once it goes to court.

To initiate the Emergent petition the petitioner would call Tucson Police Department (TPD) if it warrants a call to 911 or call Southern Arizona Mental Health Corporation (SAMHC) to dispense the Mobil Acute Services (MAC team). TPD calls the Crisis Response Network (CRN) to triage to find out which evaluating hospital has an opening. The MAC team would coordinate with TPD and CRN.

Southern Arizona Mental Health Corporation (SAMHC)

520-617-0043

The evaluating hospitals are:

Sonora Behavioral Health

6050 N. Corona Rd. Bldg. 3

Tucson, AZ 85704

520-469-8700

Palo Verde Hospital

2695 N. Craycroft Rd.

Tucson, AZ 85712

520-324-3522

University of Arizona Medical Center-South Campus

Abrams Annex

2800 E. Ajo Way

Tucson, AZ 85713

520-626-5582

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Non-Emergent (PAD/GD) Petition

Non-Emergent Petitions are facilitated by the SAMHC pre-petition evaluation team. Any party may initiate a request for a Non-Emergent Petition by calling SAMHC at 520-617-0043 or 520-618-8694. Two witnesses must be available to verify the individual's behavior if there is a hearing scheduled. A person may only be petitioned if he/she is a resident of Pima County and/or if the behavior in question occurred in Pima County. A person must also be suffering from a mental disorder and meet the legal definition of DTS, DTO, GD, or PAD.

For members who are already under Court Ordered Treatment through the Mental Health Court, MCLTC is responsible for tracking the status of the member's treatment and reports to the Mental Health Court as necessary. As such, treating providers must notify MCLTC of any treatments.

Filing of Non-Emergent Petitions

This provides instruction to the Care Manager and Pre-Petition Team relative to AAC and ARC requirements, not intended to be instructive to provider/community members.

Non-emergent Process

For behavioral health members receiving MCLTC Clinic Services, the following steps will be completed by the Clinical Team.

- For all other residents of Maricopa County (not enrolled with a MCLTC Clinic), the pre-petition team will complete these steps for petitions for COE. Any responsible individual may apply for a COE of a member who is alleged to be, as a result of a mental disorder, a danger to self or to other, persistently or acutely disabled, or gravely disabled and who is unwilling or unable to undergo a voluntary evaluation.
- For Maricopa County residents not enrolled with a MCLTC Clinic, an applicant contacts the MCLTC Customer Service Line at 800-564-5465 or the Crisis Response Network Crisis Line 800-631-1314 and requests a PAD or GD petition application be completed on an identified member in the community. An applicant can also go in person to UPC, RRC, or CPEC in order to begin the non-emergent process. The Pre-Petition team shall receive the referral and will contact the applicant to assist the applicant in completion of the **Application for Involuntary Evaluation** when a non-emergency COE is requested. All other steps, when applicable, will be the same as for MCLTC Clinic enrolled behavioral health members.
- For MCLTC Clinic enrolled behavioral health members, the Clinical Team shall assist the applicant in the completion of the application and evaluation when a non-emergency COE is requested. If at any time during the process the behavioral health member is determined to be in imminent danger of harming self or others, UPC, RRC, or CPEC will be contacted for assistance in evaluation and possible application for an emergency admission.
- For all MMCC Clinic enrolled or non-enrolled members, pre-petition screening must be

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attempted within forty-eight (48) hours, excluding weekends and holidays, of completion of the application. Pre-petition screening process includes informing the individual that an application for evaluation (**Application for Involuntary Evaluation**) has been completed, explaining the individual's rights to voluntary evaluation, reviewing the allegations, and completing a mental status examination. The **Pre-Petition Screening Report** is a detailed report of the information obtained during the assessment. This report must be completed by someone other than the applicant. If the member does consent to a voluntary evaluation the **Application for Voluntary Evaluation** shall be used.

- During the pre-petition screening, at least three attempts to contact the behavioral health member should be completed. If attempts at contacting the behavioral health member are unsuccessful and screening is not possible, screening staff will review this information with a physician. The screening agency shall prepare a report giving reasons why the screening was not possible, including opinions/conclusions of staff members who attempted to conduct pre- petition screening.
- If the behavioral health member does not consent to a voluntary outpatient evaluation or voluntary inpatient evaluation or when a voluntary evaluation is not appropriate as determined by the evaluating psychiatrist, the involuntary process shall continue.
- The Clinical Team or Pre-Petition Team will staff the application for involuntary evaluation (**Application for Involuntary Evaluation** and **Pre-Petition Screening Report**) with a psychiatrist. The psychiatrist need never have met the person in order to make a decision regarding whether or not to move forward with a Petition for COE. The psychiatrist will:
 - Review the application, pre-petition screening report, and any other collateral information made available as part of the pre-petition screening to determine if it indicates that there is reasonable cause to believe the allegations of the applicant for the COE.
 - Prepare a Petition for COE and file the petition if the psychiatrist determines that the member, due to a mental disorder, which may include a primary diagnosis of dementia and other cognitive disorders, is DTS, DTO, PAD or GD. The documents pertinent information for COE;
 - If the psychiatrist determines that there is reasonable cause to believe that the member, without immediate hospitalization, is likely to harm him/her or others, the psychiatrist must coordinate with the UPC, RRC-W or CPEC and ensure completion of the **Application for Emergency Admission for Evaluation**, and take all reasonable steps to procure hospitalization on an emergency basis.
- Pre-petition screens, application, and petition for Inpatient or Outpatient Court Ordered Evaluation can be filed on a non-emergent basis at the MIHS Desert Vista Campus Legal Office, 570 West Brown Road, Mesa, AZ 85201, and 480-344-2000. This involves all Persistently or Acutely Disabled (PAD) and Gravely Disabled (GD) petitions. Danger to Self (DTS) and Danger to Others (DTO) petitions that do not require immediate intervention can also be filed on a non-emergent basis. Please use the following forms

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for filing the non-emergent petition: **Petition for Court Ordered Evaluation and Application for Involuntary Evaluation.**

- Eight copies and the original Petition for Court-Ordered Evaluation, Application for Involuntary Evaluation, Pre-Petition Screening Report and the Police Mental Health Detention Information Sheet, must be submitted by the behavioral health member's Care Manager or the pre-petition team to the Legal Department at Maricopa Integrated Health System (MIHS) Desert Vista Campus for review by the County Attorney, preparation of the Detention Order, and filing with the Superior Court. These documents must be filed within 24 hours of completion, excluding weekends and holidays.
- Once the petition is filed with the court, the Legal Department at MIHS Desert Vista Campus Delivers the Detention Order to the Police Department to have the behavioral health member brought to the UPC, RRC or CPEC for evaluation. NOTE: The **Petition for Court Ordered Evaluation and Police Mental Health Detention Information Sheet** expire 14 days from the date the judge signs off on the order for COE.
- One of the eight copies of petition documents shall be stored by the behavioral health member's Case Manager or the pre-petition team in a secure place (such as a locked file cabinet) to ensure the behavioral health member's confidentiality. A petition for involuntary evaluation may not be stored in the medical record if the behavioral health member has not been court ordered to receive treatment.

Emergent Filing

In cases where it is determined that there is reasonable cause to believe that the member is in such a condition that without immediate hospitalization he/she is likely to harm himself/herself or others, an application for emergency admission can be filed. Only applications indicating Danger to Self and/or Danger to Others can be filed on an emergent basis and shall be filed at the Urgent Psychiatric Care (UPC), 1201 S 7th Ave; Suite #150, Phoenix, AZ 85007; 602-416-7600; Response Recovery Center- (RRC, 11361 N. 99th Ave Suite 402, Peoria AZ 85345, 602-636-4605; or Community Psychiatric Emergency Center (CPEC), 358 E. Javelina, Mesa, AZ 85210, 480-507-3180. MCLTC contracts with the UPC, RCC, and CPEC to assist the applicant in preparing the **Application for Emergency Admission for Evaluation** when an emergent evaluation is requested and can also assist when an Application for Court Ordered Evaluation on a non-emergent basis is needed due to the person not meeting criteria for an emergency admission.

Emergent process

The applicant is a person who has, based on personal observation, knowledge of the behavioral health member's behavior that is danger to self or danger to others. The applicant shall complete the **Application for Emergency Admission for Evaluation** with assistance of UPC/RRC/CPEC staff and include:

- The applicant must have seen or witnessed the behavior or evidence of mental disorder.
- The applicant, as a direct observer of dangerous behavior, may be called to testify in

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court if the application results in a petition for COE.

- Upon receipt of the Application for Emergency Admission for Emergency Evaluation (MH-104) the UPC, RRC or CPEC admitting officer will begin the assessment process to determine if enough evidence exists for an emergency admission for evaluation. If there is enough evidence to support the emergency admission for evaluation and the member does not require medical care beyond the capacity of UPC, RRC or CPEC, then the UPC, RRC or CPEC staff will immediately coordinate with local law enforcement for the detention of the member and transportation to UPC, RRC or CPEC.
- If the Application for Emergency Admission for Evaluation is accepted by the UPC, RRC or CPEC admitting officer and the member requires a level of medical support not available at the UPC, RRC or CPEC, then within 24 hours the UPC, RRC or CPEC admitting officer will coordinate admission to the MIHS Psychiatric Annex. If admission to the MIHS Psychiatric Annex cannot be completed within 24 hours of the Application for Emergency Admission for Evaluation being accepted by the UPC, RRC or CPEC admitting officer, then the MCLTC Medical Director must be notified.
- An **Application for Emergency Admission for Evaluation** may be discussed by telephone with a UPC, RRC or CPEC admitting officer, the referring physician, and a police officer to facilitate transport of the member to be evaluated at a UPC, RRC or CPEC.
- A member proposed for emergency admission for evaluation may be apprehended and transported to the UPC, RRC or CPEC by police officials through a written **Application for Emergency Admission for Evaluation** faxed by the UPC, RRC or CPEC admitting officer to the police.
- A 23-Hour Emergency Admission for Evaluation begins at the time the behavioral health member is detained involuntarily by the Admitting Officer at UPC, RRC or CPEC who determines there is reasonable cause to believe that the member, as a result of a mental disorder, is a DTS or DTO and that during the time necessary to complete prescreening procedures the member is likely, without immediate hospitalization, to suffer harm or cause harm to others.
- During the emergency admission period of up to 23 hours the following will occur:
 - The behavioral health member's ability to consent to voluntary treatment will be assessed.
 - The behavioral health member shall be offered and receive treatment to which he/she may consent. Otherwise, other than calming talk or listening, the only treatment administered involuntarily will be for the safety of the individual or others, i.e. seclusion/restraint or pharmacological restraint in accordance with A.R.S. §36-513.
 - UPC/RRC/CPEC may contact the County Attorney prior to filing a petition if it alleges that a member is DTO.
 - If the behavioral health member is determined to require a court ordered evaluation, then the petition for COE will be filed with the court within 24 hours of admission (not including weekends or court holidays). If the behavioral health member does not meet the criteria for an application for emergency admission

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but is determined to meet criteria for PAD and/or GD, UPC, RRC-W or CPEC will notify and offer to assist the applicant of the non-emergent process.

Court-Ordered Evaluation

If the pre-petition screening indicates that the member may be DTS, DTO, PAD, or GD, the screening agency will file an application for a court-ordered evaluation. The procedures for court-ordered evaluations are outlined below:

MCLTC and its subcontracted behavioral health provider must follow these procedures:

- A member being evaluated on an inpatient basis must be released within seventy-two hours (not including weekends or court holidays) if further evaluation is not appropriate, unless the member makes application for further care and treatment on a voluntary basis;
- A member who is determined to be DTO, DTS, PAD, or GD as a result of a mental disorder must have a petition for court-ordered treatment prepared, signed and filed by MCLTC's medical director or designee; and
- Title XIX/XXI funds must not be used to reimburse court-ordered evaluation services.

MCLTC encourages the utilization of outpatient evaluation on a voluntary or involuntary basis. MCLTC is not responsible to pay for the costs associated with Court Ordered Evaluation outside of the limited "medication only" benefit package available for Non-Title XIX members determined to have SMI, unless other prior payment arrangements have been made with another entity (e.g. county, hospital, provider).

Court Ordered Outpatient Evaluation

- After the pre-petition screening, if the member is refusing a voluntary evaluation and the psychiatrist determines the member is safe to go through an Outpatient Court Ordered Evaluation, then the Case Manager or pre-petition team will deliver the original Application for Involuntary Evaluation, **Pre-Petition Screening Report**, and **Petition for Court-Ordered Evaluation** to the Legal Department at Maricopa Integrated Health System(MIHS) Desert Vista Campus for review by the County Attorney, preparation of the service order, and filing with the Superior Court.
- Once the petition is filed with the court, the Legal Department at MIHS Desert Vista delivers the service order to the police department in order to have the member served legal notice of the date/time/location of the outpatient evaluation. One of the eight copies of the petition documents shall be stored by the member's Care Manager or PAD team in a secure place (such as a locked file cabinet) to ensure the behavioral health member's confidentiality. A petition for involuntary evaluation may not be stored in the medical record if the behavioral health member has not been court ordered to receive treatment.
- The MIHS Legal Department will arrange for an outpatient Court Ordered Evaluation and notify the Case Manager or Pre-Petition Team of the date and time of the evaluation.

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- If the Outpatient COE is scheduled to take place at Desert Vista, the Case Manager will arrange for transportation for the member to and from the Outpatient COE and will provide any documents requested by the psychiatrists conducting the evaluation. If the member is not enrolled at an SMI Clinic, the MCLTC Court Liaison will assist the member in arranging transportation.
- If the two evaluating psychiatrists do not believe that the member is in need of COT, then the MIHS Legal Department will forward the physicians' affidavits to the Care Manager or Pre-Petition Team with an explanation that the member has been determined not to be in need of COT.
- If the two evaluating psychiatrists completing the Outpatient Court Ordered Evaluation determine the member is in need of COT, then the two physician's **Affidavit and social** work report will be delivered to the MIHS Legal Department within 1 business day of the evaluation. The MCLTC Court Liaison will then file a Petition for Court Ordered Treatment with the Maricopa County Superior Court within 2 business days.

Voluntary Evaluation

Any MCLTC contracted behavioral health provider that receives an application for voluntary evaluation must immediately refer the member to the facility responsible for voluntary evaluations.

Voluntary Inpatient or Outpatient Evaluation

- If the individual agrees to a voluntary evaluation, complete the **Application for Voluntary Evaluation** and review with a psychiatrist.
- If the psychiatrist determines that a voluntary evaluation is appropriate, then a decision as to whether the evaluation is to take place on an inpatient or outpatient basis will be made by the psychiatrist.
- If the psychiatrist determines an inpatient voluntary evaluation is necessary, the Care Manager or PAD Team is to arrange for a voluntary admission to UPC, RRC, or CPEC, in order for the evaluation to take place, assist the member in signing in and deliver the original notarized **Application for Voluntary Evaluation** to the UPC, RRC, or CPEC Coordinator.
- If the psychiatrist determines an outpatient voluntary evaluation is acceptable, then the Case Manager or PAD Team will deliver the original, notarized **Application for Voluntary Evaluation** to the MIHS Legal Department. An outpatient evaluation will then be scheduled at Desert Vista Hospital and the Case Manager or PAD Team will be responsible for notifying the member of the date and time of the evaluation, provide transportation to and from the evaluation, and provide any documentation requested by the physician's conducting the evaluation.
- The voluntary outpatient or inpatient assessment must include evaluation by two psychiatrists and the involvement of either two social workers, or one social worker and one psychologist, who shall complete the outpatient treatment plan. The voluntary psychiatric evaluation shall include determination regarding the existence of a mental

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disorder, and whether, as a result of a mental disorder, the individual meets one or more of the standards. The psychiatric evaluation must also include treatment recommendations. The psychiatrists completing the outpatient psychiatric evaluations will submit a written affidavit to the MIHS Legal Department regarding their findings.

- If the psychiatrists do not believe that the member is in need of COT, then the MIHS Legal Department will forward the physicians' affidavits to the Care Manager or PAD Team with an explanation that the member has been determined not to be in need of COT.
- If the psychiatrists completing the voluntary inpatient evaluation or voluntary outpatient evaluation determine the member is in need of COT, then the two physician's **Affidavit** and a social work report will be delivered to the MIHS Legal Department within 1 business day of the evaluation. The MCLTC contracted behavioral health provider must follow these procedures:
- The evaluation agency must obtain the individual's informed consent prior to the evaluation (see **Application for Voluntary Evaluation** and provide evaluation at a scheduled time and place within five days of the notice that the member will voluntarily receive an evaluation;
- For inpatient evaluations, the evaluation agency must complete evaluations in less than seventy-two hours of receiving notice that the member will voluntarily receive an evaluation; and
- If a behavioral health provider conducts a voluntary evaluation service as described in this chapter, the comprehensive clinical record must include:
 - A copy of the **Application for Voluntary Evaluation**;
 - A completed informed consent form; and
 - A written statement of the member's present medical condition.

When the county does not contract with the MCLTC for court-ordered evaluations MCLTC contracts with Maricopa Integrated Health Systems for inpatient Court-Ordered Evaluations and Outpatient Court-Ordered Evaluations

Court-Ordered Treatment Following Civil Proceedings under A.R.S. Title 36

Based on the court-ordered evaluation, the evaluating agency may petition for court-ordered treatment. The behavioral health provider must follow these procedures:

- Upon determination that an individual is DTS, DTO, GD, or PAD, and if no alternatives to court-ordered treatment exist, the medical director of the agency that provided the court-ordered evaluation must file a petition for court-ordered treatment (see **Petition for Court-Ordered Treatment**);
- Any behavioral health provider filing a petition for court-ordered treatment must do so in consultation with the member's clinical team prior to filing the petition;
- The petition must be accompanied by the affidavits of the two physicians who conducted the examinations during the evaluation period and by the affidavit of the applicant for the evaluation (see **Affidavit** and attached addenda);

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- A copy of the petition, in cases of grave disability, must be mailed to the public fiduciary in the county of the patient's residence, or the county in which the patient was found before evaluation, and to any member nominated as guardian or conservator; and
- A copy of all petitions must be mailed to the superintendent of the Arizona State Hospital.

For MCLTC members who are already under Court Ordered Treatment under A.R.S. Title 36, MCLTC is responsible for tracking the status of the member's treatment and reports to the Mental Health Court as necessary. As such, treating providers must notify MCLTC of any treatments.

Responsibility of the Outpatient Agency Appointed to Supervise and Administer the Court Order for Treatment

The Outpatient Agency will schedule members on COT to see a Behavioral Health Medical Professional (BMHP) at least once every 30 days. If a member does not attend a scheduled appointment, the clinical team will attempt to locate the member and re-schedule the appointment within one (1) business day. If the member cannot be engaged, then clinical team will discuss options for engagement and options for amending the COT in order to bring the member to inpatient or sub-acute facility for assessment.

Members placed on COT after finding of Not Competent/Not Restorable in a Criminal Matter (Rule 11 COT)

Members placed on COT after having been found not competent and not restorable (Rule 11) require special treatment and tracking by the Outpatient Agency. ARS §36-544 requires the Outpatient Agency to file a notice with the court and prosecuting attorney within five (5) days of a members unauthorized absence from treatment and request the court toll (suspend) the treatment order for the period of time the patient is absent. "Unauthorized absence" means:

- The member is absent from an inpatient treatment facility without authorization; or
- The member is no longer living in a placement or residence specified by the treatment plan and has left without authorization; or
- The member left or failed to return **to the county or state without authorization.**

Additionally, the statute requires the Outpatient Agency to:

- Use information and other resources available to the agency to facilitate efforts to locate and return the patient to treatment.
- File a status report every sixty (60) days specifying the information and resources used to facilitate the member's return to treatment; and
- Notify the court of the patient's return to treatment.

After 180 days, the Outpatient Agency may petition the court to terminate the order for treatment. The court may either terminate the treatment order or require additional outreach.

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If a Notice of Noncompliance appears in the Court Order for Treatment or Minute Entry, the Outpatient Agency must report any noncompliance with the treatment order.

If the medical director intends to release a patient from a Rule 11 COT prior to the expiration of the COT, he/she must provide at least a ten (10) day notice to the court, prosecuting attorney, and any relative or victim of the patient who filed a demand for notice.

If the medical director decides not to renew a Rule 11 COT or the Application for Renewal was not filed on time, at least a ten (10) day notice of the pending expiration date of COT shall be provided to the court and prosecuting agency.

Judicial Review and COT Renewal Timelines/Forms

Judicial Review

Pursuant to ARS§36-546 each member Court Ordered Treatment must be provided with a Notice of the Right to Judicial Review 60 days after the start of COT and every 60 days thereafter. Any member of the clinical team can provide this notice and must document in a progress note the date and time notice was provided. The notice of right to judicial review can be completed verbally and/or with a form developed by the provider for this purpose. If the member does request Judicial Review, below is the timeline and paperwork that will need to be submitted:

- Member signs request for Judicial Review which is then signed by a member of the clinical team and notarized. The member does not need to make this request in person. Request for Judicial Review can be made on the phone and staff person receiving the phone call will complete the Request for Judicial Review form on behalf of the member and note that the request was made by phone on the form and also in a progress note in the medical record.
- The Psychiatric Report for Judicial Review must be completed by a psychiatrist signed and notarized, and filed with the court within 72 hours (not including weekends or court holidays) of the request for judicial review (please also note that the date of the MD signature MUST match the date of the notarization or it will be rejected).
- The original Request for Judicial Review and Psychiatric Report for Judicial Review must be filed with the court within 72 hours of the Request for Judicial Review.
- If the court orders a full hearing for the Judicial Review the medical director of the treating agency shall provide the member's attorney with a copy of the member's medical records at least 24hr prior to the hearing.

Application for COT Renewal

All renewal paperwork must be submitted to the provider agency court coordinator **NO LATER** than 45 days prior to the expiration of COT. If the Final Status Report states that renewal is requested, the following paperwork will need to be submitted:

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- A Final Status Report stating that renewal is requested and can be signed by a psychiatrist or Nurse Practitioner.
- Psychiatric Report for Annual Review of COT must be completed by a psychiatrist, signed and notarized (please note that the date of the psychiatrist's signature MUST match the date of the notarization or it will be rejected).
- **ORIGINAL** Psychiatric Report for Annual Review of COT must be delivered to the provider agency court coordinator as copies cannot be filed with the court.
- Two witness statements for those who will be attending a hearing if one should be set. (The witness statements aren't notarized so these can be scanned and emailed, preferably at the same time.)

**Please note that both psych reports must be completed by a MD. A NP or PA CANNOT complete these, nor is co-signing permitted.*

Members who are Title XIX/XXI Eligible and/or Determined to have Serious Mental Illness (SMI)

When a member referred for court-ordered treatment is Title XIX/XXI eligible and/or determined or suspected to have a Serious Mental Illness, MCLTC will:

- Conduct an evaluation to determine if the member has a Serious Mental Illness in accordance with **MCLTC Chapter 4 – Behavioral Health, Section 4.15 – SMI Eligibility Determination**, and conduct a behavioral health assessment to identify the member's service needs in conjunction with the member's clinical team; and
- Provide necessary court-ordered treatment and other covered behavioral health services in accordance with the member
- Member's needs, as determined by the member's clinical team, the behavioral health member, family members, and other involved parties and
- Perform, either directly or by contract, all treatment required by A.R.S. Title 36, Chapter 5, Article 5 and 9 A.A.C. 21, Article 5.

Transfer from one behavioral health provider to another

A member ordered by the court to undergo treatment can be transferred from one behavioral health provider to another behavioral health provider if:

- The member does not have a court appointed guardian;
- The medical director of the receiving behavioral health provider accepts the transfer; and
- The consent of the court for the transfer is obtained as necessary.
- In order to coordinate a transfer of a member under court-ordered treatment to ALTCS or another RBHA, the behavioral health member's clinical team will coordinate with the MCLTC Court Advocacy Department at contractingdepartment@MercyCareAZ.org.
- In order to coordinate a transfer of a member under COT from one SMI Clinic to

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another, the behavioral health member's current psychiatrist will discuss the transfer with the receiving psychiatrists. If both SMI Clinics agree that the transfer is appropriate, the receiving psychiatrist will then provide a Letter of Intent to Treat to the SMI Clinic Court Coordinator of the sending SMI Clinic. The SMI Clinic Court Coordinator will then prepare a motion to transfer treatment provider, review with SMI Clinic attorney, and file with the court. The member's care will not be transitioned to the receiving SMI Clinic until the new treatment provider is reflected on the COT.

Court-Ordered Treatment for Members Charged with or Convicted of a Crime

MCLTC providers may be responsible for providing evaluation and/or treatment services when an individual has been ordered by a court due to:

- Conviction of a domestic violence offense; or
- Upon being charged with a crime when it is determined that the individual is court ordered to treatment, or programs, as a result of being charged with a crime and appears to be an "alcoholic."

Domestic Violence Offender Treatment

Domestic violence offender treatment may be ordered by a court when an individual is convicted of a misdemeanor domestic violence offense. Although the order may indicate that the domestic violence (DV) offender treatment is the financial responsibility of the offender under **A.R.S. §13-3601.01**, MCLTC will cover DV services with Title XIX/XXI funds when the member is Title XIX/XXI eligible, the service is medically necessary, required prior authorization is obtained if necessary, and/or the service is provided by an in-network provider. For Non-TXIX/XXI eligible member's court ordered for DV treatment, the individual can be billed for the DV services.

Court-ordered substance abuse evaluation and treatment

Substance abuse evaluation and/or treatment (i.e., DUI services) ordered by a court under **A.R.S. §36-2027** is the financial responsibility of the county, city, town or charter city whose court issued the order for evaluation and/or treatment. Accordingly, if MCLTC receives a claim for such services, the claim will be denied with instructions to the provider to bill the responsible county, city or town.

Court-Ordered Treatment for American Indian Tribal Members in Arizona

Arizona tribes are sovereign nations, and tribal courts have jurisdiction over their members residing on reservation. Tribal court jurisdiction, however, does not extend to tribal members residing off the reservation or to state court ordered evaluation or treatment ordered because of a behavioral health crisis occurring off reservation.

Although some Arizona tribes have adopted procedures in their tribal codes, which are similar to Arizona law for court ordered evaluation and treatment, each tribe has its own laws which must be followed for the tribal court process. Tribal court ordered treatment for American

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Indian tribal members in Arizona is initiated by tribal behavioral health staff, the tribal prosecutor or other member authorized under tribal laws. In accordance with tribal codes, tribal members who may be a danger to themselves or others and in need of treatment due to a mental health disorder are evaluated and recommendations are provided to the tribal judge for a determination of whether court ordered treatment is necessary. Tribal court orders specify the type of treatment needed.

Additional information on the history of the tribal court process, legal documents and forms as well as contact information for the tribes, MCLTC liaison(s), and tribal court representatives can be found on the AHCCCS web page titled, [Tribal Court Procedures for Involuntary Commitment - Information Center](#).

Since many tribes do not have treatment facilities on reservation to provide the treatment ordered by the tribal court, tribes may need to secure treatment off reservation for tribal members. To secure court ordered treatment off reservation, the court order must be “recognized” or transferred to the jurisdiction of the state.

The process for establishing a tribal court order for treatment under the jurisdiction of the state is a process of recognition, or “domestication” of the tribal court order (see **A.R.S. §12-136**). Once this process occurs, the state recognized tribal court order is enforceable off reservation. The state recognition process is not a rehearing of the facts or findings of the tribal court. Treatment facilities, including the Arizona State Hospital, must provide treatment, as identified by the tribe and recognized by the state. [A.R.S. §12-136 Domestication or Recognition of Tribal Court Order](#) is a flow chart demonstrating the communication between tribal and state entities.

MCLTC providers must comply with state recognized tribal court orders for Title XIX/XXI and Non-Title XIX SMI members. When tribal providers are also involved in the care and treatment of court ordered tribal members, Mercy and its providers must involve tribal providers to ensure the coordination and continuity of care of the members for the duration of court ordered treatment and when members are transitioned to services on the reservation, as applicable.

This process must run concurrently with the tribal staff’s initiation of the tribal court ordered process in an effort to communicate and ensure clinical coordination with the MCLTC. This clinical communication and coordination with the MCLTC is necessary to assure continuity of care and to avoid delays in admission to an appropriate facility for treatment upon state/county court recognition of the tribal court order. The Arizona State Hospital should be the last placement alternative considered and used in this process

A.R.S. §36-540(B) states, “The Court shall consider all available and appropriate alternatives for the treatment and care of the patient. The Court shall order the least restrictive treatment alternative available.” MCLTC will partner with American Indian tribes and tribal courts in their

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geographic service areas to collaborate in finding appropriate treatment settings for American Indians in need of behavioral health services.

Due to the options American Indians have regarding their health care, including behavioral health services, payment of behavioral health services for AHCCCS eligible American Indians may be covered through a T/RBHA, RBHA or IHS/638 provider (see [Behavioral Health Services Payment Responsibilities](#) on the [AHCCCS Tribal Court Procedures for Involuntary Commitment](#) web page for a diagram of these different payment structures).

4.15 – SMI Eligibility Determination

General Requirements

This chapter applies to:

- Members who are referred for, request or have been determined to need an eligibility determination for Serious Mental Illness (SMI);
- Members who are enrolled as a member determined to have a SMI for whom a review of the determination is indicated; and
- MCLTC, subcontracted providers and the MCLTC designee.

A qualified assessor must complete all SMI evaluations. If the qualified assessor is a Behavioral Health Technician the evaluation must be reviewed, approved, and signed by a Behavioral Health Professional.

All members must be evaluated for SMI eligibility by a qualified assessor, and have an SMI eligibility determination made by the Crisis Response Network, if the member:

- Requests an SMI determination;
- A guardian/legal representative who is authorized to consent to inpatient treatment makes a request on behalf of the member;
- An Arizona Superior Court issues an order instructing that a member is to undergo a SMI evaluation/determination; or
- Has both a qualifying SMI diagnosis and functional impairment because of the qualifying diagnosis.

The SMI eligibility determination record must include all of the documentation that was considered during the review including, but not limited to current and/or historical treatment records. The record may be maintained in either hardcopy or electronic format. MCLTC will develop and make available to providers any requirements or guidance on SMI eligibility determination record location and/or maintenance.

Computation of time is as follows:

- Evaluation date with a qualified clinician = day zero (0), regardless of time of the evaluation.

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- Determination due date = Three (3) business days from day zero (0), excluding weekends and holiday.
- The final determination is required three (3) business days from day 0, not 3 business days from the date of submission to MCLTC or designee. Providers that contract with MCLTC must submit the SMI evaluation to the designees as soon as practicable, but no later than 11:59 p.m. on the next business day following the evaluation. **MCLTC or designee will have at least two (2) business days to complete the SMI determination.**

Completion Process of Initial SMI Eligibility Determination

Upon receipt of a referral for, a request, or identification of the need for an SMI determination, the behavioral health provider or designated Department of Corrections' staff member will schedule an appointment for an initial meeting with the member and a qualified assessor. This shall occur no later than 7 days after receiving the request or referral.

During the initial meeting with the member by a qualified assessor, the assessor must:

- Make a clinical assessment whether the member is competent enough to participate in an assessment;
- Obtain general consent from the member or, if applicable, the member's guardian to conduct an assessment; and
- Provide to the member and, if applicable, the member's guardian, the information required in **R9-21-301(D) (2)**, a client rights brochure, and the appeal notice required by **R9-21- 401(B)**.

If during the initial meeting with the member the assessor is unable to obtain sufficient information to determine whether the applicant is SMI, the assessor must:

- Request the additional information in order to make a determination of whether the member is SMI and obtain an authorization for the release of information, if applicable
- Initiate an assessment including completion of the [AHCCCS Medical Policy Manual 320-P Serious Mental Illness Determination](#).

Criteria for SMI Eligibility Determination

The determination of SMI requires both a qualifying SMI diagnosis and functional impairment as a result of the qualifying diagnosis.

Functional Criteria for SMI Determination

To meet the functional criteria for SMI, a member must have, as a result of a qualifying SMI diagnosis, dysfunction in at least one of the following four domains, as described below, for most of the past twelve months or for most of the past six months with an expected continued duration of at least six months:

- **Inability to live in an independent or family setting without supervision** – Neglect or disruption of ability to attend to basic needs. Needs assistance in caring for self. Unable to care for self in safe or sanitary manner. Housing, food and clothing must be provided

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or arranged for by others. Unable to attend to the majority of basic needs of hygiene, grooming, nutrition, medical and dental care. Unwilling to seek prenatal care or necessary medical/dental care for serious medical or dental conditions. Refuses treatment for life threatening illnesses because of behavioral health disorder.

- **A risk of serious harm to self or others** – Seriously disruptive to family and/or community. Pervasively or imminently dangerous to self or others' bodily safety. Regularly engages in assaultive behavior. Has been arrested, incarcerated, hospitalized or at risk of confinement because of dangerous behavior. Persistently neglectful or abusive towards others in the member's care. Severe disruption of daily life due to frequent thoughts of death, suicide, or self-harm, often with behavioral intent and/or plan. Affective disruption causes significant damage to the member's education, livelihood, career, or personal relationships.
- **Dysfunction in role performance** – Frequently disruptive or in trouble at work or at school. Frequently terminated from work or suspended/expelled from school. Major disruption of role functioning. Requires structured or supervised work or school setting. Performance significantly below expectation for cognitive/developmental level. Unable to work, attend school, or meet other developmentally appropriate responsibilities; or
- **Risk of Deterioration** – A qualifying diagnosis with probable chronic, relapsing and remitting course. Co-morbidities (like mental retardation, substance dependence, personality disorders, etc.). Persistent or chronic factors such as social isolation, poverty, extreme chronic stressors (life-threatening or debilitating medical illnesses, victimization, etc.). Other (past psychiatric history; gains in functioning have not solidified or are a result of current compliance only; court-committed; care is complicated and requires multiple providers; etc.).

The following reasons shall not be sufficient in and of themselves for denial of SMI eligibility:

- An inability to obtain existing records or information
- Lack of a face-to-face psychiatric or psychological evaluation

Member with Co-occurring Substance Abuse

For members who have a qualifying SMI diagnosis and co-occurring substance abuse, for purposes of SMI determination, presumption of functional impairment is as follows:

- For psychotic diagnoses (bipolar I disorder with psychotic features, delusional disorder, major depression, recurrent, severe, with psychotic features, schizophrenia, schizoaffective disorder and psychotic disorder NOS) functional impairment is presumed to be due to the qualifying psychiatric diagnosis;
- For other major mental disorders (bipolar disorders, major depression and obsessive compulsive disorder), functional impairment is presumed to be due to the psychiatric diagnosis, unless:
 - The severity, frequency, duration or characteristics of symptoms contributing to the functional impairment cannot be attributed to the qualifying mental health diagnosis; or

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- The assessor can demonstrate, based on a historical or prospective period of treatment, that the functional impairment is present only when the member is abusing substances or experiencing symptoms of withdrawal from substances.
- For all other mental disorders not covered above, functional impairment is presumed to be due to the co-occurring substance use unless:
 - The symptoms contributing to the functional impairment cannot be attributed to the substance abuse disorder; or
 - The functional impairment is present during a period of cessation of the co-occurring substance use of at least thirty (30) days; or
 - The functional impairment is present during a period of at least ninety (90) days of reduced use unlikely to cause the symptoms or level of dysfunction.

SMI Eligibility Determination for Inmates in the Department of Corrections (DOC)

An SMI eligibility designation/determination is done for purposes of determining eligibility for community-based behavioral health services. The Arizona Department of Health Services recognizes the importance of evaluating and determining the SMI eligibility for inmates in the Department of Corrections (DOC) with impending release dates in order to appropriately coordinate care between the DOC and the community based behavioral health system. Inmates of DOC **pending release within 6 months**, who have been screened or appear to meet the diagnostic and functional criteria, **will now be permitted to be referred** for an SMI eligibility evaluation and determination. Inmates of DOC whose release date exceeds 6 months are not eligible to be referred for an SMI eligibility evaluation and determination.

SMI Eligibility Determination for Children Transitioning into the Adult System

When the adolescent reaches the **age of 17.5** and the Child and Family Team (CFT) believes that the youth may meet eligibility criteria as an adult with a Serious Mental Illness (SMI), the T/RBHA and their subcontracted providers must ensure the young adult receives an eligibility determination as outlined in the [**AHCCCS Medical Policy Manual 320-P Serious Mental Illness Determination.**](#)

If the youth is determined eligible, or likely to be determined eligible for services as a member with a Serious Mental Illness, the adult behavioral health services care manager is then contacted to join the CFT and participate in the transition planning process. **After obtaining permission from the parent/guardian, it is the responsibility of the children's behavioral health service provider to contact and invite the adult behavioral health services care manager to upcoming planning meetings.** Additionally, the children's provider must track and report the following information to MCLTC, CFT transition date (date the adult and children's provider attended a CFT) and adult intake date. When more than one T/RBHA and/or behavioral health service provider agency is involved, the responsibility for collaboration lies with the agency that is directly responsible for service planning and delivery.

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If the young adult is not eligible for services as a member with a Serious Mental Illness, it is the responsibility of the children's behavioral health provider, through the CFT, to coordinate transition planning with the adult GMH/SA provider. The importance of securing representation from the adult service provider in this process cannot be overstated, regardless of the member's identified behavioral health category assignment (SMI, General Mental Health, Substance Abuse). The children's behavioral health provider should be persistent in its efforts to make this occur.

For additional guidance regarding the Transition to Adulthood Process for youth determined SMI prior to turning 18, see [AHCCCS Clinical Guidance Tool Transition to Adulthood Practice Protocol](#).

Completion Process of Final SMI Eligibility Determination

The licensed psychiatrist, psychologist, or nurse practitioner designated by Crisis Response Network must make a final determination as to whether the member meets the eligibility requirements for SMI status based on:

- A face-to-face assessment or reviewing a face-to-face assessment by a qualified assessor
- A review of current and historical information, if any, obtained orally or in writing by the assessor from collateral sources, and/or present or previous treating clinicians

The following must occur if the designated reviewing psychiatrist, psychologist, or nurse practitioner has not conducted a face-to-face assessment and has a disagreement with the current evaluating or treating qualified behavioral health professional or behavioral health technician (that cannot be resolved by oral or written communication):

- **Disagreement regarding diagnosis:** Determination that the member does not meet eligibility requirements for SMI status must be based on a face to face diagnostic evaluation conducted by a designated psychiatrist, psychologist, or nurse practitioner. The resolution of (specific reasons for) the disagreement shall be documented in the member's comprehensive clinical record.
- **Disagreement regarding functional impairment:** Determination that the member does not meet eligibility requirements must be based upon a face-to-face functional evaluation conducted by a designated psychiatrist, psychologist, or nurse practitioner. The psychiatrist, psychologist, or nurse practitioner shall document the specific reason(s) for the disagreement in the member's comprehensive clinical record.

If there is sufficient information to determine SMI eligibility, the member shall be provided written notice of the SMI eligibility determination within three (3) business days of the initial meeting with the qualified assessor.

Issues Preventing Timely Completion of SMI Eligibility Determination

The time to initiate or complete the SMI eligibility determination may be extended no more than 20 days if the member agrees to the extension and:

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- There is substantial difficulty in scheduling a meeting at which all necessary participants can attend
- The member fails to keep an appointment for assessment, evaluation or any other necessary meeting
- The member is capable of, but temporarily refuses to cooperate in the preparation of the completion of an assessment or evaluation
- The member or the member's guardian and/or designated representative requests an extension of time
- Additional documentation has been requested, but has not yet been received
- There is insufficient functional or diagnostic information^{1F1} to determine SMI eligibility within the required time periods.

Crisis Response Network

Crisis Response Network must:

- Document the reasons for the delay in the member's eligibility determination record when there is an administrative or other emergency that will delay the determination of SMI status
- Not use the delay as a waiting period before determining SMI status or as a reason for determining that the member does not meet the criteria for SMI eligibility (because the determination was not made within the time standards).

Situations in which Extension is due to Insufficient Information

- The Crisis Response Network shall request and obtain the additional documentation needed e.g., current and/or past medical records) and/or perform or obtain any necessary psychiatric or psychological evaluations
- The designated reviewing psychiatrist, psychologist, or nurse practitioner must communicate with the member's current treating clinician, if any, prior to the determination of SMI, if there is insufficient information to determine the member's level of functioning
- SMI eligibility must be determined within three days of obtaining sufficient information, but no later than the end date of the extension

If the member refuses to grant an extension, SMI eligibility must be determined based on the available information. If SMI eligibility is denied, the member will be notified of his/her appeal rights and the option to reapply).

¹ Insufficient diagnostic information shall be understood to mean that the information available to the reviewer is suggestive of two or more equally likely working diagnoses, only one of which qualifies as SMI, and an additional piece of existing historical information or a face-to-face psychiatric evaluation is likely to support one diagnosis more than the other(s).

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If the evaluation or information cannot be obtained within the required time period because of the need for a period of observation or abstinence from substance use in order to establish a qualifying mental health diagnosis, the member shall be notified that the determination may, with the agreement of the member, be extended for up to 90 (calendar) days.

Notification of SMI Eligibility Determination

If the eligibility determination results in approval of SMI status, the SMI status must be reported to the member in writing, including notice of his/her right to appeal the decision.

If the eligibility determination results in a denial of SMI status, the Crisis Response Network shall include in the notice above:

- The reason for denial of SMI eligibility (**Serious Mental Illness Determination**)
- The right to appeal
- The statement that Title XIX/XXI eligible members will continue to receive needed Title XIX/XXI covered services. In such cases, the member's behavioral health category assignment must be assigned based on criteria.

Re-enrollment or Transfer

If the member's status is SMI at disenrollment, or upon transfer from another T/RBHA, the member's status shall continue as SMI upon re-enrollment, opening of a new episode of care, or transfer.

Review of SMI Eligibility Determination

A review of SMI eligibility made by Crisis Response Network for individuals currently enrolled as a member with a SMI may be initiated by MCLTC or behavioral health provider:

- As part of an instituted, periodic review of all members determined to have a SMI
- When there has been a clinical assessment that supports that the member no longer meets the functional and/or diagnostic criteria
- An individual currently enrolled as a member with a SMI, or their legally authorized representative, upon their request

A review of the determination may not be requested by MCLTC or behavioral health provider within six months from the date an individual has been determined SMI eligible.

If, as a result of such review, the member is determined to no longer meet the diagnosis and functional requirements for SMI status, MCLTC must ensure that:

- Services are continued depending on Title XIX/XXI eligibility, or other MCLTC service priorities.
- Written notice of the determination made on review with the right to appeal is provided to the affected member with an effective date of 30 days after the date the written notice is issued.

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Verification of SMI Eligibility Determinations

When a T/RBHA or its contracted providers are required to verify SMI Eligibility for individuals who have previously been determined SMI, but cannot locate the member's original SMI determination documentation, or when the SMI determination is outdated (more than 10 years old as required by AHCCCS for eligibility/enrollment for benefits), **Serious Mental Illness Determination Verification** must be completed.

- **The form does not replace Serious Mental Illness Determination, but enables the MCLTC and providers to “verify” a member’s current SMI eligibility.**

The form must be completed by a licensed psychiatrist, psychologist, or nurse practitioner, and then submitted to MCLTC for approval. MCLTC is responsible for monitoring and validating the forms. MCLTC must keep copies of the validated Serious Mental Illness Determination Verification form in the member's record.

SMI Decertification

There are two established methods for removing a SMI designation, one clinical and the other an administrative option, as follows:

1. SMI Clinical Decertification

- A member who has a SMI designation or a member working with an individual from the member's clinical team may request a SMI Clinical Decertification. A SMI Clinical Decertification is a determination that a member who has a SMI designation no longer meets SMI criteria. If, as a result of a review, the member is determined to no longer meet the diagnostic and/or functional requirements for SMI status:
 - The Determining Entity shall ensure that written notice of the determination and the right to appeal is provided to the affected member with an effective date of 30 days after the date the written notice is issued.
 - MCLTC must ensure that services are continued in the event an appeal is filed timely, and that services are appropriately transitioned as part of the discharge planning process.

2. SMI Administrative Decertification

- A member who has a SMI designation may request a SMI Administrative Decertification if the member has not received behavioral health services for a period of two or more years.
 - Upon receipt of a request for Administrative Decertification, MCLTC shall direct the member to contact AHCCCS DHCM Customer Service.
 - AHCCCS will evaluate the member's request and review data sources to determine the last date the member received a behavioral health service. AHCCCS will inform the member of changes that may result with the removal

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of the member's SMI designation. Based upon review, the following will occur:

- In the event the member has not received a behavioral health service within the previous two years, the member will be provided with AMPM Exhibit 320-P-3. This form must be completed by the member and returned to AHCCCS.
- In the event the review finds that the member has received behavioral health services within the prior two year period, the member will be notified that they may seek decertification of their SMI status through the Clinical Decertification process.

SMI Clinic Transfer Protocol

- Once CRN determines the SMI decertification, CRN sends an email to the SMI clinic indicating the specific member status of decertification.
- As soon as the SMI clinic receives notification that a member has completed and been approved for SMI decertification, the SMI clinic will immediately begin working with the member in order to determine where the member wants to transfer their services.
- The SMI clinic must complete appropriate coordination between a GMH/SA provider(s) or BHMP/PCP of the member's choice in order to eliminate any gaps in care for the member.
- The transferring of services from the SMI clinic to the GMH/SA provider(s) or alternative BHMP/ PCP must be completed in less than thirty (30) days from the time the SMI clinic is notified the member is determined to no longer meet SMI criteria.
- All coordination must be appropriately documented in the member's medical record.
- It is the sending provider's responsibility to gather a release of information from the member and transfer all applicable records to the receiving provider.
- If a member is not currently receiving services from an SMI clinic but is T19, the SMI clinic that the member was paneled to under the Navigator level of care is responsible for completing the transfer of the member.
- If a member does not want to transfer to a GMH/SA provider or BHMP/PCP or refuses to sign a release of information for a receiving provider, the SMI clinic will complete appropriate outreach and engagement which requires two outreach attempts.
- The SMI clinic will offer the member the opportunity to obtain their medical records (see **MC Chapter 4.0 – Provider Requirements, Section 4.16 – Member's Medical Records**) if the member declines further assistance with the transfer process.
- If the member is unable to be contacted or declines obtaining their records, the SMI clinic must retain the original or copies of the member's medical records for at least six (6) years after the last date the member receives medical or health care services from the provider (see **MC Chapter 4.0 – Provider Requirements, Section 4.16 – Member's Medical Records**).

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MCLTC Transfer Protocol

MCLTC member transition process, in coordination with Arizona Health Care Cost Containment System (AHCCCS), helps to ensure that members' healthcare continues without interruption or delay when there is a change of health plans. When an individual has been approved for SMI decertification, MCLTC, as the relinquishing Contractor, will complete and transmit the Enrollment Transition Information (ETI) form to the appropriate parties no later than 10 business days from receipt of AHCCCS notification. MCLTC's transition coordinator will also notify the receiving health plan's transition coordinator to ensure that the member's services are appropriately transferred.

Paneling of Members with SMI

All members enrolled in MCLTC and Non-Title XIX SMI eligibility plans are paneled to an Assigned Behavioral Health Clinic (ABHC). MCLTC panels newly enrolled members to an ABHC based on member preference. If member preference is unavailable, the member is paneled to an ABHC based on geographic proximity. Paneling to an ABHC is aligned to member eligibility. Members are not paneled to an ABHC during gaps in enrollment or while eligible in a plan other than Integrated or Non-Title XIX SMI.

There are numerous scenarios where members determined with SMI may be enrolled in a plan other than Integrated or Non-Title XIX SMI.

- **Native American** – Native American members have choice and may opt-out of enrollment in an integrated plan.
- **Opt-Out Request** – A member determined SMI, who is currently enrolled in a RBHA, may opt out of receiving physical health services from the RBHA and be transferred to an Acute Care Contractor for his/her physical health services if one or more of the applicable opt out criteria are satisfied. Members who meet the opt-out criteria will continue to receive behavioral health services through Mercy Maricopa.
- **Recent Determination** – There is a 14 day transitional period for a change in health plan for Medicaid members determined with SMI.

In addition to being paneled to an ABHC, members receiving services through Assertive Community Treatment (ACT) teams must be paneled to an ACT Team. MCLTC does not panel newly enrolled members to ACT teams.

SMI clinics and ACT teams are required to manage their panels through the Member Paneling tool available in Provider Intake on the Medicaid Web Portal. Panel changes submitted through the Member Paneling tool are processed nightly and loaded directly into the Mercy Maricopa provider information systems. Specific instructions on utilization of the **Provider Intake Member Paneling Tool** are available under the [Reference Material and Guides](#) of our website.

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IHH Health Homes, SMI clinics and ACT teams that fail to manage their panels are subject to corrective action, loss or reduction of incentives and sanctions.

4.16 – Reporting of Seclusion and Restraint

Definitions

Drug Used As a Restraint: Means a pharmacological restraint as used in A.R.S. §36-513 that is not standard treatment for a client's medical condition or behavioral health issue and is administered to:

- Manage the client's behavior in a way that reduces the safety risk to the client or others;
- Temporarily restrict the client's freedom of movement as defined in A.A.C. R-21-101(26).

Mechanical Restraint: Means any device, article or garment attached or adjacent to a client's body that the client cannot easily remove and that restricts the client's freedom of movement or normal access to the client's body, but does not include a device, article, or garment:

- Used for orthopedic or surgical reasons; or
- Necessary to allow a client to heal from a medical condition or to participate in a treatment program for a medical condition as defined in A.A.C. R9-21-101(44).

Personal Restraint: Means the application of physical force without the use of any device for the purpose of restricting the free movement of a client's body, but for a behavioral health agency licensed as a Level 1 RTC or a Level 1 sub-acute agency according to A.A.C. R9-10-102 does not include:

- Holding a client for no longer than 5 minutes;
- Without undue force, in order to calm or comfort the client; or
- Holding a client's hand to escort the client from area to another as defined in A.A.C. R9-21-101(50).

Seclusion: Means the involuntary confinement of a behavioral health member in a room or an area from which the member cannot leave.

Seclusion of Individuals Determined to Have a Serious Mental Illness: Means the restriction of a behavioral health member to a room or area through the use of locked doors or any other device or method which precludes a member from freely exiting the room or area or which a member reasonably believes precludes his/her unrestricted exit. In the case of an inpatient facility, the grounds of the facility, or a ward of the facility does not constitute seclusion. In the case of a community residence, restricting a behavioral health member to the residential site, according to specific provisions of an Individual Service Plan or court order, does not constitute seclusion.

Reporting to MCLTC

Licensed behavioral health facilities and programs, including out-of-state facilities, authorized to use seclusion and restraint must report each occurrence of seclusion and restraint and

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information on the debriefing subsequent to the occurrence of seclusion or restraint to MCLTC's Quality Management Department within five (5) calendar days of the occurrence. The individual reports must be submitted on the **Policy 962, Attachment A, Seclusion and Restraint Individual Reporting Form**. This form is available on MCLTC's website.

In the event that a use of seclusion or restraint requires face-to-face monitoring, a report detailing face-to-face monitoring is submitted to MCLTC's Quality Management (QM) along with the **Policy 962, Attachment A, Seclusion and Restraint Individual Reporting Form**. The face-to-face monitoring form must include the requirements as per A.A.C. R9-21-204.

Each subcontracted licensed Level 1 Behavioral Health Inpatient Facility must also report the total number of occurrences of the use of seclusion and restraint for MCLTC members that occurred in the prior month to MCLTC QM the 5th calendar day of the month. If there were no occurrences of seclusion and restraint for MCLTC members during the reporting period, the report should so indicate.

In order to maintain consistency, all seclusion and restraint reported events for MCLTC members are to be submitted via email directly to MMIC@Aetna.com or via fax to 1-855-224-4908.

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MCLTC CHAPTER 5 – DENTAL AND VISION SERVICES

5.00 - Dental Services

DentaQuest

Effective January 1, 2015, DentaQuest will administer dental benefits for MCLTC. DentaQuest has administrative oversight for the following responsibilities:

- Credentialing
- Patient Management
- Prior Authorization
- Claims
- Customer Service Calls from Providers
- Appeals

MCLTC will administer the following for our members:

- Grievances
- Customer Service Calls from Members

Claims with dates of service on or after January 1, 2015 need to be sent to DentaQuest at the following claims address:

DentaQuest of Arizona, LLC – Attention: Claims
12121 N Corp Parkway
Mequon, WI 53092

For electronic claims submissions, DentaQuest works directly with the following Clearinghouses:

Change Healthcare (888-255-7293)
Tesla (800-724-7420)
EDI Health Group (800- 576-6412)
Secure EDI (877-466-9656)
Mercury Data Exchange (866-633-1090)

You can contact your software vendor to make certain that they have DentaQuest listed as the payer and claim mailing address on your electronic claim. Your software vendor will be able to provide you with any information you may need to ensure that submitted claims are forwarded to DentaQuest. DentaQuest's Payer ID is CX014.

If you have additional questions regarding your claims for DentaQuest, you may contact them directly at 844-234-9831. They will be happy to assist you.

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You may also utilize their Interactive Voice Response (IVR) system 24 hours a day, 7 days a week that provides up-to-date information regarding member eligibility, claim status, and much more. Benefits associated with this program and more detailed information regarding DentaQuest can be found in their Office Reference Manual on-line at www.dentaquestgov.com.

Dental Screening/Dental Treatment for children under 21

More information regarding Dental Screening/Dental Treatment for children under 21 is available under the **Chapter 100 – Mercy Care Provider Manual - Chapter 5 – Early and Periodic Screening, Diagnostic and Treatment (EPSDT), under Section 5.13 – Dental Screening and Referrals.**

The following dental services/dental treatments are covered for children under age 21:

- oral health screenings
- cleanings
- fluoride treatments
- dental sealant
- oral hygiene education
- x-rays
- fillings
- extractions
- other therapeutic and medically necessary procedures
- routine dental services

Two (2) routine preventive dental visits are covered per year. Visits to the dentist must take place within six months and one day after the previous visit. The first dental visit should take place by one year of age. Members under 21 years of age do not need a referral for dental care.

Benefits covered for children under age 21 are in accordance with AHCCCS' [Exhibit 431, Attachment A - AHCCCS Dental Periodicity Table](#). Benefits are also outlined in the DentaQuest Office Manual available at www.dentaquestgov.com.

Mercy Care assigns all members under 21 years of age to a dental home. A dental home is where the member and a dentist work together to best meet dental health needs. Having a dental home builds trust between the member and the dentist. It is a place where the member can get regular, ongoing care, not just a place to go when there is a dental problem. A “dental home” may be an office or facility where all dental services are provided in one place. Members can choose or change their assigned dental provider.

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Emergency Dental Services for Members 21 Years of Age and Older

Members 21 years of age or older have a \$1,000 annual emergency dental benefit per health plan year. The annual benefit plan year runs from October 1 - September 30. A dental emergency is an acute disorder of oral health resulting in severe pain and/or infection because of pathology or trauma.

Emergency dental services* include:

- Emergency oral diagnostic examination (limited oral examination - problem focused);
- Radiographs and laboratory services limited to the symptomatic teeth;
- Composite resin due to recent tooth fracture for anterior teeth;
- Prefabricated crowns, to eliminate pain due to recent tooth fracture only;
- Recementation of clinically sound inlays, onlays, crowns, and fixed bridges;
- Pulp cap, direct or indirect plus filling;
- Root canals and vital pulpotomies when indicated for the treatment of acute infection or to eliminate pain;
- Apicoectomy performed as a separate procedure, for treatment of acute infection or to eliminate pain, with favorable prognosis;
- Immediate and palliative procedures, including extractions if medically necessary, for relief of pain associated with an oral or maxillofacial condition;
- Tooth reimplantation of accidentally avulsed or displaced anterior tooth, with favorable prognosis;
- Temporary restoration which provides palliative/sedative care (limited to the tooth receiving emergency treatment);
- Initial treatment for acute infection, including, but not limited to, periapical and periodontal infections and abscesses by appropriate methods;
- Preoperative procedures and anesthesia appropriate for optimal patient management; and
- Cast crowns limited to the restoration of root canal treated teeth only.

*Emergency dental services do not require prior authorization.

Dental services that are **not** covered:

- Diagnosis and treatment of TMJ - except to reduce trauma
- Maxillofacial dental services that are not needed to reduce trauma
- Routine restorative procedures and routine root canal therapy
- Bridgework to replace missing teeth
- Dentures

Covered dental services not subject to the \$1,000 emergency dental limit include:

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- Extraction of teeth in preparation for radiation treatment of cancer of the jaw, neck or head.
- Members who require medically necessary dental services before getting a covered organ or issue transplant**:
 - Treatment for oral infections
 - Treatment of oral disease, including dental cleanings, treatment of periodontal disease, medically necessary extractions and simple restorations.

**These services are covered only after a transplant evaluation determines that the member is a candidate for organ or tissue transplantation.

Anesthesia related to the emergency dental services also falls under the annual \$1,000 benefit.

Emergency dental codes are covered only if they meet the criteria of emergent treatment per AHCCCS policy. For additional detail regarding this benefit, we are including the following links to the AHCCCS Medical Policy Manual:

- [Dental Services for Members 21 Years of Age and Older](#)
- [Arizona Long Term Care System Adult Dental Services](#)

The list of codes that are included in the dental emergency benefit are below:

D0140	D2390	D2933	D3347	D7250	D7440	D7560
D0191	D2740	D2940	D3348	D7251	D7441	D7970
D0220	D2750	D2950	D3410	D7260	D7450	D7971
D0230	D2751	D2952	D3421	D7261	D7451	D7972
D0270	D2752	D2954	D3425	D7270	D7460	D7980
D0272	D2790	D3110	D3426	D7285	D7461	D7981
D0273	D2791	D3120	D3430	D7286	D7465	D7982
D0274	D2792	D3220	D7111	D7310	D7510	D7983
D0277	D2794	D3221	D7140	D7311	D7511	D7999
D0330	D2910	D3310	D7210	D7320	D7520	D9223
D2330	D2915	D3320	D7220	D7321	D7521	D9230
D2331	D2920	D3330	D7230	D7410	D7530	D9243
D2332	D2931	D3331	D7240	D7411	D7540	D9248
D2335	D2932	D3346	D7241	D7415	D7550	

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Informed Consent

Informed consent is a process by which the provider advises the recipient/recipient's representative of the diagnosis, proposed treatment and alternate treatment methods with associated risks and benefits of each, as well as the associated risks and benefits of not receiving treatment.

Informed consents for oral health treatment include:

- A written consent for examination and/or any preventative treatment measure, which does not include an irreversible procedure, as mentioned below. This consent is completed at the time of initial examination and is updated at each subsequent six-month follow-up appointment.
- A separate written consent for any irreversible invasive procedure, including but not limited to, dental fillings, pulpotomy, etc. In addition, a written treatment plan must be reviewed and signed by both parties, as described below, with the member/member's representative receiving copy of the complete treatment plan.

All providers will complete the appropriate informed consents and treatment plans for AHCCCS members as listed above to provide quality and consistent care, in a manner that protects and is easily understood by the member and/or member's representative.

This requirement extends to all mobile unit providers. Consents and treatment plans must be in writing and signed/dated by both the provider and the patient or patient's representative. Completed consents and treatment plans must be maintained in the member's chart and subject to audit.

Notification Requirements for Charges to Members

Providers will provide medically necessary services within the \$1,000.00 allowable amount. If medically necessary services are greater than \$1,000.00, the provider may perform the services after the following notifications take place.

In accordance with A.A.C. R9-22-702 (Charges to Members), the provider must inform/explain to the member both verbally and in writing in the member's primary language, that the dental service requested is not covered and exceeds the \$1,000.00 limit. If the member agrees to pursue the receipt of services:

- The provider must supply the member a document describing the service and the anticipated cost of the service.
- Prior to service delivery, the member must sign and date a document indicating that he/she understands that he/she will be responsible for the cost of the service to the extent that it exceeded the \$1,000.00 limit.

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Billing for MCLTC Dental Services

Dentists will bill on the ADA form with the dental service codes and submit all claims to DentaQuest.

Dental claims need to be submitted to:

DentaQuest of Arizona, LLC. – Attention: Claims
P.O. Box 2906
Milwaukee, WI 53201-2906

Billing for Medical Services

- Physicians performing general anesthesia will bill on the CMS 1500 form with the appropriate CPT/HCPCS codes.
- Ambulatory Surgical Centers will bill on the CMS 1500 form with the appropriate CPT/HCPCS codes and modifiers.
- Outpatient facility surgical services will be billed on the UB-04 with appropriate revenue codes and CPT/HCPCS codes.

Medical claims need to be submitted to:

Mercy Care Long Term Care
Claims Department
P.O. Box 52089
Phoenix, AZ 85072-2089

5.01 - Vision Services

Vision Overview

MCLTC covers eye and optometric services provided by qualified eye/optometry professionals within certain limits based on member age and eligibility:

- Emergency eye care, which meets the definition of an emergency medical condition, is covered for all members.
- For members who are 21 years of age or older, treatment of medical conditions of the eye, excluding eye examinations for prescriptive lenses and the provision of prescriptive lenses, are covered.
- Vision examinations and the provision of prescriptive lenses are covered for members under the EPSDT, KidsCare program and for adults when medically necessary following cataract removal.
- Cataract removal is covered for all eligible members under certain conditions. For more information, please review the **AHCCCS Medical Policy Manual, Chapter 300**.

Coverage for Children (Under Age 21)

- Medically necessary emergency eye care, vision examinations, prescriptive lenses and treatments for conditions of the eye.

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- PCPs are required to provide initial vision screening in their office as part of the EPSDT program.
- Members under age 21 with vision screening of 20/60 or greater should be referred to the Nationwide for further examination and possible provision of glasses.
- Replacement of lost or broken glasses is a covered benefit.
- Contact lenses are not a covered benefit.

Nationwide Referral Instructions

Nationwide is MCLTC's contracted vendor for all vision services, including diabetic retinopathy exams. Members requiring vision services should be referred by their PCP's office to a Nationwide provider listed on MCLTC's website. The member may call Nationwide directly to schedule an appointment.

Coverage for Adults (21 years and older)

- Emergency care for eye conditions when the eye condition meets the definition of an emergency medical condition; for cataract removal and/or medically necessary vision examinations; and for prescriptive lenses if required following cataract removal.
- Routine eye exams and glasses are not a covered service for adults.
- Adults 21 years of age and older should only be referred to a contracted ophthalmologist for the diagnosis and treatment of eye disease.

Vision Community Resources for Adults

AHCCCS benefits do not include routine dental and vision services for adults. However, there are community resources available to help members obtain routine dental and vision care. For more information, call MCLTC's Member Services at 602-263-3000 or 800-624-3879 (toll-free).

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MCLTC CHAPTER 6 – GRIEVANCES, APPEALS AND CLAIM DISPUTES

6.00 - Grievances

MCLTC's Grievance System includes a process for enrollee grievances, enrollee appeals, provider claim disputes and access to the State Fair Hearing system.

A Grievance is described as any written or verbal expression of dissatisfaction over anything that does not involve appealing a decision, such as a denial or discontinuance of services or benefits. Grievances may be filed by a member or provider authorized in writing to act on the member's behalf. A grievance may be submitted orally or in writing to any MCLTC staff person. Grievances include, but are not limited to, issues regarding:

- Quality of care or services
- Accessibility or availability of services
- Interpersonal relationships (e.g. rudeness of a provider or employee, cultural barriers or insensitivity)
- Claims or billing
- Failure to respect a member's rights

To file a grievance, members and/or providers filing on behalf of a member, should contact Member Services by phone at 602-263-3000, Toll -Free at 800-634-3879, or in writing at:

Mercy Care
Member Services Department
4755 S. 44th Place
Phoenix, AZ 85040

MCLTC will respond and resolve member grievances at the time of the initial call, if possible, or within 90 days if further investigation is needed. If resolution to the grievance is not favorable to the member or representative, MCLTC will also provide written information to both members and providers, regarding the Grievance and Appeal System requirements. This includes:

- The right to a state fair hearing, the method for obtaining a state fair hearing
- The Rules that govern representation at the hearing
- The right to file grievances, appeals and claim disputes
- The requirements and timeframes for filing grievances, appeals and claims disputes
- The availability of assistance in the filing process, the toll-free numbers that the member can use to file a grievance or appeal by phone
- That benefits will continue when required by the member in an appeal or a state fair hearing request concerning certain actions which are timely filed

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- That the member may be required to pay the cost of services furnished during the appeal/hearing process if the final decision is averse to the member, and
- That a provider may file an appeal on behalf of a member with the member's written consent

If the grievance involves a quality of care concern, it will be forwarded to MCLTC's Quality Management Department for further review. The concern will be investigated, and the member and/or the member's representative will be notified in writing within 90 days of the results of the investigation.

6.01 - Provider Claim Disputes

A claim dispute is a dispute involving the payment of a claim, denial of a claim, imposition of a sanction or reinsurance. A provider may file a claim dispute based on:

- Claim Denial
- Recoupment
- Dissatisfaction with Claims Payment

Before a provider initiates a claims dispute, the following needs to occur:

- The claim dispute process should only be used after other attempts to resolve the matter have failed.
- The provider should contact MCLTC Claims and/or Provider Relations to seek additional information prior to initiating a claim dispute.
- The provider must follow all applicable laws, policies and contractual requirements when filing.
- According to the Arizona Revised Statute, Arizona Administrative Code and AHCCCS guidelines, all claim disputes related to a claim for system covered services must be filed in writing and received by the administration or the prepaid capitated provider or program contractor:
 - Within 12 months after the date of service.
 - Within 12 months after the date that eligibility is posted.
 - Or within 60 days after the date of the denial of a timely claim submission, whichever is later.

You may submit your claim dispute in writing through the mail or send electronically to us through fax. Not only do we now have the ability to receive disputes by fax, but we can also respond back to our providers via fax, allowing you to receive faster decisions. If you choose to send via fax, please fax your disputes to **602- 351-2000**.

Written claim disputes must be submitted to the MCLTC Appeals Department. Please include all supporting documentation with the initial claim dispute submission. The claim dispute must specifically state the factual and legal basis for the relief requested, along with copies of any

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supporting documentation, such as remittance advice(s), medical records or claims. Failure to specifically state the factual and legal basis may result in denial of the claim dispute.

MCLTC will acknowledge a claim dispute request within five (5) business days after receipt. If a provider does not receive an acknowledgement letter within five (5) business days, the provider must contact the Appeals Department. Once received, the claim dispute will be reviewed, and a decision will be rendered within 30 days after receipt. MCLTC may request an extension of up to 45 days, if necessary. If you are submitting via mail, the claim dispute, including all supporting documentation, should be sent to:

Mercy Care
Appeals Department
4755 S. 44th Place
Phoenix, AZ 85040

If a provider disagrees with the MCLTC Notice of Decision, the provider may request a State Fair Hearing. The request for State Fair Hearing must be filed in writing no later than 30 days after receipt of the Notice of Decision. Please clearly state "State Fair Hearing Request" on your correspondence. All State Fair Hearing Requests must be sent in writing to the follow address:

Mercy Care
Appeals Department
Attention: Hearing Coordinator
4755 S. 44th Place
Phoenix, AZ 85040
602-351-2300 (fax)

6.02 - Appeals

An appeal is a request for review of an action by an enrollee (member) or their authorized representative, such as a provider. An appeal can be filed for various reasons including the denial or limited authorization of a requested service, the type or level of service, or for the reduction, suspension or termination of a previously authorized service. An authorized representative acting on behalf of the member, with the member's written consent, may file an appeal or request a State Fair Hearing on behalf of a member.

Standard Appeals - An appeal must be filed either orally or in writing with MCLTC within 60 days after the date of the Notice of Adverse Benefit Determination. A provider may assist a member in filing an appeal. MCLTC does not restrict or prohibit a provider from advocating on behalf of a member.

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Standard Appeal Resolution - MCLTC will resolve the appeal and mail the written Notice of Appeal Resolution to the member within 30 days after the day MCLTC receives the appeal.

Expedited Appeals - If a provider believes that the time for a standard resolution appeal could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function, the provider can submit a request for an Expedited Appeal, with the member's written consent, along with supporting documentation to MCLTC. MCLTC will acknowledge an expedited appeal within one working day of receipt.

Expedited Appeal Resolution

MCLTC will resolve the appeal and mail a written Notice of Appeal Resolution to the member within 3 working days after MCLTC receives the Expedited Appeal. MCLTC will also make reasonable efforts to provide prompt oral notification to the member. This timeframe may be extended if MCLTC needs additional information and the extension is in the best interest of the member. If the request for an Expedited Appeal is denied, MCLTC will decide the appeal within the standard timeframe (30 days from the day MCLTC receives the Expedited Appeal).

Each appeal should be filed separately. To file an appeal, please submit in writing, along with all substantiating documentation to:

Mercy Care
Appeals Department
4755 S. 44th Place
Phoenix, AZ 85040
602-351-2300 (FAX)

A member may also file an Appeal orally by contacting:

Mercy Care
Appeals Department
Phone: 602-453-6098
Toll Free: 800-624-3879

An authorized representative, including a provider, acting on behalf of the member, with the member's written consent, may request a State Fair Hearing on behalf of the member. The request for State Fair Hearing must be in writing, submitted to and received by MCLTC, no later than 30 days after the date the member receives the Notice of Appeal Resolution.

All State Fair Hearing Requests must be sent in writing to the follow address:

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Mercy Care
Appeals Department
Attention: Hearing Coordinator
4755 S. 44th Place
Phoenix, AZ 85040
602-351-2300 (fax)



Mercy Care RBHA



Visit: www.MercyCareAZ.org

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RBHA CHAPTER 1 – MERCY CARE RBHA OVERVIEW

1.00 – About Mercy Care RBHA

Mercy Care RBHA (herein Mercy RBHA), as part of MC, is a not-for-profit partnership sponsored by Dignity Health and Ascension Care Management. Mercy RBHA is committed to promoting and facilitating quality health care services with special concern for the values upheld in Catholic social teaching, and preference for the poor and persons with special needs. Aetna Medicaid Administrators, LLC administers Mercy RBHA for Dignity Health and Ascension Care Management.

Mercy RBHA is a managed care organization that provides health care services to people in Arizona's Medicaid program that integrates member's behavioral health and physical health needs. Mercy RBHA provides services to the Arizona Medicaid populations that include:

- **Serious Mental Illness:** Persons who, as a result of a “mental disorder” (as defined in A.R.S. §36-501), exhibit emotional or behavioral functioning that is so impaired as to interfere substantially with their capacity to remain in the community without supportive treatment or services of a long-term or indefinite duration. In these persons, mental disability is severe and persistent, resulting in a long-term limitation of their functional capacities for primary activities of daily living such as interpersonal relationships, homemaking, self-care, employment and recreation, as defined in A.R.S. §36-550 diagnosed in persons 18 years and older.
- **Comprehensive Medical and Dental Program (CMDP):** CMDP is a health plan established to **provide** medical and dental care, inpatient, outpatient, and other services for individuals in foster care through agreements between the Arizona Department of Economic Security (ADES), the Arizona Health Care Cost Containment System (AHCCCS - the State's Medicaid Authority) and ADHS.
- **Crisis:** Behavioral health members receiving emergency/crisis services through our Crisis Response Network.
- **Division of Developmental Disabilities Long Term Care program:** Members are enrolled through the Arizona Department of Economic Security/Division of Developmental Disabilities (DDD). DDD is a Medicaid program administered by AHCCCS through the Department of Economic Security (DES). MCLTC is contracted with DDD to provide acute care services. DDD members are located in the following counties:
 - Cochise
 - Gila
 - Graham
 - Greenlee
 - La Paz
 - Maricopa
 - Pima
 - Pinal
 - Santa Cruz

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- Yuma
- **Grants:** Behavioral health members covered under grants such as:
 - SABG/GO SUDS are grant funded programs for those needing substance use disorder treatment who don't qualify for Medicaid/AHCCCS (also referred to as Non-Title XIX).
 - MAT PDOA – outreach to justice involved individuals in need of medically assisted treatment for opioid use.
 - STR – Infrastructure funding for substance use disorder providers.

The State of Arizona has chosen Mercy RBHA, a locally owned and operated non-profit health plan, as the Regional Behavioral Health Authority (RBHA) for Maricopa County.

Under contract with Mercy RBHA, providers are expected to follow the contents of this provider manual, Mercy RBHA Policies and Procedures as well as fulfill the scope of the contract terms. Mercy RBHA maintains a provider relations department for providers to ask questions and request technical assistance as well as to discuss contractual and program changes.

For more information about Mercy RBHA, its departments and their functions, please visit www.MercyCareAZ.org.

Mercy Care RBHA is dedicated to providing its members access to care for their behavioral and medical health (integrated care) needs. Our focus is on the whole-member and uses a holistic approach to care. We want to know our members' goals, use their strengths and understand their needs. We know how to provide access to high-quality, integrated care to people who have complex needs and work with the community and local health care providers to assure those needs are met.

The Arizona Health Care Cost Containment System (herein AHCCCS) has developed expectations for Mercy RBHA's Provider Manual, which includes content specific to our geographic service areas (GSA) and communities. The Mercy RBHA Provider Manual describes public behavioral and integrated care health system requirements for any entity that directly provides behavioral health/integrated care services. These entities may include:

- Behavioral health/integrated care contracted and non-contracted providers, including those that provide emergency and post-stabilization services;
- Behavioral health/integrated care prevention services providers; and
- Mercy RBHA itself.

The Mercy RBHA Provider Manual is applicable to defined populations that may access public behavioral health/integrated care services. These populations include:

- Behavioral health members receiving emergency/crisis services;
- Non-Title XIX members determined to have a Serious Mental Illness;
- Special populations, including members receiving services through the Substance Abuse

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Block Grant (SABG);

- Non-enrolled members participating in AHCCCS prevention sponsored activities;
- Non-enrolled members participating in AHCCCS HIV Early Intervention services;
- Other populations, based on the availability of funding and the prioritization of available funding.

Providers are contractually obligated to adhere to and comply with all terms of the plan and provider contract, including all requirements described in this manual in addition to all federal and state regulations governing the plan and the provider. Mercy RBHA may or may not specifically communicate such terms in forms other than the contract and this provider manual. While this manual contains basic information about Mercy RBHA as well as AHCCCS requirements, providers are required to fully understand and apply these requirements when administering covered services.

Please refer to the AHCCCS website at <https://www.azahcccs.gov/> for further information regarding AHCCCS regulations.

1.01 – Overview of the Arizona Public Behavioral Health System

AHCCCS is the single state Medicaid Agency to administer behavioral health benefits for members who are Title XIX and Title XXI eligible.

Mercy RBHA, in turn, subcontracts with community providers that administer behavioral health programs and services for children and adults and their families. Mercy RBHA is responsible for the oversight of the administration of behavioral health services for several populations funded through various sources.

Arizona state law requires Mercy RBHA to administer community based treatment services for adults who have been determined to have a Serious Mental Illness.

The Substance Abuse and Mental Health Services Administration (SAMHSA) provides funding to AHCCCS through two block grants:

- The Substance Abuse Block Grant (SABG) supports a variety of substance abuse services in both specialized addiction treatment and more generalized behavioral health settings, and
- The Mental Health Block Grant (MHBG) supports Non-Title XIX services to children determined to have Serious Emotional Disturbance (SED) and adults determined to have Serious Mental Illness (SMI).

Mercy RBHA administers other federal, state and locally funded behavioral health services. Individuals can get more information about AHCCCS programs by visiting their website at <https://www.azahcccs.gov/>.

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1.02 – Overview of Mercy RBHA

Mercy RBHA System Principles

All healthcare services must be delivered in accordance with AHCCCS system principles.

AHCCCS supports a healthcare system that includes:

- Easy access to care;
- Behavioral health member and family involvement;
- Collaboration with the Greater Community;
- Effective innovation;
- Expectation for improvement; and
- Cultural competency.

Easy Access to Care

- Accurate information is readily available that informs healthcare members, families and stakeholders how to access services;
- The healthcare network is organized in a manner that allows for easy access to behavioral health/integrated care services; and
- Services are delivered in a manner, location and timeframe that meet the needs of healthcare members and their families.

Behavioral health member and family involvement

- Behavioral health members and families are active participants in behavioral health delivery system design, prioritization of behavioral health resources and planning for and evaluating the services provided to them; and
- Behavioral health members, families and other parties involved in the member and family's lives are central and active participants in the assessment, service planning and delivery of behavioral health services and connection to natural supports.

Collaboration with the Greater Community

- Stakeholders including general medical, child welfare, criminal justice, education, Veterans Affairs Administration and other social service providers are actively engaged in the planning and delivery of integrated services to behavioral health members and their families;
- Relationships are fostered with stakeholders to maximize access by healthcare members and their families to needed resources such as housing, employment, medical and dental care, and other community services; and
- Providers of healthcare services collaborate with community stakeholders to assist healthcare members and families in achieving their goals.

Effective Innovation

- Healthcare providers are continuously educated in the application of evidence based practices;

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- The services system recognizes that substance abuse, mental health, and physical health disorders are inextricably intertwined, and integrated substance abuse and mental health evaluation and treatment is the community standard; and
- Interested healthcare members and families are provided training and supervision to be retained as providers of peer support services.

Expectation for Improvement

- Services are delivered with the explicit goal of assisting people to achieve or maintain success, recovery, gainful employment, success in age-appropriate education, return to or preservation of adults, children and families in their own homes, avoidance of delinquency and criminality, self-sufficiency and meaningful community participation;
- Services are continuously evaluated, and modified if they are ineffective in helping to meet these goals; and
- Healthcare providers instill hope that achievement of goals is possible even for the most disabled.

Integration of Primary Health and Behavioral Healthcare

Mercy RBHA utilizes an integrated care approach to positively affect the health and quality of life of our high-risk members diagnosed with a SMI, based on member-defined strengths, needs and preferences. We weave physical, behavioral and psychosocial support needs together to improve member outcomes, enhance quality of life, and reduce racial and ethnic health disparities associated with SMI, as well as disparities based on racial and ethnic backgrounds.

Mercy RBHA has adopted two models of integration for members with serious mental illness. These models are intended to provide a comprehensive array of physical and mental health care services, as well as health prevention and promotion services.

Model 1: Integrated Health Home (IHH)

An integrated health home is a place where members receive whole-member oriented care for their needs including primary care, behavioral health care, general counseling services, care coordination, specialty health service referral, medication management, health promotion, prevention, wellness services, member and family health education services (e.g., chronic disease management, healthy lifestyle, etc.), evidence-based programs (e.g., supported employment, peer support services, etc.), care management and outreach services.

Providers of integrated care must operate as a team that functions as the single-point of whole-health treatment and care for all of a member's health care needs. Co-location or making referrals without coordinating care through a team approach does not equate to integrated care. Integrated teams include (at a minimum) a PCP, BHP, registered nurse, care manager, medical assistant, team member to lead care coordinating, team member to lead wellness activities, housing coordinator, vocational coordinator and peer.

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Integrated health home include wellness programming for earlier identification and intervention that reduces the incidence and severity of serious physical and mental illness using tools such as the HRA, disease registries, etc. IHH goals include improved member's experience of care and individual health outcomes.

Model 2: Virtual Health Home

A virtual health home is designed for those members who choose to stay with their primary care practice or behavioral health clinic which are not integrated. This model provides health coaches at selected primary care practices, who work as part of team within the PCP practice and closely coordinate care with a Behavioral Health Representative at a partnered behavioral health clinic. These health coaches take a whole-member oriented approach and work with the member, the primary care physician and the behavioral health provider to coordinate care, medications and promote wellness.

Integrated Health Home Requirements

The following are additional requirements for Integrated Health Home (IHH) providers.

1. **Integrated Care Training** – All IHHs must have (at a minimum) one Master Trainer in the Connecting Minds curriculum. All staff (administrative staff, clinical, care managers, allied health, supervisors, etc.) working with an IHH must complete all four modules of the Connecting Minds: Inter-professional Collaboration for Whole Health (Connecting Minds) training within eight (8) months of hire within an IHH.
2. **Interdisciplinary Team Meetings (IDT)** – Providers, within an IHH, must attend weekly IDT meetings and use the skills and format from the Connecting Minds training.
3. **Daily Huddles** – Providers, within IHHs, are required to huddle daily using the daily huddle skills provided in the Connecting Minds training.
4. **Integrated Individual Service Plan (IISP)** – Providers within an IHH are required to complete an IISP for all members using a format with all the required elements as outlined in the Connecting Minds training.
5. **Workforce Development Report** – IHH providers must submit a yearly workforce development report on September 1st using the Mercy RBHA format. The report will provide information on identified workforce development areas such as, but not limited to: (1) number and type of practicum students, (2) institution the practicum student(s) attends, (3) dates of student practicums, (4) student practicum supervisor(s), and (5) any new graduate hires in the IHH.

Use of Terms

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An attempt was made to use consistent terminology throughout the Provider Manual to the best extent possible. Members receiving healthcare services are referred to as “behavioral health members” or simply as “members”.

Revisions to Provider Manual

Policies established as medical policies are updated annually or more frequently, if changes are necessary. Other sections of the Provider Manual are updated on an ongoing basis, but at a minimum, sections will be reviewed every year. For information or changes that must be communicated immediately, AHCCCS issues Policy Clarification Memorandums under their [Guides and Manuals for Health Plans and Providers](#) web page for both behavioral health and physical health providers. Mercy RBHA incorporates any changes made by AHCCCS into their provider manual as soon as it’s received.

Healthcare providers and others may provide comments and request for revisions to the Provider Manual. Healthcare providers and other interested members should contact the Mercy RBHA Provider Relations at 800-564-5465 to provide input and requests for updates.

- Providers should note that policy revisions will be available both on Mercy RBHA’s website at www.MercyCareAZ.org, and via email to all contracted providers.
- Provider Notices: Notices to providers regarding changes in program policy or procedures will also be distributed via e-mail to contracted providers and posted to www.MercyCareAZ.org.

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RBHA CHAPTER 2 – NETWORK PROVIDER SERVICE DELIVERY REQUIREMENTS

2.00 – Eligibility Screening for AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage and Low Subsidy Program***Title XIX/XXI Screening and Eligibility Process***

There are three steps involved in screening for Title XIX/XXI eligibility:

- First, verify the member's Title XIX or Title XXI eligibility.
- Next, for those members who are not Title XIX or Title XXI eligible; screen for potential Title XIX or other eligibility.
- Finally, as indicated by the screening tool, assist members with applications for a Title XIX or other eligibility determination.

Step #1-Accessing Title XIX/XXI or Other Eligibility Information

Contracted providers who need to verify the eligibility and enrollment of an AHCCCS member can use one of the alternative verification processes 24 hours a day, 7 days a week. These processes include:

- **AHCCCS web-based verification (Customer Support 602-417-4451):** This website allows the providers to verify eligibility and enrollment. To use the website, providers must create an account before using the applications. To create an account, go to: <https://azweb.statemedicaid.us/Account> and follow the prompts. Once the providers have an account they can view eligibility and claim information (claim information is limited to FFS). Batch transactions are also available. There is no charge to providers to create an account or view transactions. For technical web-based issues, contact AHCCCS Customer Support at 602-417-4451, Monday – Friday 7:00 a.m. to 5:00 p.m.
- **AHCCCS contracted Medical Electronic Verification Service (MEVS):** The AHCCCS member card can be “swiped” by providers to automatically access the AHCCCS’ Prepaid Medical Management System (PMMIS) for up to date eligibility and enrollment. For information on MEVS, contact the MEVS vendor - Emdeon at 800-444-4336.
- **Interactive Voice Response (IVR) system IVR:** Allows unlimited verification information by entering the AHCCCS member’s identification number on a touch-tone telephone. This allows providers access to AHCCCS’ PMMIS system for up to date eligibility and enrollment. Maricopa County providers may also request a faxed copy of eligibility for their records. There is no charge for this service. Providers may call IVR within Maricopa County at 602-417-7200 and all other counties at 800-331-5090.
- **Medifax:** Medifax allows providers to use a PC or terminal to access the AHCCCS’ PMMIS system for up to date eligibility and enrollment information. For information on EVS, contact Emdeon at 800-444-4336.
- If a member’s Title XIX or Title XXI eligibility status still cannot be determined using one of the above methods, the provider must:
 - Call Mercy RBHA Member Services at 800-564-5465 for assistance during normal business hours (8:00 am through 5:00 pm, Monday-Friday); or

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- Call the AHCCCS Verification Unit. Callers from outside Maricopa County can call 800-331-5090 or call 602-417-7200 in Maricopa County. When calling the AHCCCS Verification Unit, the provider must be prepared to provide the verification unit operator the following information:
 - Provider's identification number;
 - The member's name, date of birth, AHCCCS identification number and social security number (if known); and
 - Dates of service(s)

Step #2-Interpreting Eligibility Information

A provider will access important pieces of information when using the eligibility verification methods described in Step #1 above. The [AHCCCS Reference Subsystem Codes and Values](#) include a key code index that may be used by providers to interpret AHCCCS eligibility key codes and/or AHCCCS rate codes. Mercy RBHA must ensure that providers have access to and are familiar with the codes as they may help indicate provider responsibility for the delivery of Title XIX/XXI covered services.

- If Title XIX or Title XXI eligibility status and behavioral health provider responsibility is confirmed, the behavioral health provider must provide any needed covered behavioral health services in accordance with the [Policy and Procedures Manual](#) under AHCCCS Guides & Manuals and the [AHCCCS Covered Behavioral Health Services Guide](#).
- There are some circumstances whereby a member may be Title XIX eligible but the AHCCCS behavioral health system is not responsible for providing covered behavioral health services. This includes members enrolled as elderly or physically disabled (EPD) under the Arizona Long Term Care System (ALTCS) Program and members eligible for family planning services only through the Sixth Omnibus Reconciliation Act (SOBRA) Extension Program. A member who is Title XIX eligible through ALTCS must be referred to his/her ALTCS care manager to arrange for provision of Title XIX behavioral health services. However, ALTCS-EPD individuals who are determined to have Serious Mental Illness (SMI) may also receive Non-Title XIX SMI services from Mercy RBHA. ALTCS-Division of Developmental Disabilities (DDD) member's behavioral health services are provided through the AHCCCS behavioral health system.
- If the member is not currently Title XIX eligible, proceed to step #3 and conduct a screening for Title XIX or other eligibility.

Step #3-Screening for Title XIX or Other Eligibility

The behavioral health provider must screen all Non-Title XIX/XXI members using the [Health-e Arizona PLUS](#) online application:

- Upon initial request for behavioral health services;
- At least annually or during each Federal Health Insurance Marketplace open enrollment period thereafter, if still receiving behavioral health services; and
- When significant changes occur in the member's financial status.

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A screening is not required at the time an emergency service is delivered but must be initiated within 5 days of the emergency service if the member seeks or is referred for ongoing behavioral health services.

To conduct a screening for Title XIX or other eligibility, Mercy RBHA or provider meets with the member and completes AHCCCS eligibility screening through the [Health-e Arizona PLUS](#) online application for all Non-Title XIX members. Documentation of AHCCCS eligibility screening must be included in a comprehensive clinical record upon completion after initial screening, annual screening, and screening conducted when a significant change occurs in a financial status (see [MC Chapter 4 – Provider Requirements, Section 4.16 – Member’s Medical Records](#)).

Mercy RBHA will assist providers with contact information to obtain HEAPlus assistor modules and training from AHCCCS.

Once completed, the screening tool will indicate that the member is potentially AHCCCS eligible.

Pending the outcome of the Title XIX or other eligibility determination, the member may be provided services in accordance with [MC Chapter 4 – Provider Requirements, Section 4.29 - Copayments](#).

Upon the final processing of an application, it is possible that a member may be determined ineligible for AHCCCS health insurance. If the member is determined ineligible for Title XIX or Title XXI benefits, the member may be provided behavioral health services in accordance with [MC Chapter 4 – Provider Requirements, Section 4.29 - Copayments](#).

If the screening tool indicates that the member does not appear Title XIX or any other AHCCCS eligibility, the member may be provided behavioral health services in accordance with [MC Chapter 4 – Provider Requirements, Section 4.29 - Copayments](#). However, the member may submit the application for review by DES and/or AHCCCS *regardless* of the initial screening result. Additional information requested and verified by DES/AHCCCS may result in the member receiving AHCCCS eligibility and services after all.

AHCCCS requires Mercy RBHA to document and report the number of applicant screenings completed by providers for Title XIX SMI and Federal Health Insurance Marketplace eligibility. The reporting must include the following elements:

- Number of applicants to be screened for AHCCCS eligibility
- Number of applicant screenings for AHCCCS eligibility completed
- Number of applicant screenings for AHCCCS eligibility to be completed
- Number of AHCCCS eligible applicants because of the screening

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- Number of applicants to be screened for health coverage via the Federal Health Insurance Marketplace
- Number of applicant screenings for health coverage via the Federal Health Insurance Marketplace completed
- Number of applicant screenings for health coverage via the Federal Health Insurance Marketplace to be completed
- Number of applicants eligible for health coverage via the Federal Health Insurance Marketplace because of the screening

By the fifth day of each month, providers must submit via e-mail the data shown above in a Microsoft Excel spreadsheet to providerdeliverables@aetna.com. If the fifth of the month falls on a weekend, the data should be submitted on the previous Friday. Providers can consult with their assigned Mercy RBHA Network Relations specialist/consultant if technical assistance is needed.

Medicare Part D Prescription Drug Coverage and Low-Income Subsidy (LIS) Eligibility

Members must report to Mercy RBHA or provider if they are eligible or become eligible for Medicare, as it is considered third party insurance. See **RBHA Chapter 12 – Service Authorizations, Section 12.05 – Third Party Liability** regarding how to coordinate benefits for members with other insurance including Medicare. If a behavioral health/integrated care member is unsure of Medicare eligibility, Mercy RBHA or providers may verify Medicare eligibility by calling 800-MEDICARE (800-633-4227), with a behavioral health/integrated care member's permission and required member information. Once a member is determined Medicare eligible, Mercy RBHA or providers must offer and aid Part D enrollment and the LIS application upon a behavioral health/integrated care member's request. Mercy RBHA and providers will be tracking Part D enrollment and LIS application status of members and reporting tracking activities, when required by AHCCCS.

Enrollment in Part D

All members eligible for Medicare must be encouraged and assisted in enrolling in a Medicare Part D plan to access Medicare Part D Prescription Drug coverage. Enrollment must be in a Prescription Drug Plan (PDP), which is fee-for-service Medicare plan or a Medicare Advantage Prescription Drug Plan (MA-PD), which is a managed care Medicare plan. Upon request, Mercy RBHA or provider must assist Medicare eligible members in selecting a Part D plan. CMS developed web tools to assist with choosing a Part D plan that best meets the member's needs. The web tools can be accessed at www.medicare.gov. For additional information regarding Medicare Part D Prescription Drug coverage, call Medicare at 800-633-4227 or the Arizona State Division of Aging and Adult Services at 602-542-4446 or toll free at 800-432-4040.

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Applying for the Low-Income Subsidy (LIS)

The LIS is a program in which the federal government pays all or a portion of the cost sharing requirements of Medicare Part D on behalf of the member. If Mercy RBHA or provider determines that a member may be eligible for the LIS (see Social Security Administration (SSA) website at www.ssa.gov for income and resource limits), Mercy RBHA or provider must offer to assist the member in completing an application. Applications can be obtained and submitted through the following means:

- On-line at: <http://www.socialsecurity.gov/i1020>;
- By calling 800-772-1213;
- In member at an SSA local office; or
- By mailing a paper application to the SSA.

Reporting Part D enrollment and LIS applications

Mercy RBHA and providers must track Part D enrollment and LIS application status for Medicare eligible members. The following forms are available to assist with this: [Tracking of Medicare Part D Enrollment](#) and [Tracking of Low Income Subsidy Status \(LIS\)](#) which can be used by Mercy RBHA or behavioral health/integrated care provider to track members eligible for Medicare. This will assist Mercy RBHA to ensure that Medicare eligible members are enrolled in a Part D plan and apply for the LIS program, if applicable. By the fifth day of each month, providers must submit via e-mail a tracking report with the data elements identified in [Tracking of Medicare Part D Enrollment](#) and [Tracking of Low Income Subsidy Status \(LIS\)](#) to reporting@mercycaresaz.org. If the fifth of the month falls on a weekend, the data should be submitted on the previous Friday. Providers can consult with their assigned Mercy RBHA Network Relations Specialist/Consultant if technical assistance is needed. Periodically, AHCCCS will request Mercy RBHA to report tracking of Part D enrollment and LIS applications.

Mercy RBHA and their contracted providers must educate and encourage Non-Title SMI members to apply for health coverage from a qualified health plan using the application process located at the [Federal Health Insurance Marketplace](#) and offer assistance for those choosing to enroll during open enrollment periods and qualified life events. Members enrolled in a qualified health plan through the Federal Health Insurance Marketplace may continue to be eligible for Non-Title XIX covered services that are not covered under the Federal Health Insurance Marketplace plan.

Refusal to Participate with Screening and/or Application Process for Title XIX, Other AHCCCS Eligibility or Enrollment in a Part D Plan

On occasion, a member may decline to participate in the AHCCCS eligibility screening and application process or refuse to enroll in a Medicare Part D plan. In these cases, Mercy RBHA or provider must actively encourage the member to participate in the process of screening and applying for AHCCCS health insurance coverage or enrolling in a Medicare Part D plan.

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Arizona state law stipulates that members 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 services (see **A.R.S. §36-3408**). As such, individuals who refuse to participate in the AHCCCS screening and eligibility application or enrollment in Medicare Part D, if eligible, will not be enrolled with Mercy RBHA during their initial request for behavioral health/integrated care services or will be dis-enrolled if the member refuses to participate during an annual screening. The following conditions do not constitute a refusal to participate:

- A member's inability to obtain documentation required for the eligibility determination;
- A member is incapable of participating because of their mental illness and does not have a legal guardian; and
- A member who is enrolled in a qualified health plan through the Federal Health Insurance Marketplace and refuses to take part in the AHCCCS screening and application process will not be eligible for Non-Title XIX/XXI SMI funded services.

If a member refuses to participate in the screening and/or application process for Title XIX or other eligibility, or to enroll in a Part D plan, Mercy RBHA or behavioral health provider must ask the member to sign the **Decline to Participate in the Screening and/or Referral Process for AHCCCS Health Insurance or Medicare Part D Plan Enrollment**. If the member refuses to sign the form, document their refusal to sign in the comprehensive clinical record (See **MC Chapter 4 – Provider Requirements, Section 4.16 – Member's Medical Records**).

Special considerations for members determined to have a Serious Mental Illness (SMI)

If a member is eligible for or requesting services as a member determined to have a SMI, is unwilling to complete the eligibility screening or application process for Title XIX or to enroll in a Part D plan and does not meet the conditions above, behavioral health provider must request a clinical consultation by a Behavioral Health Medical Professional (e.g., Single Point of Contact) by contacting the member's assigned care manager or therapist and ensuring that the member is fully informed of the option and potential consequences of failing to enroll in a Part D plan. If the member continues to refuse following a clinical consultation, Mercy RBHA or behavioral health provider must request that the member sign the **Decline to Participate in the Screening and/or Referral Process for AHCCCS) Health Insurance or Medicare Part D Plan Enrollment**. Prior to the termination of behavioral health services for members determined to have a SMI who have been receiving behavioral health services and subsequently decline to participate in the screening/referral process, Mercy RBHA must provide written notification of the intended termination using **Notice of Decision and Right to Appeal**. (See **RBHA Chapter 16 – Grievance System and Member Rights, Section 16.03 – Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI)**).

Members who Refuse to Cooperate with AHCCCS Eligibility and/or Application Process or do not Enroll in Part D Plan

Mercy RBHA or behavioral health provider must inform the member who they can contact in the behavioral health system for an appointment if the member chooses to participate in the

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eligibility and/or application process in the future. Maricopa County behavioral health members should contact Mercy RBHA for assistance at 800-564-5465.

2.01 – Additional Behavioral Health Appointment Availability Information

For your reference, the [AHCCCS Contractors' Operation Manual \(ACOM 417\)](#) outlines requirements regarding access to care. For children receiving behavioral health services, the member must be seen within seven (7) calendar day for an intake assessment and within 21 calendar days for ongoing appointment.

If an AHCCCS-eligible child in the custody of DCS or an adoptive child does not receive services within these 7 and/or 21 calendar day timeframes, DCS, the out-of-home placement (e.g., foster home, kinship or group home) or adoptive parent may contact the Mercy RBHA Child Welfare Single Point of Contact at dcs@MercyCareAZ.org and the AHCCCS Customer Service line at 602-364-4558. DCS, the out-of-home placement or adoptive parent may then contact any AHCCCS-registered providers directly, regardless of whether they are a part of the Mercy RBHA provider network.

Providers shall not solely offer open access appointments and must include offering specific appointment times for intakes and ongoing services.

Appointment Availability and Timeliness of Service

- Members must be offered an appointment within the required 7 business days.
- During business hours, phone calls are answered by referral and intake staff or routed to other staff if the referral and intake staff are unavailable.
- Members should not go to voice mail during business hours.
- If a mystery shopper calls and gets a voicemail at an agency, this will count against the agency.
- Refrain from directing members solely to Mercy Care's Member Services.

If an appointment cannot be offered within the required 7 business days:

- Warm transfer the member to Mercy RBHA Member Services (800-564-5465) so a timely appointment can be found with another service provider.
- Do not tell members to call back on a different day to schedule an appointment.
- Do not tell members to call back later because there are no appointments available.
- Members who are Title 19 and Title 21 must never be placed on a "waiting list" for any Title 19/21 covered behavioral health services.
- Providers who are unable to deliver medically necessary covered behavioral health services for Title 19 or Title 21 members must ensure timely and adequate coverage of these services with another service provider.

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Appointment Availability Standards for Behavioral Health Providers for Non-Hospitalized Members

Immediate Appointment Availability

- **WHO:** All members requesting assistance unless determined not to be eligible. At the time of determination that an immediate response is needed, a member's eligibility and enrollment status may not be known. Behavioral health providers must respond to all members in immediate need of behavioral health services until the situation is clarified that the behavioral health provider is not financially responsible.
- **WHAT:** Services can be telephonic or face-to-face; the response may include any medically necessary covered behavioral health service.
- **WHEN:** Behavioral health services provided within a timeframe indicated by behavioral health condition, but no later than 2 hours from identification of need or as quickly as possible when a response within 2 hours is geographically impractical.

Urgent Appointment Availability - All Other Requests

- **WHO:** Referrals for hospitalized members not currently T/RBHA enrolled, all Title XIX/XXI eligible members and all Non-Title XIX/XXI members determined to have a Serious Mental Illness.
- **WHAT:** Includes any medically necessary covered behavioral health service.
- **WHEN:** Behavioral health services provided within a timeframe indicated by behavioral health condition but no later than 24 hours from identification of need.

Routine Appointment Availability

- **WHO:** All Title XIX/XXI members, all Non-Title XIX/XXI members determined to have a Serious Mental Illness and all members referred for determination as a member with a Serious Mental Illness.
- **WHAT:** Includes any allowable assessment service as identified in the [AHCCCS Covered Behavioral Health Services Guide](#).
- **WHEN:** Appointment for initial assessment with a BHP or *behavioral health technicians* (as defined in 9 A.A.C. 10) must meet the Mercy RBHA's credentialing requirements to provide assessment and evaluation services within 7 business days of referral or request for behavioral health services.
- **WHO:** All Mercy RBHA members.
- **WHAT:** Includes any medically necessary covered behavioral health service including medication management and/or additional services.
- **WHEN:** The first behavioral health service following the initial Assessment appointment within timeframes indicated by clinical need, but no later than seven (7) business days of the initial assessment.

Note: Standards for members receiving services as part of Substance Abuse Block Grant (SABG) funding are in **Section 2.10, Special Populations**.

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Urgent Referral for Child in DCS Custody

- **WHO:** Upon notification from DCS that a child has been or will imminently be taken into the custody of DCS, regardless of the child's Title XIX or Title XXI eligibility status.
- **WHAT:** Includes medically necessary covered behavioral health services.
- **WHEN:** Behavioral Health services must be provided within a timeframe indicated by behavioral health condition but no later than 72 hours after notification by DCS, the out-of-home placement or adoptive parent that a child has been or will be removed from their home. If the child has immediate needs, the assessment/crisis team will be dispatched within 2 hours of being notified.

For Behavioral Health Appointments for members in legal custody of the Department of Child Safety (DCS) and adopted children

Rapid Response when a child enters out-of-home placement within timeframe indicated by the behavioral health condition, but no later than 72 hours after notification by DCS, the out-of-home placement (e.g., foster home, kinship or group home) or adoptive parent that a child has been or will be removed from their home. The purpose for this urgent response is to:

- Identify immediate safety needs and presenting problems of the child, to stabilize behavioral health crises and to be able to offer immediate services the child may need;
 - Provide behavioral health services to each child with the intention of reducing the stress and anxiety that the child may be experiencing, and offering a coherent explanation to the child about what is happening and what can be expected to happen in the near-term;
 - Provide outreach and engagement with the biological family, if permission is provided by DCS guardian;
 - Provide needed behavioral health services to each child's new caregiver, including guidance about how to respond to the child's immediate needs in adjusting to foster care, behavioral health symptoms to watch for and report, assistance in responding to any behavioral health symptoms the child may exhibit, and identification of a contact within the behavioral health system;
 - Initiate the development of the CFT for each child (see [Child and Family Team Practice Protocol](#)); and
 - Provide the DCS Specialist with findings and recommendations for medically necessary covered behavioral health services for the initial Preliminary Protective Hearing, which occurs within 5 to 7 business days of the child's removal.
 - Provide the DCS Specialist and the DCS out-of-home placement (e.g., foster home, kinship or group home) with contact information for the Qualified Service Provider (QSP) assigned to provide an intake for the child within seven calendar days of the Rapid Response assessment.
- Initial assessment within seven calendar days after referral or request for behavioral health services

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- Initial appointment within timeframes indicated, by clinical need, but no later than 21 calendar days after the initial assessment
- Subsequent behavioral health services within the timeframes according to the needs of the member, but no longer than 21 calendar days from the identification of need

The appointment standards for members in legal custody of the Department of Child Safety and adopted children are intended to monitor and report appointment accessibility and availability.

Additional information may be found by reviewing our **Collaborative Protocol with the Department of Child Safety** available on our [Forms Library](#) web page that is in the Provider Manual Attachments section of our website.

Referral for Psychotropic Medications

- **WHEN:** Assess the urgency of the need immediately. If clinically indicated, provide an appointment with a BHMP within a timeframe indicated by clinical need, but no later than 30 business days from the referral/initial request for services and no later than 21 business days from the referral/initial request for services for youth who are in the custody of Department of Child Safety or adopted children.
- **WHAT:** Screening, consultation, assessment, medication management, medications, and/or lab testing services as appropriate.
- **WHO:** All Title XIX/XXI eligible members, all Non-Title XIX/XXI members enrolled with a T/RBHA, all members determined to have a Serious Mental Illness and any member in an emergency or crisis.

Referral for Specialty and Other Identified Service Needs

- **WHEN:** Assess the urgency of the need immediately. If clinically indicated, submit referrals within a timeframe indicated by clinical need, but services should be implemented no later than 30 business days from the initial request for services and no later than 21 business days from the initial request for services for youth who are in the custody of Department of Child Safety or adopted children.
- **WHAT:** Specialty and other identified service needs include but are not limited to requests for counseling, day programs, temporary hotel assistance, bed bugs treatment, biohazard cleaning, and moving assistance.
- **WHO:** All Title XIX/XXI eligible members, all Non-Title XIX/XXI members enrolled with a T/RBHA, all members determined to have a Serious Mental Illness and any member in an emergency or crisis.

All Initial Assessments/Treatment Recommendations Indicate Need for Psychotropic Medication

- **WHEN:** The initial assessment and treatment recommendations must be reviewed by a BHMP within a timeframe based on clinical need.
- **WHAT:** Screening, consultation, assessment, medication management, medications,

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and/or lab testing services as appropriate.

- **WHO:** All Title XIX/XXI eligible members, all Non-Title XIX/XXI members enrolled with a T/RBHA, all members determined to have a Serious Mental Illness and any member in an emergency or crisis.

Referrals for Hospitalized Members

Behavioral health providers must quickly respond to referrals pertaining to eligible members not yet enrolled in the T/RBHA or Title XIX/XXI eligible members who have not been receiving behavioral health services prior to being hospitalized for psychiatric reasons and members previously determined to have a SMI. Upon receipt of such a referral, the following steps must be taken:

Referrals for Members with SMI

For referrals of Title XIX/XXI eligible members and members previously determined to have a SMI: Initial face-to-face contact, an assessment and disposition must occur within 24 hours of the referral/request for services.

For referrals of members referred for eligibility determination of Serious Mental Illness:

- Initial face-to-face contact and an assessment must occur within 7 business days of the referral/request for services. Determination of SMI eligibility must be made within timeframes;
- Upon the determination that the member is eligible for services and the member needs continued behavioral health services, the member must be enrolled, and the effective date of enrollment must be no later than the date of first contact; and
- Mercy Care will assign the member to a clinic within 24 hours and the provider is required to initiate contact within 7 business days (or on the day of notification if the member is COE/COT) to schedule an initial appointment.

Wait Times

AHCCCS has established standards so that members presenting for scheduled appointments do not have to wait unreasonable amounts of time. Unless a behavioral health provider is unavailable due to an emergency, a member appearing for an established appointment must not wait for more than 45 minutes.

Behavioral health providers arranging for, or providing non-emergency transportation services for members must adhere to the following standards:

- A member must not arrive sooner than one hour before his/her scheduled appointment; and
- A member must not have to wait for more than one hour after the conclusion of his/her appointment for transportation home or to another pre-arranged destination.

Other Requirements

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All referrals from a member's primary care provider (PCP) requesting a psychiatric evaluation and/or psychotropic medications must be accepted and acted upon in a timely manner according to the needs of the member, and the response time must help ensure that the member does not experience a lapse in necessary psychotropic medications, as described above.

Title XIX and Title XXI members must never be placed on a "wait list" for any Title XIX/XXI covered behavioral health service. If the Mercy RBHA network is unable to provide medically necessary covered behavioral health services for Title XIX or Title XXI members, it must ensure timely and adequate coverage of needed services through an alternative provider until a network provider is contracted. In this circumstance, Mercy RBHA must ensure coordination with respect to authorization and payment issues. If a covered behavioral health service is temporarily unavailable to a Title XIX/XXI eligible member, the behavioral health provider must adhere to the following procedures:

- Select an appropriate Mercy RBHA contracted provider.
- Confirm that the Mercy RBHA contracted provider can deliver the needed covered service;
- Confirm the Mercy RBHA contracted provider can meet the timeliness of the needed service; and
- Coordinate the referral.
- If no Mercy RBHA contracted provider can meet the timeliness of the needed service, behavioral health members must be referred to a provider outside of Mercy RBHA's network:
 - Select an appropriate non-contracted provider (AHCCCS);
 - Confirm that the non-contracted provider can deliver the needed covered service;
 - Confirm the non-contracted provider can meet the timeliness of the needed service;
 - Call Mercy RBHA at 800-564-5465 to discuss clinical necessity for a Single Case Agreement/ad hoc; and
 - Coordinate the referral.

For Title XIX/XXI individuals in inpatient or behavioral health residential facilities who are discharge-ready but there are no discharge services available within the Mercy RBHA contracted provider network:

- Select an appropriate non-contracted provider (AHCCCS);
- Confirm that the non-contracted provider can deliver the needed covered service;
- Providers can access information relative to outpatient treatment appointment and residential bed availability by calling Mercy RBHA at 800-564-5465;
- Confirm that non-contracted provider can meet the timeliness of the needed service;
- Call Mercy RBHA at 800-564-5465 to discuss clinical necessity for a Single Case Agreement/ad hoc; and

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- Coordinate the referral.

If no non-contracted provider can deliver the needed service or meet the timeliness of the needed service, the individual may remain at the facility until necessary discharge services are arranged.

2.02 – Referral and Intake Process

Where to Send Referrals

Providers can be found on our website by using the “Find a Provider” search.

Referrals for Second Opinion

Title XIX/XXI health care members are entitled to a second opinion. Upon a Title XIX/XXI eligible healthcare member’s request or at the request of the treating physician, Mercy RBHA must provide for a second opinion from a healthcare professional within the network or arrange for the healthcare member to obtain one outside the network when an in-network provider is not available, at no cost to the member.

Referrals to Providers

Providers (not including CSAs) may complete their own Assessment and Treatment plan to begin services. The provider must document attempts made to obtain the current assessment and service plan from the referring agency in the member record. The provider is required to coordinate care with the adult recovery team on an ongoing and regular basis.

Referrals Initiated by Department of Child Safety (DCS) Pending Removal of a Child

Upon notification from the Department of Child Safety (DCS) that a child has been, or is at risk of being taken into the custody of DCS, behavioral health providers are expected to respond in an urgent manner (for additional information see [MC Chapter 4 – Provider Requirements, Section 4.02 - Appointment Availability Standards](#), [Child and Family Team Practice Protocol](#) and [The Unique Behavioral Health Service Needs of Children, Youth, and Families Involved with the DCS Practice Protocol](#)).

Accepting Referrals

Providers are required to accept referrals for behavioral health services 24 hours a day, 7 days a week. The following information will be collected from referral sources: Date and time of referral;

- Information about the referral source including name, telephone number, fax number, affiliated agency, and relationship to the member being referred;
- Name of member being referred, address, telephone number, gender, age, date of birth and, when applicable, name and telephone number of parent or legal guardian;
- Whether or not the member, parent or legal guardian is aware of the referral;
- Transportation and other special needs for assistance due to impaired mobility, visual/hearing impairments or developmental or cognitive impairment;

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- Accommodations due to cultural uniqueness and/or the need for interpreter services;
- Information regarding payment source (i.e., AHCCCS, private insurance, Medicare or self-pay) including the name of the AHCCCS health plan or insurance company;
- Name, telephone number and fax number of AHCCCS primary care provider (PCP) or another PCP as applicable;
- Reason for referral including identification of any potential risk factors such as recent hospitalization, evidence of suicidal or homicidal thoughts, pregnancy, and current supply of prescribed psychotropic medications;
- Medications prescribed by the member's PCP or other medical professional including the reason why the medication is being prescribed; and
- Names and telephone numbers of individuals the member, parent or guardian may wish to invite to the initial appointment with the referred member.

Don't Delay... Act on a referral regardless of how much information you have. While the information listed above will facilitate evaluating the urgency and type of practitioner the member may need to see, timely triage and processing of referrals must not be delayed because of missing or incomplete information.

When psychotropic medications are a part of an enrolled member's treatment or have been identified as a need by the referral source, behavioral health providers must respond as outlined in **MC Chapter 4 – Provider Requirements, Section 4.02 Appointment Availability Standards**.

Referral sources may use any written format, or they may contact Mercy RBHA and providers orally by calling 800-564-5465.

In situations in which the member seeking services or his/her family member, legal guardian or significant other contacts Mercy RBHA or provider directly about accessing behavioral health services, Mercy RBHA or provider will ensure that the protocol used to obtain the necessary information about the member seeking services is engaging and welcoming.

When an SMI eligibility determination is being requested as part of the referral or by the member directly, Mercy RBHA and providers must conduct an eligibility determination for SMI in accordance with **MCCC Chapter 4 – General Mental Health/Substance Use, Section 4.05 - Serious Mental Illness Determination**.

Responding to Referrals

Follow-Up

When a request for behavioral health services is initiated but the member does not appear for the initial appointment, the provider must attempt to contact the member and implement engagement activities consistent with **RBHA Chapter 2 – Network Provider Service Delivery Requirements, Section 2.03 - Outreach, Engagement, Reengagement and Closure**.

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Mercy RBHA or provider will also attempt to notify the entity that made the referral.

Final Dispositions

Within 30 days of receiving the initial assessment, or if the member declines behavioral health services, within 30 days of the initial request for behavioral health services, Mercy RBHA or provider must notify the following applicable referral sources of the final disposition:

- AHCCCS health plans;
- AHCCCS PCPs;
- Department of Child Safety and adoption subsidy;
- Arizona Department of Economic Security/Division of Developmental Disabilities;
- Arizona Department of Corrections;
- Arizona Department of Juvenile Corrections;
- Administrative Offices of the Court;
- Arizona Department of Economic Security/Rehabilitation Services Administration; and
- Arizona Department of Education and affiliated school districts.

The final disposition must include:

- The date the member was seen for the initial assessment; and
- The name and contact information of the provider who will assume primary responsibility for the member's behavioral health care, or
- If no services will be provided, the reason why. When required, authorization to release information will be obtained prior to communicating the final disposition to the referral sources referenced above.

Children's System of Care Referral Process

Routine Referrals

Expectations:

- Mercy RBHA Member Services Department will gather the following basic information from the guardian:
 - Obtains caller/requestor information - name, relationship to the member receiving services, address and phone number;
 - Obtains member demographic information; name, address, phone, date of birth; and
 - AHCCCS eligibility will be confirmed.
- The Member Service Representative will establish if the guardian has a provider preference. If the guardian does not have a provider preference, the youth will be referred to a Qualified Service Provider (QSP) based on geographic access, specialty services and an algorithm.
- The Member Service Representative will advise parent/guardian of QSP's in area that meets the child's needs and the guardian will select the QSP.

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- The Member Service Representative will warm transfer the call to the identified QSP. Prior to the warm transfer of the guardian, the Member Service Representative will advise the QSP of service type requested, parent/guardian name, member name, address, date of birth, and AHCCCS ID number. The QSP will gather any additional information from the caller and schedule an intake appointment within 7 days.

DCS Rapid Response Referrals

Expectations:

- A child is removed from their home and placed in DCS Custody.
- DCS, law enforcement, or other individuals including the out-of-home placement or adoptive parent make a DCS Rapid Response Referral. DCS provides appropriate documentation (generally a Temporary Custody Notice and/or Notice to Provider to Crisis Response Network (CRN)) within 24 hours of the child's removal.
- If the child is not enrolled/receiving behavioral health services:
 - A referral will be made to the TERROS or EMPACT DCS Rapid Response Team to complete behavioral health and developmental screening.
 - The caregiver will be contacted by a DCS Rapid Response Team Clinician and the team will be dispatched within the first 72 hours of a child being referred to Rapid Response. If the child has immediate needs, the assessment/crisis team will be dispatched within 2 hours of being notified.
 - If a Rapid Response referral is not submitted or the DCS Rapid Response Team is not dispatched within this timeframe, DCS, law enforcement, or individuals including the out-of-home placement or adoptive parent may contact the Mercy RBHA Designated DCS Point of Contact at dcx@MercyCareAZ.org.
 - A developmental screening and assessment will be completed. The developmental checklist and warning signs will be provided to caregivers.
 - DCS Rapid Response Team will assess to determine if high needs care management (HNCM) services are recommended.
 - The DCS Rapid Response Team will make a referral based on the youth's acuity (or the need for HNCM) and guardian's preference for an intake appointment with a QSP to complete the comprehensive assessment. If the guardian does not have a provider preference and does not need HNCM, the youth will be referred by the DCS Rapid Response Team to a QSP based geographic access, specialty services, and an algorithm.
 - The referral will be emailed to the identified QSP by the DCS Rapid Response Team. The identified provider information will be provided to the guardian.
 - The QSP will contact the DCS Specialist and/or DCS out-of-home placement to set-up an intake to begin services. If unable to contact the DCS out-of-home placement, the QSP will contact the DCS Specialist to set up an intake to begin services.
 - The QSP will notify DCS Rapid Response Team within 14 days of the referral of the status of the referral and/or the completed intake date.

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- If no response is provided within 14 days, DCS Rapid Response Team will notify Mercy RBHA.
- Mercy RBHA will collaborate with the QSP and DCS to determine next steps.
- If the child is already receiving behavioral health services:
 - CRN contacts the assigned behavioral health provider and DCS for coordination of care;
 - The behavioral health provider will attempt to contact the DCS Specialist and DCS out-of-home placement within one business day; and
 - The behavioral health provider will assess to determine next steps and for immediate treatment needs within 72 hours of notification.

Direct Support and Specialty Provider Referrals

Expectations:

- The Child and Family Team determine if a service from a Direct Support Provider (DSP) or a Specialty Provider is recommended.
- The CFT must identify the Mercy RBHA contracted provider(s) who are able to provide the needed Direct Support or Specialty service (see **Direct Support and Specialty Provider Directory**, available on our [Autism Spectrum Disorder](#) web page for a list of DSP and Specialty Providers). Please note that referrals for Meet Me Where I Am (MMWIA) and Multi-Systemic Therapy (MST) services can only be made by a High Needs Care Manager (HNCM).
- The CFT Facilitator and/or HNCM will complete the **Request for Direct Support or Specialty Provider Services** form, available on our [Forms](#) web page, and will send the form with the following documents to the identified provider agencies:
 - CFT service plan/CFT Notes;
 - Strengths Needs and Cultural Discovery (if CASII 4, 5, or 6);
 - Current assessment or most recent annual update;
 - Crisis/Support Plan;
 - CASII;
 - Current Psychiatric Notes and Evaluation (if applicable); and
 - MMWIA Prioritization Form for MMWIA referrals.
- Upon receipt of the referral form and the documents listed above, the Direct Support or Specialty Provider will review the information and determine if they are able to accept the referral.
- The Direct Support or Specialty Provider will communicate if they are able to accept or if they need to decline the referral to the CFT Facilitator and/or HNCM:
 - If the referral is accepted the guardian will be notified; and
 - The Direct Support or Specialty Provider will assess to determine next steps and for treatment needs.
- Every Monday, Direct Support and Specialty Providers will send “Referral Capacity Report” indicating the number of available referrals that can be accepted for the current

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week, this will also include Spanish- speaking capacity to the Children’s System of Care Administrator, by e-mailing DSP_SpecialtyProviders@MercyCareAZ.org.

For children in the custody of DCS or adopted children, DSP and Specialty services are to be provided within 21 days of referral.

Emergent Referrals

Process:

- Hospital notifies Mercy RBHA Member Services at 800-564-5465 of a youth that is currently inpatient without an open episode of care with a QSP.
- If the youth will not be discharged within 24 hours, Mercy RBHA will refer to a High Needs Care Management (HNCM) provider utilizing an identified algorithm.
- The referral is documented and forwarded to the Mercy RBHA Children’s Discharge Planning (CDP) team.
- The CDP team will forward the emergent referral to the assigned HNCM provider as well as to the referring hospital.
- The HNCM provider will perform the assessment within 24 hours of receipt of the referral.
- If the youth will be discharged in less than 24 hours, or is in a 23-hour observation unit, the Member Services Representative will provide the name of the HNCM provider closest to the member’s address or a preferred provider and warm transfer to that provider.
- The HNCM provider must attempt to set up the appointment and see the member within 24 hours.

Eligibility Screening and Supporting Documentation

Members who are not already AHCCCS eligible must be asked to bring supporting documentation to the screening interview to assist the behavioral health provider in identifying if the member could be AHCCCS eligible (see [RBHA Chapter 2 – Network Provider Service Delivery Requirements, 2.00 Eligibility Screening for AHCCCS Health Insurance, Medicare Part D](#)). Explain to the member that the supporting documentation will only be used for assisting the member in applying for AHCCCS health care benefits. Let the member know that AHCCCS health care benefits may help pay for behavioral health services. Ask the member to bring the following supporting documentation to the screening interview:

- Verification of gross family income for the last month and current month (e.g., pay check stubs, social security award letter, retirement pension letter)
- Social security numbers for all family members (social security cards if available)
- For those who have other health insurance, bring the corresponding health insurance card (e.g., Medicare card)

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For all applicants, documentation to prove United States citizenship or immigration status and identity (see **RBHA Chapter 13 – Contract Compliance, Section 13.01 – Verification of U.S. Citizenship or Lawful Presence for Public Behavioral Health Benefits**).

- For those who pay for dependent care (e.g., adult or child daycare), proof of the amount paid for the dependent care
- Verification of out of pocket medical expenses

Intake

Behavioral health providers must conduct intake interviews in an efficient and effective manner that is both “member friendly” and ensures the accurate collection of all the required information necessary for enrollment into the system or for collection of information for AHCCCS eligible individuals who are already enrolled. The intake process must:

- Be flexible in terms of when and how the intake occurs. For example, to best meet the needs of the member seeking services, the intake might be conducted over the telephone prior to the visit, at the initial appointment prior to the assessment and/or as part of the assessment; and
- Make use of readily available information (e.g., referral form, AHCCCS eligibility screens, Department of Child Safety related documentation) to minimize any duplication in the information solicited from the member and his/her family.

During the intake, the behavioral health provider will collect, review and disseminate certain information to members seeking behavioral health services. Examples can include:

- The collection of contact information, insurance information, the reason why the member is seeking services and information on any accommodations the member may require to effectively participate in treatment services (i.e., need for oral interpretation or sign language services, consent forms in large font, etc.).
- The collection of required demographic information and completion of client demographic information sheet, including the behavioral health member’s primary/preferred language;
- The completion of any applicable authorizations for the release of information to other parties;
- The dissemination of a Member Handbook to the member;
- The review and completion of a general consent to treatment;
- The collection of financial information, including the identification of third-party payers and information necessary to screen and apply for AHCCCS health insurance, when necessary;
- Advising Non-Title XIX/XXI members determined to have a Serious Mental Illness (SMI) that they may be assessed a co-payment.
- The review and dissemination of Mercy RBHA’s Notice of Privacy Practices (NPP) and the AHCCCS HIPAA Notice of Privacy Practices (NPP); and
- The review of the member’s rights and responsibilities as a member of behavioral health

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services, including an explanation of the appeal process.

The member and/or family members may complete some of the paperwork associated with the intake, if acceptable to the member and/or family members.

Behavioral health providers conducting intakes must be appropriately trained, approach the member and family in an engaging manner, and possess a clear understanding of the information that needs to be collected.

INTEGRATED CARE SPECIFIC REFERRAL AND INTAKE GUIDELINES

It may be necessary for a Mercy RBHA member to be referred to another provider for medically necessary services that are beyond the scope of the member's PCP. For those services, providers only need to complete the **Specialist Referral Form** available on our [Forms Library](#) web page and refer the member to the appropriate Mercy RBHA Participating Health Provider (PHP). Mercy RBHA's website includes a provider search function for your convenience.

There are two types of referrals:

- Participating providers (particularly the member's PCP) may refer members for specific covered services to other practitioners or medical specialists, allied healthcare professionals, medical facilities, or ancillary service providers.
- Member may self-refer to certain specialists for specific services, such as an OB/GYN or substance abuse treatment.

Referrals must meet the following conditions:

- The referral must be requested by a participating provider and be in accordance with the requirements of the member's benefit plan (covered benefit).
- The member must be enrolled in Mercy RBHA on the date of service (s) and eligible to receive the service.
- If Mercy RBHA's network does not have a provider to perform the requested services, members may be referred to out of network providers if:
 - The services required are not available within the Mercy RBHA network.
 - Mercy RBHA prior authorizes the services.

If out of network services are not prior authorized, the referring and servicing providers may be responsible for the cost of the service. The member may not be billed if the provider fails to follow Mercy RBHA's policies. Both referring and receiving providers must comply with Mercy RBHA policies, documents, and requirements that govern referrals (paper or electronic) including prior authorization. Failure to comply may result in delay in care for the member, a delay or denial of reimbursement or costs associated with the referral being changed to the referring provider.

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Referrals are a means of communication between two providers servicing the same member. Although Mercy RBHA encourages the use of its referral form, it is recognized that some providers use telephone calls and other types of communication to coordinate the member's medical care. This is acceptable to Mercy RBHA if the communication between providers is documented and maintained in the member's medical records.

Referring Provider's Responsibilities

- Confirm that the required service is covered under the member's benefit plan prior to referring the member.
- Confirm that the receiving provider is contracted with Mercy RBHA.
- Obtain prior authorization for services that require prior authorization or are performed by a non-PHP.
- Complete a **Specialist Referral Form** available on our [Forms Library](#) web page and mail or fax the referral to the receiving provider.

Receiving Provider's Responsibilities

PHPs may render services to members for services that do not require prior authorization and that the provider has received a completed referral form (or has documented the referral in the member's medical record). The provider rendering services based on the referral is responsible to:

- Schedule and deliver the medically necessary services in compliance with Mercy RBHA's requirements and standards related to appointment availability.
- Verify the member's enrollment and eligibility for the date of service. If the member is not enrolled with Mercy RBHA on the date of service, Mercy RBHA will not render payment regardless of referral or prior authorization status.
- Verify that the service is covered under the member's benefit plan.
- Verify that the prior authorization has been obtained, if applicable, and includes the prior authorization number on the claim when submitted for payment.
- Inform the referring provider of the consultation or service by sending a report and applicable medical records to allow the referring provider to continue the member's care.

Period of Referral

Unless otherwise stated in a provider's contract or Mercy RBHA documents, a referral is valid for the full extent of the member's care starting from the date it is signed and dated by the referring provider, if the member is enrolled and eligible with Mercy RBHA on the date of service.

Maternity Referrals

Referrals to Maternity Care Health Practitioners may occur in two ways:

- A pregnant Mercy RBHA member may self-refer to any Mercy RBHA contracted Maternity Care Practitioner.

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- The PCP may refer pregnant members to a Mercy RBHA contracted Maternity Care Practitioner.

At a minimum, Maternity Care Practitioners must adhere to the following guidelines:

- Coordinate the members maternity care needs until completion of the postpartum visits.
- Schedule a minimum of one postpartum visit at approximately six weeks postpartum.
- When necessary, refer members to other practitioners in accordance with the Mercy RBHA referral policies and procedures.
- Schedule return visits for members with uncomplicated pregnancies consistent with the American College of Obstetrics and Gynecology standards:
 - Through twenty-eight weeks of gestation – every four weeks.
 - Between twenty-nine- and thirty-six-weeks' gestation every two weeks.
 - After the thirty sixth week – once a week.
 - Schedule first-time appointments within the required time frames.
 - Members in first trimester – within seven calendar days.
 - Members in third trimester – within three calendar days.
 - High-risk Members – within three calendar days of identification or immediately when an emergency condition exists.

Ancillary Referrals

All practitioners and providers must use and/or refer to Mercy RBHA contracted ancillary providers.

Member Self-Referrals

Mercy RBHA members can self-refer to participating providers for the following covered services:

- Family Planning Services
- OB/GYN Services
- Dental Services for Members Ages 18 through 20 years old.
- Vision services for Members Ages 18 through 20 years old.
- Behavioral Health Services for Members 18 years of age and older.

When a member self refers for any of the above services, providers rendering services must adhere to the same referral requirements as described above.

2.03 – Outreach, Engagement, Reengagement and Closure

Outreach

The behavioral health system must provide outreach activities to inform the public of the benefits and availability of behavioral health services and how to access them. Mercy RBHA will disseminate information to the public, other human service providers, school administrators

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and teachers and other interested parties regarding the behavioral health services that are available to eligible members.

Outreach activities conducted by Mercy RBHA may include, but are not limited to:

- Participation in local health fairs or health promotion activities
- Involvement with local schools
- Routine contact with AHCCCS Health Plan behavioral health coordinators and/or primary care providers
- Development of homeless outreach programs
- Development of outreach programs to members who are at risk, are identified as a group with high incidence or prevalence of behavioral health issues or are underserved
- Publication and distribution of informational materials
- Liaison activities with local and county jails, county detention facilities, and local and county DCS offices and programs
- Routine interaction with agencies that have contact with substance abusing pregnant females
- Development and implementation of outreach programs that identify members with co-morbid medical and behavioral health disorders and those who have been determined to have a Serious Mental Illness (SMI) within Mercy RBHA's geographic service area, including members who reside in jails, homeless shelters, county detention facilities or other settings
- Provision of information to mental health advocacy organizations
- Development and coordination of outreach programs to Native American tribes in Arizona to provide services for tribal members

Engagement

Mercy RBHA or their subcontracted providers will actively engage the following in the treatment planning process:

- The member and/or member's legal guardian
- The member's family/significant others, if applicable and amenable to the member
- Other agencies/providers as applicable
- For members with a Serious Mental Illness who are receiving Special Assistance, the member (guardian, family member, advocate or other) designated to provide Special Assistance

Behavioral health providers must provide services in a culturally competent manner in accordance with Mercy RBHA's Cultural Competency Plan. Additionally, behavioral health providers must:

- Provide a courteous, welcoming environment that provides members with the opportunity to explore, identify and achieve their personal goals
- Engage members in an empathic, hopeful and welcoming manner during all contacts
- Provide culturally relevant care that addresses and respects language, customs, and

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values and is responsive to the member's unique family, culture, traditions, strengths, age and gender

- Provide an environment that in which members from diverse cultural backgrounds feel comfortable discussing their cultural health beliefs and practices in the context of negotiating treatment options
- Provide care by communicating to members in their preferred language and ensuring that they understand all clinical and administrative information.
- Be aware of and seek to gain an understanding of members with varying disabilities and characteristics
- Display sensitivity to, and respect for, various cultural influences and backgrounds (e.g., ethnic, racial, gender, sexual orientation, socio-economic class, and veteran status)
- Establish an empathic service relationship in which the member experiences the hope of recovery and is considered to have the potential to achieve recovery while developing hopeful and realistic expectations
- Demonstrate the ability to welcome the member, and/or the member's legal guardian, the member's family members, others involved in the member's treatment and other service providers as collaborators in the treatment planning and implementation process
- Demonstrate the desire and ability to include the member's and/or legal guardian's viewpoint and to regularly validate the daily courage needed to recover from persistent and relapsing disorders
- Assist in establishing and maintaining the member's motivation for recovery
- Provide information on available services and assist the member and/or the member's legal guardian, the member's family, and the entire clinical team in identifying services that help meet the member's goals
- Provide the member with choice when selecting a provider and the services they participate in

Reengagement

For SMI Members, the reengagement policy is as follows:

SMI Behavioral Health Clinics must attempt to re-engage members in an episode of care that have withdrawn from participation in the treatment process prior to the successful completion of treatment, refused services or failed to appear for a scheduled service. All attempts to reengage members who have withdrawn from treatment, refused services or failed to appear for a scheduled service must be documented in the comprehensive clinical record. The SMI Behavioral Health Clinic must attempt to reengage the member assigned to a Supportive or Connective level of care for eight (8) weeks minimum, with two (2) outreach attempts per week and more intensive outreach if clinically indicated. One (1) of the two (2) outreach attempts per week must be conducted in the community.

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For members assigned to an ACT level of care, the ACT team must attempt to reengage the member for eight (8) weeks minimum, with four (4) outreach attempts per week. Two (2) of the four (4) outreach attempts per week are to be conducted in the community and performing street outreach. More intensive outreach if clinically indicated individualized to the member's needs and, for example, could range from four (4) attempts each week to multiple attempts each day.

If there are safety concerns, the behavioral health provider should assess for petitionable behavior. The SMI Behavioral Health Clinic should develop their own detailed policies outlining the consistency and methods of outreach and should include but is not limited to:

- Communicating in the member's preferred language.
- Contacting the member or the member's legal guardian by telephone, at times when the member may reasonably be expected to be available (e.g., after work or school).
- Whenever possible, contacting the member or the member's legal guardian face-to-face, if telephone contact is insufficient to locate the member or determine acuity and risk.
- Sending a letter to the current or most recent address requesting contact once the outreach process has begun, informing the member of the outreach process, except when a letter is contraindicated due to safety concerns (e.g., domestic violence) or confidentiality issues. The SMI Behavioral Health Clinic will note safety or confidentiality concerns in the progress notes section of the clinical record and include a copy of the letter sent in the comprehensive clinical record.
- Sending a letter to the current or most recent address requesting contact within 72 hours once all attempts at personal contact are unsuccessful, except when a letter is contraindicated due to safety concerns (e.g., domestic violence) or confidentiality issues. The SMI Behavioral Health Clinic will note safety or confidentiality concerns in the progress notes section of the clinical record and include a copy of the letter sent in the comprehensive clinical record.
- Members on Court Ordered Treatment (COT) should not be moved to a lower level of care even after outreach has been completed.
- For members determined to have a Serious Mental Illness who are receiving Special Assistance, contacting the designated person providing Special Assistance for his/her involvement in member's reengagement efforts.

For SMI Behavioral Health Service Providers:

SMI Behavioral Health Service Providers must attempt to re-engage members in an episode of care that have withdrawn from participation in the treatment process prior to the successful completion of treatment, refused services or failed to appear for a scheduled service. All attempts to reengage members who have withdrawn from treatment, refused services or failed to appear for a scheduled service must be documented in the comprehensive clinical record.

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The SMI Behavioral Health Service Provider must attempt to reengage the member with a minimum of three (3) separate outreach attempts by:

- Communicating in the member's preferred language
- Contacting the member, member's assigned behavioral health clinical team or the member's legal guardian by telephone, at times when the member may reasonably be expected to be available (e.g., after work or school)
- Whenever possible, contacting the member, member's assigned behavioral health clinical team or the member's legal guardian face-to-face, if telephone contact is insufficient to locate the member or determine acuity and risk
- Sending a letter to the current or most recent address requesting contact once three (3) separate outreach attempts at personal contact are unsuccessful, except when a letter is contraindicated due to safety concerns (e.g., domestic violence) or confidentiality issues. The SMI Behavioral Health Service Provider will note safety or confidentiality concerns in the progress notes section of the clinical record and include a copy of the letter sent in the comprehensive clinical record
- For members determined to have a Serious Mental Illness who are receiving Special Assistance for his/her involvement in member's reengagement efforts

If the above activities are unsuccessful, the behavioral health provider must make further attempts to reengage members determined to have a Serious Mental Illness (SMI), pregnant substance abusing females, or any member determined to be at risk of relapse, decompensation, deterioration or a potential harm to self or others. Further attempts may include contacting the member or member's legal guardian face to face or contacting natural supports who the member has given permission to the provider to contact. If the member appears to meet clinical standards as a danger to self, danger to others, persistently and acutely disabled or gravely disabled the provider must determine whether it is appropriate, and make attempts as appropriate, to engage the member to seek inpatient care voluntarily. If this is not a viable option for the member and the clinical standard is met, initiate the pre-petition screening or petition for treatment process.

All attempts to reengage members determined to have a Serious Mental Illness (SMI), pregnant substance abusing women/teenagers, or any member determined to be at risk of relapse, decompensation, deterioration or a harm to self or others must be clearly documented in the comprehensive clinical record.

No Show Policy

For all members receiving Serious Mental Illness and children's services, the provider must attempt a telephonic contact with member, within 24 hours, following any missed appointment. If the provider is unable to reach telephonically, a face to face/home visit is completed within 72 hours, following missed appointment. For all members receiving General Mental Health Substance Use services, the provider must attempt a telephonic contact, within 24 hours and again within 72 hours if unable to reach on 1st attempt.

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FOLLOW-UP AFTER SIGNIFICANT AND/OR CRITICAL EVENTS

For SMI non-ACT members, the clinical team must visit the member in the inpatient setting, for physical and behavioral health, within 72 business hours and continue to visit once a week. Behavioral health providers must also document activities in the clinical record and conduct follow-up activities to maintain engagement within the following timeframes:

- Discharged from inpatient services in accordance with the discharge plan and within 7 days or no later than 30 days;
- Involved in a behavioral health crisis within timeframes based upon the member's clinical needs, but no later than 7 days;
- Refusing prescribed psychotropic medications within timeframes based upon the member's clinical needs and individual history; and
- Released from local and county jails and detention facilities within 72 hours.
- For children removed from their parent or guardian by the Department of Child Safety (DCS), within 72 hours of notification from DCS.

Additionally, for members to be released from inpatient care, behavioral health providers must help establish priority prescribing clinician appointments to ensure client stabilization, medication adherence, and to avoid re-hospitalization.

For SMI members, if the member has a hospitalization the discharge policy is as follows:

- The BHMP appointment must be scheduled within 72 business hours following discharge.
- Home visit must be completed within 5 days following discharge.
- Face to face visits must be scheduled each week for 4 weeks following discharge (weekly face to face is monitored by 7-day intervals).
- RN appointment must be scheduled within 10 days following discharge.
- The 30-day face to face visit includes development of the "30-day discharge staffing note".

If an SMI member is in a psychiatric observation unit and not moved into an inpatient setting, the clinical team will need to schedule a BHMP appointment within 24 business hours of discharge from observation and the BHMP will determine if the member should also receive 4 weeks of follow-up as defined above.

FOOD INSECURITIES

In addition to the AHCCCS minimum requirements for the comprehensive assessment, Mercy RBHA has additional elements that must be documented in the comprehensive clinical record as they relate to members residing in a limited supermarket access zip code.

As health care professionals, we need to assess member need and the social determinants of health that may be impacting the member's level of engagement, health, and treatment plan.

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The United States Department of Agriculture (USDA) makes a clear and explicit distinction between food insecurity and hunger. “Food insecurity – the condition assessed in the food security survey and represented in USDA food security reports – is a household-level economic and social condition of limited or uncertain access to adequate food. Hunger is an individual-level physiological condition that may result from food insecurity.” (Source: <https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/definitions-of-food-security.aspx>).

Every member must be evaluated for food Insecurity and proximity to a limited supermarket access zip code. Often our members cannot access the health care and food they need when they need it. Many of our members live in limited supermarket access areas or “food deserts” and are uncertain as to where their next meal will come from or where they will obtain food for themselves and their families. Therefore, it’s important to assess where our members are obtaining their food and how often. The question below can be used to evaluate member food insecurity:

In the past 12 months, have you been uncertain as to where to access your next meal?

- Uncertainty would be defined as unable to articulate or develop a plan as to how they will access food for themselves or their family.

Some examples would include:

- Not having access to available funds for food;
- Inability to find transportation to secure food and food related items;
- Outreaching friends/family members for assistance has proven to be unsuccessful;
- Unable to locate food access through community programs/resources;
- Difficulty with budget planning, etc.

The USDA survey could be used as a guide to the assessment questions as you assess food insecurity. Those questions can be found at <https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/definitions-of-food-security.aspx>.

If a member replies yes to the question above, they would be identified as food insecure or having a food insecurity. If a member identifies as being food insecure and they live in a limited supermarket access area, additional measure should be taken to address the members need. Limited supermarket access or LSA is identified within designated areas in the Phoenix Metro area. The identification of the zip codes is set forth by the 2014 reinvestment funds LSA analysis tool found on www.policymap.com/maps. As the provider, this is a useful tool to decipher whether someone lives in an LSA. Refer to data available under the ‘Quality of Life’ in this website.

If a person is identified as being food insecure and/or living in an LSA, the treatment team must assist the member by adding this designation to the treatment plan and assist the member with

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identifying resources independently to obtain food on a regular basis. Examples of interventions that may be used to address this are as follows:

- Connecting them with DES and DHS to enroll them into Federal Nutrition programs like SNAP and WIC
- Transportation by bus
- Local food pantry that can provide free groceries (a map of all pantries is available at www.azfoodbanks.org)
- Budget planning
- Referral for permanent supportive housing/peer support
- Locating or identifying the hours of a Fresh Express (fresh food vending services) or community gardens.

SERVICE PLANNING

All individuals being served in the public behavioral health system must have a written plan for services upon an initial request for services and periodic updates to the plan to meet the changing behavioral health needs for individuals who continue to receive behavioral health services. Mercy RBHA does not mandate a specific service planning tool or format. Service plans must be utilized to document services and supports that will be provided to the individual, based on behavioral health service needs identified through the member's behavioral health assessment.

If a member is in immediate or urgent need of behavioral health services, an interim service plan may need to be developed to document services until a complete service plan is developed. A complete service plan, however, must be completed no later than 90 days after the initial appointment.

The behavioral health member, his/her guardian (if applicable), advocates (if assigned) must be included in the development of the service plan. In addition, family members, designated representatives, agency representatives and other involved parties, as applicable, may be invited to participate in the development of the service plan. Behavioral health providers must coordinate with the member's health plan, PCP or others involved in the care or treatment of the individual, as applicable, regarding service planning recommendations.

The service plan must be documented in the comprehensive clinical record, be based on the current assessment, and contain the following elements:

- The member/family vision that reflects the needs and goals of the member/family;
- Identification of the member's/family's strengths;
- Measurable objectives and timeframes to address the identified needs of the member/family;
- Identification of the specific services to be provided and the frequency with which the services will be provided;

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- The signature of the member/guardian and the date it was signed;
- Documentation of whether the member/guardian agrees with the plan;
- The signature of a clinical team member and the date it was signed;
- The signature of the member providing Special Assistance, for members determined to have Serious Mental Illness who are receiving Special Assistance; and
- The **Service Plan Rights Acknowledgement Template** dated and signed by the member or guardian, the member who filled out the service plan and a BHP if a BHT fills out the service plan.

If a member is identified as being food insecure and/or food insecure and living in an LSA, the treatment team must assist the member by adding this designation to the treatment plan and assist the member with identifying resources independently to obtain food on a regular basis.

Examples of interventions that may be used to address this are as follows:

- Bus training to a nearby grocery store;
- Budget planning;
- Referral for permanent supportive housing/peer support;
- Locating or identifying the hours of a food express (fresh food vending services) truck, or community gardens.

Service plans must be completed by BHPs or BHTs who are trained on the behavioral health service plan and meet credentialing and recredentialing requirements. If a BHT completes the service plan, a BHP must review and sign the service plan within 30 days of the BHT signature.

The behavioral health member and/or their parent/guardian must be provided with a copy of their plan. Questions regarding service plans or member rights should be directed to Mercy RBHA's customer service line at 800-564-5465.

Minimum elements of the service plan for Non-Title XIX/XXI members determined to have SMI that do not have an assigned Care Manager

Service plans for Non-Title XIX/XXI members determined to have SMI who do not have an assigned Care Manager can be incorporated into the psychiatric progress notes completed by the BHP if the treatment goals reflect the needs identified on the assessment, are clearly documented, and summarize the progress made. The BHP must document when a clinical goal has been achieved and when a new goal has been added.

Additionally, Non-Title XIX/XXI members determined to have SMI, who do not have an assigned Care Manager shall have the option of accessing peer support services to assist them in developing a peer-driven, self-developed proposed service plan to be shared with their BHP for approval, adoption and implementation. These peer-driven, self-developed service plans are not required to contain all minimum elements as outlined above for those that have assigned Care Managers; however, they should consider the member-specific needs for and expected benefits from community-based support services including, but not limited to supported

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employment, peer support, family support, permanent supportive housing, living skills training, health promotion, personal assistance, and respite care. Peer-driven, self-developed proposed service plans should also address natural supports that can be leveraged and strengthened as well as outline crisis prevention approaches (e.g. warm line availability) and how the emergence of a potential crisis will be addressed.

These services should be incorporated into the peer-driven, self-developed proposed service plan as appropriate. It is recommended that a standardized process be used to develop peer-driven, self-developed proposed service plans.

Additionally, the peer-driven, self-developed proposed service plan must be reviewed with and approved by the BHP and maintained in the medical record. Progress and outcomes related to the approved peer-driven, self-developed service plan must be tracked and documented by the BHP.

Appeals or Service Plan Disagreements

Every effort should be taken to ensure that the service planning process is collaborative, solicits and considers input from each team member and results in consensus regarding the type, mix and intensity of services to be offered. If a member and/or legal or designated representative disagree with any aspect of the service plan, including the inclusion or omission of services, the team should make reasonable attempts to resolve the differences and actively address the member's and/or legal or designated representative's concerns.

Despite a BHP's best effort, it may not be possible to achieve consensus when developing the service plan. In cases that the member and/or legal or designated representative disagree with some or all of the Title XIX/XXI covered services included in the service plan, the member and/or legal or designated representative **must** be given a **Notice of Adverse Benefit Determination (NOA)** [available on our Forms Library web page](#) by the behavioral health representative on the team.

2.04 – Serious Mental Illness Decertification

SMI DECERTIFICATION

There are two established methods for removing a SMI designation, one clinical and the other an administrative option, as follows:

1. SMI Clinical Decertification

- A member who has a SMI designation or a member working with an individual from the member's clinical team may request a SMI Clinical Decertification. A SMI Clinical Decertification is a determination that a member who has a SMI designation no longer meets SMI criteria. If, because of a review, the member is determined to no longer meet the diagnostic and/or functional requirements for SMI status:

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- The Determining Entity shall ensure that written notice of the determination and the right to appeal is provided to the affected member with an effective date of 30 days after the date the written notice is issued.
- Mercy RBHA must ensure that services are continued in the event an appeal is filed timely, and that services are appropriately transitioned as part of the discharge planning process.

2. SMI Administrative Decertification

- A member who has a SMI designation may request a SMI Administrative Decertification if the member has not received behavioral health services for a period of two or more years.
 - Upon receipt of a request for Administrative Decertification, Mercy RBHA shall direct the member to contact AHCCCS DHCM Customer Service.
 - AHCCCS will evaluate the member's request and review data sources to determine the last date the member received a behavioral health service. AHCCCS will inform the member of changes that may result with the removal of the member's SMI designation. Based upon review, the following will occur:
 - In the event the member has not received a behavioral health service within the previous two years, the member will be provided with AMPM Exhibit 320-P-3. This form must be completed by the member and returned to AHCCCS.
 - In the event the review finds that the member has received behavioral health services within the prior two-year period, the member will be notified that they may seek decertification of their SMI status through the Clinical Decertification process.

SMI CLINIC TRANSFER PROTOCOL

- Once CRN determines the SMI decertification, CRN sends an email to the SMI clinic indicating the specific member status of decertification.
- As soon as the SMI clinic receives notification that a member has completed and been approved for SMI decertification, the SMI clinic will immediately begin working with the member to determine where the member wants to transfer their services.
- The SMI clinic must complete appropriate coordination between a GMH/SA provider(s) or BHMP/PCP of the member's choice to eliminate any gaps in care for the member.
- The transferring of services from the SMI clinic to the GMH/SA provider(s) or alternative BHMP/ PCP must be completed in less than thirty (30) days from the time the SMI clinic is notified the member is determined to no longer meet SMI criteria.
- All coordination must be appropriately documented in the member's medical record.
- It is the sending provider's responsibility to gather a release of information from the member and transfer all applicable records to the receiving provider.

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- If a member is not currently receiving services from an SMI clinic but is T19, the SMI clinic that the member was paneled to under the Navigator level of care is responsible for completing the transfer of the member.
- If a member does not want to transfer to a GMH/SA provider or BHMP/PCP or refuses to sign a release of information for a receiving provider, the SMI clinic will complete appropriate outreach and engagement which requires two outreach attempts.
- The SMI clinic will offer the member the opportunity to obtain their medical records if the member declines further assistance with the transfer process.
- If the member is unable to be contacted or declines obtaining their records, the SMI clinic must retain the original or copies of the member's medical records for at least six (6) years after the last date the member receives medical or health care services from the provider.

MERCY RBHA TRANSFER PROTOCOL

Mercy RBHA member transition process in coordination with Arizona Health Care Cost Containment System (AHCCCS) helps to ensure that members' healthcare continues without interruption or delay when there is a change of health plans. When an individual has been approved for SMI decertification, Mercy RBHA, as the relinquishing Contractor, will complete and transmit the Enrollment Transition Information (ETI) form to the appropriate parties no later than 10 business days from receipt of AHCCCS notification. Mercy RBHA's transition coordinator will also notify the receiving health plan's transition coordinator to ensure that the member's services are appropriately transferred.

PANELING OF MEMBERS WITH SMI

All members enrolled in the Mercy RBHA and Non-Title XIX SMI eligibility plans are paneled to an Assigned Behavioral Health Clinic (ABHC). Mercy RBHA panels newly enrolled members to an ABHC based on member preference. If member preference is unavailable, the member is paneled to an ABHC based on geographic proximity. Paneling to an ABHC is aligned to member eligibility. Members are not paneled to an ABHC during gaps in enrollment or while eligible in a plan other than Integrated or Non-Title XIX SMI.

There are numerous scenarios where a member determined with SMI may be enrolled in a plan other than Integrated or Non-Title XIX SMI.

- Native American – Native American members have choice and may opt-out of enrollment in an Integrated plan.
- Opt-Out Request – A member determined SMI, who is currently enrolled in a RBHA, may opt out of receiving physical health services from the RBHA and be transferred to an Acute Care Contractor for his/her physical health services if one or more of the applicable opt out criteria are satisfied. Members who meet the opt-out criteria will continue to receive behavioral health services through Mercy RBHA.

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- Recent Determination – There is a 14-day transitional period for a change in health plan for Medicaid members determined with SMI.

In addition to being paneled to an ABHC, members receiving services through Assertive Community Treatment (ACT) teams must be paneled to an ACT Team. Mercy RBHA does not panel newly enrolled members to ACT teams.

SMI clinics and ACT teams are required to manage their panels through the Member Paneling tool available in Provider Intake on the Medicaid Web Portal. Panel changes submitted through the Member Paneling tool are processed nightly and loaded directly into the Mercy RBHA provider information systems. Specific instructions on utilization of the **Provider Intake Member Paneling Tool** are available under the [Reference Material and Guides section](#) of our website.

IHH Health Homes, SMI clinics and ACT teams that fail to manage their panels are subject to corrective action, loss or reduction of incentives and sanctions.

2.05 – General and Informed Consent

Any member aged 18 years and older, in need of behavioral health services must give voluntary general consent to treatment, demonstrated by the member's or legal guardian's signature on a general consent form, before receiving behavioral health services.

For members under the age of 18, the parent, legal guardian, or a lawfully authorized custodial agency must give general consent to treatment, demonstrated by the parent, legal guardian, or a lawfully authorized custodial agency representative's signature on a general consent form prior to the delivery of behavioral health services.

Any member aged 18 years and older or the member's legal guardian, or in the case of members under the age of 18, the parent, legal guardian or a lawfully authorized custodial agency, after being fully informed of the consequences, benefits and risks of treatment, has the right not to consent to receive behavioral health services.

Any member aged 18 years and older or the member's legal guardian, or in the case of members under the age of 18, the parent, legal guardian or a lawfully authorized custodial agency has the right to refuse medications unless specifically required by a court order or in an emergency.

Providers treating members in an emergency are not required to obtain general consent prior to the provision of emergency services. Providers treating members pursuant to court order must obtain consent, as applicable, in accordance with [A.R.S. Title 36, Chapter 5](#).

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All evidence of informed consent and general consent to treatment must be documented in the comprehensive clinical record per the following forms available under our [Forms Library](#) web page:

- **Consent to Treatment Form;**
- **Informed Consent for Psychotropic Medication Treatment (English/Spanish)**
- **Consent for Electroconvulsive Therapy (ECT)**

General Consent

Administrative functions associated with a behavioral health member's enrollment do not require consent, but before any services are provided, general consent must be obtained. General consent is usually obtained during the intake process and represents a member's, or if under the age of 18, the member's parent, legal guardian or lawfully authorized custodial agency representative's written agreement to participate in and to receive non-specified (general) behavioral health services. See **Consent to Treatment Form**.

Informed Consent Required Information

In all cases where informed consent is required by this chapter, informed consent must include at a minimum:

- **Behavioral health member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions;**
- **Information about the member's diagnosis and the proposed treatment, including the intended outcome, nature and all available procedures involved in the proposed treatment;**
- **The risks, including any side effects, of the proposed treatment, as well as the risks of not proceeding;**
- **The alternatives to the proposed treatment, particularly alternatives offering less risk or other adverse effects;**
- **That any consent given may be withheld or withdrawn in writing or orally at any time.**
- **When this occurs, the provider must document the member's choice in the medical record;**
- **The potential consequences of revoking the informed consent to treatment; and**
- **A description of any clinical indications that might require suspension or termination of the proposed treatment.**

Documenting Informed Consent

- **Members, or if applicable the client's parent, guardian or custodian shall give informed consent for treatment by signing and dating an acknowledgment that he or she has received the information and gives informed consent to the proposed treatment.**
- **When informed consent is given by a third party, the identity of the third party and the legal capability to provide consent on behalf of the member, must be established. If the informed consent is for psychotropic medication or telemedicine and the member, or if applicable, the member's guardian refuses to sign an acknowledgment and gives verbal informed consent, the medical practitioner shall document in the member's record that the information was given, the client refused to sign an acknowledgment and that the client gives informed consent to use psychotropic medication or telemedicine.**

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Providing Informed Consent

When providing information that forms the basis of an informed consent decision for the circumstances identified above, the information must be:

- Presented in a manner that is understandable and culturally appropriate to the member, parent, legal guardian or an appropriate court; and
- Presented by a credentialed behavioral health practitioner or a registered nurse with at least one year of behavioral health experience. It is preferred that the prescribing clinician provide information forming the basis of an informed consent decision. In specific situations in which that are not possible or practicable, information may be provided by another credentialed behavioral health practitioner or registered nurse with at least one year of behavioral health experience.

Psychotropic Medications, Complementary and Alternative Treatment and Telemedicine

Unless treatments and procedures are court ordered, providers must obtain written informed consent, and if written consent is not obtainable, providers must obtain oral informed consent. If oral informed consent is obtained instead of written consent from the member, parent or legal guardian, it must be documented in written fashion. Informed consent is required in the following circumstances:

- Prior to the initiation of any psychotropic medication or initiation of Complementary and Alternative Treatment (CAM). The use of Informed Consent for Psychotropic Medication Treatment (English/Spanish), available on our [Forms Library](#) web page, is recommended as a tool to review and document informed consent for psychotropic medications; and
- Prior to the delivery of behavioral health services through telemedicine.

Electro-Convulsive Therapy (ECT), Research Activities, Voluntary Evaluation and Procedures/ Services with Known Substantial Risks or Side Effects

Written informed consent must be obtained from the member, parent or legal guardian, unless treatments and procedures are under court order, in the following circumstances:

- Before the provision of ECT;
- Prior to the involvement of the member in research activities;
- Prior to the provision of a voluntary evaluation for a member. The use of the Application for Voluntary Evaluation (English/Spanish), available on our [Forms Library](#) web page, is required for members determined to have a Serious Mental Illness and is recommended as a tool to review and document informed consent for voluntary evaluation of all other populations; and
- Prior to the delivery of any other procedure or service with known substantial risks or side effects.
- Coordination of care with the outpatient Behavioral Health Medical Provider is required.
- Member has been prescreened by anesthesiologist.
- Relative contraindications include:
 - space occupying lesions of the brain
 - high intracranial pressure
 - unstable or severe cardiovascular disease
 - recent myocardial infarction

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- recent cerebral infarction
- retinal detachment
- high anesthesia risk
- significant medical risk
- unstable musculoskeletal injuries (particularly spinal)
- **Medical clearance required checklist:**
 - Complete medical/ surgical history
 - Physical examination completed in last thirty (30) days
 - Required Basic laboratory work:
 - CBC with differential
 - chemistry panel
 - TSH, drug blood levels
 - UA
 - UDS
 - UPT urine pregnancy test
 - iron studies (as applicable)
 - EKG (within 30 days and reviewed by your medical consultant)
 - If female, please provide negative UPT (last 7 days) or if pregnant provide documentation of consult and evaluation by OB/GYN
 - Medical consultant review and clearance opinion on the nature of unstable or serious medical conditions
 - As indicated (e.g. osteoporosis, osteopenia, history of skull spinal trauma) X-Rays of the Spine- Lateral X-rays of the dorso-lumbar spine to rule out any spine fracture, before giving ECT, — Skull X-Rays - Anteroposterior and lateral view of skull to screen intracerebral pathology before ECT.

BHMP Note: You are required to have the member assigned to a behavioral health provider in the network prior to discharge. If the member is not currently assigned to a BHMP, please call Member Services 1-800-564-5465 for assistance in locating a provider.

If this is a request for ongoing ECT, coordination of care is required with the outpatient community mental health provider.

Health Information Exchange

Consent for participation in the H.I.E. is received at the clinics, typically during intake. Members have the option to opt in or out of the Health Information Exchange at any time by contacting their clinic and updating their consent documentation.

Additional Provisions

Written informed consent must be obtained from the member, legal guardian or an appropriate court prior to the member's admission to any medical detoxification, inpatient facility or residential program operated by a behavioral health provider.

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Revocation of Informed Consent

If informed consent is revoked, treatment must be promptly discontinued, except in cases in which abrupt discontinuation of treatment may pose an imminent risk to the member. In such cases, treatment may be phased out to avoid any harmful effects.

Special Requirements for Children

In accordance with **A.R.S. §36-2272**, except as otherwise provided by law or a court order, no member, corporation, association, organization or state-supported institution, or any individual employed by any of these entities, may procure, solicit to perform, arrange for the performance of or perform mental health screening in a nonclinical setting or mental health treatment on a minor without first obtaining the written or oral consent of a parent or a legal custodian of the minor child. If the parental consent is given through telemedicine, the health professional must verify the parent's identity at the site where the consent is given. This does not apply when an emergency exists that requires a member to perform mental health screening or provide mental health treatment to prevent serious injury to or save the life of a minor child.

Non-emergency Situations

In cases where the parent is unavailable to provide general or informed consent and the child is being supervised by a caregiver who is not the child's legal guardian (e.g., grandparent) and does not have power of attorney, general and informed consent must be obtained from one of the following:

- **Lawfully authorized legal guardian;**
- **Foster home, group home, kinship or another member/agency with whom the Department of Child Safety (DCS) has placed the child; or**
- **Government agency authorized by the court.**

If someone other than the child's parent intends to provide general and, when applicable, informed consent to treatment, the following documentation must be obtained and filed in the child's comprehensive clinical record:

Individual/Entity	Documentation
Legal guardian	Copy of court order assigning custody
Relatives	Copy of power of attorney document
Another member/agency	Copy of court order assigning custody
DCS out-of-home placements (for children removed from the home by DCS), such as: Foster home, group home, kinship, other member/agency in whose care DCS has placed the child	Copy of Notice to Provider – Educational and Medical (DCS Form FC-069)

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For any child who has been removed from the home by DCS, the foster home, group home kinship caregiver or other member or agency in whose care the child is currently placed can consent to evaluation and treatment for routine behavioral health services.

Examples of behavioral health services in which DCS out-of-home placements can consent to include:

- Assessment and service planning
- Counseling and therapy
- Rehabilitation services
- Medical Services
- Psychiatric evaluation
- Psychotropic medication
- Laboratory services
- Support Services
- Care Management
- Personal Care Services
- Family Support
- Peer Support
- Respite
- Sign Language or Oral Interpretive Services
- Transportation
- Crisis Intervention Services
- Behavioral Health Day Programs

DCS must consent to inpatient psychiatric acute care services, behavioral health residential treatment services (Behavioral Health Inpatient Facility – BHIF), therapeutic group homes (Behavioral Health Residential Facility – BHRF), and Home Care Training to Home Care Client (HCTC).

Any minor who has entered into a lawful contract of marriage, whether that marriage has been dissolved subsequently emancipated youth or any homeless minor may provide general and, when applicable, informed consent to treatment without parental consent (**A.R.S. §44- 132**).

Emergency Situations

In emergency situations involving a child in need of immediate hospitalization or medical attention, general and, when applicable, informed consent to treatment is not required.

Any child, 12 years of age or older, who is determined upon diagnosis of a licensed physician, to be under the influence of a dangerous drug or narcotic, not including alcohol, may be considered an emergency and can receive behavioral health care as needed for the treatment of the condition without general and, when applicable, informed consent to treatment.

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Informed Consent During Involuntary Treatment

At times, involuntary treatment can be necessary to protect safety and meet needs when a member, due to mental disorder, is unwilling or unable to consent to necessary treatment. In this case, a court order may serve as the legal basis to proceed with treatment. However, capacity to give informed consent is situational, not global, as an individual may be willing and able to give informed consent for aspects of treatment even when not able to give general consent. Individuals should be assessed for capacity to give informed consent for specific treatment and such consent obtained if the individual is willing and able, even though the individual remains under court order.

Consent for Behavioral Health Survey or Evaluation for School-Based Prevention Programs

Written consent must be obtained from a child's parent or legal guardian for any behavioral health survey, analysis or evaluation conducted about a school-based prevention program administered by AHCCCS.

Substance Abuse Prevention Program and Evaluation Consent must be used to gain parental consent for evaluation of school-based prevention programs. Providers may use an alternative consent form only with the prior written approval of Mercy RBHA. The written consent must satisfy all the following requirements:

- **Contain language that clearly explains the nature of the screening program and when and where the screening will take place;**
- **Be signed by the child's parent or legal guardian; and**
- **Provide notice that a copy of the actual survey, analysis or evaluation questions to be asked of the student is available for inspection upon request by the parent or legal guardian.**

Completion of the **Substance Abuse Prevention Program and Evaluation Consent** applies solely to consent for a survey, analysis, or evaluation only, and does not constitute consent for participation in the program itself.

2.06 – SMI Patient Navigator

The SMI Patient Navigator is a position within the Direct Care SMI Clinics service structure to ensure that all members designated as SMI, Title XIX or NTXIX have a behavioral health home. The SMI Patient Navigator staff shall screen members for service needs and based on the needs identified, conduct an assessment and treatment plan outlining necessary support services and outreach and engagement from the Direct Care SMI Clinic.

Navigator position details and contact requirements

- BHT level staff member who demonstrates competency in assessments, engagement and outreach;
- The SMI Patient Navigator shall complete an annual screening and the Mercy RBHA Health Risk Assessment (HRA);

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- The SMI Patient Navigator shall provide engagement and assistance to the members in navigating and connecting to behavioral health services;
- Members assigned to a SMI Patient Navigator shall receive outreach within 90 days upon assignment and at minimum annually thereafter; and
- Caseload will be 1-250;

All members assigned or receiving SMI Patient Navigator Services shall be screened with a provider identified screening tool and the HRA at a minimum annually. Upon completion of the screening and agreement to participate in active services, the consent to treat, assessment and treatment plan will be completed. When determining if a member needs care management services or continued SMI Patient Navigator services, the clinical team should consider the following upon completion of the screening:

- Should the screening tool or member themselves, indicate a need to continue Navigator services, the member will be engaged to complete a basic treatment plan that reflects this level of service along with completion of consents and assessment;
- Should the member needs warrant care management, the assessment and treatment plan should indicate service level need and a transition to care management should occur within regularly outlined access to care requirements; and
- There may be circumstances in which the member indicates needs that warrant crisis service utilization, which will proceed as standard crisis protocol.
- Members that received Special Assistance or are Court Ordered for Treatment (COT) should not be moved to a Navigator level of care.

Example of process:

1. Screen the member using the screening tool:
 - a. If the member is interested in care management, complete consents, assessment, and plan:
 - i. Determine if higher level of care warranted:
 1. Supportive;
 2. Connective; or
 3. Continued Navigator
 - b. If member is unable to be contacted:
 - i. Continue to reach out 3 times;
 - ii. Send a certified letter;
 - iii. Attempt one face to face contact - use of BHPPs could be applicable; and
 - iv. Connect with the PCP.

Members previously designated as SMI but may no longer require care management may be assigned to a SMI Patient Navigator to ensure continued behavioral health service connection. Movement from care management to an SMI Patient Navigator shall be determined through an assessment with the BHMP when assessing level of care. Should the member need care

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management, the SMI Direct Care clinic will transition the member to the appropriate level of care management to meet the member's needs.

Closure of an SMI member's episode of care will occur for the following reasons. All others will remain at the Navigator level of Care Management:

- Incarceration in prison (after 3 months' stay)
- Member moved out of state and move was completed with coordinated efforts from treatment team
- Member has requested decertification (last resort and should be thoroughly discussed with member by treatment team)
- Member moved to ALTCS
- Member's Death

In the above scenarios, the member will remain on a clinic's roster until the eligibility updates are provided via AHCCCS to Mercy RBHA. Once the eligibility updates are received, the clinic's roster will be updated accordingly.

2.07 – Pharmacy Management

Pharmacy Management

Prescription drugs may only be prescribed by Mercy RBHA credentialed and licensed physicians, licensed physician assistants, or licensed nurse practitioners. Prescriptions should be written to allow generic substitution whenever possible and signatures on prescriptions must be legible for the prescription to be dispensed. The [Preferred Drug List](#) (PDL) identifies the medications selected by the Pharmacy and Therapeutics Committee (P&T Committee) or per AHCCCS mandates that are clinically appropriate to meet the therapeutic needs of our members in a cost effective manner.

Updating the Preferred Drug Lists (PDLs)

Mercy RBHA's PDLs are developed, monitored and updated based on feedback from the P&T Committee and AHCCCS. Medications are added or removed based on objective, clinical and scientific data. Considerations include efficacy, side effect profile, and cost and benefit comparisons to alternative agents, if available.

Notification of PDL Updates

Mercy RBHA will not remove a medication from the PDL without first notifying providers and affected members. Mercy RBHA will provide at least 60 days' notice of such changes. Mercy RBHA is not required to send a hard copy of the PDL each time it is updated, unless requested. A memo may be used to notify providers of updates and changes and may refer providers to view the updated PDL on the Mercy RBHA website. Mercy RBHA may also notify providers of changes to the PDL via direct letter. Mercy RBHA will notify members of updates to the PDL via direct mail and by notifying the prescribing provider, if applicable.

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Prior Authorization

Prior authorization is required:

- If the drug is not included on the PDL.
- If the member has a primary insurance that reimburses for injectable medications, Mercy RBHA will only coordinate benefits as the secondary payer if the Mercy RBHA pharmacy prior authorization process was followed.
- For injectable medications dispensed by the physician and billed through the member's medical insurance, please call 602-586-1841 or toll-free 800-564-5465 to initiate prior authorization for the requested specialty medication.
- For medication quantities which exceed recommended doses.
- For specialty drugs which require certain established clinical guidelines be met before consideration for prior authorization.
- For certain medications that may require additional documentation, e.g. Hepatitis C medications.

Allow up to 24 hours for the prior authorization review process.

In instances where a prescription is written for drugs not on the PDL, the pharmacy may contact the prescriber to either request a PDL alternative or to advise the prescriber that prior authorization is required for non-PDL drugs.

Decision and Notification Standards

Mercy RBHA makes pharmacy prior authorization decisions and notifies prescribing practitioners/providers, and/or members in a timely manner, according to the standards defined below:

- Mercy RBHA makes decisions within 24 hours of the receipt of all necessary information.
- Mercy RBHA notifies requesting prescribing providers by fax, phone or electronic communication of the approved decisions within 24 hours of receipt of the submitted request for prior authorization.
- A request for additional information is sent to the prescriber by fax within 24 hours of the submitted request when the prior authorization request for a medication lacks enough information to render a decision. A final decision will be rendered within seven business days from the initial date of the request.
- If an authorization is denied, Mercy RBHA notifies members and practitioners and/or providers regarding how to initiate an expedited appeal at the time they are notified of the denial.
- Mercy RBHA *will fill at least* a 4-day supply of a covered outpatient prescription drug in an emergent situation.

Over the Counter (OTC) Medications

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A limited number of OTC medications are covered for Mercy RBHA members. OTC medications require a written prescription from the physician that must include the quantity to be dispensed and dosing instructions. Members may present the prescription at any Mercy RBHA contracted pharmacy. OTCs are limited to the package size closest to a 30-day supply. Some medications may require step therapy.

Generic vs. Brand

Generic medications represent a considerable cost savings to the health care industry and Medicaid program. As a result, generic substitution with AB-rated products is mandatory unless the brand has been specifically authorized or as otherwise noted on the PDL. Brand medications can be filled if there is not an AB-rated generic available.

Diabetic Supplies

Diabetic supplies are limited to a one-month supply (to the nearest package size) with a prescription.

Injectable Drugs

The following types of injectable drugs are covered when dispensed by a licensed pharmacist or administered by a participating provider in an outpatient setting:

- Immunizations
- Chemotherapy for the treatment of cancer
- Medication to support chemotherapy for the treatment of cancer
- Glucagon emergency kit
- Insulin; Insulin syringes
- Immunosuppressant drugs for the post-operative management of covered transplant services
- Rhogam
- Rabies vaccine

Exclusions

The following items, by way of example, are not reimbursable by Mercy RBHA:

- Anorexiant
- DESI drugs (those considered less than effective by the FDA)
- Non-FDA approved agents
- Rogaine
- Any medication limited by federal law to investigational use only
- Medications used for cosmetic purposes
- Non-indicated uses of FDA approved medications without prior approval by Mercy RBHA
- Lifestyle medications (such as medications for erectile dysfunction)
- Medications used for fertility

Family Planning Medications and Supplies

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Family Planning Services are an available benefit for Mercy RBHA. These benefits include:

- Over-the-counter items related to family planning (condoms, foams, suppositories, etc.) are covered and do not require prior authorization. However, the member must present a written prescription, to the pharmacy including the quantity to be dispensed. A supply for up to 30-days is covered.
- Injectable medications, administered in the provider's office, such as Depo-Provera will be reimbursed at the Mercy RBHA Fee Schedule, unless otherwise stated in the provider's contract.
- Oral contraceptives are covered for Mercy RBHA members.

Requests for Non-PDL Drugs

A physician requesting a change to Mercy RBHA's Preferred Drug List (PDL) should include the following information in the request:

- Basic product information
- Indications for use
- Therapeutic advantage
- Which drug(s) it would replace in the current PDL
- Any supporting literature from medical journals

The requesting physician may be invited to attend the Pharmacy and Therapeutics Committee meeting to support the PDL addition request and answer questions. Requests should be sent to:

Mercy Care RBHA
Corporate Pharmacy Director
4645 E. Cotton Center Blvd.
Building 1, Suite 200
Phoenix, AZ 85040

Psychotropic Medication: Prescribing and Monitoring

Psychotropic medication will be prescribed by a psychiatrist who is a licensed physician, or a licensed nurse practitioner, licensed physician assistant, or physician trained or experienced in the use of psychotropic medication; that has seen the client and is familiar with the client's medical history or, in an emergency, is at least familiar with the client's medical history.

When a client on psychotropic medication receives a yearly physical examination, the results of the examination will be reviewed by the physician prescribing the medication. The physician will note any adverse effects of the continued use of the prescribed psychotropic medication in the client's record.

Whenever a prescription for medication is written or changed, a notation of the medication, dosage, frequency or administration, and the reason why the medication was ordered or changed will be entered in the client's record.

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Assessments

Reasonable clinical judgment, supported by available assessment information, must guide the prescription of psychotropic medications. To the extent possible, candidates for psychotropic medications must be assessed prior to prescribing and providing psychotropic medications. Psychotropic medication assessments must be documented in the member's comprehensive clinical record. Behavioral health medical providers (BHMPs) can use assessment information that has already been collected by other sources and are not required to document existing assessment information that is part of the member's comprehensive clinical record. At a minimum, assessments for psychotropic medications must include:

- An adequately detailed medical and behavioral health history;
- A mental status examination;
- A diagnosis;
- Target Symptoms;
- A review of possible medication allergies;
- A review of previously and currently prescribed psychotropic medications including any noted side effects and/or potential drug-drug interactions;
- Current medications prescribed by the PCP and medical specialists;
- Current over the counter (OTC) medications, including supplements;
- For sexually active females of childbearing age, a review of reproductive status (pregnancy); and
- For post-partum females, a review of breastfeeding status;

Annual reassessments must ensure that the provider prescribing psychotropic medication notes in the client's record:

- The reason for the use of the medication and the effectiveness of the medication;
- The appropriateness of the current dosage;
- All medication (including medications prescribed by the PCP and medical specialists, OTC medications, and supplements) being taken and the appropriateness of the combination of the medications; and
- Any side effects such as weight gain and/or abnormal/involuntary movements if treated with an anti-psychotic medication.

Informed Consent

Informed consent must be obtained from the member and/or legal guardian for each psychotropic medication prescribed. When obtaining informed consent, the BHP must communicate in a manner that the member and/or legal guardian can understand and comprehend. It is preferred that the prescribing clinician provide information forming the basis of an informed consent decision. In specific situations in which this is not possible or practicable, information may be provided by another credentialed behavioral health medical practitioner or registered nurse with at least one year of behavioral health experience.

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The comprehensive clinical record must include documentation of the essential elements for obtaining informed consent. Essential elements for obtaining informed consent for medication are contained within the [Informed Consent for Psychotropic Medication Treatment](#). The use of this form is recommended as a tool to document informed consent for psychotropic medications. If Informed Consent for Psychotropic Medication Treatment is not used to document informed consent, the essential elements for obtaining informed consent must be documented in the member's individual comprehensive clinical record in an alternative fashion.

Psychotropic Medication Monitoring

Psychotropic medications are known to affect health parameters. Depending on the specific psychotropic medication(s) prescribed, these parameters must be monitored according to current national guidelines, considering individualized factors. At a minimum, these must include:

- **Heart Rate and Blood Pressure:** On initiation of any medication, follow up at week 12, and at least annually thereafter or more frequently as clinically indicated.
- **Weight/Body Mass Index (BMI):** On initiation of any medication, follow up at week 4, 8, 12, each visit and at least annually thereafter.
- **Abnormal Involuntary Movements (AIMS):** On initiation of any antipsychotic medication, follow up at week 12, and at least every six months thereafter or more frequently as clinically indicated.
- **Fasting glucose:** On initiation of any medication affecting this parameter, follow up at week 12, and at least annually thereafter or more frequently as clinically indicated.
- **Lipids:** On initiation of any medication affecting this parameter and at least annually thereafter or more frequently as clinically indicated.
- **Complete Blood Count (CBC):** On initiation of any medication affecting this parameter and at least annually thereafter or more frequently as clinically indicated.
- **Liver function:** On initiation of any medication affecting this parameter and at least annually thereafter or more frequently as clinically indicated.
- **Lithium level:** Within one week of initiation of lithium or significant change in dose, follow up at 6 months, and at least annually thereafter or more frequently as clinically indicated.
- **Thyroid functions:** On initiation of lithium, at 6 months, at any significant change in dose, and at least annually thereafter, or more frequently as clinically indicated.
- **EKGs:** On initiation of any medication affecting the QT interval, then as clinically indicated.
- **Renal function:** On initiation of lithium, follow up at 3 months, 6 months, at any significant change in dose, and at least annually thereafter or more frequently as clinically indicated.
- **Valproic acid level:** Within one week of initiation of valproic acid or divalproex or significant change in dose and at least annually thereafter or more frequently as clinically indicated.

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- **Carbamazepine level:** Within one week of initiation of carbamazepine or significant change in dose and at least annually thereafter or more frequently as clinically indicated.
- **Review of all Medications,** including medications prescribed by the PCP and medical specialists, OTC medications, and supplements at least annually or more frequently as clinically necessary.
- **Children** are more vulnerable than adults about developing several antipsychotic induced side effects. These included higher rates of sedation, extrapyramidal side effects (except for akathisia), withdrawal dyskinesia, prolactin elevation, weight gain and at least some metabolic abnormalities. (Journal of Clinical Psychiatry 72:5 May 2011)

Polypharmacy

Commonly used psychotropic medication combinations include the following: medication combinations used to treat multiple disorders in the same patient, medication combinations that offer unique treatment advantages for a single disorder, and medication combinations to address side effects of an effective agent (Practice Parameter on the Use of Psychotropic Medication in Children and Adolescents J. AM. ACAD. CHILD ADOLESC. PSYCHIATRY, 48:9, SEPTEMBER 2009).

Mercy RBHA recognizes two types of polypharmacy: intra-class polypharmacy and inter-class polypharmacy. Below are Mercy RBHA expectations regarding prescribing multiple psychotropic medications to a member being treated for a behavioral health condition:

- **Intra-class Polypharmacy:** Defined as more than two medications prescribed at the same time within the same class, other than for cross-tapering purposes. The member's medical record must contain documentation specifically describing the rationale and justification for the combined use.
- **Inter-class Polypharmacy:** Defined as more than three medications prescribed at the same time from different classes of medications for the overall treatment of behavioral health disorders. The medical record must contain documentation specifically describing the rationale and justification for the combined use.
- **Polypharmacy in Children aged Birth to Five:** Defined as use of more than one psychotropic medication at a time (see [Practice Guidelines for Children: Birth to Five Years of Age](#)).

Reporting Requirements

Mercy RBHA has established system requirements for monitoring the following:

- Adverse drug reactions;
- Adverse drug event; and
- Medication errors.

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The above referenced events are identified, reported, tracked, reviewed and analyzed by Mercy RBHA.

An incident report must be completed for any medication error, adverse drug event and/or adverse drug reaction that results in harm and/or emergency medical intervention.

Complementary and Alternative Medicine (CAM)

Complementary and alternative medicine (CAM) is not AHCCCS reimbursable.

When a BHP uses Complementary and Alternative Medicine (CAM), (see [the Arizona Medical Board's Guidelines for Physicians Who Incorporate or Use Complementary or Alternative Medicine in Their Practice](#)) informed consent must be obtained from the member or guardian, when applicable, for each CAM prescribed. When obtaining informed consent, behavioral health medical practitioners must communicate in a manner that the member and/or legal guardian can understand and comprehend. The comprehensive clinical record must include documentation of the essential elements for obtaining informed consent. Essential elements for obtaining informed consent for medication are contained within the Informed Consent for Psychotropic Medication Treatment.

The use of [Informed Consent for Psychotropic Medication Treatment](#) is recommended as a tool to document informed consent for CAM. If Informed Consent for Psychotropic Medication Treatment is not used to document informed consent, the essential elements for obtaining informed consent must be documented in the member's individual comprehensive clinical record in an alternative fashion.

Pharmacy Education Meetings

The Mercy RBHA pharmacy department will be conducting pharmacist to Behavioral Health Provider (BHP) pharmacy education meetings throughout the year. These meetings will allow time to review new psychotropic education, BHP's report card, and to address any other issues or concerns including but not limited to outlier and high-risk members. The pharmacy claim data will be utilized to rank, trend, and compare all BHPs over time and to other peers. Prescriber report cards are provided and will include pharmacy related data such as but not limited to total member count, average cost per prescription, number of prescriptions filled per quarter, total costs for all prescriptions filled, average number of prescriptions per participant, number of adult and child/adolescent inter-class poly-pharmacy claims, and top twenty medications filled for the specified BHP.

Discarded Physician-Administered Medications

Discarded federally and state reimbursable physician-administered medications shall not be billed to Mercy RBHA. **A.A.C. R9-22-209(C)** provides that pharmaceutical services are covered only if they are prescribed. The unused portion of a physician administered drug is not covered because it's not medically necessary or prescribed.

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A.R.S. §36-2918(A)(1) prohibits a person from making a claim for an item or service that the person knows or has reason to know was not provided as claimed.

A.R.S. §36-2918(A)(3)(b) prohibits a person from submitting a claim for items and services that substantially exceed the needs of the patient.

2.08 – Pre-Petition Screening, Court Ordered Evaluation, and Court Ordered Treatment

At times, it may be necessary to initiate civil commitment proceedings to ensure the safety of a person, or the safety of other persons, due to a member's mental disorder when that member is unable or unwilling to participate in treatment. In Arizona, state law permits any responsible person to apply for pre-petition screening when another member may be, because of a mental disorder:

- A danger to self (DTS);
- A danger to others (DTO);
- Persistently or acutely disabled (PAD); or
- Gravely disabled (GD).

If the person who is the subject of a court ordered commitment proceeding is subject to the jurisdiction of an Indian tribe rather than the state, the laws of that tribe, rather than state law, will govern the commitment process.

Pre-petition screening includes an examination of the person's mental status and/or other relevant circumstances by a designated screening agency. Upon review of the application, examination of the person and review of other pertinent information, a licensed screening agency's medical director or designee will determine if the person meets criteria for DTS, DTO, PAD, or GD because of a mental disorder.

If the pre-petition screening indicates that the person may be DTS, DTO, PAD, or GD, the screening agency will file an application for a court-ordered evaluation. Based on the immediate safety of the member or others, an emergency admission for evaluation may be necessary. Otherwise, an evaluation will be arranged for the person by a designated evaluation agency within timeframes specified by state law.

Based on the court-ordered evaluation, the evaluating agency may petition for court-ordered treatment on behalf of the member. A hearing, with the member and his/her legal representative and the physician(s) treating the member, will be conducted to determine whether the member will be released and/or whether the agency will petition the court for court-ordered treatment. For the court to order ongoing treatment, the person must be determined, because of the evaluation, to be DTS, DTO, PAD, or GD. Court-Ordered Treatment (COT) may include a combination of inpatient and outpatient treatment. Inpatient treatment

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days are limited contingent on the member's designation as DTS, DTO, PAD, or GD. Members identified as:

- DTS may be ordered up to 90 inpatient days per year;
- DTO and PAD may be ordered up to 180 inpatient days per year; and
- GD may be ordered up to 365 inpatient days per year.

If the court orders a combination of inpatient and outpatient treatment, a mental health agency will be identified by the court to supervise the person's outpatient treatment. Before the court can order a mental health agency to supervise the person's outpatient treatment, the agency medical director must agree and accept responsibility by submitting a written treatment plan to the court.

At every stage of the pre-petition screening, court-ordered evaluation, and court-ordered treatment process, a person will be provided an opportunity to change his/her status to voluntary. Under voluntary status, the person is no longer considered to be at risk for DTS/DTO and agrees in writing to receive a voluntary evaluation.

County agencies and Mercy RBHA contracted agencies responsible for pre-petition screening and court-ordered evaluations must use the following forms prescribed in **9 A.A.C. 21, Article 5** for persons determined to have a Serious Mental Illness; agencies may also use the following forms AHCCCS Forms found under the [AHCCCS Medical Policy Manual, Section 320-U](#), for all other populations:

- Application for Involuntary Evaluation
- Application for Voluntary Evaluation
- Application for Emergency Admission for Evaluation
- Petition for Court-Ordered Evaluation
- Petition for Court-Ordered Treatment Gravely Disabled Person
- Affidavit
- Special Treatment Plan for Forced Administration of Medications

In addition to court ordered treatment as a result of civil action, an individual may be ordered by a court for evaluation and/or treatment upon: 1) conviction of a domestic violence offense; or 2) upon being charged with a crime when it is determined that the individual is court ordered to treatment, or programs, as a result of being charged with a crime and appears to be an "alcoholic".

Licensing Requirements

Behavioral health providers who are licensed by the Arizona Department of Health Services/Division of Public Health Licensing Services as a court-ordered evaluation or court-ordered treatment agency must adhere to ADHS licensing requirements.

Pre-Petition Screening

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PINAL COUNTY

Pinal County contracts with Horizon Health and Wellness and CPR to complete Pre-Petition Screening within Pinal County. These services can be accessed by calling Nursewise at 1-866-495-6735.

GILA COUNTY

In Gila County, Community Bridges Inc. is the designated screening agency; however other behavioral health agencies may be granted permission upon request to the Gila County Attorney's Office. Community Bridges, Inc. can be contacted at 1-877-931-9142.

MARICOPA COUNTY

There is an intergovernmental agreement between Maricopa County and AHCCCS for the management, provision of, and payment for Pre-Petition Screening and Court Ordered Evaluation. AHCCCS in turn contracts with Mercy RBHA for these pre-petition screening and court ordered evaluation functions. Mercy RBHA is required to coordinate provision of behavioral health services with the member's contractor responsible for the provision of behavioral health services.

The pre-petition screening includes an examination of the member's mental status and/or other relevant circumstances by a designated screening agency. The designated screening agency must follow these procedures:

- The pre-petition screening agency must help, if needed, to the applicant in the preparation of the application for court-ordered evaluation (see Application for Involuntary Evaluation).
- Any behavioral health provider that receives an application for court-ordered evaluation (see Application for Involuntary Evaluation) must immediately refer the applicant for pre-petition screening and petitioning for court-ordered evaluation to the designated pre-petition screening agency or county facility.

Filing of Non-Emergent Petitions

This provides instruction to the Care Manager and Pre-Petition Team relative to AAC and ARC requirements, not intended to be instructive to provider/community members.

Non-emergent Process

For behavioral health members receiving Mercy RBHA Clinic Services, the following steps will be completed by the Clinical Team.

- For all other residents of Maricopa County (not enrolled with a Mercy RBHA), the pre-petition team will complete these steps for petitions for COE. Any responsible individual may apply for a COE of a member who is alleged to be, because of a mental disorder, a danger to self or to other, persistently or acutely disabled, or gravely disabled and who is unwilling or unable to undergo a voluntary evaluation.
- For Maricopa County residents not enrolled with a Mercy RBHA Clinic, an applicant

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contacts the Mercy RBHA Customer Service Line at 800-564-5465 or the Crisis Response Network Crisis Line 800-631-1314 and requests a PAD or GD petition application be completed on an identified member in the community. An applicant can also go in person to UPC, RRC, or CPEC to begin the non-emergent process. The Pre-Petition team shall receive the referral and will contact the applicant to assist the applicant in completion of the Application for Involuntary Evaluation when a non-emergency COE is requested. All other steps, when applicable, will be the same as for Mercy RBHA Clinic enrolled behavioral health members.

- For Mercy RBHA Clinic enrolled behavioral health members, the Clinical Team shall assist the applicant in the completion of the application and evaluation when a non-emergency COE is requested. If at any time during the process the behavioral health member is determined to be in imminent danger of harming self or others, UPC, RRC, or CPEC will be contacted for assistance in evaluation and possible application for an emergency admission.
- For all Mercy RBHA Clinic enrolled or non-enrolled members, pre-petition screening must be attempted within forty-eight (48) hours, excluding weekends and holidays, of completion of the application. Pre-petition screening process includes informing the individual that an application for evaluation (Application for Involuntary Evaluation) has been completed, explaining the individual's rights to voluntary evaluation, reviewing the allegations, and completing a mental status examination. The Pre-Petition Screening Report is a detailed report of the information obtained during the assessment. This report must be completed by someone other than the applicant. If the member does consent to a voluntary evaluation the Application for Voluntary Evaluation shall be used.
- During the pre-petition screening, at least three attempts to contact the behavioral health member should be completed. If attempts at contacting the behavioral health member are unsuccessful and screening is not possible, screening staff will review this information with a physician. The screening agency shall prepare a report giving reasons why the screening was not possible, including opinions/conclusions of staff members who attempted to conduct pre- petition screening.
- If the behavioral health member does not consent to a voluntary outpatient evaluation or voluntary inpatient evaluation or when a voluntary evaluation is not appropriate as determined by the evaluating psychiatrist, the involuntary process shall continue.
- The Clinical Team or Pre-Petition Team will staff the application for involuntary evaluation (Application for Involuntary Evaluation and Pre-Petition Screening Report) with a psychiatrist. The psychiatrist need never have met the person to decide regarding whether to move forward with a Petition for COE. The psychiatrist will:
 - Review the application, pre-petition screening report, and any other collateral information made available as part of the pre-petition screening to determine if it indicates that there is reasonable cause to believe the allegations of the applicant for the COE.
 - Prepare a Petition for COE and file the petition if the psychiatrist determines that the member, due to a mental disorder, which may include a primary diagnosis of

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- dementia and other cognitive disorders, is DTS, DTO, PAD or GD. The Petition for Court Ordered Evaluation documents pertinent information for COE;
- If the psychiatrist determines that there is reasonable cause to believe that the member, without immediate hospitalization, is likely to harm him/her or others, the psychiatrist must coordinate with the UPC, RRC-W or CPEC and ensure completion of the Application for Emergency Admission for Evaluation and take all reasonable steps to procure hospitalization on an emergency basis.
 - Pre-petition screens, application, and petition for Inpatient or Outpatient Court Ordered Evaluation can be filed on a non-emergent basis at the MIHS Desert Vista Campus Legal Office, 570 West Brown Road, Mesa, AZ 85201, and 480-344-2000. This involves all Persistently or Acutely Disabled (PAD) and Gravely Disabled (GD) petitions. Danger to Self (DTS) and Danger to Others (DTO) petitions that do not require immediate intervention can also be filed on a non-emergent basis. Please use the following forms for filing the non-emergent petition: Petition for Court Ordered Evaluation and Application for Involuntary Evaluation.
 - Eight copies and the original Petition for Court-Ordered Evaluation, Application for Involuntary Evaluation, Pre-Petition Screening Report and the Police Mental Health Detention Information Sheet, must be submitted by the behavioral health member's Care Manager or the pre-petition team to the Legal Department at Maricopa Integrated Health System (MIHS) Desert Vista Campus for review by the County Attorney, preparation of the Detention Order, and filing with the Superior Court. These documents must be filed within 24 hours of completion, excluding weekends and holidays.
 - Once the petition is filed with the court, the Legal Department at MIHS Desert Vista Campus Delivers the Detention Order to the Police Department to have the behavioral health member brought to the UPC, RRC or CPEC for evaluation. NOTE: The Petition for Court Ordered Evaluation and Police Mental Health Detention Information Sheet) expire 14 days from the date the judge signs off on the order for COE.
 - One of the eight copies of petition documents shall be stored by the behavioral health member's Case Manager or the pre-petition team in a secure place (such as a locked file cabinet) to ensure the behavioral health member's confidentiality. A petition for involuntary evaluation may not be stored in the medical record if the behavioral health member has not been court ordered to receive treatment.

Emergent Filing

In cases where it is determined that there is reasonable cause to believe that the member is in such a condition that without immediate hospitalization he/she is likely to harm himself/herself or others, an application for emergency admission can be filed. Only applications indicating Danger to Self and/or Danger to Others can be filed on an emergent basis and shall be filed at the Urgent Psychiatric Care (UPC), 1201 S 7th Ave; Suite #150, Phoenix, AZ 85007; 602-416-7600; Response Recovery Center- (RRC, 11361 N. 99th Ave Suite 402, Peoria AZ 85345, 602-636-4605; or Community Psychiatric Emergency Center (CPEC), 358 E. Javelina, Mesa, AZ

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85210, 480-507-3180. Mercy RBHA contracts with the UPC, RCC, and CPEC to assist the applicant in preparing the **Application for Emergency Admission for Evaluation** when an emergent evaluation is requested and can also assist when an Application for Court Ordered Evaluation on a non-emergent basis is needed due to the person not meeting criteria for an emergency admission.

Emergent process

The applicant is a person who has, based on personal observation, knowledge of the behavioral health member's behavior that is danger to self or danger to others. The applicant shall complete the **Application for Emergency Admission for Evaluation** with assistance of UPC/RRC/CPEC staff and include:

- The applicant must have seen or witnessed the behavior or evidence of mental disorder.
- The applicant, as a direct observer of dangerous behavior, may be called to testify in court if the application results in a petition for COE.
- Upon receipt of the Application for Emergency Admission for Emergency Evaluation (MH-104) the UPC, RRC or CPEC admitting officer will begin the assessment process to determine if enough evidence exists for an emergency admission for evaluation. If there is enough evidence to support the emergency admission for evaluation and the member does not require medical care beyond the capacity of UPC, RRC or CPEC, then the UPC, RRC or CPEC staff will immediately coordinate with local law enforcement for the detention of the member and transportation to UPC, RRC or CPEC.
- If the Application for Emergency Admission for Evaluation is accepted by the UPC, RRC or CPEC admitting officer and the member requires a level of medical support not available at the UPC, RRC or CPEC, then within 24 hours the UPC, RRC or CPEC admitting officer will coordinate admission to the MIHS Psychiatric Annex. If admission to the MIHS Psychiatric Annex cannot be completed within 24 hours of the Application for Emergency Admission for Evaluation being accepted by the UPC, RRC or CPEC admitting officer, then the Mercy RBHA Medical Director must be notified.
- An Application for Emergency Admission for Evaluation may be discussed by telephone with a UPC, RRC or CPEC admitting officer, the referring physician, and a police officer to facilitate transport of the member to be evaluated at a UPC, RRC or CPEC.
- A member proposed for emergency admission for evaluation may be apprehended and transported to the UPC, RRC or CPEC by police officials through a written Application for Emergency Admission for Evaluation faxed by the UPC, RRC or CPEC admitting officer to the police.
- A 23-Hour Emergency Admission for Evaluation begins at the time the behavioral health member is detained involuntarily by the Admitting Officer at UPC, RRC or CPEC who determines there is reasonable cause to believe that the member, as a result of a mental disorder, is a DTS or DTO and that during the time necessary to complete prescreening procedures the member is likely, without immediate hospitalization, to suffer harm or cause harm to others.
- During the emergency admission period of up to 23 hours the following will occur:

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- The behavioral health member's ability to consent to voluntary treatment will be assessed.
- The behavioral health member shall be offered and receive treatment to which he/she may consent. Otherwise, other than calming talk or listening, the only treatment administered involuntarily will be for the safety of the individual or others, i.e. seclusion/restraint or pharmacological restraint in accordance with A.R.S. §36-513.
- UPC/RRC/CPEC may contact the County Attorney prior to filing a petition if it alleges that a member is DTO.
- If the behavioral health member is determined to require a court ordered evaluation, then the petition for COE will be filed with the court within 24 hours of admission (not including weekends or court holidays). If the behavioral health member does not meet the criteria for an application for emergency admission but is determined to meet criteria for PAD and/or GD, UPC, RRC-W or CPEC will notify and offer to assist the applicant of the non-emergent process.

Court-Ordered Evaluation

If the pre-petition screening indicates that the member may be DTS, DTO, PAD, or GD, the screening agency will file an application for a court-ordered evaluation. The procedures for court-ordered evaluations are outlined below:

Mercy RBHA and its subcontracted behavioral health provider must follow these procedures:

- A member being evaluated on an inpatient basis must be released within seventy-two hours (not including weekends or court holidays) if further evaluation is not appropriate, unless the member makes application for further care and treatment on a voluntary basis;
- A member who is determined to be DTO, DTS, PAD, or GD because of a mental disorder must have a petition for court-ordered treatment prepared, signed and filed by Mercy RBHA's medical director or designee; and
- Title XIX/XXI funds must not be used to reimburse court-ordered evaluation services.

Mercy RBHA encourages the utilization of outpatient evaluation on a voluntary or involuntary basis. Mercy RBHA is not be responsible to pay for the costs associated with Court Ordered Evaluation outside of the limited "medication only" benefit package available for Non-Title XIX members determined to have SMI, unless other prior payment arrangements have been made with another entity (e.g. county, hospital, provider).

Court Ordered Outpatient Evaluation

- After the pre-petition screening, if the member is refusing a voluntary evaluation and the psychiatrist determines the member is safe to go through an Outpatient Court Ordered Evaluation, then the Case Manager or pre-petition team will deliver the original Application for Involuntary Evaluation, Pre-Petition Screening Report, and Petition for

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Court-Ordered Evaluation to the Legal Department at Maricopa Integrated Health System(MIHS) Desert Vista Campus for review by the County Attorney, preparation of the service order, and filing with the Superior Court.

- Once the petition is filed with the court, the Legal Department at MIHS Desert Vista delivers the service order to the police department to have the member served legal notice of the date/time/location of the outpatient evaluation. One of the eight copies of the petition documents shall be stored by the member's Care Manager or PAD team in a secure place (such as a locked file cabinet) to ensure the behavioral health member's confidentiality. A petition for involuntary evaluation may not be stored in the medical record if the behavioral health member has not been court ordered to receive treatment.
- The MIHS Legal Department will arrange for an outpatient Court Ordered Evaluation and notify the Case Manager or Pre-Petition Team of the date and time of the evaluation.
- If the Outpatient COE is scheduled to take place at Desert Vista, the Case Manager will arrange for transportation for the member to and from the Outpatient COE and will provide any documents requested by the psychiatrists conducting the evaluation. If the member is not enrolled at an SMI Clinic, the Mercy RBHA Court Liaison will assist the member in arranging transportation.
- If the two evaluating psychiatrists do not believe that the member needs COT, then the MIHS Legal Department will forward the physicians' affidavits to the Care Manager or Pre-Petition Team with an explanation that the member has been determined not to need COT.
- If the two evaluating psychiatrists completing the Outpatient Court Ordered Evaluation determine the member needs COT, then the two physician's Affidavit and social work report will be delivered to the MIHS Legal Department within 1 business day of the evaluation. The Mercy RBHA Court Liaison will then file a Petition for Court Ordered Treatment with the Maricopa County Superior Court within 2 business days.

Voluntary Evaluation

Any Mercy RBHA contracted behavioral health provider that receives an application for voluntary evaluation must immediately refer the member to the facility responsible for voluntary evaluations.

Voluntary Inpatient or Outpatient Evaluation

- If the individual agrees to a voluntary evaluation, complete the Application for Voluntary Evaluation and review with a psychiatrist.
- If the psychiatrist determines that a voluntary evaluation is appropriate, then a decision as to whether the evaluation is to take place on an inpatient or outpatient basis will be made by the psychiatrist.
- If the psychiatrist determines an inpatient voluntary evaluation is necessary, the Care Manager or PAD Team is to arrange for a voluntary admission to UPC, RRC, or CPEC, for the evaluation to take place, assist the member in signing in and deliver the original

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- notarized Application for Voluntary Evaluation to the UPC, RRC, or CPEC Coordinator.
- If the psychiatrist determines an outpatient voluntary evaluation is acceptable, then the Case Manager or PAD Team will deliver the original, notarized Application for Voluntary Evaluation to the MIHS Legal Department. An outpatient evaluation will then be scheduled at Desert Vista Hospital and the Case Manager or PAD Team will be responsible for notifying the member of the date and time of the evaluation, provide transportation to and from the evaluation, and provide any documentation requested by the physician's conducting the evaluation.
 - The voluntary outpatient or inpatient assessment must include evaluation by two psychiatrists and the involvement of either two social workers, or one social worker and one psychologist, who shall complete the outpatient treatment plan. The voluntary psychiatric evaluation shall include determination regarding the existence of a mental disorder, and whether, because of a mental disorder, the individual meets one or more of the standards. The psychiatric evaluation must also include treatment recommendations. The psychiatrists completing the outpatient psychiatric evaluations will submit a written affidavit to the MIHS Legal Department regarding their findings.
 - If the psychiatrists do not believe that the member needs COT, then the MIHS Legal Department will forward the physicians' affidavits to the Care Manager or PAD Team with an explanation that the member has been determined not to need COT.
 - If the psychiatrists completing the voluntary inpatient evaluation or voluntary outpatient evaluation determine the member needs COT, then the two physician's Affidavit and a social work report will be delivered to the MIHS Legal Department within 1 business day of the evaluation. The Mercy RBHA contracted behavioral health provider must follow these procedures:
 - The evaluation agency must obtain the individual's informed consent prior to the evaluation (see Application for Voluntary Evaluation and provide evaluation at a scheduled time and place within five days of the notice that the member will voluntarily receive an evaluation;
 - For inpatient evaluations, the evaluation agency must complete evaluations in less than seventy-two hours of receiving notice that the member will voluntarily receive an evaluation; and
 - If a behavioral health provider conducts a voluntary evaluation service as described in this chapter, the comprehensive clinical record must include:
 - A copy of the Application for Voluntary Evaluation;
 - A completed informed consent form; and
 - A written statement of the member's present medical condition.

When the county does not contract with the Mercy RBHA for court-ordered evaluations Mercy RBHA contracts with Maricopa Integrated Health Systems for inpatient Court-Ordered Evaluations and Outpatient Court-Ordered Evaluations

Court-Ordered Treatment Following Civil Proceedings under A.R.S. Title 36

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Based on the court-ordered evaluation, the evaluating agency may petition for court-ordered treatment. The behavioral health provider must follow these procedures:

- Upon determination that an individual is DTS, DTO, GD, or PAD, and if no alternatives to court-ordered treatment exist, the medical director of the agency that provided the court-ordered evaluation must file a petition for court-ordered treatment (see Petition for Court-Ordered Treatment);
- Any behavioral health provider filing a petition for court-ordered treatment must do so in consultation with the member's clinical team prior to filing the petition;
- The petition must be accompanied by the affidavits of the two physicians who conducted the examinations during the evaluation period and by the affidavit of the applicant for the evaluation (see Affidavit and attached addenda);
- A copy of the petition, in cases of grave disability, must be mailed to the public fiduciary in the county of the patient's residence, or the county in which the patient was found before evaluation, and to any member nominated as guardian or conservator; and
- A copy of all petitions must be mailed to the superintendent of the Arizona State Hospital.

Responsibility of the Outpatient Agency Appointed to Supervise and Administer the Court Order for Treatment

For Mercy RBHA members on COT, the Outpatient Agency appointed by the court to supervise and administer COT is responsible to file status reports as ordered by the court. These are typically ordered at 45 days, 180 days, and 305 days after COT start date. Status review hearings where a team member must appear may also be ordered by the court.

The Outpatient Agency will schedule members on COT to see a Behavioral Health Medical Professional (BMHP) at least once every 30 days. If a member does not attend a scheduled appointment, the clinical team will attempt to locate the member and re-schedule the appointment within one (1) business day. If the member cannot be engaged, then clinical team will discuss options for engagement and options for amending the COT to bring the member to inpatient or sub-acute facility for assessment.

Members placed on COT after finding of Not Competent/Not Restorable in a Criminal Matter (Rule 11 COT)

Members placed on COT after having been found not competent and not restorable (Rule 11) require special treatment and tracking by the Outpatient Agency. ARS §36-544 requires the Outpatient Agency to file a notice with the court and prosecuting attorney within five (5) days of a member's unauthorized absence from treatment and request the court toll (suspend) the treatment order for the period the patient is absent. "Unauthorized absence" means:

- The member is absent from an inpatient treatment facility without authorization; or
- The member is no longer living in a placement or residence specified by the treatment plan and has left without authorization; or
- The member left or failed to return to the county or state without authorization.

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Additionally, the statute requires the Outpatient Agency to:

- Use information and other resources available to the agency to facilitate efforts to locate and return the patient to treatment.
- File a status report every sixty (60) days specifying the information and resources used to facilitate the member's return to treatment; and
- Notify the court of the patient's return to treatment.

After 180 days, the Outpatient Agency may petition the court to terminate the order for treatment. The court may either terminate the treatment order or require additional outreach.

If a Notice of Noncompliance appears in the Court Order for Treatment or Minute Entry, the Outpatient Agency must report any noncompliance with the treatment order.

If the medical director intends to release a patient from a Rule 11 COT prior to the expiration of the COT, he/she must provide at least a ten (10) day notice to the court, prosecuting attorney, and any relative or victim of the patient who filed a demand for notice.

If the medical director decides not to renew a Rule 11 COT or the Application for Renewal was not filed on time, at least a ten (10) day notice of the pending expiration date of COT shall be provided to the court and prosecuting agency.

Judicial Review and COT Renewal Timelines/Forms

Judicial Review

Pursuant to ARS§36-546 each member Court Ordered Treatment must be provided with a Notice of the Right to Judicial Review 60 days after the start of COT and every 60 days thereafter. Any member of the clinical team can provide this notice and must document in a progress note the date and time notice was provided. The notice of right to judicial review can be completed verbally and/or with a form developed by the provider for this purpose. If the member does request Judicial Review, below is the timeline and paperwork that will need to be submitted:

- Member signs request for Judicial Review which is then signed by a member of the clinical team and notarized. The member does not need to make this request in person. Request for Judicial Review can be made on the phone and staff person receiving the phone call will complete the Request for Judicial Review form on behalf of the member and note that the request was made by phone on the form and in a progress note in the medical record.
- The Psychiatric Report for Judicial Review must be completed by a psychiatrist signed and notarized and filed with the court within 72 hours (not including weekends or court holidays) of the request for judicial review (please also note that the date of the MD signature MUST match the date of the notarization or it will be rejected).

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- The original Request for Judicial Review and Psychiatric Report for Judicial Review must be filed with the court within 72 hours of the Request for Judicial Review.
- If the court orders a full hearing for the Judicial Review the medical director of the treating agency shall provide the member's attorney with a copy of the member's medical records at least 24hr prior to the hearing.

Application for COT Renewal

All renewal paperwork must be submitted to the provider agency court coordinator **NO LATER** than 45 days prior to the expiration of COT. If the Final Status Report states that renewal is requested, the following paperwork will need to be submitted:

- A Final Status Report stating that renewal is requested and can be signed by a psychiatrist or Nurse Practitioner.
- Psychiatric Report for Annual Review of COT must be completed by a psychiatrist, signed and notarized (please note that the date of the psychiatrist's signature **MUST** match the date of the notarization or it will be rejected).
- **ORIGINAL** Psychiatric Report for Annual Review of COT must be delivered to the provider agency court coordinator as copies cannot be filed with the court.
- Two witness statements for those who will be attending a hearing if one should be set. (The witness statements aren't notarized so these can be scanned and emailed, preferably at the same time.)

**Please note that both psych reports must be completed by a MD. A NP or PA CANNOT complete these, nor is co-signing permitted.*

Members who are Title XIX/XXI Eligible and/or Determined to have Serious Mental Illness (SMI)

When a member referred for court-ordered treatment is Title XIX/XXI eligible and/or determined or suspected to have a Serious Mental Illness, Mercy RBHA will:

- Conduct an evaluation to determine if the member has a Serious Mental Illness, and conduct a behavioral health assessment to identify the member's service needs in conjunction with the member's clinical team; and
- Provide necessary court-ordered treatment and other covered behavioral health services in accordance with the member
- Member's needs, as determined by the member's clinical team, the behavioral health member, family members, and other involved parties and
- Perform, either directly or by contract, all treatment required by A.R.S. Title 36, Chapter 5, Article 5 and 9 A.A.C. 21, Article 5.

Transfer from one behavioral health provider to another

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A member ordered by the court to undergo treatment can be transferred from one behavioral health provider to another behavioral health provider if:

- The member does not have a court appointed guardian;
- The medical director of the receiving behavioral health provider accepts the transfer; and
- The consent of the court for the transfer is obtained as necessary.
- In order to coordinate a transfer of a member under court-ordered treatment to ALTCS or another RBHA, the behavioral health member's clinical team will coordinate with the Mercy RBHA Court Advocacy Department at contractingdepartment@MercyCareAZ.org.
- To coordinate a transfer of a member under COT from one SMI Clinic to another, the behavioral health member's current psychiatrist will discuss the transfer with the receiving psychiatrists. If both SMI Clinics agree that the transfer is appropriate, the receiving psychiatrist will then provide a Letter of Intent to Treat to the SMI Clinic Court Coordinator of the sending SMI Clinic. The SMI Clinic Court Coordinator will then prepare a motion to transfer treatment provider, review with SMI Clinic attorney, and file with the court. The member's care will not be transitioned to the receiving SMI Clinic until the new treatment provider is reflected on the COT.

Court-Ordered Treatment for Members Charged with or Convicted of a Crime

Mercy RBHA providers may be responsible for providing evaluation and/or treatment services when an individual has been ordered by a court due to:

- Conviction of a domestic violence offense; or
- Upon being charged with a crime when it is determined that the individual is court ordered to treatment, or programs, because of being charged with a crime and appears to be an "alcoholic."

Domestic Violence Offender Treatment

Domestic violence offender treatment may be ordered by a court when an individual is convicted of a misdemeanor domestic violence offense. Although the order may indicate that the domestic violence (DV) offender treatment is the financial responsibility of the offender under **A.R.S. §13-3601.01**, Mercy RBHA will cover DV services with Title XIX/XXI funds when the member is Title XIX/XXI eligible, the service is medically necessary, required prior authorization is obtained if necessary, and/or the service is provided by an in-network provider. For Non-TXIX/XXI eligible member's court ordered for DV treatment, the individual can be billed for the DV services.

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Court-ordered substance abuse evaluation and treatment

Substance abuse evaluation and/or treatment (i.e., DUI services) ordered by a court under **A.R.S. §36-2027** is the financial responsibility of the county, city, town or charter city whose court issued the order for evaluation and/or treatment. Accordingly, if Mercy RBHA receives a claim for such services, the claim will be denied with instructions to the provider to bill the responsible county, city or town.

Court-Ordered Treatment for American Indian Tribal Members in Arizona

Arizona tribes are sovereign nations, and tribal courts have jurisdiction over their members residing on reservation. Tribal court jurisdiction, however, does not extend to tribal members residing off the reservation or to state court ordered evaluation or treatment ordered because of a behavioral health crisis occurring off reservation.

Although some Arizona tribes have adopted procedures in their tribal codes, which are like Arizona law for court ordered evaluation and treatment, each tribe has its own laws which must be followed for the tribal court process. Tribal court ordered treatment for American Indian tribal members in Arizona is initiated by tribal behavioral health staff, the tribal prosecutor or other member authorized under tribal laws. In accordance with tribal codes, tribal members who may be a danger to themselves or others and in need of treatment due to a mental health disorder are evaluated and recommendations are provided to the tribal judge for a determination of whether court ordered treatment is necessary. Tribal court orders specify the type of treatment needed.

Additional information on the history of the tribal court process, legal documents and forms as well as contact information for the tribes, Mercy RBHA liaison(s), and tribal court representatives can be found on the AHCCCS web page titled, [Tribal Court Procedures for Involuntary Commitment - Information Center](#).

Since many tribes do not have treatment facilities on reservation to provide the treatment ordered by the tribal court, tribes may need to secure treatment off reservation for tribal members. To secure court ordered treatment off reservation, the court order must be “recognized” or transferred to the jurisdiction of the state.

The process for establishing a tribal court order for treatment under the jurisdiction of the state is a process of recognition, or “domestication” of the tribal court order (see **A.R.S. §12-136**). Once this process occurs, the state recognized tribal court order is enforceable off reservation. The state recognition process is not a rehearing of the facts or findings of the tribal court. Treatment facilities, including the Arizona State Hospital, must provide treatment, as identified by the tribe and recognized by the state. [A.R.S. §12-136 Domestication or Recognition of Tribal Court Order](#) is a flow chart demonstrating the communication between tribal and state entities.

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Mercy RBHA providers must comply with state recognized tribal court orders for Title XIX/XXI and Non-Title XIX SMI members. When tribal providers are also involved in the care and treatment of court ordered tribal members, Mercy and its providers must involve tribal providers to ensure the coordination and continuity of care of the members for the duration of court ordered treatment and when members are transitioned to services on the reservation, as applicable.

This process must run concurrently with the tribal staff's initiation of the tribal court ordered process to communicate and ensure clinical coordination with the Mercy RBHA. This clinical communication and coordination with the Mercy RBHA is necessary to assure continuity of care and to avoid delays in admission to an appropriate facility for treatment upon state/county court recognition of the tribal court order. The Arizona State Hospital should be the last placement alternative considered and used in this process

A.R.S. §36-540(B) states, "The Court shall consider all available and appropriate alternatives for the treatment and care of the patient. The Court shall order the least restrictive treatment alternative available." Mercy RBHA will partner with American Indian tribes and tribal courts in their geographic service areas to collaborate in finding appropriate treatment settings for American Indians in need of behavioral health services.

Due to the options American Indians have regarding their health care, including behavioral health services, payment of behavioral health services for AHCCCS eligible American Indians may be covered through a T/RBHA, RBHA or IHS/638 provider (see [Behavioral Health Services Payment Responsibilities](#) on the [AHCCCS Tribal Court Procedures for Involuntary Commitment](#) web page for a diagram of these different payment structures).

2.09 – Housing for Individuals Determined to have Serious Mental Illness (SMI)

AHCCCS, along with Mercy RBHA have worked collaboratively to ensure a variety of housing options and support services are available to assist members determined to have a Serious Mental Illness (SMI) live as independently as possible. Recovery often starts with safe, decent and affordable housing so that individuals can live, work, learn, and participate fully in their communities. Safe, stable, and familiar living arrangements are critical to a member's ability to benefit from treatment and support services.

For members determined to have SMI who can live independently, Mercy RBHA has several programs to support independent living, such as rent subsidy programs, supported housing programs, bridge subsidy housing assistance while obtaining federal funding, and provider owned or leased homes and apartment complexes that combine housing services with other covered behavioral health services. Similarly, TRBHA housing programs include rent subsidy programs, owner occupied home repairs, move-in assistance and eviction prevention programs coupled with needed supported housing services to maintain independent living.

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Mercy RBHA believes in permanent supportive housing and has adopted the SAMHSA model for permanent supportive housing programs. The 12 Key Elements of the SAMHSA Permanent Supportive Housing Program are:

1. Tenants have a lease in their name, and, therefore, they have full rights of tenancy under landlord-tenant law, including control over living space and protection against eviction.
2. Leases do not have any provisions that would not be found in leases held by someone who does not have a psychiatric disability.
3. Participation in services is voluntary and tenants cannot be evicted for rejecting services.
4. House rules, if any, are like those found in housing for people who do not have psychiatric disabilities and do not restrict visitors or otherwise interfere with a life in the community.
5. Housing is not time-limited, and the lease is renewable at tenants' and owners' option.
6. Before moving into Permanent Supportive Housing, tenants are asked about their housing preferences and are offered the same range of choices as are available to others at their income level in the same housing market.
7. Housing is affordable, with tenants paying no more than 30 percent of their income toward rent and utilities, with the balance available for discretionary spending.
8. Housing is integrated. Tenants can interact with neighbors who do not have psychiatric disabilities.
9. Tenants have choices in the support services that they receive. They are asked about their choices and can choose from a range of services, and different tenants receive different types of services based on their needs and preferences.
10. As needs change over time, tenants can receive more intensive or less intensive support services without losing their homes.
11. Support services promote recovery and are designed to help tenants choose, get, and keep housing.
12. The provision of housing and the provision of support services are distinct.

Mercy RBHA Housing Requirements***State Funded Supported Housing Programs***

Mercy RBHA complies with the following requirements to effectively manage limited housing funds in providing supported housing services to enrolled individuals:

- Mercy RBHA uses supported housing allocations for individuals with a SMI and according to any restrictions pertaining to the funding source. For example, an allocation may require it be used for Title XIX/XXI members, while another allocation may require it be used for Non-Title XIX members.
- Housing must be safe, stable, and consistent with the member's recovery goals and be the least restrictive environment necessary to support the member. Shelters, hotels, and similar temporary living arrangements do not meet this expectation.
- Mercy RBHA and its subcontracted providers must not actively refer, or place individuals

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determined to have SMI in a homeless shelter, licensed supervisory care homes, unlicensed board and care homes, or other similar facilities.^{3F³}

- Mercy RBHA may charge up to, but not greater than, 30% of a tenant's income towards rent. If a rent payment is increased in state funded housing programs, Mercy RBHA's subcontracted providers must provide the tenant with a 30-day notice at the time of the tenant's annual recertification.
- Mercy RBHA does not use supported housing allocations for room and board charges in residential treatment settings (Level II and Level III facilities). However, Mercy RBHA may allow residential treatment settings to establish policies, which require that members earning income contribute to the cost of room and board.
- Mercy RBHA may provide move-in assistance and eviction prevention services to those members in permanent housing. When move-in assistance is provided, Mercy RBHA prioritizes assistance with deposits and payment for utilities over other methods of assistance, such as move-in kits or furnishings, consisting of pots and pans, dishes, sheets, etc. Mercy RBHA encourages its subcontracted providers to seek donations for necessary move-in/home furnishing items whenever possible. Mercy RBHA does not use supported housing allocations or other funding received from AHCCCS (including block grant funds) to purchase furniture.
- For appeals related to supported housing services, Mercy RBHA and its subcontracted providers must follow the requirements in **Chapter 16 – Grievance System and Member Rights, Section 16.03 – Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI)**.
- Housing related grievances and requests for investigation for members determined to have SMI must be addressed in accordance with **Chapter 16 – Grievance System and Member Rights, Section 16.02 – Conduct of Investigations Concerning Members with Serious Mental Illness**.

Other MERCY RBHA Housing Requirements

Mercy RBHA submits Housing Plans and periodic reports on housing programs to AHCCCS, as outlined in the AHCCCS/Mercy RBHA contract.

Mercy RBHA Housing Programs and Requirements

Mercy RBHA's housing programs include specialized housing units to meet the needs of members determined to have SMI who are difficult to place in the community partly due to crime free/drug free ordinances and specific behavioral health related service needs. Current specialized housing includes housing that is specifically designed to provide and accommodate the following services or conditions for members determined to have SMI:

- Housing for females with co-occurring disorders who are homeless;
- Apartment complexes for members determined to have SMI with criminal backgrounds released from jail with a major biological disorder;
- Housing for members determined to have SMI who are hearing impaired or deaf;
- Housing for members determined to have SMI who have sexualized behaviors and need

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on-site support;

- Gender based house model living for older females determined to have SMI;
- Apartment complex housing and services to 18-25-year-old adults transitioning from the children's system of care to the adult system of care;
- Respite homes for members with developmental disabilities who are determined to have SMI (joint AHCCCS/ DES/DD program);
- Specialized homes for polydipsia;
- Homes that specialize in dialectical behavioral therapy;
- Housing for members determined to have SMI with limited English proficiency; and
- Housing suited to meet medical needs of members determined to have SMI with diabetes and other chronic diseases.

For additional information specific to Mercy RBHA's Housing Programs and Requirements contact a Clinical Housing Coordinator via Customer Service at 800-564-5465.

Federal Programs and Assistance

The US Department of Housing and Urban Development (HUD) provides funding for adults who are homeless and disabled. On May 20, 2009, President Obama signed into law a bill to reauthorize HUD's McKinney-Vento Homeless Assistance Programs. The bill, known as the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act, made numerous changes to HUD's homeless assistance programs:

- Significantly increases resources to prevent homelessness.
- New incentives will place more emphasis on rapid re-housing, especially for homeless families.
- The existing emphasis on creating permanent supportive housing for people experiencing chronic homelessness will continue, and families have been added to the definition of chronically homeless.
- Rural communities will have the option of applying under a different set of guidelines that may offer more flexibility and more assistance with capacity building.

HUD published the HEARTH Continuum of Care (CoC) Program interim rule on July 31, 2012 and it became effective August 31, 2012. Changes made include codifying the Continuum of Care process, expanding the definition of homelessness, and focusing selection criteria more on performance. The purpose of the CoC Homeless Assistance Program is to reduce the incidence of homelessness in CoC communities, by assisting homeless individuals and families in quickly transitioning to self-sufficiency and permanent housing, as authorized under Title IV of the McKinney-Vento Homeless Assistance Act.

The HEARTH Act consolidates the programs formerly known as the Supportive Housing Program (SHP), the Shelter Plus Care (S+C) Program, and the Section 8 Moderate Rehabilitation for Single Room Occupancy (SRO) Program into one grant program: The Continuum of Care program.

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Mercy RBHA works in collaboration with the Arizona Department of Housing (ADOH) and AHCCCS and the three Continuums of Care to ensure the revised requirements of the HEARTH Act are met, allowing Arizona to maximize the HUD Continuum of Care Homeless Assistance Programs awarded throughout the State.

Mercy RBHA and its subcontracted providers awarded HUD funding are required to participate in the Homeless Management Information System (HMIS), a software application designed to record and store client-level information on the characteristics and service needs of homeless members. The HMIS is used to coordinate care, manage program operations, and better serve clients.

Federal HUD Housing Choice Voucher Program

- Tenants pay 30% of their adjusted income towards rent.
- Vouchers are portable throughout the entire country after one year.
- Permanent housing is obtainable for individuals following program rules.
- The program is accessed through local Public Housing Authorities through a waiting list.
- Initial screening is conducted by the Public Housing Authority; however, the final decision is the responsibility of the landlord.
- A Crime Free - Drug Free Lease Addendum is required.

To receive additional information regarding these programs, contact Mercy RBHA's Clinical Housing Coordinator via Customer Service at 800-564-5465.

2.10 – Special Assistance for Members Determined to have a Serious Mental Illness (SMI)

Mercy RBHA and subcontracted providers must identify and report to the AHCCCS Office of Human Rights (OHR) members determined to have a Serious Mental Illness (SMI) who meets the criteria for Special Assistance. If the member's Special Assistance needs appear to be met by an involved family member, friend, designated representative or guardian, Mercy RBHA or behavioral health provider must still submit a notification to the OHR. Mercy RBHA, subcontracted providers and AHCCCS Office of Grievance and Appeals (OGA) must ensure that the member designated to provide Special Assistance is involved at key stages.

General Requirements

Criteria for Identifying Need for Special Assistance

A member who has been determined to have a SMI needs Special Assistance if he or she is unable to do any of the following:

- Communicate preferences for services;
- Participate effectively in individual service planning (ISP) or inpatient treatment;
- Discharge planning (ITDP); or
- Participate effectively in the appeal, grievance, or investigation processes;

AND the member's limitations are due to any of the following:

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- Cognitive ability/intellectual capacity (such as cognitive impairment, borderline intellectual functioning, or diminished intellectual capacity);
- Language barrier (an inability to communicate, other than the need for an interpreter/translator); or
- Medical condition (including, but not limited to traumatic brain injury, dementia or severe psychiatric symptoms).

A member who is subject to a general guardianship has been found to be incapacitated under **A.R.S. §14-5304** and therefore automatically satisfies the criteria for Special Assistance. Similarly, if Mercy RBHA or its subcontracted provider recommends a member with a SMI for a general guardianship or a guardianship is in the legal process (in accordance with **R9-21-206** and **A.R.S. §14-5305**), the member automatically satisfies the criteria for Special Assistance.

The existence of any of the following circumstances for an individual should prompt Mercy RBHA and its subcontracted provider to more closely review the individual's need for Special Assistance:

- Developmental disability involving cognitive ability;
- Residence in a 24-hour setting;
- Limited guardianship; or
- Mercy RBHA or its subcontracted provider is recommending and/or pursuing the establishment of a limited guardianship; or
- Existence of a serious medical condition that affects his/her intellectual and/or cognitive functioning (such as dementia, traumatic brain injury (TBI), etc.)

Member Qualified to Make Special Assistance Determinations

The following may deem a member to need Special Assistance:

- A qualified clinician providing treatment to the member;
- A care manager of Mercy RBHA or subcontracted provider;
- The member's clinical team;
- Mercy RBHA;
- A program director of a subcontracted provider;
- The Deputy Director of AHCCCS; or
- A hearing officer assigned to an appeal involving a member determined to have an SMI.

Screening for Special Assistance

Mercy RBHA's subcontracted providers must screen whether members determined to have a SMI need Special Assistance on an ongoing basis. Minimally this screening must occur at the following stages:

- Assessment and annual updates;
- Development of or update to the Individual Service Plan (ISP);
- Upon admission to a psychiatric inpatient facility;
- Development of or update to the Inpatient Treatment and Discharge Plan (ITDP);

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- Initiation of the grievance or investigation processes;
- Filing of an appeal; and
- Existence of a condition which may be a basis for a grievance, investigation or an appeal, and/or the member's dissatisfaction with a situation that could be addressed by one or more of these processes.

Documentation

Mercy RBHA's subcontracted providers shall document in the clinical record each time a member is screened for Special Assistance, indicating what factors were considered and the conclusion reached. If it is determined that the member is in need of Special Assistance, they must notify the Office of Human Rights (OHR) by completing **Notification of Members in Need of Special Assistance**, available in our [Forms Library](#) web page, in accordance with the procedures outlined below.

Before submitting the **Notification of Members in Need of Special Assistance**, available in our [Forms Library](#) web page, Mercy RBHA's subcontracted providers shall check if the member is already identified as in need of Special Assistance. A notation of Special Assistance designation and a completed **Notification of Members in Need of Special Assistance**, available in our [Forms Library](#) web page, should already exist in the clinical record. However, if it is unclear, subcontracted providers must review Mercy RBHA data or contact Mercy RBHA to inquire about status. Mercy RBHA maintains a database on members in need of Special Assistance and share data with subcontracted providers on a regular basis, at a minimum quarterly.

Notification to Office of Human Rights

If the member is not correctly identified as Special Assistance, Mercy RBHA's subcontracted providers must notify the Office of Human Rights (OHR) using **Notification of Members in Need of Special Assistance (Part A)**, available in our [Forms Library](#) web page, within five working days of identifying a member in need of Special Assistance. If the member's Special Assistance needs require immediate assistance, the notification form must be submitted immediately, with a notation indicating the urgency. **Mercy RBHA and subcontracted providers should inform the member of the notification and explain the benefits of having another member involved who can provide Special Assistance, if able.** If the member is under a guardianship or one is in process, the documentation of such must also be submitted to OHR. However, if the documentation is not available at the time of submission of the **Notification of Member in Need of Special Assistance**, available in our [Forms Library](#) web page, the form should be submitted within the required timeframes, followed by submittal of the guardianship documentation.

The Office of Human Rights (OHR) administration (Office Chief or Lead Advocate) reviews the notification form to confirm that a complete description of the necessary criteria is included. In the event necessary information is not provided, OHR contacts the staff member submitting the form to obtain clarification. The OHR responds to the Mercy RBHA subcontracted provider by

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completing **Notification of Members in Need of Special Assistance, Part B**, available in our [Forms Library](#) web page, within five working days of receipt of notification and any necessary clarifying information from Mercy RBHA. If the need for Special Assistance is urgent, the OHR will respond as soon as possible, but generally within one working day of receipt of the notification form.

The notification process is complete only when OHR returns the form, with Part B completed, to the Mercy RBHA subcontracted providers. The Mercy RBHA subcontracted providers should follow up with the OHR if no contact is made or Part B is not received within five working days.

OHR designates which agency/member will provide Special Assistance when processing the **Notification of Members in Need of Special Assistance**, available in our [Forms Library](#) web page. When the agency/member provides Special Assistance changes, OHR will need to process an “updated Part B” to document the change. In the event the member or agency currently identified as providing Special Assistance is no longer actively involved, Mercy RBHA or subcontracted provider must notify OHR. If an OHR advocate is also assigned, notification to the advocate is enough.

Members No Longer in Need of Special Assistance

The MERCY RBHA subcontracted provider must notify the OHR within ten days of an event or a determination that an individual is no longer in need of Special Assistance using Part C of the original **Notification of Members in Need of Special Assistance**, available in our [Forms Library](#) web page, (with Parts A & B completed when first identified), noting:

- The reasons why Special Assistance is no longer required;
- The effective date;
- The name, title, phone number and e-mail address of the staff member completing the form; and
- The date the form is completed.

The following are instances that should prompt Mercy RBHA’s subcontracted provider to submit a Part C:

- The original basis for the member meeting Special Assistance criteria is no longer applicable and the member does not otherwise meet criteria; The subcontracted provider must first discuss the determination with the member or agency providing Special Assistance to obtain any relevant input; this includes when a member is determined to no longer be a member with a SMI (proper notice and appeal rights must be provided and the time period to appeal must have expired);
- The member passes away;
- The member’s episode of care is ended with Mercy RBHA (Non-Title XIX member with a SMI will also be dis-enrolled) and the member is not transferred to another T/RBHA.
- Submission of a Part C is not needed when a member transfers to another T/RBHA, as the Special Assistance designation follows the member.

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The Mercy RBHA subcontracted providers must first perform all required re-engagement efforts, which includes contacting the member providing Special Assistance, per **RBHA Chapter 2 – Network Provider Service Delivery Requirements, Section 2.03 – Outreach, Engagement, Reengagement and Closure**, proper notice and appeal rights must be provided and the time to appeal must have expired.

Upon receipt of the **Notification of Members in Need of Special Assistance, Part C**, available in our [Forms Library](#) web page, the OHR administration reviews the content to confirm accuracy and completeness and send it back to the agency that submitted it, copying Mercy RBHA or its subcontracted provider.

Requirements of Mercy RBHA and Providers

The Mercy RBHA subcontracted providers must maintain open communication with the member/agency (guardian, family member, friend, OHR advocate, etc.) assigned to meet the member's Special Assistance needs. Minimally, this involves providing timely notification to the member providing Special Assistance to ensure involvement in the following stages:

- ISP planning and review: Including any instance when the member decides about service options and/or denial/modification/termination of services; (service options include not only a specific service but also potential changes to provider, site, doctor and care manager assignment); and
- ISP development and updates;
- ITDP planning: Which includes any time the member is admitted to a psychiatric inpatient facility and involvement throughout the stay and discharge;
- Appeal process: Includes circumstances that may warrant the filing of an appeal, so all notices of action (NOAs) or notices of decisions (NODs) issued to the member/guardian must also be copied to the member designated to meet Special Assistance needs; and
- Investigation or grievance: Includes circumstances when initiating a request for investigation/grievance may be warranted.

If such procedures are delayed ensuring the participation of the member providing Special Assistance, the Mercy RBHA subcontracted provider must document the reason for the delay in the clinical record and ensure that the member receives the needed services in the interim.

Mercy RBHA's subcontracted providers shall provide relevant details and a copy of the original **Notification of Members in Need of Special Assistance**, available in our [Forms Library](#) web page, (both Parts A and B) to the receiving entity and when applicable, care manager when a member in need of Special Assistance is:

- Admitted to an inpatient facility;
- Admitted to a residential treatment setting; or
- Transferred to a different T/RBHA, care management provider site or care manager.

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Subcontracted providers must periodically review whether the member's Special Assistance needs are being met by the member or agency designated to meet those needs. If a concern arises, the Mercy RBHA subcontracted provider should initially address the problem with the member providing Special Assistance. If the issue is not promptly resolved, they must take further action to address the issue, which may include contacting the OHR administration for assistance.

Confidentiality

Mercy RBHA and subcontracted providers shall grant access to clinical records of members in need of Special Assistance to the OHR in accordance with all federal and state confidentiality laws.

Human Rights Committee (HRCs) and their members shall safeguard the monthly list that contains the names of those members in need Special Assistance regarding any Protected Health Information (PHI). HRCs must inform Mercy RBHA in writing of how it will maintain the confidentiality of the Special Assistance lists. If HRCs request additional information that contains PHI that is not included in the monthly report, they must do so in accordance with the requirements set out in ***Disclosures to Human Rights Committee***.

Office of Grievance and Appeals Reporting Requirements

Upon receipt of a request for investigation, grievance or an appeal, Mercy RBHA OGA must review whether the member is already identified as in need of Special Assistance.

If so, the Mercy RBHA OGA must ensure that:

- A copy of the request for investigation or grievance is sent to OHR within five days of receipt of the request. Mercy RBHA OGA must also forward a copy of the final grievance/investigation decision to the OHR within five days of issuing the decision.
- The results of the Informal conference (IC) regarding appeals are sent to OHR. Mercy RBHA OGA shall also forward a copy of any subsequent notice of hearing.

Documentation and Reporting Requirements

Mercy RBHA's subcontracted providers must maintain a copy of the completed **Notification of Member in Need of Special Assistance**, available in our **Forms Library** web page, (Parts A, B and updated B, if any) in the member's comprehensive clinical record. In the event a member was identified as no longer needing Special Assistance and a Part C of the notification form was completed, Mercy RBHA and subcontracted providers must maintain a copy of the Notification of Member in Need of Special Assistance in the comprehensive clinical record.

Mercy RBHA's subcontracted providers must also clearly document in the clinical record (i.e. in the assessment, ISP, ITDP, face sheet) and care management/client tracking system if an individual is identified as Special Assistance, the member assigned currently to provide Special Assistance, the relationship, contact information of phone number and mailing address.

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To support Mercy RBHA and OHR in maintaining accurate and up-to-date information on members in need of Special Assistance, subcontracted providers are required to follow Mercy RBHA's quarterly procedures for data updates about currently identified/active members in need of Special Assistance.

Mercy RBHA must share Special Assistance data with its subcontracted providers that provide care management to individuals determined to have a SMI and verify that a process exists at each care management provider to ensure this data is accessible by front-line provider staff (at a minimum quarterly). Mercy RBHA must also establish a process with such providers to obtain quarterly updates on individuals currently identified as Special Assistance to support the Mercy RBHA quarterly data updates process with the OHR.

Other Requirements

The Human Rights Committees (HRC) must make periodic visits to individuals in need of Special Assistance placed in residential settings to determine whether the services meet their needs, and their satisfaction with their residential environment. Mercy RBHA provides training for all appropriate staff on the requirements related to Special Assistance. Subcontracted providers are required to train their staff on the requirements related to Special Assistance.

2.11 – Arizona State Hospital (AzSH)

Admissions

To ensure that individuals are treated in the least restrictive and most appropriate environment that can address their individual treatment and support their needs, the criteria for clinically appropriate admissions to AzSH are as follows:

- The behavioral health member must not require acute medical care beyond the scope of medical care available at AzSH.
- Mercy RBHA or other referral source has made reasonably good-faith efforts to address the individual's target symptoms and behaviors in an inpatient setting(s).
- For behavioral health members who are also enrolled with the Arizona Department of Economic Security/Division of Developmental Disabilities (DES/DDD), the DES/DDD Director or designee agrees with the recommendation for admission.
- MERCY RBHA and other referral source have completed Utilization Review of the potential admission referral and it is recommending admission to the AzSH as necessary and appropriate, and as the least restrictive option available for the member given his/her clinical status.
- When a community provider agency or other referral source believes that a civilly committed or voluntarily admitted adult is a candidate to be transferred from another Level I Behavioral Health treatment facility for treatment at AzSH, the agency will contact the Mercy RBHA AzSH Liaison to discuss the recommendation for admission to AzSH. Mercy RBHA will initiate the Mercy RBHA AzSH Review Process. Mercy RBHA must agree with the other referral source that a referral for admission to AzSH is

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necessary and appropriate. If the candidate is not T/RBHA enrolled, Mercy RBHA will initiate an SMI determination and the enrollment process prior to application or at the latest within twenty-four (24) hours of admission pursuant to **MCCC Chapter 3 – Behavioral Health, Section 3.06 – Behavioral Health Appointment Standards** to AzSH. The enrollment date is effective the first date of contact by Mercy RBHA. Mercy RBHA will also complete a Title XIX application once T/RBHA enrollment is completed. For all non-T/RBHA enrolled Tribal behavioral health members, upon admission to AzSH, the hospital will enroll the member, if eligible in the AHCCCS Indian Health Program.

- For TRBHA (Tribal RBHA only) enrolled behavioral health members, Mercy RBHA must also agree with the referring agency that admission to AzSH is necessary and appropriate, and Mercy RBHA must prior authorize the member's admission (see **RBHA Chapter 12 – Service Authorizations, Section 12.00 - Securing Services and Prior Authorization**).
- Mercy RBHA and/or other referral sources must contact the AzSH Admissions Office and forward a completed packet of information regarding the referral to the Admissions Office and if determined to be SMI and previously assessed as requiring Special Assistance, then the existing Special Assistance form should be included in the package. If the form has not been completed, please refer to **RBHA Chapter 2 – Network Provider Service Delivery Requirements, Section 2.10 - Special Assistance for Members Determined to have a Serious Mental Illness (SMI)** for further instructions.
- The Admissions Office confirms receipt of the complete packet and notifies the referral source of missing or inadequate documentation within two business days of receipt. AzSH cannot accept any member for admission without copies of the necessary legal documents.
- For T-XIX enrolled members, the **Certification of Need (CON)**, available in our [Forms Library](#) web page, should be included in the application for admission. Mercy RBHA needs to generate a Letter of Authorization (LOA) or issue a denial. The LOA should be provided to the AzSH Admissions Department with the application for admission to AzSH.
- Mercy RBHA is responsible for notifying AzSH's Admissions Office of any previous court ordered treatment days utilized by the behavioral health member. Behavioral health members referred for admission must have a minimum of forty-five (45) inpatient court ordered treatment days remaining to qualify for admission. The behavioral health member's AHCCCS eligibility will be submitted by Mercy RBHA to the AzSH Admissions Office with the admission application and verified during the admission review by the AzSH Admissions Office. The AzSH Admissions Office will notify (AHCCCS) Member Services of the behavioral health member's admission to AzSH and any change in health plan selection, or if any other information is needed.
- The Chief Medical Officer or Acting Designee will review the information within two (2) business days after receipt of the completed packet and determine whether the information supports admission and whether AzSH can meet the behavioral health member's treatment and care needs.

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- If the AzSH Chief Medical Officer or Acting Designee determines that the behavioral health member does not meet criteria for admission, the Chief Medical Officer or Acting Designee will provide a written statement to the referral source. If the admission is denied, the AzSH Admissions Office will send the denial statement to the referral source.
- If the admission is approved, the Admissions Office will send the acceptance statement from the Chief Medical Officer or Acting Designee to the referral source.
- A Court Order for transfer is not required by AzSH when the proposed behavioral health member is already under a Court Order for treatment with forty-five (45) remaining inpatient days. However, in those jurisdictions in which the court requires a court order for transfer be issued, the referring agency will obtain a court order for transfer to AzSH.
- If a Court Order for transfer is not required, the AzSH Admissions Office will set a date and time for admission. It is the responsibility of the referring agency to make the appropriate arrangements for transportation to AzSH.
- When AzSH is unable to admit the accepted behavioral health member immediately, the behavioral health member will be placed on a Mercy RBHA list for AzSH. If the behavioral health member's admission is pending, the referral agency must provide AzSH a clinical update in writing, including if any alternative placements have been explored while pending, and if the need for placement at AzSH is still necessary prior to admission is requested.

Adult Members under Civil Commitment

The behavioral health member must have a primary diagnosis of Mental Disorder (other than Cognitive Disability, Substance Abuse, Paraphilia-Related Disorder, or Antisocial Personality Disorder) as defined in **A.R.S. §36-501**, which correlates with the symptoms and behaviors precipitating the request for admission, and be determined to meet DTO, DTS, GD, or PAD criteria as the result of the mental disorder.

The behavioral health member is expected to benefit from proposed treatment at AzSH (**A.R.S. §36-202**). The behavioral health member must have completed 25 days of mandatory treatment in a local mental health treatment agency under T-36 Court Ordered Treatment (COT), unless waived by the court as per **A.R.S. §36-541** or, if PAD, waived by the Chief Medical Officer of AzSH.

AzSH must be the least restrictive alternative available for treatment of the member (**A.R.S. §36-501**) and the less restrictive long-term level of care available elsewhere in the State of Arizona to meet the identified behavioral health needs of the behavioral health member.

The behavioral health member must not suffer more serious harm from proposed care and treatment at AzSH (see **A.A.C. R9-21-507(B) (1)**).

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Hospitalization at AzSH must be the most appropriate level of care to meet the member's treatment needs, and the member must be accepted by the Chief Medical Officer for transfer and admission (**A.A.C. R9-21-507(B)(2)**).

Treatment and Community Placement Planning

AzSH will begin treatment and community placement planning immediately upon admission, utilizing the Adult Clinical Team model.

All treatment is patient-centered and is provided in accordance with AHCCCS-established five principles of member-centered treatment for adult behavioral health members determined to have Serious Mental Illness (SMI).

Behavioral health members shall remain assigned to their original provider network throughout their admission, unless the member initiates a request to transfer to a new clinic site or treatment team.

For members who are admitted under the services of an ACT team the member should be stepped down to a supportive level of care within the same provider network. The member would remain under supportive level of care with the same provider network while at AzSH and reassessed for ACT services during discharge planning. ACT level of care to supportive level of care should occur if a member has been at AzSH for 60 days and expected to remain at AzSH beyond 60 days. For members who are admitted to AzSH with a planned stay of less than 60 days these members should remain on the ACT team. Current treatment team should treat each case individually and assess all areas of the members treatment needs prior to making a change from ACT level of care to supportive level of care.

- Consideration of comprehensive information regarding previous treatment approaches, outcomes and recommendations/input from Mercy RBHA and other outpatient community treatment providers is vital.
- Representative(s) from the outpatient treatment team are expected to participate in treatment planning throughout the admission to facilitate enhanced coordination of care and successful discharge planning.
- Treatment goals and recommended assessment/treatment interventions must be carefully developed and coordinated with the outpatient providers (including Mercy RBHA, ALTCS Health Plan, DDD, other provider(s), the behavioral health member's legal guardian, family members, significant others as authorized by the behavioral health member and Advocate/designated representative whenever possible.
- The first ITDP meeting, which is held within 10 days of the behavioral health member's admission, should address specifically what symptoms or skill deficits are preventing the behavioral health member from participating in treatment in the community and the specific goals/objectives of treatment at AzSH. This information should be used to establish the treatment plan.

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- The first ITDP meeting should also address the discharge plan for reintegration into the community. The behavioral health member's specific needs for treatment and placement in the community, including potential barriers to community placement and successful return to the community, should be identified and discussed.

AzSH will provide all treatment plans to the responsible agency. The responsible agency should indicate review of an agreement/disagreement with the treatment plan on the document. Any disagreements should be discussed as soon as possible and resolved as outlined in **9 A.A.C. 21**.

Treatment plans are reviewed and revised collaboratively with the Adult Clinical Team at minimum every 60 days, depending upon the behavioral health member's treatment progress.

Any noted difficulties in collaboration with the outpatient provider treatment teams will be brought to the attention of Mercy RBHA to be addressed. Mercy RBHA AzSH Liaison will monitor the participation of the outpatient team and assist when necessary. AZSH liaison will refer all SMI TXIX members to Mercy RBHA Management team for care coordination activities once discharge planning is noted.

Through the Adult Clinical Team, AzSH will actively address the identified symptoms and behaviors which led to the admission and link them to the community rehabilitation and recovery goals whenever possible. AzSH will actively seek to engage the behavioral health member and all involved parties to establish understandable, realistic, achievable and practical treatment, discharge goals and interventions.

While in AzSH and depending upon the behavioral health member's individualized treatment needs, a comprehensive array of evaluation and treatment services are available and will be utilized as appropriate and as directed by the behavioral health member's treatment plan and as ordered by the behavioral health member's treating psychiatrist.

Recertification of Need (RON)

The AzSH Utilization Manager is responsible for the recertification process for all Title XIX/XXI eligible members and is the contact for AzSH for all Mercy RBHA continued stay reviews.

The AzSH Utilization Manager will work directly with the behavioral health member's attending physician to complete the **Recertification of Need (RON)**, available in our [Forms Library](#) web page. The RON will be sent to Mercy RBHA within five (5) days of expiration of the current CON/ RON. If required by Mercy RBHA, the Utilization Manager will send to Mercy RBHA Utilization Review staff additional information/documentation needed for review to determine continued stay.

All Mercy RBHA decisions regarding the approval or denial for continued stay will be rendered prior to the expiration date of the previous authorization and upon receipt of the

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RON for those behavioral health members. Mercy RBHA authorization decisions are based on review of chart documentation supporting the stay and application of the AHCCCS Level Continued Stay criteria. If continued stay is approved, Mercy RBHA sends a LOA to the AzSH Utilization Management Department with the completed RON and updated standard nomenclature diagnosis codes (if applicable). Denials will be issued upon completion of the denial process described in **RBHA Chapter 12 – Service Authorizations, Section 12.00 – Securing Services and Prior Authorization**.

Adult Members on Conditional Release from the Arizona State Hospital (AzSH) include but are not limited to coordination with AzSH for the following:

- Active discharge planning.
- Participation in the development of conditional release plans
- Member outreach and engagement to ensure compliance with the approved conditional release plan. Each area of the plan needs to be actively reviewed and monitored for compliance by the responsible agency.
- At minimum the member must receive weekly care management contact.
- The team must notify Mercy RBHA and the Psychiatric Security Review Board (PSRB) immediately of non-compliance for any portion of the conditional release plan.
- The team must outline steps taken to support the member in meeting the release requirements and immediately remediate any identified concerns.
- Outpatient staffing to review progress must be completed at least monthly.
- Care Coordination activities must be completed with member's treatment team and providers of both physical and behavioral health services.
- Weekly updates must be communicated to Mercy RBHA.
- Monthly comprehensive status reports need to be completed and submitted to Mercy RBHA, the PSRB and AHCCCS.

Through the active coordination by the Adult Clinical Team and with Mercy RBHA oversight, the goal is to ensure enough support is provided to members on conditional release and to ensure that the member remains in compliance with their conditional release plan.

Transition to Community Placement Setting

The behavioral health member is ready for community placement and is placed on the Discharge Pending List when the following criteria are met:

- The agreed upon discharge goals set at the time of admission with Mercy RBHA have been met by the behavioral health member.
- The behavioral health member presents no imminent danger to self or others due to psychiatric disorder. Some behavioral health members, however, may continue to exhibit occasional problematic behaviors. These behaviors must be considered on a case-by-case basis and do not necessarily prohibit the member from being placed on the

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Discharge Pending List. If the behavioral health member is psychiatrically stable and has met all treatment goals but continues to have medical needs, the behavioral health member remains eligible for discharge/community placement.

- All legal requirements have been met.

Once a behavioral health member is placed on the Discharge Pending List, Mercy RBHA must immediately take steps necessary to transition the behavioral health member into community-based treatment as soon as possible. Mercy RBHA has up to thirty (30) days to transition the behavioral health member out of AzSH. Mercy RBHA's outpatient treatment team should identify and plan for community services and supports with the member's inpatient clinical team 60–90 days out from the member's discharge date. This will allow enough time to identify appropriate community covered behavioral health services.

When the behavioral health member has not been placed in a community placement setting within 30 days, a quality of care concern will be initiated by Mercy RBHA.

Adult Members Adjudicated Guilty Except Insane (GEI) on Conditional Release from the Arizona State Hospital (AzSH).

Requirements include, but are not limited to coordination with AzSH and Mercy RBHA for the following:

- Active discharge planning.
- Participation in the development of conditional release plans
- Member outreach and engagement to ensure compliance with the approved conditional release plan. Each area of the plan needs to be actively reviewed and monitored for compliance by the responsible agency.
- At minimum the member must receive weekly care management contact.
- The team must notify Mercy RBHA and the Psychiatric Security Review Board (PSRB) immediately of non-compliance for any portion of the conditional release plan.
- The team must outline steps taken to support the member in meeting the release requirements and immediately remediate any identified concerns.
- Outpatient staffing to review progress must be completed at least monthly.
- Care Coordination activities must be completed with member's treatment team and providers of both physical and behavioral health services.
- Weekly updates must be communicated to Mercy RBHA.
- Monthly comprehensive status reports need to be completed and submitted to Mercy RBHA, the PSRB and AHCCCS.

Through the active coordination by the Adult Clinical Team and with Mercy RBHA oversight, the goal is to ensure enough support is provided to members on conditional release and to ensure that the member remains in compliance with their conditional release plan.

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Other Contractual Considerations

AzSH acknowledges that it and its providers have an independent responsibility to provide mental health and/or dual diagnosis substance abuse services, including covered services, to eligible members and that coverage or payment determinations by Mercy RBHA does not absolve AzSH or its providers of responsibility to render appropriate services to eligible members.

AzSH must render and must ensure that contracted providers render covered services in a quality and cost-effective manner pursuant to Mercy RBHA applicable standards and procedures and in accordance with generally accepted medical standards and all applicable laws and regulations.

AzSH shall not discriminate against any eligible member based on race, color, gender identity, sexual orientation, age, religion, national origin, handicap, health status, or source of payment in providing services under this chapter.

AzSH agrees to identify and initiate appropriate referrals to Children's Rehabilitation Services (CRS) for all eligible members age 18 up to the age of twenty-one (21) years whose condition is identified as an eligible CRS diagnosis. The **Collaborative Protocol for Coordination of Care with United HealthCare's Children's Rehabilitative Services (CRS) Programs**, available in our [Forms Library](#) web page, is available on our website for further review.

AzSH further agrees to comply with AHCCCS policies regarding appropriate referrals to the ADES/DDD, and the AHCCCS/ALTCS programs.

Under the HIPAA regulations, confidential information must be safeguarded pursuant to **42 C.F.R. Part 431(F), A.R.S. §§ 36-107, 36-509, 36-2903, 41-1959, 46-135, A.A.C. R9-22**, and any other applicable provisions of state or federal law.

Mercy RBHA will abide by and cooperate with complaint, grievance, and appeal process maintained to fairly and expeditiously resolve eligible member's, provider's, and AzSH's concerns pertaining to any service provided; issues related to this chapter; and/or allow an eligible member, provider, or AzSH to appeal a determination that a service is not medically necessary; and to resolve SMI eligible member allegations of rights violations under the AHCCCS rules (**A.A.C. R9-21**) for SMI eligible members.

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Denial Process

All decisions by Mercy RBHA to deny authorization for admission or continued stay must be made to the AzSH Utilization Manager via phone and followed by fax. The denial letter must specify the reason(s) for denial specifically applying Mercy RBHA level of care criterion to each case.

The AzSH Utilization Manager will request to appeal Mercy RBHA decision in writing and document the date and time the formal appeal was requested in the behavioral health member's utilization management file.

Claims, Billing and Reimbursement

Claims

Mercy RBHA will coordinate and reimburse medical care for eligible members who are inpatient at the Arizona State Hospital according to ACOM Policy 432 and AMPM Policy 1020.

AzSH agrees to file claims for covered services in the form and manner required by Mercy RBHA.

AzSH agrees to cooperate with Mercy RBHA in providing any information reasonably requested in connection with claims and in obtaining necessary information relating to coordination of benefits, subrogation, verification of coverage, and health status.

All claims will be submitted on a UB04 form or electronically.

The billing amount will be the filed program rate for the program in which the behavioral health member resides. The payment amount will be the lesser of the published amount in the B2 matrix or the program rate.

Mercy RBHA provides the name and address to which claims are to be sent in writing to the AzSH Finance Department and any changes thereof.

Time Frames

The claim will be submitted to Mercy RBHA within six (6) months after the date of service.

Payment by Mercy RBHA will be made within thirty/ninety (30/90) days upon receipt of clean claims. This standard will be based on the Center for Mental Health Services (CMS) requirement that 90% of clean claims be paid in thirty (30) days and 99% in ninety (90) days.

An explanation of any denials will be received from the Mercy RBHA within thirty/ninety (30/90) days of the Mercy RBHA receiving the initial claim submission.

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Resubmissions will be provided to Mercy RBHA within thirty (30) days of the receipt of the denial.

Availability of Funds

Payments made by Mercy RBHA to AzSH and the continued authorization of covered services are conditioned upon the receipt of funds by AHCCCS, and in turn, the receipt of funds to Mercy RBHA from AHCCCS authorized for expenditure in the manner and for the purposes provided in this chapter.

Mercy RBHA must not be liable to AzSH for any purchases, obligations, or cost of services incurred by AzSH in anticipation of such funding.

Indemnification

Mercy RBHA agrees to indemnify and to hold AzSH harmless from any costs, claims, judgments, losses, damages, or expenses, including attorneys' fees, which AzSH incurs because of the negligent acts or omissions of the Mercy RBHA, Mercy RBHA employees, agents, directors, trustees, and/or representatives.

AzSH agrees to indemnify and to hold Mercy RBHA harmless from any costs, claims, judgments, losses, damages, or expenses, including attorneys' fees, which the Mercy RBHA incurs because of the negligent acts or omissions of AzSH, AzSH employees, agents, directors, trustees, and/or representatives.

Mercy RBHA External Medical Record Review

Mercy RBHA utilization review specialists may obtain information from the health record of the AzSH patient to review the utilization of the hospital's services. All procedures as outlined in this chapter will follow standards set forth by the Joint Commission; the Centers for Medicare and Medicaid Services; and all federal, state and local laws, rules and regulations, including the Health Insurance Portability and Accountability Act (HIPAA).

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RBHA CHAPTER 3 – ADDITIONAL MERCY CARE RBHA PROVIDER RESPONSIBILITIES

3.00 – Provider Selection

Within the Mercy RBHA provider network, there are five behavioral health service delivery systems organized by population and/or service array. These systems include services for:

- Adults with a serious mental illness;
- Adults with a general mental health and/or substance abuse condition (GMH/SA);
- Children/adolescents;
- Prevention; and
- Crisis services.

Additionally, for adults with serious mental illness the development and monitoring activities includes healthcare primary care physicians, contracted specialists, ancillary healthcare providers and hospital facilities.

Providers and groups of providers who are interested in joining the Mercy RBHA provider network should submit a letter of interest to Provider Relations at 860-975-0841. Based on the identified needs within the network, applicants will receive written notification within 30 days of their letter of interest with Mercy RBHA's decision. In the event a provider or group is excluded or denied, they will be provided with a reason as to why their application to join the network was not approved.

3.01 – Health Information Exchange

Mercy RBHA maintains a state-of-the-art health information exchange (HIE) that will facilitate the exchange of near-real time clinical information across all providers involved in the member's care. Communication between members of the treatment team will be supported by our state-of-the art health information exchange (HIE), which allows behavioral health and physical health providers to share clinical information such as assessments, treatment plans, medication information, and service notes in near real time. Our HIE connects every member of the care team across specialties, regardless of organizational boundaries, in a secure manner with technological sophistication to support integration.

Mercy RBHA's HIE is used to facilitate the exchange of real-time member and quality information between our entire network as well as system partners who provide services to our members. Mercy RBHA's downloadable technology is available to all care providers. Our HIE connects every member of the care team regardless of organizational boundaries and technological sophistication so that care can be effectively coordinated around a common member. This application runs on a platform on which users can select and run a variety of applications, similar to downloading applications on a smartphone.

Providers are granted access to the HIE by being a member of the Mercy RBHA network of providers. Once connected, the provider office will have access to the system and the ability to

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grant access to those within their organization that have a clinical need to access the patient information and ensure those granted access are in compliance with HIPAA rules and regulations and any agreement set forth by Mercy RBHA.

Mercy RBHA complies with all requirements of federal and state confidentiality statutes, rules and regulations, including HIPAA Privacy and Security, as well as those requirements specific to behavioral health records to protect medical records and any other personal health information that may identify a particular member or subset of members. Consent for participation in the HIE is received at the clinics, typically during intake.

Mercy RBHA regularly collaborates with system stakeholders. This is a key element of our efforts to transform and enhance the delivery of services via strong partnerships across the entire system through seamless coordination, information sharing, problem solving and continuous quality improvement. For that reason, we strive to work cooperatively and collaboratively to provide a delivery system that is fully integrated, patient-centered and focused on quality. We demonstrate our commitment through our accessibility, engagement and follow-through.

3.02 – Psychiatric Visit Information

The **Psychiatric Visit Information Form**, available on our [Forms Library](#), web page is intended to be an information gathering tool, for families/ foster families/ group home staff to fill out prior to a Behavioral Health Medical Practitioner (BHMP) appointment. It is not mandatory but will give the BHMP updated information on any changes/updates affecting the member.

3.03 – Care Management Contact Guidelines

Contact Guidelines for Title XIX/Non-Title XIX SMI Members

Level of Care	Face to Face Contact Guideline	Home Visit Contact Guideline
Connective	Quarterly; Every 90 days	Yearly; Every 365 days
Supportive	Monthly; Every 30 days	Quarterly; Every 90 days
ACT	4 contacts every 7 days for high fidelity clinical indication. Minimum of 1 contact every 7 days but team should provide face to face services dependent on the member's individual need.	Weekly; Every 7 days

Targeted thresholds for performance in each of these areas are identified as:

- Connective and Supportive have an expected compliance to the target of 80%; and
- ACT, being aligned with SAMHSA fidelity scores, is targeted to meet or exceed 3.1 average face to face meeting per week on a monthly average.

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According to contact guidelines and clinical necessity, when scheduling SMI members for future BHMP, RN, or PCP appointments, Behavioral Health/Integrated Health Home staff must ensure that the member is able to schedule an appointment while the member is at the clinic after completing the previous BHMP, RN, or PCP appointment.

Contact Guidelines for Children in the Custody of DCS

- The Children's Qualified Service Provider (QSP) must initiate and document a minimum of **one (1)** contact each month for all children with CMDP coverage for a period of at least **one (1) year** from the date of behavioral health enrollment, unless services are declined by the guardian or the child is no longer in DCS custody. If the child has identified needs that may benefit from more frequent behavioral health services, the QSP must engage the child as frequently as is necessary to meet the needs.

3.04 – Care Management Caseload Ratio Guidelines

Caseload Ratios for children in High Needs Care Management (HNCM)

Caseload ratios for children in HNCM are to be 1 HNCM to 20 children with a case load ratio no higher than 25 children to allow for continuity of care. A caseload ratio between 20 and 25 must be the result of one or more of the following exceptions:

- Children/adolescents who have been served by the high needs care management model and no longer need the level of care
- Siblings of children in HNCM being managed by the same entity increases coordination of care for these children and their families/caretakers.

Caseload Ratios for Title XIX/Non-Title XIX SMI Members

Established Clinical Targets and Maximum Ceilings for ACT, Supportive and Connective	
Assertive Community Treatment (ACT) Specialists	12 members
Supportive Care Managers	30 members with a maximum of 40
Connective Care Managers	70 members with a maximum of 100

Maximum Ceilings	
Supportive	Connective
40	0
38	5
36	10
34	15
32	20

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Maximum Ceilings	
Supportive	Connective
30	25
28	30
26	35
24	40
22	45
20	50
18	55
16	60
14	65
12	70
10	75
8	80
6	85
4	90
2	95
0	100

Targeted thresholds for caseload ratios are identified as 90% per clinic/stand-alone ACT team (not per agency).

3.05 – Intra-RBHA Clinic Transfers

Transfer Guidelines

- The direct care clinic (DCC) and/or agency shall implement a transfer for members needing specialized services which are unable to be provided by the current clinic, team and/or agency, or when the member or guardian requests a transfer to a new site and/or agency. In accordance with the 9 guiding principles of member empowerment and self-determination, personal preference is given the utmost consideration and the member or guardian must agree with the transfer.
- In cases where the member or guardian would like to transfer to an integrated DCC or specialized DCC.
- If the request for transfer is due to lack of services or dissatisfaction, clinical leadership at the transferring agency will meet with the member or guardian to discuss and attempt to resolve.
- Agencies will respect the member's or guardian's choice and voiced request to transfer services to another agency.
- If transferring from an integrated clinic, discussion and documentation should occur for choice of PCP with the member. The integrated clinic shall assist member in choosing the PCP from Mercy RBHA website. The integrated clinic will outreach to the new identified PCP to include discussion about member care, transfer of medical records,

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and ensuring the PCP is aware of BH clinic information. An appointment with the outside PCP will be made in partnership with the member. The integrated clinic will ensure the member has a supply of medical medications that will last until the PCP appointment.

- If transferring to an integrated clinic, the member must agree to the PCP located at the integrated clinic. The member must sign the consent form agreeing with receiving services from the PCP as well as the BHMP at the integrated clinic. The BH clinical team will ensure the member has a supply of medical medications until the transfer appointment at the integrated clinic.
- If special assistance is being provided by the Office of Human Rights (OHR) for the member, they must be notified prior to the transfer.
- Agencies will respond to the transfer request within seven (7) business days as evidenced by sending all necessary documents to be transferred to the receiving clinic/care management team. The referring agency clinic shall enter a progress note in the member's medical record indicating a transfer packet request was delivered and note any deficiencies, if any, in the packet.
- If the medical record documentation is incomplete or not current, the referring agency will make every attempt to complete/update the documentation by the time of the transfer. Transfers will not be delayed due to incomplete documentation or documentation from another source of medical record i.e., NextGen. All transfer activities should be documented in the member's medical record.
- If the member is refusing to engage with the transferring agency, outreach documentation is needed to explain the reason for the refusal and ongoing efforts to engage the member in completing the documentation prior to the transfer.
- Transfers between and to supportive teams and connective teams are expected to be completed in less than forty-five (45) days from the time the receiving clinic receives the transfer request. If the transfer is not complete in the 45 day timeline, smimemberservicesrequest@MercyCareAZ.org should be contacted for assistance and notification of the delay.
- Outpatient Transfers between and to ACT teams (ex: supportive to ACT, ACT to ACT and ACT to FACT) are expected to be completed in less than twenty-one (21) days from the time the receiving ACT team receives the transfer request. The ACT team should screen members within two weeks of the receiving the outpatient referral to ensure they meet ACT criteria. If the member meets ACT Criteria and the transfer is not complete in the 21 day timeline, smimemberservicesrequest@mercymaricopa.org should be contacted. For Inpatient Level 1 referrals, Newly Determined SMI ACT referrals, referral waitlist and transfer protocols please refer to the **ACT Operational Manual**, available on our [Provider Manual](#) web page.
- Transfers between ACT teams are expected to be completed in less than twenty-one (21) days from the time the receiving clinic receives the transfer request. If the transfer is not complete in the 21 day timeline, smimemberservicesrequest@MercyCareAZ.org should be contacted.

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- If the referring agency concludes that the requested transfer should not take place as a result of the member's "clinical instability" and/or it would not be in the best clinical interest of the member, the agency chief medical officer can request approval from Mercy RBHA's Medical Director to delay the transfer until the risk is ameliorated. The smimemberservicesrequest@MercyCareAZ.org mailbox can be utilized to start this process. The Mercy RBHA Medical Director shall issue a decision to the agency within five (5) business days. If the transfer request of the member is rejected, the clinical team shall notify all members making the request as to why the request was denied and of the member's right to appeal the decision.
- Violent and/or threatening behaviors may result in legal action that prevents the member from continuing to receive services at their current agency clinic. If there is any question regarding "clinical instability" from the receiving clinic, the SMI member services mailbox should be utilized.
 - It is expected that these members be managed within their current network and that alternate clinics within that network should be able to immediately meet all the member's needs.
 - If the member refuses continued treatment at the current network and requests transfer, they shall be offered clinic selection from the agency clinic map.
 - The "clinical instability" guidelines above may apply.
 - Regular time frames for transfers will apply.
- If there is a delay regarding a member's pending transfer due to a clinic's temporary lack of capacity, once the clinic resumes accepting referrals transfers, they will be scheduled in order of the original request date of the packet referral. Under these circumstances, any member unable to transfer to a site initially requested will be offered the option of transferring to an alternative open clinic based on the member's preference.
- A transfer is complete once the member has attended an initial appointment at the receiving clinic and the medical record has been delivered to the receiving clinic.
 - The referring clinic is responsible for ensuring the member has transportation to the transfer appointment, delivering all medications (if applicable) and delivering the medical record. Additionally if the member has a guardian or receives special assistance, the referring team is responsible for ensuring the guardian or designated representative is in attendance.
 - If the member fails to keep the scheduled appointment with the newly assigned clinical team, it is the responsibility of the referring clinic's clinical team to engage in outreach efforts to determine the reason for the missed appointment and assist in rescheduling the missed appointment with the receiving clinic. The referring clinic is responsible for ensuring the member has transportation to the initial appointment at the new clinic. The referring clinic retains all responsibility for the member's care as outlined in the ISP until the completion of the transfer process.

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- If the member is currently on court-ordered treatment, Mercy RBHA's Court Liaison Administrator, needs to be notified via email once the transfer is complete. The referring clinic will send all emails to currans2@MercyCareAZ.org.
- For any concerns regarding the transfer guidelines, you can contact Mercy RBHA for appropriate interventions or questions at smimemberservicesrequest@MercyCareAZ.org.

Transfer Process

- The clinical director/site administrator of the referring clinic will ensure that documentation is prepared and delivered to the receiving clinic within 7 days after the Release of Information is signed. All transfer activities will be documented in the medical record.
- The member or guardian and OHR (if applicable) will be notified of the transfer referral by the referring clinic with the intention that the receiving clinic assign the member to a clinical team within the required timeframes. This will be documented in the medical record.
- The referring clinic shall prepare a transfer packet to include the following medical record information:
 - Transfer of care cover sheet
 - Part E
 - Part D
 - AUD
 - ARCP
 - Medical sheet
 - Last three doctor notes
 - Last three progress notes
 - Face sheet
 - COT/Special Assistance or guardianship paperwork
 - A progress note indicating a conversation with the member or member's guardian with the transfer request
 - Last psychiatric evaluation
 - Labs from the past year
 - EKG from the past year, if applicable
 - Medication lists for the past year and current medication list to include medical and physical health medications
 - Progress notes for the past year (last 3 progress notes)
- The clinical director/single point of contact from the transferring agency will place a personal telephone call to the clinical director/single point of contact receiving the case and will discuss any special needs or circumstances involving the individual such as court ordered treatment, court ordered evaluations and/or special treatment needs.

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- The referring clinic shall ensure the member has adequate transportation and/or other special circumstances needed i.e. interpreter services to the initial appointment at the receiving clinic.
- The referring clinic must attend the initial appointment to ensure proper coordination for both TXIX and NTXIX members.
- The member's medical record must be delivered by the referring clinic by the time of the initial appointment at the receiving clinic.
- The referring and receiving clinics shall log all medical record tracking information and make the necessary changes to the clinical team affiliations in the electronic medical record to ensure the member is appropriately designated to the desired agency/clinic.
- In all cases in which a member is being treated with medication, the transferring agency/clinic shall ensure a 30 day supply (from the date of transfer) is given to the member prior to the change in clinics. Should this be a concern based on clinical indicators, the clinical team will ensure that the member has the ability to obtain medications while waiting for the transfer. The receiving agency/clinic is responsible for ensuring a medication management appointment is scheduled within 30 days of the date of transfer so that medications are not disrupted. The referring clinic must ensure the member's medications are delivered to the receiving clinic, if applicable.
- If member chooses to transfer to an integrated clinic, the clinical team must coordinate care with the transferring PCP in order to ensure the individual has at least 30 days of medical medications. The receiving integrated clinic is responsible for ensuring a medication management appointment is scheduled within 30 days of the date of transfer so that medications are not disrupted.
- The receiving agency clinic shall schedule an initial appointment for the member within 45 calendar days for supportive and connective level members and 21 days for ACT members. If the transfer timelines are not met, smimemberservicesrequest@MercyCareAZ.org should be contacted.
- Within 3 days of receiving the transfer request, the receiving clinic shall contact the referring clinic's clinical director to:
 - Provide the date and time of the initial appointment for transfer;
 - Provide the date and time of the initial appointment with the newly assigned BHMP (this may occur on the same date as the transfer); and
 - Schedule time to discuss concerns and/or special treatment needs as identified by the transfer packet documentation or arranges a prescriber to prescriber call if needed.
- If the member chooses to transfer to an integrated clinic, the ART will need to assist the member in changing their PCP assignment.

If there are any concerns, questions, conflicts, etc., regarding the transfer process, the smimemberservicesrequest@MercyCareAZ.org mailbox should be utilized for resolution if not able to resolve between the two agencies.

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3.06 – Provider Financial Reporting

The **Provider Financial Reporting Guide**, available on our [Forms Library](#) web page, has been developed to ensure that all Mercy RBHA subcontracted providers and vendors develop and understand the financial requirements and responsibilities inherent in their contract with Mercy RBHA. The primary objectives of this reporting guide are to establish consistency and uniformity in financial reporting and to provide guidelines to assist providers in meeting contractual reporting requirements.

The Guide includes:

- General Accounting Requirements
- Requirements for Reporting
- Unaudited Annual and Quarterly Reports
- Audited Financial Reporting
- Provider Delivery Schedule
- Fee Schedule and Funding Requests

3.07 – Provider Deliverables

There are provider deliverables required under AHCCCS and Mercy RBHA. Mercy RBHA produced the **Provider Deliverables**, available under our [Forms Library](#) web page, which has a list of deliverables that includes a description of the deliverables, how they should be submitted, who they should be submitted to and how often they should be submitted. If you have any questions regarding the deliverables, contact your Network Relations Specialist/Consultant at 602-586-1880 or 866-602-1979.

Compliance

Providers who are compliant with Deliverable standards require no further action until the next submission.

Providers who are “Out of Compliance” with Deliverable standards will be contacted by the Network Relations Specialist/Consultant to re-educate the provider on compliance requirements related to Deliverables standards. The Network Relations Specialist/Consultant will continue to monitor provider compliance each month.

Corrective Action Plan

Mercy RBHA will require a Corrective Action Plan (CAP) from all Providers identified as “Out of Compliance” with Deliverable’s standards. CAP’s will be due from the Providers within 15 business days of notice for non-compliance. The Provider Relations representative will send a follow up letter to the providers reminding them of the CAP due date and content.

If compliance is not evident after additional interventions, the case will be escalated to the Mercy RBHA Chief Operating Officer (COO) with recommendations for further actions, which

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may include referral restrictions, sanctions or possible termination from the network for breach of contract.

Submission of Provider Deliverables to Mercy RBHA

Provider Use of SFTP

Mercy RBHA has chosen to use Secure File Transfer Protocol (SFTP) for files exchanged with providers because it is secure and can be set up for automatic routing. A provider can choose between two ways to use SFTP for file transfer:

- The provider's IT group can establish an SFTP environment on the provider's server; or
- A provider can apply for a username and password to sign on to a Mercy RBHA SFTP environment and upload/download the file there. A routing tag used for internal routing is set up for each provider; the routing tag is never seen by the provider, as it is strictly used for routing within Mercy RBHA data systems. A provider can complete the **SFTP Connectivity Enrollment Form** available under our [Forms Library](#) web page, (in the Forms section of the Provider Manual) and submit it through their Network Relations Specialist/Consultant to initiate their SFTP set up.

File Naming Conventions

Certain conventions must be followed so that we can take advantage of receipt logging and available SFTP automation. The names of files to be transferred are chosen so that they follow this pattern:

Recipient_ReportName_YYYYMMDD_Sender

The four parts of the name are separated by an underscore ('_'). For example, the October access-to-care report that is sent to the Children's System of Care team at Mercy RBHA from the People of Color Network has this name:

CSOC_Accesstocare_201410_POCN

In this case, the date portion (YYYYMMDD) was designed to use just a year and month, so that the file name reflects the month being reported. Admin Review information for General Mental Health (GMH) members being sent to Lifewell Behavioral Wellness from the Mercy RBHA Quality Management Provider Monitoring team might have this name:

LBW_Admin Review-GMH_20141023_QMPM

There is a "master list" of provider abbreviations to ensure consistency; the file name and other conventions are shared with providers by the program areas. Certain basic information about each deliverable and a link to the associated template will appear in the Mercy RBHA Provider Manual.

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Incoming Files

Files will be routed to the appropriate program area's network drive/folder and also to a Sharepoint location for automatic logging of receipt of the file. The software "sweeps" the arrival area every minute, reviewing the names of files to identify any that are to be automatically routed. The name of the arriving file will be prefixed with the provider's routing tag when it is delivered. For example, the access-to-care report from People of Color Network described above would arrive as:

RBHAProvPeoColorScha79_ CSOC_Accesstocare_201410_POCN

The routing tag ends after the first underscore. The SFTP software is configured to use the member (CSOC) and report name (Accesstocare) to route the file to the program area's network drive/folder; that information along with the date portion (201410) and sender (POCN) are used at the Sharepoint to log that specific deliverable as received.

Outgoing Files

To send a file to a provider, a program area will label the file with the appropriate name, and also affix the intended member's routing tag to the front of the file name. For example, the Admin Review file destined for Lifewell described above would be constructed as:

RBHAProvLifeWellScha123_ LBW_Admin Review-GMH_20141023_QMPM

The file can then be placed (copied or cut-and-pasted) into the established outgoing SFTP folder. SFTP software will delete the file from this folder, and move the file to where the provider can sign on and retrieve it (or move it to the provider's system, depending on how they have set up the SFTP). The routing tag is removed when the file leaves the Mercy RBHA SFTP area. Note that if the file is placed in the outgoing SFTP folder without the routing tag, it will be moved to a Mercy RBHA server and deleted – it will **not** be routed to the provider. If an archive folder is configured for the program area, a copy of the file will be placed in the archive when it is sent to the provider; a date-timestamp reflecting when the file is sent will be added to the file name.

3.08 – Business Continuity and Disaster Preparedness

Mercy RBHA provides health care benefits to its Members. In order to provide benefits, the Contracted Facilities, Providers and Vendors must be able to recover from any disruption in services as quickly as possible. This recovery can be accomplished by the development of Business Continuity and Incident Management Plans that contains strategies for recovery. The Business Continuity and Incident Management Plans are part of the Federal Government's Continuity of Operations Programs (COOP) requirements.

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Responsibilities

The Facility, Provider or Vendor shall develop and maintain a Business Continuity and Incident Management Plan which assures Mercy RBHA that the provision of covered services will occur as stated in 42 C.F.R. 438.207 and 42 C.F.R. 438.208. A summary of the Business Continuity and Incident Management Plan should be submitted with the **Business Continuity and Incident Management Plan Checklist** available under our [Forms Library](#) web page, to the designated Compliance Officer, within 15 days from the start of each contract year. The comprehensive summary shall be no longer than five pages and shall address all Business Continuity and Incident Management Plan requirements outlined below. Facilities, Providers or Vendors shall prepare adequate Business Continuity and Incident Management Plans that are reviewed and tested at least annually, and updating them as needed.

Business Continuity and Incident Management Plan

- The Business Continuity and Incident Management Plan (Plan) shall be reviewed and updated at least annually by the Facility, Provider or Vendor.
- The Facility, Provider or Vendor shall ensure that its staff is trained and familiar with the Plan.
- The Plan should be specific to the Contractor's operations in Arizona and reference local resources. Generic Plans which do not reference operations in Arizona and their relationship to Mercy RBHA are not appropriate.
- The Plan should contain, at a minimum, planning and training for:
 - Complete loss of use of the main site (e.g. major fire or flood).
 - Complete loss of systems and applications (e.g. data center disaster).
 - Loss of a critical Third Party Supplier (e.g. internet and telephones).
 - Wide-spread Severe Staffing Shortage (e.g. pandemic).
 - How the Facility, Provider or Vendor will communicate with Mercy RBHA during a business disruption. *(Plan should include Woodrow Terrell, (602) 402-8190 as the specific contact at Mercy RBHA).* The Plan shall contain a listing of key customer priorities and key factors that could cause disruption and timelines for when a Facility, Provider or Vendor will be able to resume critical customer services when a disruption occurs. The Facility, Provider or Vendor shall also include any additional priorities as identified to be critical key priorities or factors.
 - How Mercy RBHA will contact the Facility, Provider or Vendor in the event of a business disruption outside of normal business hours. *(The name and phone numbers for two contacts).*
 - Provisions for periodic testing, at least annually. Results of the tests are documented.
- The Plan should identify the Facility, Provider or Vendor's greatest priorities and provide recovery guidelines and procedures to respond to an event impacting the critical functions at a basic level until normal functions have been restored.

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- The Plan should address how, during a business disruption, the Facility, Provider or Vendor will provision for facilities, hospitals or other locations in the event members are being displaced.
- The Plan should provide the procedures to follow during a disruption when transporting members and other critical resources to alternate operating locations.
- The Plan should include realistic timelines for the resumption of basic services for the Facility, Provider or Vendor's greatest priorities.
- The Plan should include primary and alternate Business Continuity Planning Coordinators and includes primary and alternate methods of contact for each.
- The Plan should include actions performed by the Facility, Provider or Vendor that benefit the general public before a disruption occurs (e.g. educational outreach, protecting vulnerable populations, having appropriate interventions).
- The Plan should include plans and procedures can be performed by the Facility, Provider or Vendor to benefit the general public during a disruption (e.g. limiting adverse public health effects, coordinating efforts with government departments and agencies, reducing public health risks, and other activities designed to mitigate health adverse effects and/or deaths).
- The Plan should include procedures for providing counselling to their employees and volunteers during and after the most severe disruptions.

Resources

The Federal Emergency Management Agency (FEMA) has a website which contains additional information on Business Continuity and Incident Management Planning, including checklists for reviewing a Plan. Mercy RBHA encourages the Facility, Provider or Vendor to use relevant parts of these checklists in the evaluation and testing of its own Business Continuity and Incident Management Plans. The Facility, Provider or Vendor can also reference the Arizona Governor's Office of Homeland Security and Emergency Preparedness and the Ready websites for supplementary information. Links to these websites are provided:

Federal Emergency Management Agency: <http://www.fema.gov/>

FEMA Continuity of Operations Program: <http://www.fema.gov/continuity-operations>

Arizona Division of Emergency Management: <https://dema.az.gov/emergency-management>

Arizona Department of Emergency & Military Affairs: <http://www.azdema.gov/>

Arizona Department of Homeland Security: <http://www.azdohs.gov/>

Arizona Emergency Information Network: <https://ein.az.gov/>

Ready: <http://www.ready.gov/>

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RBHA CHAPTER 4 – COVERED AND NON-COVERED SERVICES

4.00 – Covered and Non-Covered Services

Behavioral Health Covered Services

Mercy RBHA will cover behavioral health services consistent with the table below. [AHCCCS Covered Behavioral Health Services Guide](#) has a complete list of covered services.

AVAILABLE BEHAVIORAL HEALTH SERVICES*

SERVICES		TITLE XIX/XXI CHILDREN AND ADULTS	NON-TITLE XIX/XXI MEMBERS DETERMINED TO HAVE SMI
TREATMENT SERVICES			
Behavioral Health Counseling and Therapy	Individual	Available	Available*****
	Group	Available	Available*****
	Family	Available	Available*****
Behavioral Health Screening, Mental Health Assessment and Specialized Testing	Behavioral Health Screening	Available	Available*****
	Mental Health Assessment	Available	Available
	Specialized Testing	Available	Not Available
Other Professional	Traditional Healing	Not Available with Title XIX/XXI funding**	Not Available**
	Auricular Acupuncture	Not Available with Title XIX/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	Psycho Educational Services	Available	Available

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Employment	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	Available*****
SUPPORT SERVICES			
Care Management		Available	Available (See Care 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	Available*****
Respite Care****		Available	Available
Supported Housing		Provided based on available grant funds**	Provided based on available grant funds*
Sign Language or Oral Interpretive Service		Provided at no charge to the member	Provided at no charge to the member
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 Intervention - Stabilization		Available	Available
INPATIENT SERVICES			
Hospital		Available	Available but limited*****

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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**	Available*****
BEHAVIORAL HEALTH DAY PROGRAMS		
Supervised Day	Available	Available
Therapeutic Day	Available	Available*****
Medical Day	Available	Available*****

*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 AHCCCS 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 member.

*****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

*****Pending availability of funding

Physical Health Care Services

The table below lists physical health care services available for Title XIX/XXI eligible members determined to have a Serious Mental Illness (SMI), who are receiving both behavioral health and physical health care services from Mercy RBHA (see the AHCCCS Covered Services, Acute Care, listed in the [AHCCCS Medical Policy Manual](#), for further information on covered physical health care services and dental services).

Available Physical Health Care Services

SERVICES	TITLE XIX		TITLE XXI
	<	≥21	≤19
Audiology	X	X	X
Breast Reconstruction after Mastectomy	X	X	X
Chiropractic Services	X		X

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Cochlear Implants	X		X
Emergency Dental Services	X	X	X
Preventative & Therapeutic Dental Services	X		X
Limited Medical and Surgical Services by a Dentist (for Members Age 21 and older)		X	
Dialysis	X	X	X
Emergency Services – Medical	X	X	X
Emergency Eye Exam	X	X	X
Vision Exam/Prescriptive Lenses	X		X
Lens Post Cataract Surgery	X	X	X
Treatment for Medical Condition of the Eye	X	X	X
Health Risk Assessment & Screening Tests (for Members age 21 and older)		X	
Preventive Examinations in the Absence of any Known Disease or Symptom	X		X
HIV/AIDS Antiretroviral Therapy	X	X	X
Home Health Services	X	X	X
Hospice	X	X	X
Hospital Inpatient Medical	X	X	X
Hospital Observation	X	X	X
Hospital Outpatient Medical	X	X	X
Hysterectomy (medically necessary)	X	X	X
Immunizations	X	X	X
Laboratory	X	X	X
Maternity Services	X	X	X
Family Planning	X	X	X

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Early and Periodic Screening, Diagnosis and Treatment (Medical Services)	X		X
Other Early and Periodic Screening, Diagnosis and Treatment Services Covered by Title XIX	X		X
Medical Foods	X	X	X
Durable Medical Equipment	X	X	X
Medical Supplies	X	X	X
Prosthetic	X	X	X
Orthotic Devices	X	X	X
Nursing Facilities (up to 90 days)	X	X	X
Non-Physician First Surgical Assistant	X	X	X
Physician Services	X	X	X
Foot and Ankle Services	X	X	X
Prescription Drugs	X	X	X
Primary Care Provider Services	X	X	X
Private Duty Nursing	X	X	X
Radiology and Medical Imaging	X	X	X
Occupational Therapy – Inpatient	X	X	X
Occupational Therapy – Outpatient (limitations apply)	X	X	X
Physical Therapy – Inpatient	X	X	X
Physical Therapy – Outpatient (limitations apply)	X	X	X
Speech Therapy – Inpatient	X	X	X
Speech Therapy – Outpatient (limitations apply)	X		X
Respiratory Therapy	X	X	X
Total Outpatient Parenteral Nutrition	X	X	X

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Non-Experimental Transplants Approved for Title XIX Reimbursement*			
Transplant Related Immunosuppressant Drugs	X	X	X
Transportation – Emergency	X	X	X
Transportation – Non-emergency	X	X	X
Triage	X	X	X
Well Exams		X	

*See the AHCCCS Medical Policy Manual, Chapter 300, Policy 310, 310-DD, *Covered Transplants and Related Immunosuppressant Medications*.

Coverage Criteria

Except for emergency care, all covered services must be medically necessary and provided by a primary care provider or other qualified providers. Benefit limits apply.

Mercy RBHA has specific covered and non-covered medical services. Participating providers are required to administer covered and non-covered services to members in accordance with the terms of their contract and member's benefit package.

Covered Services

For a complete listing of covered medical services for Mercy RBHA, please refer to Mercy RBHA's **Member Handbook**, available under our [Member Handbook](#) web page.

Providers may arrange medically necessary non-emergent transportation for Mercy RBHA members by calling Member Services at 800-564-5465.

Member Handbook

Mercy RBHA is responsible for the **Member Handbook**, available on our **Member Handbook** web page. Providers can request member handbooks by completing the **Member Handbook Order Form**, available on our **Forms Library** web page, in its entirety and submit to your Provider Relations representative. Handbooks are packaged 40 handbooks to one box. There is a minimum order of one box.

Member handbooks must be distributed to members receiving services as follows (see AHCCCS ACOM Chapter 400, Policy 404 for more information):

- Members diagnosed with SMI who are enrolled with Mercy RBHA must receive a member handbook within 12 business days of receipt of notification of the enrollment date;
- Members enrolled with a T/RBHA and are receiving behavioral health services through

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Mercy RBHA and are not diagnosed with SMI, must receive a member handbook within 12 business days of the member receiving his/her first service.

Documentation of receipt of the member handbook must be filed in the member's record. See **Member Handbook Receipt**, available on our **Forms Library** web page, for the minimum requirements to document member's receipt of the handbook.

- Member Handbooks will be available and easily accessible at all provider sites and is available on the Mercy RBHA website ([Member Handbook](#)). Upon request, copies must be made available to known consumer and family advocacy organizations and other human service organizations. The Member Handbook is available in both English and Spanish.
- Members receiving healthcare services have the right to request and obtain a Member Handbook at least annually. Mercy RBHA notifies members of their right to request and obtain a Member Handbook at least annually by publishing this information using notices or newsletters accessible on Mercy RBHA's website.
- AHCCCS may require Mercy RBHA to revise the Member Handbook and distribute it to all current enrollees if there is a significant program change. AHCCCS determines if a change qualifies as significant.

Member Handbooks are reviewed annually, and if needed, updated by Mercy RBHA.

Non-Covered Services

The following services are considered non-covered services:

- Services from a provider who is NOT contracted with Mercy RBHA (unless prior approved by the Health Plan);
- Cosmetic services or items;
- Personal care items such as combs, razors, soap etc.;
- Any service that needs prior authorization that was not prior authorized;
- Services or items given free of charge, or for which charges are not usually made;
- Services of special duty nurses, unless medically necessary and prior authorized;
- Physical therapy that is not medically necessary;
- Routine circumcisions;
- Services that are determined to be experimental by the health plan medical director;
- Abortions and abortion counseling, unless medically necessary, pregnancy is the result of rape or incest, or if physical illness related to the pregnancy endangers the health of the mother;
- Health services if you are in prison or in a facility for the treatment of tuberculosis;
- Experimental organ transplants, unless approved by AHCCCS;
- Sex change operations;
- Reversal of voluntary sterilization;
- Medications and supplies without a prescription;
- Treatment to straighten teeth, unless medically necessary and approved by Mercy RBHA;

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- Prescriptions not on our list of covered medications, unless approved by Mercy RBHA; and
- Physical exams for qualifying for employment or sports activities.

Other Services that are Not Covered for Adults (age 21 and over)

- Hearing aids, including bone-anchored hearing aids;
- Cochlear implants;
- Insulin pumps;
- Microprocessor controlled lower limbs and microprocessor-controlled joints for lower limbs;
- Percussive vests;
- Routine eye examinations for prescriptive lenses or glasses;
- Outpatient Hospice – Effective 10/1/09 hospice for Acute Care adult members (21 years or older) is not covered.
- Routine dental services, unless related to the treatment of a medical condition such as acute pain, infection, or fracture of the jaw;
- Chiropractic services (except for Medicare QMB members); and
- Outpatient speech therapy (except for Medicare QMB members).

Medicare Part D Prescription Drug Coverage

Members 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).

SMI Support Services

Dependent on available funding, limited eviction prevention services, as listed below, are available to assist members in securing housing and remaining housed. Members may request services through their assigned behavioral health clinic. The member's clinical team will determine whether a member is eligible and whether any requested service is appropriate on a case by case basis. All services are subject to availability of funding.

Hotel Assistance

- Provides enrolled SMI members temporary assistance to address a member's immediate homeless status.
 - This service is available for seven (7) days with a maximum of \$70.00 per night.
 - This service is available only one (1) time, per fiscal year, per member,
 - This service is dependent on the availability of funding and eligibility as determined by the member's clinical team on a case by case basis.

Bed Bug Treatment

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- Provides enrolled SMI members with assistance to remove bed bugs from their independent living situation.
 - This service is available to member for a total lifetime benefit of \$1,525.00
 - This service is dependent on availability of funding and eligibility as determined by the member's clinical team on a case by case basis.

Startup Boxes

- Provides enrolled SMI members moving into their first independent place of residence (apartment) with one start up box containing necessary household essentials.
 - This service is dependent on availability of funding and eligibility as determined by the member's clinical team on a case by case basis.

Biohazard Cleaning

- Provides enrolled SMI members a maximum of \$1,525.00, once per fiscal year, to assist with biohazard cleaning.
- This covers human bodily fluids.
 - This service is dependent on availability of funding and eligibility as determined by the member's clinical team on a case by case basis.

Move In Assistance

- Provides enrolled SMI members with assistance with move in costs (including required deposits).
- This service is available to members for a total lifetime benefit of \$1,525.00.
- This service is dependent on availability of funding and eligibility as determined by the member's clinical team on a case by case basis.

Moving Assistance

- Provides enrolled SMI members with assistance with moving their belongings from one location to another (including storage units).

GMH/SU and SMI Support Services

Rental & Utility Assistance

- Provides enrolled GMSHA and SMI member's assistance for eviction prevention and utility shut off prevention.
 - Eviction is determined by formal notice to the member (member's name must be on the lease or rental agreement).
 - Utility shut off prevention is determined by formal notice to the member (member's name must be on the utility agreement).
- Provides a maximum lifetime amount of \$1,500.00 per member.

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- This service is dependent on availability of funding and eligibility as determined by the member's clinical team on a case by case basis.

Move In Assistance

- Provides enrolled GMSHA and SMI member's with move in assistance (not packing) to a new place of residence. This is for assistance related to moving into housing in the community.
 - Provides a maximum lifetime amount of \$1,500.00 per member.
 - This service is dependent on availability of funding and eligibility as determined by the member's clinical team on a case by case basis.

Providers are responsible for specific deliverable requirements related to the use and tracking of these funds.

- The direct care clinic will submit all receipts to SMIMemberServicesRequest@MercyCareAZ.org within five (5) business days.
- It is the responsibility of the direct care clinic to ensure Mercy RBHA receives the receipt within the five (5) business days. If the provider fails to meet these standards or demonstrates a pattern of non-compliance, the provider will be subject to Corrective Action, Notice to Cure and/or Sanctions.

PLAN SPECIFIC TERMS**RBHA CHAPTER 5 – NETWORK REQUIREMENTS****5.00 – Provider Network Development and Management**

To ensure that Mercy RBHA has established a process to develop, maintain and monitor their network of contracted providers sufficient in size, scope and types of providers to deliver all covered services according to the AHCCCS standards and requirements.

NETWORK DEVELOPMENT

Mercy RBHA will develop and maintain a network of providers that:

- Is sufficient in size, scope and types of providers to deliver all covered behavioral health services and satisfy all the service delivery requirements; and
- Can deliver culturally and linguistically appropriate services, in-home and community-based services for the American Indian members and other culturally diverse populations. These cultural and linguistic needs must take into consideration the prevalent language(s), including sign language, spoken by populations in the geographic service area.

Mercy RBHA must design, establish and maintain a network that covers, at a minimum

- Covered services that are accessible to all current and anticipated Title XIX/XXI and non-Title XIX/XXI members, as applicable, in terms of timeliness, amount, duration and scope;
- Current and anticipated utilization of services and the number of network providers not accepting new referrals;
- The geographic location of providers and their proximity to members, considering distance, travel time, the means of available transportation and access for members with a disability;
- The identification of current network gaps and the methodology used to identify them, and the immediate short-term interventions identified when a gap occurs, including provisional credentialing;
- Interventions to fill network gaps and barriers to those interventions; outcome measures/evaluation of interventions;
- Member Satisfaction Survey data, complaint, grievance and appeal data;
- Issues, concerns and requests brought forth by other state agency personnel;
- Ongoing activities for network development based on identified gaps and future needs projection;
- Specialized health competencies to deliver services to children, youth and adults with developmental or cognitive disabilities, sexual offenders, sexual abuse trauma victims, individuals with substance use disorders, individuals in need of dialectical behavior therapy; and infants and toddlers under the age of five (5) years; and
- A network of providers that delivers (24) twenty-four hour substance use disorder/psychiatric crisis stabilization services.

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Network Management

Mercy RBHA must:

- Monitor network compliance with all policies and rules of AHCCCS and the Contractor, including:
 - AHCCCS Minimum Network Standards in association with the AHCCCS Contractor Operations Manual Chapter 436;
 - Process to evaluate its Provider Services Staffing levels based on the needs of the provider community;
 - A process to track and trend provider inquiries that include timely acknowledgement and resolution including systemic actions as appropriate;
 - Recruit, select, credential, re-credential and contract with providers in a manner that incorporates quality management utilization, office audits, medical record reviews, and provider profiling;
 - Provide training for providers and maintain records of such training;
 - Network compliance with all policies and procedures related to the grievance/appeal processes and ensuring the member's care is not compromised during the grievance/appeal processes;
 - The adequacy, accessibility and availability of its provider network to meet the needs of its members, including the provision of care to members with limited proficiency in English; and
 - On-going monitoring of out-of-state providers to ensure compliance with AHCCCS standards of care and to identify gaps in the system of care.
- Tracking and responding to provider inquiries:
 - Mercy RBHA tracks and trends provider inquiries/complaints/requests for information and take systemic action as necessary and appropriate;
 - Mercy RBHA ensures that provider calls are acknowledged within three (3) business days of receipt, are resolved and the result communicated to the provider within thirty (30) business days of receipt (includes referrals from AHCCCS);
 - Mercy RBHA ensures adequate staffing to handle provider inquiries/complaints/requests for information and ensure that staff members are trained, at a minimum, in the following:
 - Provider inquiry processing and tracking (including resolution timeframes);
 - Mercy RBHA procedures for initiating provider contracts or AHCCCS provider registration;
 - Claim submission methods and resources;
 - Claim dispute and appeal procedures;
 - Identifying and referring quality of care issues; and
 - Fraud, waste, and program abuse reporting requirements.

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Mercy RBHA must monitor the number of members assigned to each Primary Care Provider (PCP) and the PCP's total capacity in order to assess the providers' ability to meet AHCCCS appointment standards.

Reporting

Mercy RBHA will provide all required deliverables with the frequency and due dates specified as stated in their respective Contract/IGA; inclusive of incident report for out-of-state placements.

5.01 – Material Changes

Mercy RBHA must ensure the timely and accurate reporting of material changes to the network, affecting behavioral health members to AHCCCS. Mercy RBHA also ensures that all subcontracted providers adhere to the requirements of this chapter.

Mercy RBHA develops and maintains a Network with sufficiency in size, scope and types of providers to deliver all covered behavioral health services and satisfy all the service delivery requirements. Mercy RBHA will:

- Communicate with the network providers regarding contractual and/or program changes and requirements;
- Provide or arrange for medically necessary covered services should the network become temporarily insufficient within the contracted service area;
- Process provisional credentials.

Mercy RBHA Responsibilities

During the material transition process, Mercy RBHA is responsible for:

- Communicating with providers regarding contract requirements and program changes;
- Ensuring the provision of medically necessary covered services should the network become temporarily insufficient within the contracted service area;
- Monitoring the adequacy, accessibility and availability of the provider network to meet the needs of the members, including the provision of care to members with limited proficiency in English; and
- Expedited and temporary credentialing process.

Material Network Change – AHCCCS Notifications

For all Mercy RBHA Provider Changes:

Notify Mercy RBHA of any material change in the size, scope or configuration of the Contractor's provider network that differs from the most recent network inventory.

Submit the notification of a material change in the provider network, including draft letter to notify affected members, ninety (90) days prior to the expected implementation of the change.

A **Notification of Changes to the Network**, available on our [Forms Library](#) web page, is required. The completed form must be submitted electronically to Mercy RBHA Network

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Management to your assigned Network Relations Specialist/Consultant using email MaterialChanges@MercyCareAZ.org.

Mercy RBHA will notify AHCCCS in writing within one (1) day of knowledge of any unexpected network material change, see form for specific requirements.

The Mercy RBHA Member Notification Letter is required to be sent out to all members affected by the change at least 30 days prior to any material change. This letter must be submitted to and approved by the AHCCCS Policy Office before it is printed, posted or disseminated to members.

Mercy RBHA may require subcontracted providers to submit a **Network Material Change Transaction Grid Template**, available on our [Forms Library](#) web page, (template to be copied into an excel spreadsheet by provider) used to provide a plan for transitioning members affected by the change, deficiency or condition to their current provider and to assure the restoration of the network to full capacity. If required, Mercy RBHA will provide the Transition Grid and specific monthly reporting requirements. The Transition Grid will be submitted for a period to be determined by Mercy RBHA.

Mercy RBHA is responsible for the content of any Member Notification Letter sent to members by their subcontracted provider's, and cannot delegate this responsibility to notify Mercy RBHA members of any material network change described in this chapter to subcontracted providers.

5.02 – Peer/Recovery Support Training, Certification and Supervision Requirements

Peer/Recovery Support Specialist and Trainer Qualifications

Members with lived experience of recovery from mental health and/or substance abuse disorders serve an important role as behavioral health providers; and Mercy RBHA expects consistency and quality in peer-delivered behavioral health services and support for peer-delivered behavioral health services statewide.

- Individuals training or seeking credentialing and employment as Peer/Recovery Support Specialists must:
 - Self-identify as a “peer”, and
 - Meet the requirements to function as a behavioral health paraprofessional, behavioral health technician, or behavioral health professional.
- Individuals meeting the above criteria may be credentialed as a Peer/Recovery Support Specialist by completing training and passing a competency test through an AHCCCS/OIFA approved Peer Support Employment Training Program. AHCCCS/OIFA oversees the approval of all credentialing materials including curriculum and testing tools. Credentialing through an AHCCCS/OIFA approved Peer Support Employment Training Program is applicable statewide.
- Agencies may employ individuals prior to the completion of credentialing through a Peer Support Employment Training Program. However, other required trainings must be

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completed prior to delivering behavioral health services. See Peer/Recovery Support Specialist Employment Training Program Approval Process. An individual must be credentialed as a Peer/Recovery Support Specialist under the supervision of a qualified individual prior to billing Peer Support Services.

- Mercy RBHA's Office of Individual and Family Affairs provides continuing education opportunities relevant to peer/recovery support services through the online learning management system, Relias. In addition to online education OIFA will periodically offer live training sessions.

Peer/Recovery Support Specialist Employment Training Approval Process

A Peer/Recovery Support Employment Training Program must submit its program curriculum, competency exam, and exam-scoring methodology (including an explanation of accommodations or alternative formats of program materials available to individuals who have special needs) to the AHCCCS Office of Individual and Family Affairs (OIFA). AHCCCS/OIFA will issue feedback or approval of the curriculum, competency exam, and exam-scoring methodology in accordance with ***Peer/Recovery Support Employment Training Curriculum Standards***.

Approval of curriculum is binding for no longer than three years after AHCCCS approval. Three years after initial approval and thereafter, the program must resubmit their curriculum for review and re-approval to AHCCCS/OIFA. If a program makes substantial changes (meaning change to content, classroom time, etc.) to their curriculum or if there is an addition to required elements (see ***Peer Support/Recovery Employment Training Curriculum Standards***) during this three year period, the program must submit the updated curriculum to AHCCCS/OIFA for review and approval.

AHCCCS/OIFA will base approval of the curriculum, competency exam and exam scoring methodology only on the elements included in this chapter. If a Peer/Recovery Support Employment Training Program requires regional or culturally specific training exclusive to a GSA or tribal community, the specific training cannot prevent employment or transfer of Peer/Recovery Support Specialist certification based on the additional elements or standards.

Competency Exam

Individuals seeking certification and employment as a Peer/Recovery Support Specialist must complete and pass a competency exam with a minimum score of 80% upon completion of required training. Each Peer/Recovery Support Employment Training Program has the authority to develop a unique competency exam. However, all exams must include at least one question related to each of the curriculum core elements listed in ***Peer/Recovery Support Employment Training Curriculum Standards***. Individuals certified in another state may obtain certification after passing a competency exam. If an individual does not pass the competency exam, the Peer/Recovery Support Employment Training Program may require that the individual repeat or complete additional training prior to taking the competency exam again.

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Peer/Recovery Support Employment Training Curriculum Standards

A Peer/Recovery Support Employment Training Program curriculum must include, at a minimum, the following core elements:

- **Concepts of Hope and Recovery:**
 - Instilling the belief that recovery is real and possible;
 - The history of the recovery movement and the varied ways that behavioral health issues have been viewed and treated over time and in the present;
 - Knowing and sharing one's story of a recovery journey; how one's story can assist others in many ways;
 - Mind- Body-Spirit connection and holistic approach to recovery; and
 - Overview of the Individual Service Plan (ISP) and its purpose.
- **Advocacy and Systems Perspective:**
 - Overview of state and national behavioral health system infrastructure and the history of Arizona's behavioral health system;
 - Stigma and effective stigma reduction strategies: countering self-stigma; role modeling recovery; and valuing the lived experience;
 - Introduction to organizational change - how to utilize member-first language and energize one's agency around recovery, hope, and the value of peer support;
 - Creating a sense of community; the role of culture in recovery;
 - Forms of advocacy and effective strategies – consumer rights and navigating behavioral health system; and
 - Introduction to the Americans with Disabilities Act (ADA).
- **Psychiatric Rehabilitation Skills:**
 - Strengths based approach; identifying one's own strengths and helping others identify theirs; building resilience;
 - Distinguishing between sympathy and empathy; emotional intelligence;
 - Understanding learned helplessness; what it is, how it is taught and how to assist others in overcoming its effects;
 - Introduction to motivational interviewing; communication skills and active listening;
 - Healing relationships – building trust and creating mutual responsibility;
 - Combating negative self-talk: noticing patterns and replacing negative statements about one's self; using mindfulness to gain self-confidence and relieve stress;
 - Group facilitation skills; and
 - Introduction to Culturally & Linguistically Appropriate Services (CLAS) Standards; creating a safe and supportive environment.
- **Professional Responsibilities of the Peer Support Employee and Self-Care in the Workplace:**
 - Qualified peers must receive training on the following elements prior to delivering any covered healthcare services:

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- Professional boundaries and ethics - the varied roles of the helping professional;
- Collaborative supervision and the unique features of the Peer/Recovery Support Specialist;
- Confidentiality laws and information sharing – understanding the Health Insurance Portability and Accountability Act (HIPAA);
- Responsibilities of a mandatory reporter; what to report and when;
- Understanding common signs and experiences of mental illness, substance abuse, addiction and trauma;
- Orientation to commonly used medications and potential side effects;
- Guidance on proper service documentation, billing and using recovery language throughout documentation;
 - Self-care skills and coping practices for helping professionals; the importance of ongoing supports for overcoming stress in the workplace; resources to promote personal resilience; and, understanding burnout and using self-awareness to prevent compassion fatigue, vicarious trauma and secondary traumatic stress.

Some curriculum elements include concepts included in required training. Peer/Recovery Support employment training programs must not duplicate training required of peers for employment with a licensed agency or Community Service Agency (CSA). Training elements in this chapter must be specific to the Peer/Recovery Support Specialist's role in the public healthcare system and instructional for peer-delivered services.

Supervision of Certified Peer/Recovery Support Specialists

Agencies employing Peer/Recovery Support Specialists must provide supervision by individuals qualified as Behavioral Health Technicians or Behavioral Health Professionals. Supervision must be appropriate to the services being delivered and the Peer/Recovery Support Specialist's qualifications as a Behavioral Health Technician, Behavioral Health Professional or Behavioral Health Paraprofessional. Supervision must be documented and inclusive of both clinical and administrative supervision.

Individuals providing supervision must receive training and guidance to ensure current knowledge of best practices in providing supervision to Peer/Recovery Support Specialists.

Mercy RBHA, Office of Individual and Family Affairs (OIFA) oversees and can make available to providers policies and procedures regarding resources available to agencies for establishing supervision requirements and any expectations for agencies regarding Mercy RBHA monitoring/oversight activities for this requirement.

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Process for Submitting Evidence of Certification

Agencies employing Peer/Recovery Support Specialists who are providing peer support services are responsible for keeping records of required qualifications and certification. Mercy RBHA, Office of Individual and Family Affairs (OIFA) ensure that Peer/Recovery Support Specialists meet qualifications and have certification, as described in this chapter, through quarterly provider deliverable reporting.

5.03 - Parent/Family Support Provider Training, Credentialing and Supervision Requirements

The Arizona Health Care Cost Containment System/Office of Individual and Family Affairs (AHCCCS/OIFA) has established training requirements and credentialing standards for Credentialed Parent/Family Support roles providing Parent/Family Support Services, as described in the Covered Behavioral Health Services Guide. Mercy RBHA recognizes the importance of the Credentialed Parent/Family Support role as a viable component in the delivery of integrated services and expects statewide support for these roles. Mercy RBHA expects consistency and quality in parent/family delivered support of integrated services in both the Children's and Adult Systems statewide.

Credentialed Parent/Family Support Provider and Trainer Qualifications

Individuals credentialed in another state must submit their credential to AHCCCS/ OIFA. The individual must demonstrate their state's credentialing standards meet those of AHCCCS prior to recognition of their credential.

- Individuals seeking employment as a Credentialed Parent/Family Support Provider or Trainer in the children's system must:
 - Be a parent or primary caregiver with lived experience who has raised or is currently raising a child with emotional, behavioral, mental health or substance use needs; and
 - Meet the requirements to function as a behavioral health professional, behavioral health technician, or behavioral health paraprofessional.
- Individuals seeking employment as a Credentialed Parent/Family Support Provider or Trainer in the adult system must:
 - Have lived experience as a primary natural support for an adult with emotional, behavioral, mental health or substance abuse needs, and
 - Meet the requirements to function as a Behavioral Health Professional (BHP), Behavioral Health Technician (BHT), or Behavioral Health Paraprofessional (BHPP).

Credentialed Parent/Family Support Provider Training Program Approval Process

A Credentialed Parent/Family Support Provider Training Program must submit its program curriculum, competency exam, and exam-scoring methodology (including an explanation of accommodations or alternative formats of program materials available to individuals who have special needs) to AHCCCS/OIFA. AHCCCS/OIFA will issue feedback or approval of the curriculum, competency exam, and exam-scoring methodology.

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Approval of curriculum is binding for no longer than three years. Three years after initial approval and thereafter, the program must resubmit their curriculum for review and re-approval. If a program makes substantial changes (meaning change to content, classroom time, etc.) to its curriculum or if there is an addition to required elements during this three-year period, the program must submit the updated content to AHCCCS/OIFA for review and approval no less than 60 days before the changed or updated curriculum is to be utilized.

AHCCCS/OIFA will base approval of the curriculum, competency exam, and exam-scoring methodology only on the elements included in this policy. If a Credentialed Parent/Family Support Provider Training Program requires regional or culturally specific training exclusive to a GSA or specific population, the specific training cannot prevent employment or transfer of parent/family support credentials based on the additional elements or standards.

Competency Exam

Individuals seeking employment as a Credentialed Parent/Family Support Provider must complete and pass a competency exam with a minimum score of 80% upon completion of required training. Each Credentialed Parent/Family Support Provider Training Program has the authority to develop a unique competency exam. However, all exams must include questions related to each of the curriculum core elements listed. Agencies employing Credentialed Parent/Family Support Providers who are providing parent/family support services are required to ensure that its employees are competently trained to work with its population.

Individuals certified or credentialed in another state must submit their credential to AHCCCS/OIFA. The individual must demonstrate their state's credentialing standards meet those of AHCCCS prior to recognition of their credential.

Individuals certified or credentialed in another state may obtain credentialing with AHCCCS after passing a competency exam. If an individual does not pass the competency exam, the Credentialed Parent/Family Support Provider Training Program shall require that the individual complete additional training prior to taking the competency exam again.

Credentialed Parent/Family Support Provider Employment Training Curriculum Standards

A Credentialed Parent/Family Support Provider Employment Training Program curriculum must include the following core elements for members working with both children and adults:

- **Communication Techniques:**
 - Member first, strengths-based language; using respectful communication; demonstrating care and commitment;
 - Active listening skills: The ability to demonstrate empathy, provide empathetic responses and differentiate between sympathy and empathy; listening non-judgmentally; and
 - Using self-disclosure effectively; sharing one's story when appropriate.

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- **System Knowledge:**
 - Overview and history of the Arizona Behavioral Health (BH) System: Jason K., Arizona Vision and 12 Principles and the Child and Family Team (CFT) process; Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems; Adult Recovery Team (ART); and Arnold v. Sarn; Introduction to the Americans with Disabilities Act (ADA); funding sources for behavioral health systems;
 - Overview and history of the family and peer movements; the role of advocacy in systems transformation;
 - Rights of the caregiver/enrolled member; and
 - Transition Aged Youth: Role changes when bridging the Adult System of Care (ASOC) and Children's System of Care (CSOC) at transition for an enrolled member, family and team.
- **Building Collaborative Partnerships and Relationships:**
 - Engagement; identifies and utilizes strengths;
 - Utilize and model conflict resolution skills, and problem solving skills;
 - Understanding individual and family culture, biases, stigma, and system's cultures; and
 - The ability to identify, build and connect individuals and families, including families of choice to natural, community and informal supports.
- **Empowerment:**
 - Empower family members and other supports to identify their needs, and promote self-reliance;
 - Identify and understand stages of change; and
 - Be able to identify unmet needs.
- **Wellness:**
 - Understanding the stages of grief and loss;
 - Understanding self-care and stress management;
 - Understanding compassion fatigue, burnout, and trauma;
 - Resiliency and recovery; and
 - Healthy personal and professional boundaries.

Some curriculum elements may include concepts that are part of the required training, as described in AHCCCS Medical Policy Manual (AMPM) Policy 1060 and the Behavioral Health Practice Tool on Unique Needs of Children, Youth and Families Involved with DCS. Credentialed Parent/Family Support Provider training programs must not duplicate training required of individuals for employment with a licensed agency or Community Service Agency (CSA). Training elements in this section are specific to the Credentialed Parent/Family Support role in the public behavioral health system and instructional for parent/family support interactions.

Mercy RBHA, Office of Individual and Family Affairs (OIFA) can make available policies and procedures as well as additional resources for development of curriculum.

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Supervision of Credentialed Parent/Family Support Providers

Agencies employing Credentialed Parent/Family Support Providers must provide supervision by individuals qualified as Behavioral Health Technicians or Behavioral Health Professionals. Supervision must be appropriate to the services being delivered and the qualifications of the Credentialed Parent/ Family Support Provider as a BHT, BHP or BHPP. Supervision must be documented and inclusive of both clinical and administrative supervision.

Individuals providing supervision must receive training and guidance to ensure current knowledge of best practices in providing supervision to Credentialed Parent/Family Support Providers.

Mercy RBHA, Office of Individual and Family Affairs can make available to the providers policies and procedures regarding resources available to agencies for establishing supervision requirements and any expectations for provider's regarding Mercy RBHA monitoring/oversight activities for this requirement.

Process of Credentialing

Agencies employing Credentialed Parent/Family Support Providers who are providing parent/family support services are responsible for keeping records of required qualifications and credentialing. Mercy RBHA, Office of Individual and Family Affairs (OIFA) ensure that Parent/Family Support Providers meet qualifications and have certification, as described in this chapter, through quarterly provider deliverable reporting.

5.04 – Out of State Treatment

General Requirements

When Mercy RBHA considers an out-of-state treatment for a child or young adult (18 – 21 years old), the following conditions apply:

- A. The Child and Family Team (CFT) or Adult Recovery Team will consider all applicable and available in-state services and determine that the services do not adequately meet the specific needs of the member;
- B. The member's family/guardian (not including those not under guardianship between 18 and under 21 years of age) is in agreement with the out-of-state treatment;
- C. The out-of-state treatment facility is registered as an AHCCCS provider; and is willing to accept AHCCCS rates or enter into a Single Case Agreement (SCA) with Mercy RBHA;
- D. The out-of-state treatment facility meets the Arizona Department of Education Academic Standards; and
- E. A plan for the provision of non-emergency medical care must be established.
- F. In the event that a member has been placed out-of-state secondary to an emergency situation, unforeseen event, or by a third party liability insurance, Mercy RBHA must address all above conditions as soon as notification of the out-of-state treatment is received.

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Conditions before Referral for Out-of-State Placement

Documentation in the clinical record must indicate the following conditions have been met before a referral for an out-of-state treatment is made:

- All less restrictive, clinically appropriate treatment interventions have either been provided or considered by the CFT or ART and found not to meet the member's needs;
- The CFT or ART has been involved in the service planning process and is in agreement with the out-of-state treatment;
- The CFT or ART has determined how they will remain active and involved in service planning once the out-of-state treatment has occurred;
- The CFT or ART develops a proposed Individual Service Plan that includes a discharge plan has been developed that addresses the needs and strengths of the member;
- All applicable prior authorization requirements have been met;
- The Arizona Department of Education has been consulted to ensure that the educational program in the out-of-state placement meets the [Arizona Department of Education Academic Standards](#) and the specific educational needs of the member;
- Coordination has occurred with other state agencies involved with the member, including notification to the DDD Medical Director when the individual is enrolled DD eligible;
- The member's AHCCCS Health Plan Behavioral Health Coordinator or health care provider has been contacted and a plan for the provision of any necessary non-emergency medical care has been established and is included in the comprehensive clinical record. The Qualified Service Provider (QSP) in coordination with the family/legal guardian will coordinate with the AHCCCS Health Plan to make arrangements and document all contacts and arrangements;
- Mercy RBHA Health Plan Coordinator will send notification of the pending out-of-state transition with the admission date and facility to the appropriate Health Plan AHCCCS Behavioral Health Coordinator.
- Cultural considerations have been explored and incorporated into the ISP; and
- In the event that a member has been placed out-of-state secondary to an emergency situation or unforeseen event, Mercy RBHA must address all above conditions as soon as notification of the out-of-state placement is received.

The Individual Service Plan (ISP)

For a member placed out-of-state, the ISP developed by the CFT or ART must require that:

- Discharge planning is initiated at the time of request for prior authorization or notification of admission(if placed prior by TPL or another state agency), including:
 - The measurable treatment goals being addressed by the out-of-state placement and the criteria necessary for discharge back to in-state services;
 - The planned or proposed in-state residence where the member will be returning;
 - The recommended services and supports required once the member returns from the out-of-state placement;
 - What needs to be changed or arranged to accept the member for subsequent in-

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- state treatment that will meet the member's needs;
 - How effective strategies implemented in the out-of-state treatment will be transferred to the member's subsequent in-state treatment;
 - The actions necessary to integrate the member into family and community life upon discharge; and
 - The CFT or ART actively reviews the member's progress with clinical staffing occurring at least every 30 days. Clinical staffing must include the staff of the out-of-state facility.
- The member's family/guardian is involved throughout the duration of the treatment. This may include family counseling in member or by teleconference or video-conference;
 - The CFT or ART must ensure that essential and necessary health care services are provided in coordination with the member's medical health plan; Home passes are allowed as clinically appropriate and in accordance with the [AHCCCS Covered Behavioral Health Services Guide](#). For youth in Department of Child Safety (DCS) custody, home passes must be determined only in close collaboration with DCS.

Initial Notification to AHCCCS Office of Management

Mercy RBHA is required to obtain approval from the AHCCCS Office of Medical Management prior to an out-of-state treatment and upon discovering that a Mercy RBHA enrollee is in an out-of-state treatment using [AHCCCS Exhibit 450-1, Out-of-State Placement Form](#). Prior authorization must be obtained before making a referral for out-of-state treatment; in accordance with Mercy RBHA criteria. Mercy RBHA requires their providers assist with supplying the information required on the form and with providing copies of supporting clinical documentation.

Process for Initial Notification to Mercy RBHA

For behavioral health providers contracted with Mercy RBHA, the provider is required to coordinate with Mercy RBHA the intent to make a referral for out-of-state treatment as follows:

For children/adolescent and adults under the age of 21, the QSP Clinical Leadership is expected to follow guidelines regarding Securing Services and Prior Authorization.

If a child/adolescent or adult under age 21 is approved for an inpatient treatment, and all in-state inpatient providers have been exhausted:

- The QSP Clinical Leadership will coordinate with applicable key stakeholders (i.e. DCS, JPO, and DDD) and verify they are in agreement for an out of state placement. If there is disagreement, which cannot be resolved, the QSP Clinical Leadership may contact Mercy RBHA for assistance in resolution.
- When the QSP Clinical Leadership and key stakeholders agree on the treatment, the QSP Clinical Leadership will complete the [AHCCCS Exhibit 450-1, Out of State Placements Form](#) and submit to the Mercy RBHA Utilization Management Department via secure e-

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mail to ChildrensDischargePlanning@MercyCareAZ.org within 2 business days for identifying the need for out-of-state treatment.

- The Mercy RBHA Care Management Department will review the form and forward by secure email to the AHCCCS Office of Medical Management at MedicalManagement@azahcccs.gov for review and approval prior to placing the child or young adult.
- When the out-of-state treatment is approved AHCCCS, Mercy RBHA will notify the QSP Clinical Leadership and direct them to complete the out of state placement process.
- Mercy RBHA will identify out-of-state AHCCCS registered providers and send referrals to the provider and care management team.
- Once the accepting facility is identified, Mercy RBHA will facilitate a Single Case Agreement (SCA) and coordination transportation.

Periodic Updates to AHCCCS Office of Medical Management

In addition to providing initial notification, updates are required to be submitted every 30 days to AHCCCS regarding the member's progress in meeting the identified criteria for discharge from the out-of-state treatment. The QSP Clinical Leadership will complete the [AHCCCS Exhibit 450-1, Out of State Placements Form](#) and submit to the Mercy RBHA UM Department via secure e-mail to ChildrensDischargePlanning@MercyCareAZ.org no later than 5 business days before the 30 day update is due to AHCCCS. The 30 day update timelines will be based upon the date of admission to the out-of-state treatment as reported by Mercy RBHA to AHCCCS. The update will include a review of progress, CFT participation, evaluation of the discharge plan and availability of services based on the member's needs.

Mercy RBHA reviews the form for completeness and submits it to the AHCCCS Office of Medical Management.

Additionally, Mercy RBHA must submit notification to AHCCCS within forty-eight (48) hours of Mercy RBHA being notified when an out-of-state treatment is discontinued.

5.05 – Family and Youth Involvement in the Children's Behavioral Health System

Effective Family Participation in Service Planning and Delivery

Through the Child and Family Team (CFT) process, parents/caregivers and youth are treated as full partners in the planning, delivery and evaluation of services and supports.

Parents/caregivers and youth are equal partners in the local, regional, tribal and state representing the family perspective as participants in systems transformation. Mercy RBHA subcontracted providers must:

- Ensure that families have access to information on the CFT process and have the opportunity to fully participate in all aspects of service planning and delivery.
- Approach services and view the enrolled child in the context of the family rather than isolated in the context of treatment.
- Recognize that families are the primary decision-makers in service planning and

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delivery.

- Provide culturally and linguistically relevant services that appropriately respond to a family's unique needs.
- Assess the family's need for family support partner and make family support available to the CFT when requested.
- Provide information to families on how they can contact staff at all levels of the service system inclusive of the provider agency, Mercy RBHA, and AHCCCS at intake and throughout the CFT process.
- Work with Mercy RBHA to develop training in family engagement and participation, roles and partnerships for provider staff, parents/caregivers, youth and young adults (see the AHCCCS protocol [Family and Youth Involvement in the Children's Behavioral Health System](#) for more information on these roles).

Responsibilities of MERCY RBHA and Providers

Family members, youth and young adults must be involved in all levels of the behavioral health system, whether it is serving on boards, committees and advisory councils or as employees with meaningful roles within the system. To ensure that family members, youth and young adults are provided with training and information to develop the skills needed, Mercy RBHA and its subcontracted providers must:

- Support parents/caregivers, youth and young adults in roles that have influence and authority;
- Establish recruitment, hiring and retention practices for family, youth and young adults within the agency that reflect the cultures and languages of the communities served;
- Provide training for families, youth and young adults in cultural competency;
- Assign resources to promote family, youth and young adult involvement including committing money, space, time, personnel and supplies;
- Demonstrate a commitment to shared decision making;
- Ensure that service planning and delivery is driven by family members, youth and young adults;
- Support requests for services from family members, youth and young adults that respond to their unique needs, including providing information/educational materials to explore various service options;
- Obtain consent which allows families, youth and young adults to opt out of some services and choose other appropriate services;
- Provide contact information and allow contact with all levels of personnel within the agency for families, youth and young adults; and
- Make a Family Support Partner (FSP) available to the family when requested by the CFT.

Responsibilities of Mercy RBHA

- Support family, youth and young adults in roles that have influence and promote shared responsibility and active participation;

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- Assign resources to promote family, youth and young adult involvement including committing money, space, time, personnel and supplies;
- Involve parents/caregivers, youth and young adults as partners at all levels of planning and decision making, including delivery of services, program management and funding; and
- Develop and make available to providers, policies and procedures specific to these requirements.

Organizational Commitment to Employment to Family Members

Mercy RBHA subcontracted providers must demonstrate commitment to employment of parents/caregivers, and young adults by:

- Providing positions for parents/caregivers and young adults that value the first member experience;
 - Providing compensation that values first-member experience commensurate with professional training;
 - Establishing and maintaining a work environment that values the contribution of parents/caregivers, youth and young adults;
 - Providing supervision and guidance to support and promote professional growth and development of parent/caregivers and young adults in these roles;
 - Providing the flexibility needed to accommodate parents/family members and young adults employed in the system, without compromising expectations to fulfill assigned tasks/roles;
 - Promoting tolerance of the family, youth and young adult roles in the workplace;
 - Committing to protect the integrity of these roles; and
- Developing and making available to providers policies and procedures specific to these requirements.

Adherence Measurements

Adherence to this chapter will be measured through the use of one or more of the following:

- Surveys, including the Annual Network Family Survey and Youth Satisfaction Survey;
- Analysis of the behavioral health system, including the Annual Network Inventory and Analysis of Family Roles and System of Care Practice Reviews; and
- Other sources as required by the AHCCCS contracts or Mercy RBHA IGAs.

5.06 – Use of Telemedicine

Mercy RBHA and subcontracted providers shall use teleconferencing to extend the availability of clinical, educational and administrative services. All clinical services provided through the interactive video teleconferencing will conform to established policies for confidentiality and maintenance of records.

Mercy RBHA will ensure that all prescribing of controlled substance through telemedicine will conform to all federal and state regulations.

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Interactive video functions are approved for the following purposes:

- Direct clinical services;
- Case consultations;
- Collateral services;
- Training and education;
- Administrative activities of participating agencies;
- Management activities including Quality Management, Grievance and Appeal, Finance, Advocacy, Utilization and Risk Management, Clinical Consultation, and MIS; and
- Other uses as approved by Mercy RBHA.

Mercy RBHA shall establish policies and procedures for scheduling and prioritization of use of interactive video conferencing.

Reimbursement for telemedicine services should follow customary charges for the delivery of the appropriate procedure code(s).

Informed Consent

Before a health care provider delivers health care via Telemedicine, verbal or written informed consent from the behavioral health member or their health care decision maker must be obtained.

Informed consent can be provided by the behavioral health medical practitioner or registered nurse with at least one year of behavioral health experience. When providing informed consent it must be communicated in a manner that the member and/or legal guardian can understand and comprehend. A listing of specific elements that must be provided is under our General and Informed Consent section.

Exceptions to this consent requirement include:

- If the telemedicine interaction does not take place in the physical presence of the patient; and
- In an emergency situation in which the patient or the patient's health care decision maker is unable to give informed consent; or(3) To the transmission of diagnostic images to a health care provider serving as a consultant or the reporting of diagnostic test results by that consultant.

If a recording of the interactive video service is to be made, a separate consent to record shall be obtained. Items to be included in the consent are:

- Identifying information;
- A statement of understanding that a recording of information and images from the interactive video service will be made;
- A description of the uses for the recording;

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- A statement of the member's right to rescind the use of the recording;
- A date upon which permission to use of the recording will be void unless otherwise renewed by signature of the member receiving the recorded service; and
- For members receiving services related to alcohol and other drugs or HIV status, written, time-limited informed consent must be obtained that specifies that no material, including video-tape, may be re-disclosed.

If a telemedicine session is recorded, the recording must be maintained as a component on the member's medical record, in accordance with **45 C.F.R. Part 164.524**. Mercy RBHA has established a process that allows members to attain telemedicine information in their medical records.

Licensure

Before a health care provider delivers behavioral health care services through telemedicine, the treating healthcare provider must be licensed in the state in which the patient resides (see **A.R.S. §36-3601-3603**).

Confidentiality

At the time services are being delivered through interactive video equipment, no member, other than those agreed to by the member receiving services will observe or monitor the service either electronically or from "off camera".

To ensure confidentiality of telemedicine sessions, providers must do the following when providing services via telemedicine:

- The videoconferencing room door must remain closed at all times;
- If the room is used for other purposes, a sign must be posted on the door, stating that a clinical session is in progress; and
- Implement any additional safeguards to ensure confidentiality.

Documentation

Medical records of telemedicine interventions must be maintained according to usual practice.

Electronically recorded information of direct, consultative or collateral clinical interviews will be maintained as part of the member's clinical record. All policies and procedures applied to storage and security of clinical information will apply.

All required signatures must be documented in the medical record, and must be made available during auditing activities performed by AHCCCS.

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RBHA CHAPTER 6 – DENTAL AND VISION SERVICES

6.00 – Dental Services***Dental Screening/Dental Treatment for children under 21***

More information regarding Dental Screening/Dental Treatment for children under 21 is available under the **Chapter 100 – Mercy Care Provider Manual - Chapter 5 – Early and Periodic Screening, Diagnostic and Treatment (EPSDT)**, under Section 5.13 – Dental Screening and Referrals.

The following dental services/dental treatments are covered for children under age 21:

- oral health screenings
- cleanings
- fluoride treatments
- dental sealant
- oral hygiene education
- x-rays
- fillings
- extractions
- other therapeutic and medically necessary procedures
- routine dental services

Two (2) routine preventive dental visits are covered per year. Visits to the dentist must take place within six months and one day after the previous visit. The first dental visit should take place by one year of age. Members under 21 years of age do not need a referral for dental care.

Benefits covered for children under age 21 are in accordance with AHCCCS' [Exhibit 431, Attachment A - AHCCCS Dental Periodicity Table](#). Benefits are also outlined in the DentaQuest Office Manual available at www.dentaquestgov.com.

Mercy Care assigns all members under 21 years of age to a dental home. A dental home is where the member and a dentist work together to best meet dental health needs. Having a dental home builds trust between the member and the dentist. It is a place where the member can get regular, ongoing care, not just a place to go when there is a dental problem. A “dental home” may be an office or facility where all dental services are provided in one place. Members can choose or change their assigned dental provider.

Emergency Dental Services for Members 21 Years of Age and Older

Members 21 years of age or older have a \$1,000 annual emergency dental benefit per health plan year. The annual benefit plan year runs from October 1 - September 30. A dental emergency is an acute disorder of oral health resulting in severe pain and/or infection as a result of pathology or trauma.

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Emergency dental services* include:

- Emergency oral diagnostic examination (limited oral examination - problem focused);
- Radiographs and laboratory services, limited to the symptomatic teeth;
- Composite resin due to recent tooth fracture for anterior teeth;
- Prefabricated crowns, to eliminate pain due to recent tooth fracture only;
- Recementation of clinically sound inlays, onlays, crowns, and fixed bridges;
- Pulp cap, direct or indirect plus filling;
- Root canals and vital pulpotomies when indicated for the treatment of acute infection or to eliminate pain;
- Apicoectomy performed as a separate procedure, for treatment of acute infection or to eliminate pain, with favorable prognosis;
- Immediate and palliative procedures, including extractions if medically necessary, for relief of pain associated with an oral or maxillofacial condition;
- Tooth reimplantation of accidentally avulsed or displaced anterior tooth, with favorable prognosis;
- Temporary restoration which provides palliative/sedative care (limited to the tooth receiving emergency treatment);
- Initial treatment for acute infection, including, but not limited to, periapical and periodontal infections and abscesses by appropriate methods;
- Preoperative procedures and anesthesia appropriate for optimal patient management; and
- Cast crowns limited to the restoration of root canal treated teeth only.

*Emergency dental services do not require prior authorization.

Dental services that are **not** covered:

- Diagnosis and treatment of TMJ - except to reduce trauma
- Maxillofacial dental services that are not needed to reduce trauma
- Routine restorative procedures and routine root canal therapy
- Bridgework to replace missing teeth
- Dentures

Covered dental services not subject to the \$1,000 emergency dental limit include:

- Extraction of teeth in preparation for radiation treatment of cancer of the jaw, neck or head.
- Members who require medically necessary dental services before getting a covered organ or issue transplant**:
 - Treatment for oral infections

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- Treatment of oral disease, including dental cleanings, treatment of periodontal disease, medically necessary extractions and simple restorations.

**These services are covered only after a transplant evaluation determines that the member is a candidate for organ or tissue transplantation.

Anesthesia related to the emergency dental services also falls under the annual \$1,000 benefit.

Emergency dental codes are covered only if they meet the criteria of emergent treatment per AHCCCS policy. For additional detail regarding this benefit, we are including the following links to the AHCCCS Medical Policy Manual:

- [Dental Services for Members 21 Years of Age and Older](#)
- [Arizona Long Term Care System Adult Dental Services](#)

The list of codes that are included in the dental emergency benefit are below:

D0140	D2390	D2933	D3347	D7250	D7440	D7560
D0191	D2740	D2940	D3348	D7251	D7441	D7970
D0220	D2750	D2950	D3410	D7260	D7450	D7971
D0230	D2751	D2952	D3421	D7261	D7451	D7972
D0270	D2752	D2954	D3425	D7270	D7460	D7980
D0272	D2790	D3110	D3426	D7285	D7461	D7981
D0273	D2791	D3120	D3430	D7286	D7465	D7982
D0274	D2792	D3220	D7111	D7310	D7510	D7983
D0277	D2794	D3221	D7140	D7311	D7511	D7999
D0330	D2910	D3310	D7210	D7320	D7520	D9223
D2330	D2915	D3320	D7220	D7321	D7521	D9230
D2331	D2920	D3330	D7230	D7410	D7530	D9243
D2332	D2931	D3331	D7240	D7411	D7540	D9248
D2335	D2932	D3346	D7241	D7415	D7550	

6.01 – Vision Services

Vision Overview

Mercy RBHA covers eye and optometric services provided by qualified eye/optometry professionals within certain limits based on member age and eligibility:

- Emergency eye care, which meets the definition of an emergency medical condition, is covered for all members.

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- For members who are 21 years of age or older, treatment of medical conditions of the eye, excluding eye examinations for prescriptive lenses and the provision of prescriptive lenses, are covered.
- Vision examinations and the provision of prescriptive lenses are covered for members under the EPSDT program and for adults when medically necessary following cataract removal.
- Cataract removal is covered for all eligible members under certain conditions. For more information, visit the AHCCCS website under Medical Policy for AHCCCS Covered Services.

Coverage for Eligible Members 18, 19 & 20 Years of Age

- Medically necessary emergency eye care, vision examinations, prescriptive lenses and treatments for conditions of the eye.
- PCPs are required to provide initial vision screening in their office as part of the EPSDT program.
- Members 18-20 years of age with vision screening of 20/60 or greater should be referred to the contracted vision provider for further examination and possible provision of glasses.
- Replacement of lost or broken glasses is a covered benefit.
- Contact lenses are not a covered benefit.

Nationwide Referral Instructions

Nationwide is Mercy RBHA's contracted vendor for all vision services, including diabetic retinopathy exams. Members requiring vision services should be referred by the PCP's office to a Nationwide provider listed on Mercy RBHA's website. The member may call Nationwide directly to schedule an appointment.

Coverage for Eligible Members 21 Years and Over

- Emergency care for eye conditions when the eye condition meets the definition of an emergency medical condition; for cataract removal and/or medically necessary vision examinations; and for prescriptive lenses if required following cataract removal.
- Routine eye exams and glasses are not a covered service for adults.
- Adults 21 years of age and older should be referred to Nationwide for the diagnosis and treatment of eye diseases as well.

6.02 – Dental and Vision Community Resources for Adults

AHCCCS benefits do not include routine dental and vision services for adults. However, there are community resources available to help members obtain routine dental and vision care. For more information, call Mercy RBHA's Member Services at 800-564-5465.

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RBHA CHAPTER 7 – CARE COORDINATION

7.00 – Integrated Care Management

Care Management

Mercy RBHA's Care Management program has been designed to improve member health outcomes. The program provides needed care in the most appropriate setting and in a culturally competent and accessible format. Additional information can be found on our website under [Care Management](#). Referrals for care management can be completed by calling the Care Management Referral Line at 602-798-2627 or e-mailing the Care Management Department at MMICCareManagementReferrals@aetna.com.

Responsibilities

Mercy RBHA's Chief Medical Officer (CMO) is responsible for directing and overseeing Mercy RBHA's care management program with the assistance of the Medical Management Administrator and the Director of Care Management. This oversight includes ensuring the incorporation of treatment practice guidelines into the care management practice and program.

Mercy RBHA has established a policy for a Care Management program that covers the following objectives:

- Identify the top tier of high risk/high cost members with Serious Mental Illness (SMI) in a fully integrated health care program (estimated at twenty percent [20%]);
- Effectively transition members from one level of care to another;
- Streamline, monitor and adjust member's care plans based on progress and outcomes;
- Reduce hospital admissions and unnecessary emergency department and crisis service use; and
- Provide members with the proper tools to self-manage care in order to safely live, work, and integrate into the community:
 - Inform members of particular health care conditions that require follow up; and
 - Educate members on the benefits of complying with prescribed treatment regimens.

General Requirements

For all members determined to have a SMI diagnosis who are receiving physical health care services through Mercy RBHA, Mercy RBHA must:

- Establish and maintain a Care Management Program (CMP).
- Allow the member to select (or Mercy RBHA) a PCP or BH clinician who is formally designated as having primary responsibility for coordination of the member's overall health care.
- Educate and communicate with PCPs who treat depression, anxiety and ADHD. Identify members with special health care needs and:

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- Ensure an assessment by a qualified health care professional for ongoing needs is completed.
 - Ensure ongoing communication among providers.
 - Ensure that a mechanism for direct access to specialists exists, as appropriate.
 - For members in the Integrated plan who are discharging from the Arizona State Hospital (AzSH), Mercy RBHA must provide all insulin dependent diabetic members with the same brand and model glucose monitoring device as used in the hospital upon discharge from AzSH;
- On an ongoing basis, utilize tools and strategies to develop a case registry for all SMI members which at a minimum, will include:
 - Diagnostic classification methods that assign primary and secondary chronic co-morbid conditions;
 - Predictive models that rely on administrative data to identify those members at high risk for over-utilization of behavioral health and physical health services, adverse events, and higher costs;
 - Incorporation of health risk assessments into predictive modeling in order to tier members into categories of need to design appropriate levels of clinical intervention, especially for those members with the most potential for improved health-related outcomes and more cost-effective treatment; and
 - Criteria for identifying the top tier of high cost, high risk members for enrollment into the Care Management Program.
- Assign and monitor Care Management caseloads consistent with a member's acuity and complexity of need for Care Management.
- Allocate Care Management resources to members consistent with acuity, and evidence-based outcome expectations.
- Provide technical assistance to Care Managers including case review, continuous education, training and supervision.
- Communicate Care Management activities with all of the Mercy RBHA organizational units with emphasis on regular channels of communication with the Mercy RBHA's Medical Management, Quality Management and Adult Systems of Care departments.
- Assist in facilitating communication to exchange information between PCP and Behavioral Health provider, including monitoring to ensure coordination and remediation if the communication does not occur.
- Have Care Managers who, at a minimum, will be required to complete a comprehensive case analysis review of each member enrolled in Mercy RBHA's Care Management Program at the Supportive and Intensive levels of care on a quarterly basis. The case analysis review shall include, at a minimum:
 - A medical record chart review;
 - Consultation with the member's treatment team;
 - Review of administrative data such as claims/encounters; and
 - Demographic and customer service data.

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Eligibility

Mercy RBHA's care management program is available to enrolled members who qualify for the care management program, are Title XIX and have been determined to have a status of seriously mentally ill (SMI). The assessed needs of the member determine the level and type of care management. Typical members are those who:

- Are at high risk of poor health outcomes and high utilization;
- Have an acute or chronic diagnosis or condition; and
- Have inappropriately managed their health care, and require more complex or frequent healthcare and services.

Member Identification for Care Management

Mercy RBHA utilizes data from multiple sources to identify members who may benefit from care management to meet their individualized needs. These tools allow for members to be stratified into a case registry and their specific risks identified, including chronic co-morbid conditions and specific gaps in care. Members may be identified through population-based tools (i.e., predictive modeling) and individual-based tools (i.e., Health Risk Assessment [HRA]).

On a daily basis, HRAs are incorporated into the care management business application, in addition to predictive modeling data, to further identify members that may need care management. This data also assist in identifying the appropriate care management level, particularly for those members with the greatest potential for improved health outcomes and increased cost-effective treatment.

In addition, members are identified for care management through various referral sources from within Mercy RBHA and through external sources, also known as Surveillance Referrals. These referral sources include, but are not limited to, the following:

- Member self-referral
- Family and/or caregiver
- Interdisciplinary Team (IDT)
- Utilization Management (UM) referral
- Quality Management (QM) referral
- Various other Mercy RBHA departments
- Discharge planner referral
- Provider referral
- Provider submissions of the American College of Obstetricians and Gynecologists (ACOG) comprehensive assessment tool
- Provider submission of an Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Tracking Form
- AHCCCS – Arizona Health Care Cost Containment System
- Department of Economic Security (DES)/Division of Developmental Disabilities

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To make a referral on behalf of a member to the Care Management program, contact 800-564-5465, Option 2 for Provider Calls, then select Option 1 to speak with a Mercy RBHA Member Service Representative (MSR). Upon receipt of referral, Mercy RBHA's Care Management department will assess the member's eligibility against the aforementioned criteria and provide written notification of placement decision within 30 days of referral.

Care Planning

The care manager and members of the treatment team each participate in the development of the care plan which is designed to prioritize goals that consider the member's and caregiver's strengths, needs, goals, and preferences. All providers participating in the member's care will receive a copy of this plan and are asked to update it as necessary.

The care plan will support and help to inform the member's Individual Recovery Plan/Individual Service Plan, but will not be a substitute for that plan. The treatment team assigned to the member at the Assigned Behavior Health Clinic (ABHC) or Integrated Health Home (IHH) should work with the member to incorporate items from the care plan into the member's Individual Recovery Plan/Individual Service Plan which supports the overall wellness of the member.

As part of the care planning process, the care manager documents a schedule for follow up with the treatment team and convenes care plan reviews at intervals consistent with the identified member care needs and to ensure progress and safety. Care plan reviews are pre-scheduled and designed to evaluate progress toward care plan goals and meeting member needs. The care plan can be revised or adjusted at any point based on member progress and outcomes. The care plan identifies the next point of review and is saved in the member's electronic record in the care management business application system.

Case Rounds

A member's unique care needs can also be addressed through formal interdisciplinary case rounds. In case rounds, both treatment and non-treatment staff may present cases to their peers and treatment leaders to seek guidance and recommendations on how to best address the member's physical, behavioral and social care needs. Case rounds typically focus on members who are at high risk, have complex co-morbid conditions and/or have difficulty sustaining an effective working relationship with treatment and/or non-treatment staff. Case rounds may also include representatives from the member's treatment team. Case rounds are done at minimum bi-weekly, twice a month.

7.01 - Chronic Condition Management

Chronic condition management is part of the Care Management program. It is intended to enhance the health outcomes of members. Chronic condition management targets members who have illnesses that have been slow to respond to coordinated management strategies in the areas of diabetes, respiratory (COPD, asthma), and cardiac (CHF). Also included in chronic

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condition management are High Risk Obstetrical members and members who are diagnosed with HIV/AIDS. The primary goal of disease management is to positively affect the outcome of care for these members through education and support and to prevent exacerbation of the condition, which may lead to unnecessary hospitalization.

The objectives of chronic condition management programs are to:

- Identify members who would benefit from the specific chronic condition management program.
- Educate members on their disease, symptoms and effective tools for self-management.
- Monitor members to encourage/educate about self-care, identify complications, assist in coordinating treatments and medications, and encourage continuity and comprehensive care.
- Provide evidence-based, nationally recognized expert resources for both the member and the provider.
- Monitor effectiveness of interventions.

The following conditions are specifically included in Mercy RBHA's Chronic Condition Management programs and have associated [Clinical Practice Guidelines](#) that are reviewed annually by the Medical Management/Utilization Management Committee.

Asthma

The Asthma Disease Management program offers coordination of care for identified members with primary care physicians, specialists, community agencies, the member's caregivers and/or family. Member education and intervention is targeted to empower and enable compliance with the physician's treatment plan.

Providers play an important role in helping members manage this chronic disease by promoting program goals and strategies, including:

- Preventing chronic symptoms.
- Maintaining "normal" pulmonary function.
- Maintaining normal activity levels.
- Maintaining appropriate medication ratios.
- Preventing recurrent exacerbation and minimizing the need for emergency treatment or hospitalizations.
- Providing optimal pharmacotherapy without adverse effects.
- Providing education to help members and their families better understand the disease and its prevention/treatment.

Chronic Obstructive Pulmonary Disease (COPD)

The COPD Disease Management program is designed to decrease the morbidity and

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mortality of members with COPD. The goal of the program is to collaborate with providers to improve the quality of care provided to members with COPD, decrease complication rates and utilization costs, and improve the member's health. The objectives of the COPD Disease Management program are to:

- Identify and stratify members.
- Provide outreach and disease management interventions.
- Provide education through program information and community resources.
- Provide provider education through the COPD guidelines, newsletters and provider profiling.

Congestive Heart Failure (CHF)

The CHF Disease Management program is designed to develop a partnership between Mercy RBHA, the PCP and the member to improve self-management of the disease. The program involves identification of members with CHF and subsequent targeted education and interventions. The CHF Chronic Condition Management program educates members with CHF on their disease, providing information on cardiac symptoms, blood pressure management, weight management, nutritional requirements and benefits of smoking cessation.

Diabetes

The Diabetes Chronic Condition Management program is designed to develop a partnership between Mercy RBHA, the PCP and the member to improve self-management of the disease. The program involves identification of members with diabetes and subsequent targeted education and interventions. In addition, the program offers providers assistance in increasing member compliance with diabetes care and self-management regimens. Providers play an important role in helping members manage this chronic condition. Mercy RBHA appreciates providers' efforts in promoting the following program goals and strategies:

- Referrals for formal diabetes education through available community programs;
- Referrals for annual diabetic retinal eye exams by eye care professionals as defined in Mercy RBHA's Diabetes Management Clinical Guidelines;
- Laboratory exams that include:
 - Glycohemoglobins at least twice annually
 - Micro albumin
 - Fasting lipid profile annually; and
- Management of co-morbid conditions like blood pressure, CHF, and blood cholesterol.

HIV/AIDS

Early identification and intervention of members with HIV allows the care manager to assist in developing basic services and information to support the member during the disease process. The care manager links the member to community resources that offer various services, including housing, food, counseling, dental services and support groups. The member's cultural needs are continually considered throughout the care coordination process.

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The Mercy RBHA care manager works closely with the PCP, the Mercy RBHA corporate director of pharmacy, and a Mercy RBHA medical director to assist in the coordination of the multiple services necessary to manage the member's care. PCPs wishing to provide care to members with HIV/AIDS must provide documentation of training and experience and be approved by the Mercy RBHA credentialing process. These PCPs must agree to comply with specific treatment protocols and AHCCCS requirements. PCPs may elect to refer the member to an AHCCCS approved HIV specialist for the member's HIV treatment.

High Risk Obstetrical

Members that have been identified as high-risk obstetrical patients, either for medical or social reasons, are assigned to an OB care manager to try to ensure a good newborn/mother outcome. The care manager may refer the expectant mother to a variety of community resources, including WIC, food banks, childbirth classes, smoking cessation, teen pregnancy care management, shelters and counseling to address substance abuse issues. A care manager monitors the pregnant woman throughout the pregnancy, and provides support and assistance to help reduce risks to the mother and baby.

Care managers also work very closely with the PCP to make sure that the member is following through with all prenatal appointments and the prescribed medical regimen. Members with complex medical needs are also assigned a care manager so that all of the member's medical and perinatal care issues are addressed appropriately.

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RBHA CHAPTER 8 – COORDINATION OF CARE

8.00 – Inter-T/RBHA Coordination of Care

General Provisions

Computation of Time – In computing any period prescribed or allowed by this chapter, the period begins the day after the act, event, or decision occurs and includes all calendar days and the final day of the period. If the final day of the period is a weekend or legal holiday, the period is extended until the end of the next day that is not a weekend or a legal holiday. If the period is not designated as calendar days and is less than 11 days, then intermediate Saturdays, Sundays, and legal holidays must not be included in the computation.

Jurisdictional Responsibilities

For adults (members 18 years and older), the T/RBHA jurisdiction is determined by the member's current place of residence, except members who are unable to live independently must not be transferred to another T/RBHA except for members who are unable to live independently but are involved with Arizona Department of Economic Security/Division of Developmental Disabilities (ADES/DDD). This is applicable regardless of where the adult guardian lives.

Responsibility for service provision, other than crisis services, remains with the home T/RBHA when the enrolled member is visiting or otherwise temporarily residing in a different T/RBHA area but:

- Maintains a place of residence in his or her previous location with an intent to return and
- The anticipated duration of the temporary stay is less than three months.
- When an Arizona Long Term Care System (ALTCSS)/DDD member is placed temporarily in a group home while a permanent placement is being developed in the home T/RBHA service area, covered services remain the responsibility of the home T/RBHA.

For children (ages 0-17 years), T/RBHA responsibility is determined by the current place of residence of the child's parent(s) or legal guardian unless the AHCCCS-eligible child is in the custody of DCS, remains with the same court of jurisdiction and moves to another county due to the location of an out-of-home placement (e.g., foster home, kinship or group home).

Inter-T/RBHA transfers must be completed within 30 days of referral by the home T/RBHA. The home T/RBHA must ensure that activities related to arranging for services or transferring a case does not delay a member's discharge from an inpatient or residential setting.

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Out-of-Area Service Provision

Crisis Services

Crisis services must be provided without regard to the member's enrollment status. When a member presents for crisis services the T/RBHA will:

- Provide needed crisis services;
- Ascertain the member's enrollment status with all T/RBHAs and determine whether the member's residence is temporary or permanent.
 - If the member is enrolled with another T/RBHA, notify the home T/RBHA within 24 hours of the member's presentation. The home T/RBHA or their contracted providers is fiscally responsible for crisis services and must:
 - Decide with the T/RBHA at which the member presents to provide needed services, funded by the home T/RBHA;
 - Arrange transportation to return the member to the home T/RBHA area; or
 - Determine if the member intends to live in the new T/RBHA and if so, initiate a transfer. Members who are unable to live independently but clearly express an intent/desire to permanently relocate to another service area can be transferred. However, the home T/RBHA must decide for housing and consider this a temporary placement for three months. After three months, if the member continues to clearly express an intent/desire to remain in this new service area, the inter-T/RBHA transfer can proceed.
 - If the member is not enrolled with any T/RBHA, lives in GSA 6 and has presented for services, behavioral health providers must notify the Mercy RBHA to initiate an enrollment. Providers should notify Mercy RBHA at 800-564-5465.
 - If the member is not enrolled with any T/RBHA, lives outside of GSA 6 and is presenting for crisis services, Mercy RBHA must enroll the member, provide needed crisis services and initiate the inter-T/RBHA transfer.
 - If T/RBHA or provider receives a referral regarding a hospitalized member whose residence is located outside the T/RBHA or provider must immediately coordinate the referral with the member's designated T/RBHA.

Non-Emergency Services

If the member is not enrolled with a T/RBHA, lives outside of the service area, and requires services other than a crisis or urgent response to a hospital, the T/RBHA must notify the designated T/RBHA associated with the member's residence within 24 hours of the member's presentation. The designated T/RBHA must proceed with the member's enrollment if determined eligible for services. The designated T/RBHA is fiscally responsible for the provision of all medically necessary covered services including transportation services for eligible members.

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Courtesy Dosing of Methadone

A member receiving methadone administration services who is not a member of take-home medication may receive up to two courtesy doses of methadone from a T/RBHA while the member is traveling out of the home T/RBHA's area. All incidents of provision of courtesy dosing must be reported to the home T/RBHA. The home T/RBHA must reimburse the T/RBHA providing the courtesy doses upon receipt of properly submitted bills or encounters.

Referral for Service Provision

If a home T/RBHA initiates a referral to another T/RBHA or a service provider in another T/RBHA's area for the purposes of obtaining behavioral health services, the home T/RBHA must:

- Maintain enrollment and financial responsibility for the member during the period of out-of-area behavioral health services,
- Establish contracts with out-of-area service providers and authorize payment for services,
- Maintain the responsibilities of the behavioral health provider, and
- Provide or arrange for all needed services when the member returns to the home T/RBHA's area.

Children in the Custody of DCS

If an AHCCCS-eligible child is in the custody of DCS, remains with the same court of jurisdiction and moves to another county due to the location of an out-of-home placement (e.g., foster home, kinship or group home); they will remain enrolled with their original T/RBHA. The child may continue any current treatment in the previous county and/or seek new or additional treatment in the out-of-home placement's county.

Inter-T/RBHA

A transfer will occur when:

- An adult member voluntarily elects to change their place of residence to an independent living setting from one T/RBHA's area to another.
- Members who are unable to live independently but clearly express an intent/desire to permanently relocate to another service area can be transferred. However, the home T/RBHA must decide for housing and consider this to be a temporary placement for 3 months. After 3 months, if the member continues to clearly express an intent/desire to remain in this new service area, the inter-RBHA transfer can proceed.
- Members who are unable to live independently and are involved with ADES/DDD can be transferred to another T/RBHA. Members involved with ADES/DDD who are permanently placed and reside in a supervised setting are the responsibility of the T/RBHA in which the supervised setting is located. This is applicable regardless of where the adult guardian lives.
- The parent(s) or legal guardian(s) of a child change their place of residence to another T/RBHA's area; or

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- The court of jurisdiction of a dependent child changes to another T/RBHA's area.
 - A transfer will not occur when an AHCCCS-eligible child is in the custody of DCS, remains with the same court of jurisdiction and moves to another county due to the location of an out-of-home placement (e.g., foster home, kinship or group home).

Inter-T/RBHA transfers are not to be initiated when a member is under pre-petition screening or court ordered evaluation).

Timeframes for initiating an Inter-T/RBHA transfer

The home T/RBHA shall initiate a referral for an Inter-T/RBHA transfer:

- 30 days prior to the date on which the member will move to the new area; or
- If the planned move is in less than 30 days, immediately upon learning of the member's intent to move.

Inter-RBHA Process

The referral is initiated when the home T/RBHA provides a completed **Inter-T/RBHA Transfer Request Form**. In addition, the following information must be provided to the receiving T/RBHA as quickly as possible:

- The member's comprehensive clinical record,
- Consents for release of information;
- For Title XIX eligible members between the ages of 21 and 64, the number of days the member has received services in an IMD in the contract year (July 1 – June 30);
- The number of hours of respite care the member has received in the contract year (July 1 – June 30); and
- The receiving T/RBHA must not delay the timely processing of an Inter-T/RBHA transfer because of missing or incomplete information.

Upon receipt of the transfer packet, the receiving T/RBHA must:

- Notify the home T/RBHA within seven calendar days of receipt of the referral for Inter-T/RBHA transfer;
- Proceed with deciding for the transfer; and
- Notify the home T/RBHA if the information contained in the referral is incomplete.

Within 14 days of receipt of the referral for an Inter-T/RBHA transfer, the receiving T/RBHA or its subcontracted providers must:

- Schedule a meeting to establish a transition plan for the member. The meeting must include:
 - The member or the member's guardian or parent, if applicable;
 - Representatives from the home T/RBHA;
 - Representatives from the Arizona State Hospital (AzSH), when applicable;
 - The behavioral health provider and representatives of the CFT/adult clinical

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- team;
- Other involved agencies; and
- Any other relevant participant at the member's request or with the consent of the member's guardian.
- Establish a transition plan that includes at least the following:
 - The member's projected moving date and place of residence;
 - Treatment and support services needed by the member and the timeframe within which the services are needed;
 - A determination of the need to request a change of venue for court ordered treatment and who is responsible for making the request to the court, if applicable;
 - Information to be provided to the member regarding how to access services immediately upon relocation;
 - The enrollment date, time and place at the receiving T/RBHA and the formal date of transfer, if different from the enrollment date;
 - The date and location of the member's first service appointment in the receiving T/RBHA's GSA;
 - The individual responsible for coordinating any needed change of health plan enrollment, primary care provider assignment and medication coverage;
 - The member's behavioral health provider in the receiving T/RBHA's GSA, including information on how to contact the behavioral health provider;
 - Identification of the member at the receiving T/RBHA who is responsible for coordination of the transfer, if other than the member's behavioral health provider;
 - Identification of any special authorization required for any recommended service (e.g., non-formulary medications) and the individual who is responsible for obtaining needed authorizations; and
 - If the member is taking medications prescribed for a behavioral health issue, the location and date of the member's first appointment with a practitioner who can prescribe medications. There must not be a gap in the availability of prescribed medications to the member.

On the official transfer date, the home T/RBHA must enter a closure and disenrollment into CIS. The receiving T/RBHA must enter an intake and enrollment into CIS at the time of transfer. If the member scheduled for transfer is not located or does not show up for his/her appointment on the date arranged by the T/RBHAs to transfer the member, the T/RBHAs must collaborate to ensure appropriate re- engagement activities occur and proceed with the inter-T/RBHA transfer, if appropriate. Each T/RBHA must designate a contact member responsible for the resolution of problems related to enrollment and disenrollment

When a member presents for crisis services, providers must first deliver needed behavioral health services and then determine eligibility and T/RBHA enrollment status. Members enrolled

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after a crisis event may not need or want ongoing behavioral health services through the T/RBHA. Providers must conduct re- engagement efforts however, members who no longer want or need ongoing behavioral health services must be dis-enrolled (i.e., closed in the CIS) and an inter-T/RBHA transfer must not be initiated. Members who will receive ongoing behavioral health services will need to be referred to the appropriate T/RBHA and an inter-T/RBHA transfer initiated, if the member presented for crisis services in a GSA other than where the member resides.

Timeframes specified above cover circumstances when behavioral health members inform their provider or T/RBHA prior to moving to another service area. When behavioral health members inform their provider or T/RBHA less than 30 days prior to their move or do not inform their provider or T/RBHA of their move, the designated T/RBHA must not wait for all the documentation from the previous T/RBHA before scheduling services for the behavioral health member.

Complaint Resolution

A member determined to have a Serious Mental Illness that is the subject of a request for out-of-area service provision or Inter-T/RBHA transfer may file an appeal.

Any party involved with a request for out-of-area service provision or Inter-T/RBHA transfer may initiate the complaint resolution procedure. Parties include the home T/RBHA, receiving T/RBHA, member being transferred, or the member's guardian or parent, if applicable; the Arizona State Hospital (AzSH), if applicable, and any other involved agencies.

The following issues may be addressed in the complaint resolution process:

- Any timeframe or procedure contained in this policy;
- Any dispute concerning the level of care needed by the member; and
- Any other issue that delays the member's discharge from an inpatient or residential setting or completion of an Inter-T/RBHA transfer.

Procedure for Non-Emergency Disputes**First Level**

- A written request for the complaint resolution process shall be addressed to:
 - The member's behavioral health provider at the home T/RBHA, or other individual identified by the T/RBHA, if the issue concerns out-of-area service provision; or
 - The identified behavioral health provider at the receiving T/RBHA, or other individual identified by the T/RBHA, if the issue concerns an Inter-T/RBHA transfer.
- The behavioral health provider must work with involved parties to resolve the issue within five days of receipt of the request for complaint resolution.

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- If the problem is not resolved, the behavioral health provider must, on the fifth day after the receipt of the request, forward the request for complaint resolution to the second level.

Second Level

- Issues concerning out-of-area service provision must be forwarded to the Chief Executive Officer, or designee, of the home T/RBHA.
- Issues concerning Inter-T/RBHA transfers must be forwarded to the Chief Executive Officer, or designee, of the receiving T/RBHA.
- The Chief Executive Officer must work with the Chief Executive Officer of the other involved T/RBHA to resolve the issue within five days of receipt of the complaint resolution issue.
- If the problem is unresolved, the Chief Executive Officer must, on the fifth day after the receipt of the request, forward the request to the Deputy Director of AHCCCS.

Third Level

- The Deputy Director of AHCCCS, or designee, will convene a group of financial and/or clinical personnel as appropriate to the complaint resolution issue to address and resolve the issue.
- The Deputy Director will issue a final decision within five days of receipt of the request.

Procedure for Emergency Disputes

An emergency dispute includes any issue in which the member is at risk of decompensation, loss of residence, or being in violation of a court order. The home T/RBHA must ensure that medically necessary behavioral health services continue pending the resolution of an emergency dispute between T/RBHAs.

First Level

- Issues concerning out-of-area service provision must be forwarded to the Chief Executive Officer, or designee, of the home T/RBHA.
- Issues concerning Inter-T/RBHA transfers must be forwarded to the Chief Executive Officer, or designee, of the receiving T/RBHA.
- The Chief Executive Officer must work with the Chief Executive Officer of the other involved T/RBHA to resolve the issue within two days of receipt of the complaint resolution issue.
- If the problem is unresolved, the Chief Executive Officer must, on the second day after the receipt of the request, forward the request to the Deputy Director of AHCCCS.

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Second Level

- The Deputy Director of AHCCCS, or designee, will convene a group of financial and/or clinical personnel as appropriate to the complaint resolution issue, to address and resolve the issue.
- The Deputy Director will issue a final decision within two days of receipt of the request.

8.01 – Coordination of Care with AHCCCS Health Plans, PCPs and Medicare Providers

Coordinating Care with AHCCCS Health Plans

The following procedures will assist behavioral health providers in coordinating care with AHCCCS Health Plans:

- If the identity of the member's primary care provider (PCP) is unknown, subcontracted providers must contact the Complete Care Health Plan or the Behavioral Health Coordinator of the member's designated health plan to determine the name of the member's assigned PCP. See the **AHCCCS Contracted Health Plans Behavioral Health Coordinators**, available on our [Forms Library](#) web page, for contact information for the Behavioral Health Coordinators for each AHCCCS Health Plan.
- If the member is determined to have a serious mental illness, providers should contact Mercy RBHA Member Services to determine the name and contact information for the member's PCP. T/RBHA enrolled members who have never contacted their PCP prior to entry into the behavioral health system should be encouraged to seek a baseline medical evaluation. T/RBHA enrolled members should also be prompted to visit their PCP for routine medical examinations annually or more frequently if necessary.
- Mercy RBHA subcontracted providers should request medical information from the member's assigned PCP. Examples include current diagnosis, medications, pertinent laboratory results, last PCP visit, Early Periodic Screening, Diagnosis and Treatment (EPSDT) screening results and last hospitalization. If the PCP does not respond to the request, the subcontracted provider should contact the health plan's Behavioral Health Coordinator for assistance.
- Mercy RBHA subcontracted providers must address and attempt to resolve coordination of care issues with AHCCCS Health Plans and PCPs at the lowest possible level. If problems persist, contact the Mercy RBHA Complete Care Health Plan and Provider Coordinator via Customer Services at 800-564-5465.

Mercy RBHA and Complete Care Health Plan and Provider Coordinator

Mercy RBHA has designated a Complete Care Health Plan and Provider Coordinator who gathers, reviews and communicates clinical information requested by PCPs, Complete Care Behavioral Health Coordinators and other treating professionals or involved stakeholders.

Mercy RBHA maintains a designated and published phone number for the Complete Care Health Plan and Provider Coordinator or a clearly recognized prompt on an existing phone number that facilitates prompt access to the Complete Care Health Plan and Provider Coordinator and that is staffed during business hours. The phone number is (800) 564-5465.

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Mercy RBHA provides Complete Care Health Plan and Provider Coordinators with training, which includes, at a minimum, the following elements:

- Provider inquiry processing and tracking (including resolution timeframes);
- Mercy RBHA procedures for initiating provider contracts or AHCCCS provider registration;
- Claim submission methods and resources;
- Claim dispute and appeal procedures; and
- Identifying and referring quality of care issues.

Sharing Information with PCPs, AHCCCS Complete Care Health Plans, Other Treating Professionals and Involved Stakeholders

To support quality medical management and prevent duplication of services, behavioral health providers are required to disclose relevant behavioral health information pertaining to Title XIX and Title XXI eligible members to the assigned PCP, AHCCCS Complete Care Health Plans, other treating professionals and other involved stakeholders within the following required timeframes:

- **Urgent** – requests for intervention, information, or response within 24 hours.
- **Routine** – Requests for intervention, information, or response within 10 days.

Coordination of Care for Members with a Serious Mental Illness

Members with a Serious Mental Illness receive their behavioral health and medical care through an integrated service delivery system. Members have the choice to receive services in the setting that meets their needs and preferences, including:

- A co-located setting.
- An integrated Patient-Centered Medical Home.
- A virtual health home in which the member receives services from different providers that share information through the Mercy RBHA health information exchange.

Mercy RBHA's subcontracted providers are responsible for actively participating on the member's clinical team, working with the member to develop the member's Individual Service Plan, and sharing information on the member's progress, and the services and medications the member is receiving.

Coordination of Care for Members

For all Title XIX/XXI enrolled members who are not determined to have a Serious Mental Illness, subcontracted providers are required to:

- Notify the assigned PCP of the results of PCP initiated behavioral health referrals;
- Provide a final disposition to the health plan Behavioral Health Coordinator in response to PCP initiated behavioral health referrals;
- Coordinate the placement of members in out-of-state treatment settings;
- Notify, consult with or disclose information to the assigned PCP regarding members with

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Pervasive Developmental Disorders and Developmental Disabilities, such as the initial assessment and treatment plan and care and consultation between specialists;

- Provide a copy to the PCP of any executed advance directive, or documentation of refusal to sign an advance directive, for inclusion in the behavioral health member's medical record; and
- Notify, consult with or disclose other events requiring medical consultation with the member's PCP.

Upon request by the PCP or member, information for any enrolled member must be provided to the PCP.

When contacting or sending any of the above referenced information to the member's PCP, subcontracted providers must provide the PCP with an agency contact name and telephone number in the event the PCP needs further information.

Mercy RBHA subcontracted providers should use **Communication Document** for coordinating care with the AHCCCS Health Plan PCP or Behavioral Health Coordinator. The form includes the required elements for coordination purposes and must be completed in full for coordination of care to be considered to occur. For complex problems, direct provider-to-provider contact is recommended to support written communications.

Communication Document will not have to be used if there is a properly documented progress note. To be considered properly documented the progress note must:

- Include a header that states "Coordination of Care";
- Be legible; and
- Include all the required elements contained in the **Communication Document**.

Responsibility for Fee-for-Service Members

It is the responsibility of Mercy RBHA to provide fee-for-service behavioral health services to Title XIX/XXI eligible members **not** enrolled with an AHCCCS Health Plan.

Mercy RBHA is responsible for providing all inpatient emergency behavioral health services for fee-for-service members with psychiatric or substance abuse diagnoses.

Mercy RBHA is responsible for behavioral health services to Native American Title XIX and Title XXI eligible members referred by an Indian Health Services (IHS) or tribal facility for emergency services rendered at non-IHS facilities.

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Responsibility for Members enrolled in AHCCCS Health Plan

Mercy RBHA is responsible for behavioral health services during Prior Period Coverage. This is limited to the behavioral health services only and after the individual has been medically cleared. The Health Plan Contractor is still obligated to provide all necessary medical services. The following rules apply for other areas of coverage:

Pre-petition Screenings and Court Ordered Evaluations

Payment for pre-petition screenings and court ordered evaluation is the responsibility of the county. In Maricopa County, these services are provided through the Mercy RBHA provider network.

Emergency Behavioral Health Services

When a Title XIX or Title XXI eligible member presents in an emergency room setting, the member's AHCCCS Health Plan is responsible for all emergency medical services including triage, physician assessment, and diagnostic tests.

Mercy RBHA, or when applicable, its designated behavioral health provider, is responsible for psychiatric and/or psychological evaluations in emergency room settings provided to all Title XIX and Title XXI members enrolled with Mercy RBHA.

Mercy RBHA is responsible for providing all non-inpatient emergency behavioral health services to Title XIX and Title XXI eligible members. Examples of non-inpatient emergency services include assessment, psychiatric evaluation, mobile crisis, peer support and counseling.

Mercy RBHA is responsible for providing all inpatient emergency behavioral health services to members with psychiatric or substance abuse diagnoses for all Title XIX and Title XXI eligible members.

Mercy RBHA is responsible for Emergency transportation of a Title XIX or Title XXI eligible member to the emergency room (ER) when the member has been directed by Mercy RBHA or a subcontracted provider to present to this setting to resolve a behavioral health crisis. Mercy RBHA or the subcontracted provider directing the member to present to the ER must notify the emergency transportation provider of Mercy RBHA's fiscal responsibility for the service.

Emergency transportation of a Title XIX or Title XXI eligible member required to manage an acute medical condition, which includes transportation to the same or higher level of care for immediate medically necessary treatment, is the responsibility of the member's AHCCCS Health Plan.

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Non-emergency Behavioral Health Services

For Title XIX and Title XXI eligible members, Mercy RBHA is responsible for the provision of all non-emergency behavioral health services.

If a Title XIX or Title XXI eligible member is assessed as needing inpatient psychiatric services by Mercy RBHA or a subcontracted provider prior to admission to an inpatient psychiatric setting, Mercy RBHA is responsible for authorizing and paying for the full inpatient stay.

When a medical team or health plan requests a behavioral health or psychiatric evaluation prior to the implementation of a surgery, medical procedure or medical therapy to determine if there are any behavioral health contraindications, Mercy RBHA is responsible for the provision of this service. Surgeries, procedures or therapies can include gastric bypass, interferon therapy or other procedures for which behavioral health support for a patient is indicated.

Non-emergency Transportation

Transportation of a Title XIX or Title XXI eligible member to an initial behavioral health intake appointment is the responsibility of Mercy RBHA.

Medical Treatment for Members in Behavioral Health Treatment Facilities

When a Title XIX or Title XXI eligible member is in a residential treatment center and requires medical treatment, the AHCCCS Health Plan is responsible for the provision of covered medical services for members designated as GMH/SU or children. For members determined to have a Serious Mental Illness, Mercy RBHA is responsible for the provision of, and payment for their medical care. Subcontracted providers are responsible for arranging for those services and coordinating with the member's PCP to obtain prior authorization, as needed.

If a non-SMI, Title XIX or Title XXI eligible member is in an inpatient psychiatric facility and requires medical treatment, those services are included in the per diem rate for the treatment facility. If the member requires inpatient medical services that are not available at the inpatient psychiatric facility, the member must be discharged from the psychiatric facility and admitted to a medical facility. The AHCCCS Health Plan is responsible for medically necessary services received at the medical facility, even if the member is enrolled with Mercy RBHA. For members determined to have a Serious Mental Illness, Mercy RBHA retains responsibility for all medically-necessary medical and behavioral health services provided while the member is in a facility.

PCPs Prescribing Psychotropic Medications

Within their scope of practice and comfort level, an AHCCCS Health Plan PCP may elect to treat select behavioral health disorders. The select behavioral health disorders that AHCCCS Health Plan PCPs can treat are:

- Attention-Deficit/Hyperactivity Disorder;
- Uncomplicated depressive disorders; and

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- Anxiety disorders.

The “Agreed Conditions”

Certain requirements and guiding principles regarding medications for psychiatric disorders have been established for members under the care of both a health plan PCP and Mercy RBHA subcontracted provider simultaneously. The following conditions apply:

- Title XIX and Title XXI enrolled members must not receive medications for psychiatric disorders from the health plan PCP and behavioral health provider simultaneously. If a member is identified to be simultaneously receiving medications from the health plan PCP and Mercy RBHA subcontracted behavioral health provider, the behavioral health provider must immediately contact the PCP to coordinate care and agree on who will continue to medically manage the member’s behavioral health condition.
- Medications prescribed by providers within the behavioral health system must be filled by Mercy RBHA contracted pharmacies under the pharmacy benefit. This is particularly important when the pharmacy filling the prescription is part of the contracted pharmacy network for both Mercy RBHA and the member’s AHCCCS Health Plan. Mercy RBHA and contracted providers must take active steps to ensure that prescriptions written by providers by Mercy RBHA providers are not charged to the member’s AHCCCS Health Plan.

General Requirements

When it is necessary for a Mercy RBHA member to be referred to another provider for medically necessary services that are beyond the scope of the member’s primary care physician (PCP), the PCP only needs to call Member Services and refer the member to the appropriate Mercy RBHA provider. Mercy RBHA’s website includes a provider search function for your convenience.

Transitions of Members with ADHD, Depression, and/or Anxiety to Care of Primary Care Physician

Members who have a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD), depression and/or anxiety and who are stable on their medications may transition back to the care of their PCP for the management of these diagnoses, if the member, their guardian or parent and the PCP agree to this treatment transition. Mercy RBHA requires its subcontracted providers to facilitate this process and to ensure that the following steps are taken:

- The subcontracted provider must contact the member’s PCP to discuss the member’s current medication regime and to confirm that the PCP is willing and able to provide treatment for the member’s ADHD, depression, and/or anxiety.
- If the PCP agrees to transition treatment for the member’s diagnosis of ADHD, depression and/or anxiety, the subcontracted provider must provide the PCP with a transition packet that includes (at a minimum):
 - A written statement indicating that the member is stable on a medication

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- regime;
- A medication sheet or list of medications currently prescribed by the Mercy RBHA Behavioral Health Medical Practitioner (BHMP);
- A psychiatric evaluation;
- Any relevant psychiatric progress notes that may assist in the ongoing treatment of the member;
- A discharge summary outlining the member's care and any adverse responses the member has had to treatment or medication; and
- A copy of the packet must be sent to the member's AHCCCS Health Plan Behavioral Health Coordinator as well as to the member's PCP.
- The subcontracted provider and Mercy RBHA must ensure that the member's transition to the PCP is seamless, and that the member does not go without medications during this transition period.

General Psychiatric Consultations

Behavioral health practitioners must be available to AHCCCS Health Plan PCPs to answer diagnostic and treatment questions of a general nature.

General psychiatric consultations are not member specific and are usually conducted over the telephone between the PCP and the behavioral health practitioner.

One-Time Face-to-Face Psychiatric Evaluations

Behavioral health providers must be available to conduct a face-to-face evaluation with a Title XIX/XXI eligible member upon his/her PCP's request.

A one-time face-to-face evaluation is used to answer PCPs specific questions and provide clarification and evaluation regarding a member's diagnosis, recommendations for treatment, need for behavioral health care, and/or ongoing behavioral health care or medication management provided by the PCP.

The PCP must have seen the member prior to requesting a one-time face-to-face psychiatric evaluation with the behavioral health provider.

AHCCCS Health Plan PCPs must be provided current information about how to access psychiatric consultation services. A PCP requesting a general psychiatric consultation should call Mercy RBHA Member Services directly at 800-564-5465. To request a one-time face-to-face psychiatric consultation, the PCP should complete the **Communication Document** (please specify the type of service requested) and fax it to 844-424-3975. The Member Services staff will arrange for psychiatric consultations to be provided within 24 hours of request.

Mercy RBHA is obligated to offer general consultations and one-time face-to-face psychiatric evaluations and must provide direct and timely access to behavioral health medical

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practitioners (physicians, nurse practitioners and physician assistants) or other behavioral health practitioners if requested by the PCP.

Coordination of Care with Medicare Providers

Effective October 1, 2015, in accordance with AHCCCS directives; Complete Care members with Medicare Prime plans or Medicare Advantage as their primary payer will be realigned for **General Mental Health/Substance Abuse** (GMH/SU) benefits from their current Regional Behavioral Health Authority (RBHA) to their Complete Care plans. Prior to October 1, 2015, this coverage is facilitated by the Mercy RBHA in Maricopa County.

Mercy RBHA dual eligible members will continue to receive their care through Mercy RBHA.

Medicare Advantage Plans

Medicare health plans, also known as Medicare Advantage (MA) plans, are managed care entities that have a Medicare contract with the Centers for Medicare and Medicaid Services (CMS) to provide services to Medicare beneficiaries. MA plans provide the full array of Medicare benefits, including Medicare Part A, hospital insurance; Medicare Part B provides medical insurance; and Medicare Part D provides prescription drug coverage.

Many of the AHCCCS Contracted Health Plans are MA plans (see **AHCCCS Contracted Health Plans Behavioral Health Coordinators**, [available under our Forms Library web page](#)). These plans provide Medicare Part A, Part B and Part D benefits in addition to Medicaid services for dual eligible members and are referred to as MA-PD SNPs (Medicare Advantage-Prescription Drug/Special Needs Plans).

Inpatient Psychiatric Services

Medicare has a lifetime benefit maximum for inpatient psychiatric services. When the benefit is exhausted AHCCCS becomes the primary payer. Mercy RBHA implements cost sharing responsibilities and billing for inpatient psychiatric services.

Mercy RBHA will coordinate inpatient care and discharge planning care with the inpatient team for Medicare members receiving inpatient services with Medicare providers.

Outpatient Behavioral Health Services

Medicare provides some outpatient behavioral health services that are also AHCCCS covered behavioral health services. Mercy RBHA implements cost sharing responsibilities and billing for outpatient behavioral health services.

Mercy RBHA will coordinate outpatient care with Medicare providers for Medicare members receiving covered behavioral health services.

Medication Assisted Treatment (MAT)

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Mercy RBHA providers are responsible to provide “whole-patient” services to members, including behavioral services and MAT services. If a member is receiving behavioral health services from a provider but is also in need of MAT services from another provider; providers are responsible for coordinating care to best serve the member. Providers are expected to adhere to HIPPA standards.

Prescription Medication Services

Medicare eligible behavioral health members must enroll in a Medicare Part D Prescription Drug Plan (PDP) or a Medicare Advantage Prescription Drug Plan (MA-PD) to receive the Part D benefit. PDPs only provide the Part D benefit and any Medicare registered provider may prescribe medications to behavioral health members enrolled in PDPs. Some MA-PDs may contract with Mercy RBHA or subcontracted providers to provide the Part D benefit to Medicare eligible behavioral health members.

While PDPs and MA-PDs are responsible for ensuring prescription drug coverage to behavioral health members enrolled in their plans, there are some prescription medications that are not included on plan formularies (non-covered) or are excluded Part D drugs. Mercy RBHA is responsible for covering non-covered or excluded Part D behavioral health prescription medications listed on the Mercy RBHA formulary, in addition to Part D cost sharing.

8.02 – Coordination of Behavioral Health Care with Other Governmental Entities

Department of Child Safety (DCS)

When a child receiving behavioral health, services is also in the custody of DCS, the subcontracted provider must work towards effective coordination of services with the DCS Specialist. Providers are expected to:

- Coordinate the development of the behavioral health service plan with the child welfare case plan to avoid redundancies and/or inconsistencies.
- Ensure an urgent response to DCS initiated referrals for children who have been removed from their homes.
- Provide the DCS Specialist and the juvenile court with preliminary findings and recommendations on behavioral health risk factors, symptoms and service needs for hearing.
- Work collaboratively on child placement decisions if placement and funding are being sought for behavioral health treatment.
- Invite the DCS Specialist, DCS providers and resource parents to participate in the behavioral health assessment and service planning process as members of the Child and Family Team (CFT).
- Strive to be consistent with the service goals established by other agencies serving the child or family. Behavioral health service plans must be directed by the CFT toward the behavioral health needs of the child, and the team should seek the active participation of other involved agencies in the planning process.
- Attend team meetings such as Team Decision Making (TDM) and Family Group Decisions

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(as appropriate) for providing input about the child and family's health needs. Where it is possible, TDM and CFT meetings should be combined.

- Coordinate, communicate and expedite necessary services to stabilize in-home and out-of-home placements provided by DCS.
- Provide behavioral health services during the reunification process and/or other permanency plan options facilitated by DCS. Parent-child visitation arrangements and supervision are the responsibility of DCS. Therapeutic visitation is not a covered behavioral health service.
- Ensure responsive coordination activities and service delivery that supports DCS planning and facilitates adherence to DCS established timeframes (see [AHCCCS Clinical Guidance Tool Practice Protocol, The Unique Behavioral Health Service Needs of Children, Youth, and Families Involved with DCS](#)).

ADES/ADHS ARIZONA Families F.I.R.S.T. (Families in Recovery Succeeding Together) Program

Providers must ensure coordination for parents/families referred through the Arizona Families F.I.R.S.T (AFF) program (see [Overview of the Arizona Families F.I.R.S.T. Program Model & Referral Process](#)).

The AFF program provides expedited access to substance abuse treatment for parents and caregivers referred by DCS and the ADES/FAA Jobs Program. AHCCCS participates in statewide implementation of the program with ADES (see **A.R.S. 8-881**). Mercy RBHA and providers must:

- Accept referrals for Title XIX and Title XXI eligible and enrolled members and families referred through AFF;
- Accept referrals for Non-Title XIX and Non-Title XXI members and families referred through AFF and provide services, if eligible;
- Ensure that services made available to members who are Non-Title XIX and Non-Title XXI eligible are provided by maximizing available federal funds before expending state funding as required in the [Governor's Executive Order 2008 -01](#);
- Collaborate with DCS, the ADES/FAA JOBS Program and Substance Abuse Treatment providers to minimize duplication of assessments and achieve positive outcomes for families; and
- Develop procedures for collaboration in the referral process to ensure effective service delivery through the Mercy RBHA system of care. Appropriate authorizations to release information must be obtained prior to releasing information.

The goal of the AFF Program is to promote permanency for children, stability for families, protect the health and safety of abused and/or neglected children and promote economic security for families. Substance abuse treatment for families involved with DCS must be family centered, provide for enough support services and must be provided in a timely manner.

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Arizona Department of Education (ADE), Schools or Other Local Educational Authorities

AHCCCS has delegated the functions and responsibilities as a State Placing Agency to Mercy RBHA for members in Maricopa County. Mercy RBHA and providers work in collaboration with the ADE to place children with behavioral health service providers.

Providers serving children can gain valuable insight into an important and substantial element of a child's life by soliciting input from school staff and teachers. Subcontracted providers can collaborate with schools and help a child achieve success in school by:

- Working in collaboration with the school and sharing information to the extent permitted by law and authorized by the child's parent or legal guardian;
- For children receiving special education services, actively consider information and recommendations contained in the Individual Education Plan (IEP) during the ongoing assessment and service planning process;
- For children receiving special education services, participate with the school in developing the child's IEP and share the behavior treatment plan interventions, if applicable;
- Inviting teachers and other school staff to participate in the CFT if agreed to by the child and legal guardian;
- Having a clear understanding of the IEP requirements as described in the [Disabilities Education Act \(IDEA\) of 2004](#);
- Ensuring that students with disabilities who qualify for accommodations under of the **Section 504 of the Rehabilitation Act of 1973** are provided adjustments in the academic requirements and expectations to accommodate their needs and enable them to participate in the general education program; and
- Ensuring that transitional planning occurs prior to and after discharge of an enrolled child from any out-of-home placement.

Arizona Department of Economic Security/Division of Developmental Disabilities (ADES/DDD)

Members qualifying for services through DDD can fall into several different categories based on their eligibility status and the extent of their diagnosed disability. There are three general groupings:

Type of DDD Eligibility	What behavioral health services are available?	Who is responsible for providing the behavioral health services?
Title XIX and eligible for ALTCS	All Title XIX covered services	Mercy RBHA and subcontracted providers
Title XIX and not eligible for ALTCS	All Title XIX covered services	Mercy RBHA and subcontracted providers
Non-Title XIX	Services provided based on eligibility for services*	Mercy RBHA and subcontracted providers based on eligibility for services*

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Providers strive toward effective coordination of services with members receiving services through DDD by:

- Working in collaboration with DDD staff and service providers involved with the member;
- Aiding DDD providers in managing difficult behaviors;
- Inviting DDD staff to participate in the development of the behavioral health service plan and all subsequent planning meetings as members of the member's clinical team;
- Incorporating information and recommendations in the Individual or Family Support Plan (ISP) developed by DDD staff, when appropriate, while developing the member's ISP;
- Ensuring that the goals of the ISP, of a member diagnosed with developmental disabilities who is receiving psychotropic medications, includes reducing behavioral health symptom and achieving optimal functioning, not merely the management and control of challenging behavior;
- Actively participating in DDD team meetings; and
- For members diagnosed with Pervasive Developmental Disorders and Developmental Disabilities, sharing all relevant information from the initial assessment and ISP with DDD to ensure coordination of services.

For DDD members with a co-occurring behavioral health condition or physical health condition who demonstrate inappropriate sexual behaviors and/or aggressive behaviors, a Community Collaborative Care Team (CCCT) may be developed. The CCCT will consist of experts from multiple agencies involved in coordinating care for DDD members who have been unresponsive to traditional ALTCs and Behavioral Health services. For additional information regarding the roles and responsibilities of the CCCT and coordination of care expectations, please see the [AHCCCS Medical Policy Manual \(AMPM\), Policy 570, Community Collaborative Care Teams](#).

For more information about the collaboration between Mercy RBHA and DES/DDD, please review our **Collaborative Protocol with Department of Economic Security/Division of Developmental Disabilities (DES/DDD) – Child and Adult**, available on our [Forms Library](#) web page.

Department of Economic Security/Arizona Early Intervention Program (ADES/AzEIP)

Providers can strive toward effective coordination of care for children identified as having, or likely having, disabilities or developmental delays by:

- Ensuring that children birth to three years of age are referred to AzEIP in a timely manner when information obtained in their behavioral health assessment reflects developmental concerns;
- Ensuring that children found to require behavioral health services as part of the AzEIP evaluation process receive appropriate and timely service delivery;
- Ensuring that, if an AzEIP team has been formed for the child, the behavioral health provider will coordinate team functions to avoid duplicative processes between systems; and

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- Coordinating enrollment in Mercy RBHA's children's system of care when a child transfers to the children's DDD system.

Courts and Corrections

Mercy RBHA and behavioral health providers are expected to collaborate and coordinate care for behavioral health members involved with:

- The Arizona Department of Corrections (ADC) & Community Corrections (Parole)
- Arizona Department of Juvenile Corrections (ADJC)
- Maricopa County Jail & Correctional Health Services
- The Arizona Superior Court & Maricopa County Probation
- Municipal Mental Health Courts, such as the City of Glendale and Mesa Courts

When a member receiving behavioral health services is also involved with a court or correctional agency, providers work towards effective coordination of services by:

- Working in collaboration with the appropriate staff involved with the member;
- Inviting probation or member's parole officer to participate in the development of the ISP and all subsequent planning meetings as members of the member's clinical team with member's approval;
- Actively considering information and recommendations contained in probation or parole case plans when developing the ISP; and
- Ensuring that the provider evaluates and participates in transition planning prior to the release of eligible members and arranges and coordinates care upon the member's release.

Mercy RBHA and the Arizona Department of Corrections (ADC) have an established mutually agreed upon protocol to ensure effective and efficient delivery of behavioral health services. The **Collaborative Protocol between MERCY RBHA and Arizona Department of Corrections (ADC)**, available on our [Forms Library](#) web page, defines the respective roles and responsibilities of each party.

Mercy RBHA and the Arizona Department of Juvenile Corrections (ADJC) have an established mutually agreed upon protocol to ensure effective and efficient delivery of behavioral health services. The Collaborative Protocol between Mercy RBHA and Arizona Department of Juvenile Corrections defines the respective roles and responsibilities of each party.

Mercy RBHA and the Maricopa County Adult Probation have an established mutually agreed upon protocol, **Collaborative Protocol with Adult Probation**, available on our [Forms Library](#) web page, to ensure effective and efficient delivery of behavioral health services; this agreement encompasses Maricopa County Jail, Correctional Health Services and Maricopa County Probation. The Collaborative Protocol between Mercy RBHA and Maricopa County Adult Probation defines the respective roles and responsibilities of each party.

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Additional data sharing agreements have been developed with the City of Glendale Municipal Court, City of Tempe Municipal Court and the City of Mesa Municipal Court.

The **Collaborative Protocol with Maricopa County Juvenile Probation Department** is available on our [Forms Library](#) web page as well.

Arizona County Jails

In Maricopa County and Pinal County, when a member receiving behavioral health services has been determined to have, or is perceived to have, a Serious Mental Illness and is detained in a Maricopa County or Pinal County jail, the subcontracted provider must assist the member by:

- Working in collaboration with the appropriate staff involved with the member;
- Ensuring that screening and assessment services, medications and other behavioral health needs are provided to jailed members upon request;
- Ensuring that the member has a viable discharge plan, that there is continuity of care if the member is discharged or incarcerated in another correctional institution, and that pertinent information is shared with all staff involved with the member's care or incarceration with member approval;
- Determining whether the member is eligible for the Jail Diversion Program; and
- Ensuring that both an appointment with a Behavioral Health Medical Professional and a Primary Care Provider occur within the first 7 days after release if member is incarcerated for 30 days or longer.

For all other members receiving behavioral health services in Maricopa County and all other Arizona counties, behavioral health providers must ensure that appropriate coordination also occurs for behavioral health members with jail personnel at other county jails.

For further information regarding Mercy RBHA enrolled members who are incarcerated, please contact the Court Liaison Department through customer service at 800-564-5465 or visit www.MercyCareAZ.org.

Arizona Department of Economic Security/Rehabilitation Services Administration (ADES/RSA)

Mercy RBHA and the Arizona Department of Economic Security/Rehabilitation Services Administration (ADES/RSA) have a mutually developed collaborative protocol to ensure effective and efficient provision of comprehensive rehabilitative and employment support services for individuals with SMI to achieve increased independence or gainful employment. The Collaborative Protocol between Mercy RBHA and ADES/RSA defines the respective roles and responsibilities of each party. The **Collaborative Protocol with RSA District I** is available on our [Forms Library](#) web page.

When a member determined to have a Serious Mental Illness is receiving behavioral health services and is concurrently receiving services from RSA, the provider ensures effective coordination of care by:

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- Working in collaboration with the vocational rehabilitation (VR) counselor or employment specialists in the development and monitoring of the member's employment goals;
- Ensuring that all related vocational activities are documented in the comprehensive clinical record and collaborative protocols;
- Inviting RSA staff to be involved in planning employment related supportive services to ensure coordination and consistency with the delivery of vocational services;
- Participating and collaborating with RSA in the development and implementation of Regional Protocols; and
- Allocating functional work space and other resources for VR counselors or employment specialists working with enrolled members who have been determined to have a Serious Mental Illness.

Prevocational and Employment related services available through Mercy RBHA are distinct from vocational services available through RSA. Please refer to the [AHCCCS Behavioral Health Covered Services Guide](#) for additional details.

Arizona Department of Health Services/Office of Assisted Living Licensing

When a member receiving behavioral health services is residing in an assisted living facility, providers must coordinate with the Office of Assisted Living Licensing to ensure that the facility is licensed and that there are no existing violations or legal orders. Providers must also determine and ensure that the member living in an assisted living facility is at the appropriate level of care. The provider can coordinate with the Office of Assisted Living Licensing to determine the level of care that a particular assisted living facility is licensed to provide.

For further information regarding Mercy RBHA enrolled members who are seeking Assisted Living services, please call customer service at 1-800-564-5465, or visit www.MercyCareAZ.org.

Providers, members, and community stakeholders should contact the Mercy RBHA Housing Department through customer service at 1-800-564-5465 to report unsafe conditions.

Veterans Administration Health Care System

Mercy RBHA and the Veterans Administration Health Care System have a mutually developed collaborative protocol available to ensure effective communication and coordination of services. The Collaborative Protocol between Mercy RBHA and the Veterans Administration Health Care System defines the respective roles and responsibilities of each party. The **Collaborative Protocol with Veterans Administration Health Care Services** is available in our [Forms Library](#) web page.

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8.03 – Care Coordination for Management of Hospitalized Members Related to Integrated Health Program Service Requirements

The provider:

- Is responsible for coordination of care with AHCCCS Health Plans, primary care providers and Medicare providers.
- Must have ACT and specialty ACT teams available 24/7 to provide crisis and/or coordination of services to assist in the assessment of members who are seeking or in need of ED or inpatient services or are being discharged from ED or inpatient facilities.
- Is responsible for ensuring that the primary care provider (PCP) and other specialty providers are involved in the treatment planning process to ensure medical interventions and physical health concerns are identified in the Individual Service Plan (ISP).
- Must maintain complete, accurate, and timely documentation of all delivered services. The provider should share electronic medical records and participate in health information exchange (HIE) to ensure information is shared between all providers delivering care to members.
- Shall coordinate care with the primary care provider/Integrated Health provider, as well as other providers involved in any treatment related to the member's care.
- Will document coordination and participation in ongoing communication with SMI Clinic/provider, adult recovery team (ART)/children and family team (CFT), where applicable, and with Mercy RBHA.
- Will document coordination and participation in discharge planning efforts with SMI Clinic/provider, ART/CFT (where applicable) and with Mercy RBHA.

Coordination of Care for Members with a Serious Mental Illness

Members with a Serious Mental Illness receive their behavioral health and medical care through an integrated service delivery system. Members have the choice to receive services in the setting that meets their needs and preferences, including:

- Separate behavioral health and physical health providers
- An integrated health home
- A virtual health home

Mercy RBHA's subcontracted providers are responsible for actively participating on the member's clinical team, working with the member to develop the member's integrated Individual Service Plan, and sharing information on the member's progress, and the services and medications the member is receiving.

8.04 – Transition from Child to Adult Services

Planning for the transition into the adult behavioral health system must begin for any young adult involved in behavioral health care when the young adult reaches the age of 16. Planning must begin immediately for young adults entering behavioral health care who are 16 years or older at the time they enter care.

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A transition plan that starts with an assessment of self-care and independent living skills, social skills, work and education plans, earning potential and psychiatric stability must be incorporated in the young adult's Individual Service Plan (ISP).

Elements Addressed as Part of Young Adult's Transition Plan

Not all young adults transfer to the adult Serious Mental Illness (SMI) or General Mental Health/Substance Abuse (GMH/SU) system, but for young adults who do, providers must ensure a smooth transition. To accomplish a smooth transition, providers must develop a clear and explicit process and procedure that will ensure and support the delivery of children's and adult services during the transition period. Providers must ensure that adult system staff attend and are a part of the Child and Family Team (CFT) during the four to six months prior to the child turning 18 in order to provide information and be part of the service planning, development and coordination effort that needs to take place so the individualized needs of that young adult can be met on the day they turn 18 years of age. Providers must also ensure that any coordination efforts that remain after a young adult turns 18 are appropriately handled by the children's provider. This may include attendance at intakes, level of care admissions, and/or support to the young adult in successfully connecting to the adult provider.

Some of the elements to be addressed by the CFT and/or Behavioral Health Provider as part of a transition plan include:

- Identifying the young adult's behavioral health needs into adulthood;
- Identifying personal strengths that will assist the young adult when he/she transitions to the adult system;
- Identifying staff who will coordinate services after the young adult reaches age 18, including any changes in the behavioral health provider, clinical team, guardian or family involvement;
- Identifying and collaborating with other involved state agencies and stakeholders to jointly establish a behavioral health service plan and prevent duplication of services.
- Establishing how the transition will be implemented;
- Planning for where the young adult will reside upon turning 18 and how he/she will support him/herself. If an SMI eligibility determination is made, consider initiating a referral for housing, if needed;
- Identifying the need for referrals to and assistance with applications for Supplemental Security Income (SSI), Rehabilitation Services Administration (RSA), SMI eligibility determination, Title XIX and Title XXI eligibility, housing, guardianship, training programs, etc. In addition, the team and/or behavioral health provider should assist in gathering necessary information to expedite these applications/determinations when the time comes to apply, including obtaining medical and school records to substantiate these needs. The team and/or behavioral health provider begin to develop a timeline and task list for when appointments are needed;

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- Identifying the need for transportation to appointments and other necessary activities;
- Identifying special needs that the young adult may have and/or whether the young adult will require special assistance services;
- Identifying whether the young adult has appropriate life skills, social skills and employment or education plans;
- Taking necessary action if the young adult is not eligible for Title XIX or Title XXI benefits and/or Social Security Disability Income (SSDI) and is not determined to meet criteria for SMI services. Identifying supports needed to be in place for a successful transition;
- Following guidelines established in [AHCCCS Clinical Guidance Tool Practice Protocol, Transition to Adulthood](#); and
- Meeting the provisions of the JK Settlement Agreement and the Arizona Vision and 12 Principles.

The services that have been planned, developed and provided for the young adult can continue to be provided after the young adult has turned 18 years of age, if continuation of these services is the choice of the young member when he/she reached the age of majority. Providers shall properly encounter and receive payment for the provision of services of staff involved, including adult system staff.

Providers are responsible for the provision of services for Title XIX/XXI eligible members 18 years of age through 20 years of age (who are still a part of the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program) regardless of their designation as SMI or GMH/SU. Services include care management services and all other covered services that the member's treatment team determines to be needed to meet individualized needs.

Child Transition to Adult Services – Year Prior

When a young adult receiving behavioral health, services reaches the age of 17, behavioral health providers must determine whether the young adult is potentially eligible for services as an adult with a Serious Mental Illness. If so, behavioral health providers must refer the young adult for an SMI eligibility determination.

When a young adult receiving behavioral health services reaches age 17.5, the CFT and/or the behavioral health provider must:

- Submit the SMI Packet Evaluation;
- Assist the young adult and/or family or guardian in applying for potential benefits (e.g., SSI, food stamps, etc.);
- Assist the young adult and/or family in determining whether an application for Title XIX or Title XXI benefits is to be submitted; if the young adult and/or family is already eligible, determine if eligibility will continue for the young adult once he/she turns 18; if young adult's current eligibility will not continue, assist the family in completing the re-application process;

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- Assist the young adult and/or family to schedule their first well visit with a primary care provider to occur on or after their 18th birthday (An EPSDT visit is synonymous with a well visit);
- Address any new authorization requirements for sharing protected health information due to the young adult turning 18 to ensure that the clinical team can continue to share information;
- Ensure that the young adult's behavioral health category assignment is changed. Once the young adult's behavioral health category assignment has been changed, ongoing behavioral health service appointments must be provided according to the timeframes for routine appointments; and
- Upon turning 18 years of age, if the member is not eligible for services as a member determined to have a Serious Mental Illness or the member has been determined ineligible for Title XIX or Title XXI services, behavioral health providers can continue to provide behavioral health services.

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RBHA CHAPTER 9 – CONCURRENT REVIEW

9.00 - Concurrent Review

Continued authorization request determinations are based on written medical care criteria that assess the need for the continued stay. The extension of a stay will be assigned a new review date each time a review occurs. Any review that does not appear to meet medical necessity criteria will be sent to medical director review for final determination. Complete Care Medical and Behavioral Inpatient, Complete Care Long Term Inpatient or Rehabilitation, Behavioral Health Inpatient, Behavioral Health Residential or HCTC Facilities are notified of determinations and next review dates. For all other requests for prior authorized services, contact Mercy RBHA Utilization Management Department at 800-564-5465 or submit a faxed request to 800-217-9345 prior to the expiration of the covered authorization. For notification of Inpatient Behavioral Health Admission, please fax to 855-825-3165. For notification of Physical Health admissions, please fax to 866-300-3926.

Federal regulations from the Centers for Medicare and Medicaid Services (CMS) limit federal funding for services to persons in Institute of Mental Disease (IMD) who are aged 21-64. Federal Rule **42 C.F.R. 438.6(e)** prohibits the use of federal Medicaid funding to Managed Care Organizations whose members are in IMDs for more than 15 days during a calendar month.

Federal regulations for IMDs include the following:

- Is limited to adults aged 21-64;
- Eliminates existing federal authority allowing the Arizona Health Care Cost Containment System (AHCCCS) to utilize IMDs with no limits (the "in lieu of" option);
- Limits coverage for IMD stays to 15 days during a calendar month;
- Defines an IMD as a facility established and maintained primarily for the care and treatment of people with mental diseases;
- Is intended to improve access to short-term inpatient psychiatric and substance-use disorder treatment for Medicaid managed care members.

Mercy RBHA is committed to coordinating with facilities for members who have reached the 10th day of inpatient hospitalization in an IMD facility during a calendar month. The following grid outlines the requirements for care coordination for IMD facilities:

IMD Admission Day

At admission

Action to be Completed

Mercy RBHA will notify upon admission the estimated number of inpatient IMD days that a member has utilized in the current calendar month.*

With 24 hours of Admission

IMD facility shall develop a discharge plan and communicate this specific plan to the Mercy RBHA Utilization Management (UM) consultant.

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10 th Day	A peer-to-peer discussion regarding discharge coordination will occur.
13 th Day	Determination is made if the member will be discharged by day 15. If medically necessary care is required beyond 15 days, and a safe transfer can be made, a transfer will be facilitated to a non-IMD treatment setting.
14 th Day	The Mercy RBHA UM Consultant will contact the facility to ensure the member is being discharged or that an appropriate transfer has been arranged.
15 th Day	Member will be discharged or transferred and the facility must provide same day discharge information to Mercy Care Plan / Mercy RBHA to confirm the discharge of the member.

***IMD days are calculated based on calendar days, not business days.**

Acute Medical and Behavioral Health Facilities

Initial institutional stays are based on the adopted criteria, the member's specific conditions, and the projected discharge date. Reviews will occur on a schedule dictated by the member's diagnosis or condition. Emergency initial concurrent reviews are completed within one business day of Mercy RBHA's receipt of notification of admission. Subsequent reviews will be determined based on the member's specific condition not to exceed 7 days. Providers are notified of the next review date. Providers receive notification of next review date and are responsible for requesting further stay and providing clinical information on the scheduled review date.

Acute Long Term Inpatient or Rehabilitation Facilities

Ongoing reviews of members in acute long term inpatient or rehabilitation units of facilities are conducted on a schedule dictated by the member's diagnosis and condition not to exceed 7 days. Providers receive notification of next review date and are responsible for requesting further stay and providing clinical information on scheduled review date.

Skilled Nursing Facilities (SNF)

Mercy RBHA will provide medically necessary nursing facility services for integrated members receiving physical healthcare services, including when the member has ALTCS pending. Ongoing reviews of members in skilled nursing facility units are conducted on a schedule dictated by the member diagnosis and condition not to exceed 7 days. Providers are notified of next review date and are responsible for requesting further stay and providing clinical information on scheduled review date.

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Mercy RBHA will be responsible for nursing facility reimbursement only during the time the member is enrolled with the contractor and if the member becomes ALTCS-eligible and is enrolled with an ALTCS contractor before the end of the maximum ninety (90) days per contract year of nursing facility coverage. The ninety (90) day per AHCCCS contract year limitation is monitored and will be applied for nursing facility services. AHCCCS is notified electronically when a member has been residing in a nursing facility for forty-five (45) days.

Child and Adolescent Behavioral Health Inpatient (BHIF)

The initial authorization is valid for 30 days. Providers are notified of next review date and are responsible for requesting further stay and providing clinical information on the scheduled review date.

Concurrent reviews will be scheduled based on the member's progress according to continued stay criteria not to exceed 30 days. An accurate and complete **Recertification of Need (RON)**, available on our **Forms Library** web page, from the Child and Adolescent Inpatient Residential Facility must be completed every 30 days from date of CON.

Behavioral Health Residential Facilities (BHRF)

The initial authorization is valid up to 60 days. Concurrent reviews are conducted within 60 days of admission of a prior authorized service. Providers are notified of next review date and are responsible for requesting further stay and providing clinical information on the scheduled review date. Subsequent reviews are scheduled based on the member's progress according to continued stay criteria not to exceed 60 days.

Child and Adolescent HCTC

The initial authorization is valid up to 90 days. Providers are notified of next review date and are responsible for requesting further stay and providing clinical information on the scheduled review date.

Concurrent reviews are conducted within 90 days of admission of a prior authorized service. Subsequent reviews are scheduled based on the member's progress according to continued stay criteria not to exceed 90 days.

Adult Behavioral Health Residential Facilities

For the SMI population, the initial authorization for adult behavioral health residential facilities is valid up to 60 days. A request for continued stay authorization will be coordinated telephonically by the rendering provider to Mercy RBHA Utilization Management at 800- 564-5465, 2 weeks prior to the last day of the expiration of the current authorization. BHRF level of care for GMH/SU population does not require prior authorization except for Eating Disorder Treatment.

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RBHA CHAPTER 10 – PHARMACY MANAGEMENT

10.00 – Drug List

Access to Medication Using the Behavioral Health Drug List

To ensure coverage of medications through Mercy RBHA, providers must utilize the [AHCCCS Behavioral Health Drug List](#).

The Mercy RBHA **Medication Preferred Drug List (PDL)** can be found on our [Pharmacy](#) web page.

Title XIX/XXI eligible members receiving medication(s) have the right to notice and appeal when a decision affects coverage for medication(s). Non-Title XXI/XXI members determined SMI have the right to notice and appeal when a decision affects medication coverage.

Members can appeal by contacting Mercy RBHA at 800-564-5465 or by submitting a letter or completed **Appeal or SMI Grievance Form**, available on our [Forms Library](#) web page, no later than 60 calendar days after the date of Notice to:

Aetna Medicaid Administrators LLC
Corporate Director of Pharmacy
4645 E. Cotton Center Blvd.
Building 1, Suite 200
Phoenix, AZ 85040

Behavioral health members with third party coverage, such as Medicare and private insurance, will have access to medications on their health plan's PDL through their third party insurer. If the desired/recommended prescription drug is not included on the health plan's PDL but may be covered by requesting an exception or submitting an appeal, the provider must attempt to obtain an exception for the medication or assist the member in submitting an appeal with the health plan. Mercy RBHA will cover medications for members determined to have SMI, regardless of Title XIX/XXI eligibility, when their third party insurer will not grant an exception for a medication that is a medication on the [AHCCCS Behavioral Health Drug List](#).

Applicable co-payments must only be collected. For members with coverage from third party payers, co-payments are collected.

Mercy RBHA does not require prior authorization processes for medications, which have been approved for payment under Medicare plans and are on the AHCCCS Behavioral Health Drug List.

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10.01 - Prior Authorization

AHCCCS requires that Mercy RBHA prior authorize coverage of those medications indicated in the AHCCCS Behavioral Health Drug List as requiring prior authorization and those that have age limits.

When these prior authorization criteria are utilized, the requirements must be met.

Behavioral health providers may request prior authorization by completing the appropriate **Prior Authorization Requests for Medications** found on our [Pharmacy](#) web page.

Please call the Pharmacy Help Desk through customer service at (800) 564-5465 or fax a completed Prior Authorization form for Title XIX and Title XXI SMI eligible members to (855)-247-3677 and for GMH/SA eligible members to (855)-246-7736.

10.02 - Behavioral Health Provider Input to Drug List

Behavioral health providers can offer suggestions for adding or deleting medications to the [AHCCCS Behavioral Health Drug List](#) or Mercy RBHA's Medication Preferred Drug List.

To propose additions or deletions to the [AHCCCS Behavioral Health Drug List](#), a behavioral health professional should submit a written request to the address below:

Mercy Care RBHA
Attn: Chief Medical Officer
4755 S. 44th Place
Phoenix, AZ 85040

Additions: Requests for additions must include the following information:

- Medication requested (trade name and generic name, if applicable);
- Dosage forms, strengths and corresponding costs of the medication requested;
- Average daily dosage;
- Indications for use (including pharmacological effects, therapeutic uses of the medication and target symptoms);
- Advantages of the medication (including any relevant research findings if available);
- Adverse effects reported with the medication;
- Specific monitoring required; and
- The drugs on the current PDL that this medication could replace.

Deletions: A detailed summary of the reason for requesting the deletion.

The Mercy RBHA Chief Medical Officer or designee will present requests, as determined appropriate, to the Mercy RBHA Pharmacy and Therapeutics Committee.

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RBHA CHAPTER 11 – QUALITY MANAGEMENT

11.00 – Quality Management

Mercy RBHA works in partnership with providers to continuously improve the care given to our enrollees. The Mercy RBHA Quality Management (QM) Program is comprised of the following areas:

- The Quality of Care Department monitors the quality of care provided by the provider network, as well as the review and resolution of issues related to the quality of health care services provided to enrollees.
- Provider Monitoring is responsible for quality improvement activities and clinical studies using data collected from providers and encounters.
- The Credentialing Department is responsible for provider credentialing/recredentialing activities.
- The Performance Improvement Department monitors and improves HEDIS and other clinical performance measure rates, maternity, family planning and EPSDT quality indicators.

Quality Management Department Responsibilities

The Quality Management Department is responsible for development of Clinical Practice Guidelines and policies related to quality management. Whenever possible, Mercy RBHA adopts AHCCCS requirements and practice guidelines from national organizations known for their expertise in the area of concern. Please refer to the [Clinical Practice Guidelines](#) located on the Mercy RBHA Provider website.

Quality Management and Performance Improvement Plan

Under the leadership of the Chief Medical Officer, Mercy RBHA's Quality Management department has developed a written Annual QM Plan that addresses MERCY RBHA's proposed methodology to meet or exceed AHCCCS minimum performance standards for contractual performance measures, as well as statewide performance improvement projects (PIPs). The QM Plan describes the components of the program and how the activities improve the quality of care and service delivery for enrolled members.

Measurement Tools

Mercy RBHA must measure performance using measurement tools specified by CMS and AHCCCS and report its performance to CMS/AHCCCS. Mercy RBHA is required to make available to CMS/AHCCCS information from these measures to provide enrollees with a means to assess the value they receive for their health care dollar and to hold health plans responsible for their performance. As a contracting medical provider, you may be required to assist in medical record data collection.

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Procedures for HEDIS/Clinical Performance Measure Improvement

All contracted providers are expected to meet MPS as established by AHCCCS and/or Mercy RBHA. It is equally as important that rates improve year over year. Providers must implement and maintain strategies to monitor and continuously improve their rates.

Mercy RBHA's Performance Improvement Department is available to providers for technical assistance. Examples of the types of technical assistance available include:

- Strategies/best practices for improving rates
- Clarification on rate calculations
- Clarification on billing/documentation related to performance measures
- Assistance in improving maternity quality indicators:
 - Reduction of elective inductions of labor and Caesarean sections;
 - Reduction of low birth weight/very low birth weight;
 - Increasing utilization of family planning benefits after delivery; and
 - Reduction of pre-term deliveries.
- Assistance in improving EPSDT quality indicators (Title XIX integrated members ages 18-20):
 - Use of EPSDT Forms;
 - Required screenings;
 - Increasing utilization of biannual preventive dental visits; and
 - Increasing utilization of annual EPSDT visits.

Chronic Care Improvement Plan

Mercy RBHA is required to have a Chronic Care Improvement Program (CCIP). This program must identify enrollees with multiple or sufficiently severe chronic conditions who meet criteria for participation in the program, and must have a mechanism for monitoring enrollee participation in the program. As a contracted medical provider, you may be required to assist in medical record data collection or verification to confirm eligibility or participation in the CCIP.

Quality of Care Concerns

Documentation Related to Quality of Care Concerns

Quality of Care (QOC) concerns may be referred by state agencies, internal AHCCCS sources or internal Mercy RBHA departments (e.g., Grievance and Appeals, Utilization Management, Children's System of Care, Adult System of Care, Medical Management, etc.), and external sources (e.g., behavioral health members; providers; other stakeholders; Incident, Accident, and Death reports). A QOC can be referred for any participating or non-participating provider and out of state placements. Upon receipt of a QOC concern, AHCCCS follows the procedures below. As participants in the QOC process, Mercy RBHA follows these same procedures:

- Document each issue raised, when and from whom it was received and the projected time frame for resolution.
- Determine promptly whether the issue is to be resolved through one or more of the following Mercy RBHA areas:

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- Quality of Care;
- Customer Service/Complaint Resolution;
- Grievance and appeals process; and/or
- Fraud, waste, and program abuse.
- Acknowledge receipt of the issue and explain to the member or provider the process that will be followed to resolve his or her issue through written correspondence. If the issue is being addressed as other than a QOC investigation, explain to the member or provider the process that will be followed to resolve their issue using written correspondence. QOC related concerns will remain in the quality management arena due to state and federal regulations: **42 U.S.C. 1320c-9, 42 U.S.C. 11101 et seq., A.R.S. §36-2401, A.R.S. §36-2402, A.R.S. §36-2403, A.R.S. §36-2404, A.R.S. §36-2917.**
- Assist the member or provider as needed to complete forms or take other necessary actions to obtain resolution of the issue.
- Ensure confidentiality of all member information.
- Inform the member or provider of all applicable mechanisms for resolving the issue.
- Document all processes (include detailed steps used during the investigation and resolution stages) implemented to ensure complete resolution of each issue, including but not limited to:
 - Corrective action plan(s) or action(s) taken to resolve the concern;
 - Documentation that education/training was completed. This may include, but is not limited to, in-service attendance sheets and training objectives;
 - New policies and/or procedures; and
 - Follow-up with the member that includes, but is not limited to:
 - Assistance as needed to ensure that the immediate health care needs are met; and
 - Closure/resolution letter that provides sufficient detail to ensure all covered, medically necessary care needs are met and a contact name/telephone number to call for assistance or to express any unresolved concerns.

Process of Evaluation and Resolution of Quality of Care Concerns

The quality of care concern process at Mercy RBHA includes documentation of identification, research, evaluation, intervention, resolution, and trending of member and provider issues. Resolution must include both member and system interventions when appropriate. The quality of care process must be a stand-alone process and shall not be combined with other agency meetings or processes. This process is also outlined in the AHCCCS Desktop Protocol – Quality of Care and Peer Review.

- Mercy RBHA completes the following actions in the QOC process:
 - Identification of the quality of care issues;
 - Initial assessment of the severity of the quality of care issue;
 - Prioritization of action(s) needed to resolve immediate care needs when appropriate;

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- Review of trend reports to determine possible trends related to the provider(s) involved in the allegation(s) including: type(s) of allegation(s), severity and substantiation, etc.;
 - Research, including, but not limited to: a review of the log of events, documentation of conversations, and medical records review, mortality review, etc.; and
 - Quantitative and qualitative analysis of the research, which may include root cause analysis.
- For substantiated QOC allegations it is expected that some form of action is taken, for example:
 - Developing an action plan to reduce/eliminate the likelihood of the issue reoccurring;
 - Determining, implementing, and documenting appropriate interventions;
 - Monitoring and documenting the success of the interventions;
 - Incorporating interventions into the organization's Quality Management (QM) program if appropriate; or
 - Implementing new interventions/approaches, when necessary.
- Each issue/allegation must be resolved; member and system resolutions may occur independently from one another. The following determinations should be used for each allegation in a QOC concern:
 - **Substantiated** – the alleged complaint (allegation) or reported incident was verified or proven to have happened based on evidence and had a direct effect on the quality of the member's behavioral health care. Substantiated allegations require a level of intervention such as a performance improvement plan, or a corrective action plan of steps to be taken to improve the quality of care or service delivery and/or to ensure the situation will not likely happen again.
 - **Unable to Substantiate** – there was not enough evidence at the time of the investigation to show whether a QOC allegation did occur or did not occur. The evidence was not sufficient to prove or disprove the allegation. No intervention or corrective action is needed or implemented.
 - **Unsubstantiated** – there was enough credible evidence (preponderance of evidence) at the time of the investigation to show that a QOC allegation did occur. The allegation is based on evidence, verified or proven, to have not occurred. No intervention or corrective action is needed or implemented.
- Mercy RBHA uses the following process to determine the level of severity of the quality of care issue:
 - **Level 0** (Track and Trend Only) – An issue no longer has an immediate impact and has little possibility of causing, and did not cause, harm to the member and/or other members, an allegation that is unsubstantiated or unable to be substantiated when the QOC is closed.
 - **Level 1** – Concern that MAY potentially impact the member and/or other members if not resolved.

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- **Level 2** – Concern that WILL LIKELY impact the member and/or other members if not resolved promptly.
- **Level 3** – Concern that IMMEDIATELY impacts the member and/or other members and is considered potentially life threatening or dangerous.
- **Level 4** – Concern that NO LONGER impacts the member. Death or an issue no longer has an immediate impact on the member, an allegation that is substantiated when the QOC is closed.
- Mercy RBHA reports issues to the appropriate regulatory agency including Adult Protective Services, AHCCCS, Department of Child Safety, Attorney General’s Office, or law enforcement agency for further research/review or action. Initial reporting may be made verbally, but must be followed by a written report within one business day.
- Cases are referred to the Peer Review Committee when appropriate. Any case ending in a severity level of 3 or higher is automatically referred to the Peer Review Committee. Referral to the Peer Review Committee shall not be a substitute for implementing interventions.
- If an adverse action is taken with a provider due to a quality of care concern, Mercy RBHA will report the adverse action to the AHCCCS Clinical Quality Management Unit (CQM) as well as to the National Practitioner Data Bank. Mercy RBHA, as an active participant in the process, must notify AHCCCS of any adverse action taken against a provider.
- Upon receiving notification that a health care professional’s organizational provider or other provider’s affiliation with their network is suspended or terminated as a result of a quality of care issue, Mercy RBHA will provide written notification to the appropriate regulatory/licensing board and AHCCCS. Mercy RBHA, as active participants in the process, are required to notify Mercy RBHA of the same.
- When the review of a quality of care concern is complete, Mercy RBHA will submit a closing letter to AHCCCS Clinical Quality Management (CQM). These letters will include the following:
 - A description of the issues/allegations, including new issues/allegations identified during the investigation/review process;
 - A substantiation determination and severity level for each allegation;
 - An overall substantiation determination and level of severity for the case;
 - Written response from or summary of the documents received from referrals made to outside agencies such as accrediting bodies, or medical examiner.

Tracking/Trending of Quality of Care Issues

Mercy RBHA uses data pulled from QOC database to monitor the effectiveness of QOC-related activities to include complaints and allegations received from members and providers, as well as from outside referral sources. Mercy RBHA also tracks and trends QOC data and reports trends and potential systemic problems to AHCCCS.

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The data from the QOC database will be analyzed and evaluated to determine any trends related to the quality of care or service in Mercy RBHA's service delivery system or provider network, and aggregated for the state. When problematic trends are identified through this process, Mercy RBHA will incorporate the findings in determining systemic interventions for quality improvement. Mercy RBHA incorporates trended data into systemic interventions.

- As evaluated trended data is available, Mercy RBHA will prepare and present analysis of the QOC tracking and trending information for review and consideration of action by the Quality Management Committee and Chief Medical Officer, as Chair-member of the Quality Management Committee.
- Quality tracking and trending information from all closed quality of care issues within the reporting quarter will be submitted to AHCCCS/Division of Health Care Management/Clinical Quality Management (AHCCCS/ DHCM/CQM) utilizing the Quarterly Quality Management Report. The report will be submitted within 45 days after the end of each quarter and will include the following reporting elements:
 - Types and numbers/percentages of substantiated quality of care issues;
 - Interventions implemented to resolve and prevent similar incidences; and
 - Resolution status of "substantiated", "unsubstantiated" and "unable to substantiate" QOC issues.

If a significant negative trend is found, Mercy RBHA may choose to consider it for a performance improvement activity to improve the issue resolution process itself, and/or to make improvements that address other system issues raised during the resolution process.

Mercy RBHA will submit to AHCCCS CQM all pertinent information regarding an incident of abuse, neglect, exploitation and unexpected death as soon as aware of the incident. Pertinent information must not be limited to autopsy results only, but must include a broad review of all issues and possible areas of concern. Delays in the receipt of autopsy results shall not result in a delay in the investigation of a quality of care concern by Mercy RBHA. Delayed autopsy results will be used to confirm the resolution of the QOC concern. Mercy RBHA will also revise closing letters to AHCCCS if the cause and manner of death changes the findings of a QOC investigation.

Mercy RBHA must ensure that member health records are available and accessible to authorized staff of their organization and to appropriate State and Federal authorities, or their delegates, involved in assessing quality of care or investigating member or provider quality of care concerns, complaints, allegations of abuse, neglect, exploitation grievances and Health Care Acquired Conditions (HCAC). Member record availability and accessibility must be in compliance with Federal and State confidentiality laws, including, but not limited to, Health Insurance Portability and Accountability Act (HIPAA) and **42 C.F.R. 431.300 et seq.**

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Provider-Preventable Conditions

If a Health Care Acquired Condition (HCAC) or Other Provider Preventable Condition (OPPC) is identified, Mercy Care will conduct a quality of care investigation and report the occurrence and results of the investigation to the AHCCCS Clinical Quality Management Unit. Mercy RBHA must also submit a list of HCAC cases that were opened and investigated as part of the quarterly report deliverable to AHCCCS 45 days following the end of the quarter.

11.01 – Performance Improvement Projects

Mercy RBHA is committed to establishing high quality healthcare services. One method for achieving this is through adherence to the standards and guidelines set by CMS. Mercy RBHA adheres to CMS standards and guidelines and, in turn, promotes improvement in the quality of healthcare provided to members through the development and implementation of Performance Improvement Projects (PIPs). Performance Improvement Projects consist of utilizing a comprehensive protocol endorsed by [CMS](#), as described in the [AHCCCS Medical Policy Manual \(AMPM\), Chapter 900](#) and [42 CFR 438.240](#). The protocol standards and guidelines help to ensure that Medicaid managed care organizations meet these quality assurance requirements when conducting Medicaid External Quality Review Activities.

Performance Improvement Projects (PIPs)

A PIP is a systematic process created to:

- Identify, plan and implement system interventions to improve the quality of care and services provided to members;
- Evaluate and monitor the effectiveness of system interventions and data on an ongoing basis; and
- Result in significant performance improvement sustained over time through the use of measures and interventions.

PIPs are designed to:

- Demonstrate achievement and sustainment of improvement for significant aspects of clinical care and non-clinical services;
- A clinical study topic would be one for which outcome indicators measure a change in behavioral health status or functional status; and,
- A non-clinical or administrative study topic would be one for which indicators measure changes in member satisfaction or processes of care.

Correct significant systemic issues come to the attention of Mercy RBHA in part through:

- Data from Mercy RBHA functional areas (e.g.: network, medical director's office);
- Statewide contractor performance data and contract monitoring activities;
- Tracking and trending of complaints, grievance and appeal data and quality of care concerns;
- Provider credentialing and profiling as well as other oversight activities, such as chart reviews;

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- Quality Management/Utilization Management data analysis and reporting; and
- Member and/or provider satisfaction surveys and feedback.

Mercy RBHA contracted healthcare providers play an integral role in the implementation of the Mercy RBHA PIPs. Healthcare providers shall participate with any or all aspects of the PIP implementation process.

There are ten (10) steps to be undertaken when conducting PIPs:

1. Select the study topic(s). In general, a clinical or non-clinical issue selected for study should affect a significant number of members and have a potentially significant impact on health, functional status or satisfaction.
2. Define the study question(s). It is important to clearly state, in writing, the question(s) the study is designed to answer. Stating the question(s) helps maintain the focus of the PIP and sets the framework for data collection, analysis, and interpretation.
3. Select the study indicator(s). A study indicator is a quantitative or qualitative characteristic reflecting a discrete event (e.g., a member has stopped taking medication and has experienced a crisis which resulted in hospitalization), or a status (e.g., a member has/has not experienced a crisis that resulted in hospitalization) that is to be measured. Each project should have one or more quality indicators for use in tracking performance and improvement over time.
4. Use a representative and generalizable study population. Once a topic has been selected, measurement and improvement efforts must be system-wide. A decision needs to be made as to whether to review data for the entire population or use a sample of the population.
5. Use sound sampling techniques (if sampling is used). If a sample is to be used to select members of the study, proper sampling techniques are necessary to provide valid and reliable information on the quality of care provided. When conducting a study designed to estimate the rates at which certain events occur, the sample size has a large impact on the level of statistical confidence in the study estimates.
6. Reliably collect data. Procedures used to collect data for a given PIP must ensure that the data collected on the PIP indicators are valid and reliable. Validity is an indication of the accuracy of the information obtained. Reliability is an indication of the repeatability or reproducibility of a measurement. Potential sources of data include administrative data (e.g., enrollment, claims, and encounters), medical records, tracking logs, results of any provider interviews and results of any member interviews and surveys. Data can be collected from either automated data systems or by a manual review of records.
7. Implement intervention and improvement strategies. Real, sustained improvements in care result from a continuous cycle of measuring and analyzing performance, and developing and implementing system-wide improvements in care. Actual improvements in care depend on thorough analysis and implementation of appropriate solutions.
8. Analyze data and interpret study results. Data analysis begins with examining the

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performance on the selected clinical or non-clinical indicators. The analysis of the study data should include an interpretation of the extent to which the PIP was successful and what follow-up activities are planned as a result.

9. Plan for “real” improvement. When a change in performance is found, it is important to know whether the change represents “real” change or random chance. This can be assessed in several ways, but is most confidently done by calculating the degree to which an intervention is statistically significant.
10. Achieve sustained improvement. Real change results from changes in the fundamental processes of health care delivery. Such changes should result in sustained improvements. In contrast, a one-time improvement can result from unplanned accidental occurrences or random chance. If real change has occurred, the project should be able to achieve sustained improvement.

Mercy RBHA targets specific areas for quality improvement and may request that contracted providers participate in initiatives for one or more of the performance improvement projects identified in this chapter. When applicable, contracted providers are expected to collaborate with Mercy RBHA, other providers, stakeholders, and community members to implement recommended improvement strategies that are developed as a result of an identified performance improvement project.

11.02 – Peer Review

Peer Review

Mercy RBHA has established and maintains a Peer Review Committee. The Peer Review Committee serves as the primary entity responsible for ensuring Mercy RBHA and subcontracted providers adhere to a clinically appropriate peer review process. The AHCCCS Bureau of Quality and Integration may submit a matter for peer review to the Chair of the Peer Review Committee, or designee.

Matters appropriate for peer review may include, but are not limited to:

- Questionable clinical decisions;
- Lack of care and/or substandard care;
- Inappropriate interpersonal interactions or unethical behavior;
- Physical or sexual abuse by provider staff;
- Allegations of criminal or felonious actions related to practice;
- Issues that immediately impact the member and that are life threatening or dangerous;
- Unanticipated death of a member;
- Issues that have the potential for adverse outcome; or
- Allegations from any source that bring into question the standard of practice.

Peer Review Committee membership will include:

- The Chief Medical Officer (Chair);
- The Deputy Chief Medical Officer;

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- The QM Administrator;
- Quality of Care Reviewers;
- QM Medical Directors
- At least one provider of the same or similar specialty under review and representation of healthcare professionals from local communities in which Mercy RBHA has enrolled members; and
- Mercy RBHA's CMO may invite provider with a special scope of practice when necessary.

Non-voting Members:

- Licensed Practitioners, internal and external, when necessary

The Peer Review Committee will convene at least quarterly but, in emergent cases, an ad hoc meeting will be called by the Chair or designee.

The Peer Review Committee will examine selected peer review outcomes from Mercy RBHA's and information made available through the quality management process to monitor Mercy RBHA's peer review process. As a result of the review, the Peer Review Committee will make recommendations to Mercy RBHA's Chief Medical Officer that may include, but are not limited to:

- Peer contact;
- Education;
- Rehabilitative service referral;
- Credentialing review;
- Corrective Action Plans; and/or
- Other corrective actions as deemed necessary.

The Peer Review Committee and Quality Management Committee must review its monitoring process and corresponding guidance documents annually.

The Peer Review Committee may also make recommendations for Mercy RBHA Chief Medical Officers to refer cases to AHCCCS, Department of Child Safety (DCS) or Adult Protective Services (APS), Arizona Medical Board and/or other professional regulatory review boards as applicable, for further investigation or action and notification to regulatory agencies.

Mercy RBHA must implement recommendations made by the Peer Review Committee. Some Peer Review recommendations may be appealable agency actions under Arizona law. A Mercy RBHA subcontracted provider may appeal such a decision through the administrative process described in **A.R.S. §41-1092, et seq.**

All aspects of the peer review process must be kept confidential and must not be discussed outside of committee except for the purposes of implementing recommendations made by

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the Peer Review Committee. Confidentiality must be extended to, but is not limited to, all of the following:

- Peer review reports;
- Meeting minutes;
- Documents;
- Discussions;
- Recommendations; and
- Participants.

All participants in the Peer Review Committee must sign a confidentiality and conflict of interest statement at the initiation of each peer review committee meeting.

Procedures for Mercy RBHA Peer Review

Evidence of a quality deficiency in the care or service provided, or the omission of care or service, by a healthcare professional or provider is subject to peer review. The evidence may include, but is not limited to, information received in a report from a state regulatory board or agency, Medicare/Medicaid sanctions, the National Practitioner Data Bank (NPDB), a member complaint, provider complaint, observations by individuals working for or on behalf of Mercy RBHA, or other federal, state, or local government agencies.

The Mercy RBHA Peer Review Committee is chaired by the Chief Medical Officer (CMO) and the membership includes Administrators and Managers of other departments within Mercy RBHA and representation of healthcare professionals from local communities in which Mercy RBHA has enrolled members (including physical health care Primary Care Physicians (PCPs and or Specialist). Mercy RBHA's CMO may invite providers with a special scope of practice when necessary. A PCP must be part of the Peer Review Committee when a physical health care case is being reviewed. A Behavioral Health Medical Professional (BHMP) must be part of the Peer Review Committee when a behavioral health case is being reviewed.

The CMO is responsible for implementing the quality and utilization management programs, which include peer review. As the chair-member of the Peer Review Committee, the CMO directs and actively participates in, or oversees, all aspects of the confidential peer review process. Each member of the Peer Review Committee signs a statement at all Peer Review Committee meetings acknowledging agreement with Mercy RBHA's confidentiality and conflict of interest standards.

The Quality Management (QM) department is responsible for the initial referral evaluation of quality and utilization concerns, generation of healthcare professional or provider notification letters, referral review, and presentation of quality and utilization concerns to the CMO. The CMO recommends cases that need to go to Peer Review.

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The QM Department schedules Peer Review Committee meetings and coordinates peer review support operations by processing, researching, and documenting referrals. The QM Department also assists with peer review follow-up activities in accordance with Mercy RBHA policies and procedures, or as directed by the CMO.

The Peer Review Committee is responsible for making recommendations to the CMO. Together they must determine appropriate action which may include, but not limited to: peer contact, education, credentials, limits on new member enrollment, sanctions, or other corrective actions. The CMO is responsible for implementing the actions.

Peer Review Committee Recommendations

Based upon the presented information, the Peer Review Committee may:

- Request additional information.
- Assign or adjust the severity level.
- Request an outside peer review consultation and report prior to rendering a decision, if such a consultation was not already ordered by the CMO or Mercy RBHA medical director.
- Require the CMO to develop an action plan, which may include, but is not limited to the following:
 - **Peer contact:** The Committee may recommend that the Mercy RBHA medical director or CMO personally contact the healthcare professional or provider to discuss the committee's action.
 - **Education:** The Committee may recommend that information or educational material be sent to the healthcare professional or provider or that the healthcare professional or provider seek additional training. Confirmation of the completed training will be required to be sent to Mercy RBHA.
 - **Committee appearance:** The Committee may recommend that the healthcare professional or provider attend a committee meeting to discuss the issue with committee members
 - **Credentials action:** The Committee may recommend that Mercy RBHA reduce, restrict, suspend, terminate, or not renew the healthcare professional's Mercy RBHA credentials necessary to treat members as a participating provider.
- The healthcare professional may be required to develop a Corrective Action Plan (CAP) to:
 - Ensure the specific member issue has been adequately resolved.
 - Reduce/eliminate the likelihood of the issue reoccurring.
 - Determine, implement and document appropriate interventions.
 - Be reviewed at the following Quality Management Committee
- The QM department monitors the success of the CAP/interventions.
- The Peer Review Committee may require new interventions/approaches when necessary.

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11.03 – Behavioral Health Satisfaction Survey

This chapter outlines the process for Mercy RBHA and behavioral health providers that deliver covered behavioral health services to Title XIX or Title XXI eligible members receiving services in the public behavioral health system.

The surveys request independent feedback from Title XIX/XXI adult members/guardians and families of youth receiving services through Arizona's publicly funded behavioral health system. The surveys measure consumers' perceptions of behavioral health services in relation to the following domains:

- Access to timeliness of behavioral health care
- Perceived outcome of behavioral health care
- Communication with clinicians
- Patient rights
- Member services and assistance
- Overall rating of behavioral health provider

The information collected from the surveys is used to improve the public behavioral health system. Results from the survey provide comprehensive data to make systemic program improvements.

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RBHA CHAPTER 12 – SERVICE AUTHORIZATIONS

12.00 – Securing Services and Prior Authorization

Purpose of Utilization Review Process

Mercy RBHA Utilization Management activities are designed to ensure a comprehensive, systematic, and ongoing process to monitor the appropriate use of health care resources in the amount and duration necessary to achieve the best possible health outcomes. Mercy RBHA analyzes and monitors provider and member outcomes to guide improvement activities to enhance clinical and program efficiency and quality.

The goals of utilization review are to evaluate the medical necessity criteria of the admission and/or the service provided. Ensuring the appropriateness of all medically necessary and covered services for pre-services, concurrent, and post-services delivered to members and monitoring, reviewing, and detecting under- or over-utilization of services.

Mercy RBHA adopts tools, such as service planning guidelines, to retrospectively review the utilization of services. The goals of utilization review include:

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

12.01 - Securing Services Does Not Require Authorization

The clinical team, or PCP in coordination with the clinical team, is responsible for identifying and securing the service needs of each behavioral health or integrated member through the assessment and service planning processes. Rather than identifying pre-determined services, the clinical team should focus on identifying the underlying needs of the behavioral health member, including the type, intensity, and frequency of support and treatment 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 utilizing Mercy RBHA's network of Participating Healthcare Providers (PHP). This is done in conjunction with the clinical team, the behavioral health member, family, and natural supports. If the service is available through a contracted provider, the member can access the service directly. If the requested service is only available through a non-contracted provider, the clinical team is responsible for coordinating with Mercy RBHA to obtain the requested service as outlined below.

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Although Adult HCTC is not a prior authorized service, Mercy RBHA requires the submission of the **Adult HCTC Application**, available on our [Forms Library](#) web page, in order to access this service.

Prior authorization for the following physical health services is not required:

- Emergency services
- Non-par facility services for the following obstetrical services:
 - OB observation
 - Vaginal delivery if stay is no longer than forty-eight hours
- Cesarean delivery if the stay is no longer than ninety-six hours
- Medical observation

12.02 - Accessing Services with Non-Contracted Providers

If Mercy RBHA's network does not have a Participating Healthcare Provider (PHP) to perform the requested and medically necessary service, the member may be referred to out of network providers. Out of network requests are prior authorized and a member may be referred if:

- The services required are not available within the Mercy RBHA network.
- Mercy RBHA prior authorizes the services.

In order to prior authorize the service, a provider must be AHCCCS registered in order to receive reimbursement.

If out of network services are not prior authorized, the referring and servicing providers may be responsible for the cost of the service. The member may not be billed if the provider fails to follow Mercy RBHA's policies. Both referring and receiving providers must comply with Mercy RBHA's policies, documents, and requirements that govern referrals (paper or electronic), including prior authorization. Failure to comply may result in delay in care for the member, a delay or denial of reimbursement, or costs associated with the referral being changed to the referring provider. If a team has made all attempts to find an in network provider for a medically necessary service and is unable to secure the service within the required timeframes, the team may submit a Single Case Agreement or request a Letter of Agreement to Mercy RBHA for these services with an AHCCCS registered provider.

Mercy RBHA requires the following information in order to process the prior authorization:

- Requested services (including covered service codes and units)
- Provider demographic information (name, license, address, phone number, AHCCCS ID)

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- Copy of the service plan indicating needed services have been documented
- Reason for referral to a non-contracted provider (e.g., specialty not available in network)
- Reason this service is the only medically viable alternative for the member
- Time frames for processing requests;
 - **Expedited Service Authorization Request:** A request for services in which either the requesting provider indicates or the MCP determines that following the standard timeframes for issuing an authorization decision could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. In these circumstances, the authorization decision must be expedited and must be made within 72 hours from the date of receipt of the service request. If the due date for an expedited authorization decision falls on a weekend (Saturday and Sunday) or legal holiday as defined by the State of Arizona, the expedited decision must be made on the day preceding the weekend or holiday.
 - **Expedited Authorization Request Downgraded to a Standard Request:** When MCP receives an expedited request for a service authorization and the requested service is not of an expedited medical nature, the MCP will downgrade the expedited authorization request to a standard request.
 - **Standard Service Authorization Request:** A request from the member, the representative, or a provider for a service for the member. The authorization decision must be made within 14 calendar days from the date of receipt of the service request.

The process for securing services through a non-contracted provider is as follows for Behavioral and Physical Health requests:

- Securing Non-Contracted Behavioral Health Adult & Children's Services:
 - Mercy RBHA contracts directly with providers for all levels of care.
 - It is the outpatient team's responsibility to secure all clinically necessary services in support of the treatment plan, including those from non-contracted providers. In the event the outpatient team is unable to secure services through a Mercy RBHA contracted provider, follow the process below. Single Case Agreements (SCAs) must be requested, completed, and executed before claims can be submitted or paid.
 - The **Behavioral Health Outpatient Single Case Agreement Request**, available on our [Forms Library](#) web page.
 - All requests for SCAs are required to be faxed to the Prior Authorization Department at (860) 975-1040.
 - Non-contracted providers need to be AHCCCS-registered. SCA

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agreements will be at the AHCCCS rate unless otherwise stated.

- Securing Non-Contracted Physical Health Services
 - Maricopa contracts directly with providers for all levels of care
 - Physical health providers can request SCA or LOA for all services when a service through Mercy RBHA In-Network provider is not available
 - Use the Physical Health **Prior Authorization Standard Request Form**, available on our [Forms Library](#) web page.
 - All requests for SCAs are required to be faxed to the Prior Authorization Department fax number at (844) 424-3976.
 - Upon execution of the SCA or LOA, the provider will receive a copy of the SCA/LOA via e-mail from Mercy RBHA Contracts and/or via fax from Mercy RBHA.
- In the event that a request to secure covered services through a non-contracted provider is denied, a notice of the action must be provided.
- If Mercy RBHA is unable to secure a SCA/LOA with a non-contracted provider, Mercy RBHA will contact the requestor of the service to identify alternate providers until appropriate services have been obtained.

In order for a provider to expedite payment of a Single Case Agreement or Letter of Agreement, be sure to include a copy of the SCA/ LOA with the claim.

12.03- Accessing Services that Require Prior Authorization

Emergency Situations

Prior authorization is never applied in an emergency situation. A retrospective review may be conducted after the member's immediate behavioral health needs have been met. If upon review of the circumstances, the behavioral or physical health service (integrated members) 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.

Behavioral Health emergency inpatient admissions require the provider to notify Mercy RBHA of all admissions via fax at 855-825-3165.

Services Requiring Prior Authorization:

- Non-emergency admission to and continued stay in an inpatient medical facility; psychiatric or detoxification acute inpatient facility;
- Non-emergency admission to and continued stay for eating disorder facilities
- Admission to and continued stay in a behavioral health inpatient facility (BHIF)

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Level I);

- Admission to and continued stay in a behavioral health residential facility (BHRF) (This is not required for GMH/SA with the exception of residential services for Eating Disorder Treatment.);
- Admission to and continued stay in treatment for child and adolescent home care training to home care client (HCTC) services;
- Non-emergency services outside the geographic service area of Mercy RBHA;
- Non-emergency services outside the Mercy RBHA contracted Provider Network;
- Psychological, psychosexual and neuropsychological testing;
- Specific pharmacy practices;
- Electroconvulsive therapy (ECT); and
- Non-emergency out of network single case agreements or letter of agreements
- Physical Health services such as pain management, elective surgery.
- In order to determine if a Physical Health service is required a provider may utilize the [ProPat](#) link in our Secure Web Portal.

Physical Health Providers under Integrated Care

Mercy RBHA requires prior authorization for selected acute outpatient services, hospice, skilled nursing services, rehabilitation services, planned outpatient procedures and/or planned hospital procedures. Questions related to specific outpatient services that require prior authorization can be directed to Member Services at 800-564-5465.

Prior authorization guidelines are reviewed and updated regularly. To request an authorization, find out what requires authorization, or to check on the status of an authorization, please visit [Mercy RBHA's Secure Web Portal](#). You may also call our Prior Authorization Department at 800-564-5465.

Mercy RBHA has prior authorization staff to authorize health care 24 hours per day, seven days per week. This staff includes Arizona-licensed nurses and physicians.

Mercy RBHA employs licensed clinicians to review and make prior authorization decisions. Any decision to reduce or deny a request for services based on medical necessity criteria review must be made by a Mercy RBHA medical director or physician designee.

A denial of a request for a requested service or equipment, admission to or continued stay in an inpatient facility, BHIF, BHRF or Child/Adolescent HCTC can only be made by a Mercy RBHA medical director or physician designee, after an offer of verbal or written collaboration with the request provider or clinician. If the offer is declined, a decision can

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be made based on the available information.

Following a decision to deny but prior to the Notice being sent to the member, the attending facility physician or requesting provider can ask for a second level physician review. A second level physician review is when a different Mercy RBHA medical director reviews the provided information and makes a final determination.

For Title XIX/XXI covered services requested by members who is Title XIX/XXI eligible or who have been determined to have a serious mental illness and are Title XIX, the provider must provide the member(s) requesting services with a **Notice of Adverse Benefit Determination**, available on our [Forms Library](#) web page.

Notice must be provided in accordance Notice and Appeal Requirements. When a request does not appear to meet medical necessity criteria and is being considered for denial, a discussion with a facility attending physician, requesting provider or their designee is offered. Notification will be given prior to a final denial decision and still allows for a determination to be made within appropriate time frames.

12.04 - How to Request a Prior Authorization

The following documentation is required in order to obtain prior authorization:

- For a non-emergent admission to an acute inpatient, psychiatric acute hospital or sub-acute facility, detoxification or for an eating disorder, a **SAMPLE Certification of Need (CON)**, available on our Forms Library web page, must be completed and a telephonic request must be called in to Mercy RBHA's Prior Authorization line at 800-564-5465. Please refer to our **Authorization Criteria for Behavioral Health Residential Facility, Adult Title XIX SMI**, available on our **Forms Library** web page, for further detail.
- Child/Adolescent Behavioral Health Inpatient Facility (BHIF) non-emergent request, the Clinical Team must submit a **Therapeutic Residential Service Request for Children and Adolescents**, available on our [Forms Library](#) web page, via fax to 855-825-3165 regardless of TPL coverage. **Authorization cannot be provided without all the requested documentation.**
 - A Certification of Need (CON) must be completed after approval by the requesting provider prior to admission.
 - Approval for child/adolescent behavioral health inpatient facility (BHIF) is valid for up to forty-five days. If not admitted before the expiration of the 45 days the clinical team must submit the **Child and Adolescent 45 Day Clinical Review for Continued Prior Authorization of Residential Facility** form, available on our [Forms Library](#) web page.
 - **Please review our Authorization Criteria for Behavioral Health -Inpatient Facility**

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Children/Adolescent, available on our [Forms Library](#) web page, for additional detail.

- For Adult or Child /Adolescent Behavioral Health Residential Facility (BHRF) or Child HCTC non-emergent request, the Clinical Team must complete the appropriate form:
 - **Adult BHRF request - (Referral for Behavioral Health Residential Facility Services for Adults** application, available on our [Forms Library](#) web page, and submit via fax to 855-825-3165). Approval is valid for 45 days.
 - **Child/Adolescent BHRF or HCTC – Therapeutic Residential Service Request for Children and Adolescents**, available on our [Forms Library](#) web page, application and fax to Mercy RBHA at 855-825-3165 followed by telephonic notification to Mercy RBHA Utilization Management via Mercy RBHA's Member Services Department at 800-564-5465.
- **Authorization cannot be provided without all the required documentation.**
 - Approval for child/adolescent behavioral health residential facilities is valid for up to forty-five days and a **Child and Adolescent 45 Day Clinical Review for Continued Prior Authorization of Residential Facility**, available on our [Forms Library](#) web page, must be submitted if additional days are needed.
 - Approval for child/adolescent HCTC is valid for up to sixty days and a **Child and Adolescent 60 Day Clinical Review for Continued Prior Authorization of HCTC**, available on our [Forms Library](#) web page, must be faxed to Mercy RBHA at 855-825-3165.
 - **Authorization Criteria for Behavioral Health Residential Facility, Children/Adolescent** and **Authorization Criteria For Home Care Training for the Home Care Client (HCTC) Children/Adolescent**, available on our [Forms Library](#) web page,
- Non-emergency inpatient eating disorder requires prior authorization according to MCG guidelines. Complete the **Inpatient Eating Disorder Request for Prior Authorization**, available on our [Forms Library](#) web page, form and fax to 844-424-3976 or for urgent request call 800-564-5465 to review with the Mercy RBHA Utilization Management Department.
- Electroconvulsive therapy (ECT) requires prior authorization according to MCG criteria. Complete the **ECT Prior Authorization Form**, available on our [Forms Library](#) web page, and fax to 844-424-3976; or for urgent requests call 800-564-5465 to review with Mercy RBHA's Utilization Management Department.
- Behavioral Health psychological and psychosexual testing approval is made in accordance with MCG guidelines. Neuropsychological testing approval will be according to the guidelines in [AHCCCS Medical Policy Manual, Policy 320-L](#),

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Neuropsychological Testing. To request psychological, psychosexual and neuropsychological testing prior authorization, complete the **Psychological and Neuropsychological Testing Prior Authorization** form, available on our [Forms Library](#) web page. Fax the request form to Mercy RBHA's Utilization Management Department at 844-424-3976.

- Physical Health request for services such as pain management, elective surgery - in order to determine if a Physical Health service is required a provider may utilize the [ProPat](#) link on our Secure Web Portal.
- Mercy RBHA requires prior authorization for selected Durable Medical Equipment (DME). Questions related to specific DME that require prior authorization can be directed to Member Services at 800-564-5465. Additionally, individuals who are discharged from the Arizona State Hospital (AzSH) must be provided with the same brand and model of glucometer and supplies the individual was trained on while in the hospital.
- For requests for prior authorizations for medications, Mercy RBHA contracted prescribing clinicians shall refer to our Drug List. Formulary medications do not require prior authorization. [Prior Authorization Criteria](#) can be found under the Prior Authorization Guidelines and the Prior Authorization Requests can be found under **Prior Authorization Request Form**, available on our [Forms Library](#) web page.

Prior Authorizations for Medications

Mercy RBHA utilizes the AHCCCS drug lists. The lists denote all drugs which require prior authorization. The approved prior authorization criteria are available on the Mercy RBHA website. For implementation of this process for prior authorization the following requirements must be met:

- Adherence to all prior authorization requirements outlined in this chapter, including prior authorization availability 24 hours a day, seven days a week;
- Assurance that a member will not experience a gap in access to prescribed medications due to a change in prior authorization requirements. Mercy RBHA 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.

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Timeframe for Decisions

Decision to prior authorize services must be made according to these guidelines:

- Mercy RBHA makes pharmacy PA decisions and notifies prescribing practitioners/providers, and/or members in a timely manner, according to the standards defined below:
 - Mercy RBHA makes decisions within 24 hours of the receipt of all necessary information.
 - Mercy RBHA notifies requesting prescribing providers by fax, phone or electronic communication of the approved decisions within 24 hours of receipt of the submitted request for prior authorization.
 - A request for additional information is sent to the prescriber by fax within 24 hours of the submitted request when the prior authorization request for a medication lacks sufficient information to render a decision. A final decision will be rendered within seven business days from the initial date of the request.
 - If an authorization is denied, Mercy RBHA notifies members and practitioners and/or providers regarding how to initiate an expedited appeal at the time they are notified of the denial.
- Mercy RBHA will fill at least a 4-day supply of a covered outpatient prescription drug in an emergent situation.

12.05 - Third Party Liability (TPL)

Mercy RBHA matches TPL for copays and deductible if the provider is an AHCCCS registered provider. For the following services we require notification or a prior authorization request to ensure coordination of care and proactive discharge planning.

Emergency Inpatient Behavioral Health admissions with TPL

Providers are required to notify MERCY RBHA at the time of admission for all TPL. Mercy RBHA reviews for members with TPL coverage in an acute hospital to match the TPL authorization and to confirm that proactive discharge planning is in place. Providers are required to notify Mercy RBHA at the time that the TPL has denied and to appeal all decisions if they believe the member needs further inpatient treatment. Mercy RBHA will review for continued stay determinations based on clinical information provided and medical care criteria that assess the need for the continued stay. If approved, Mercy RBHA will assign a next review date based on the member's specific condition not to exceed 7 days. Providers receive notification of next review date and are responsible for requesting further stay and providing clinical information on the scheduled review date.

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Child/Adolescent Behavioral Health Inpatient Facility prior authorization request with TPL

When a clinical team has identified a request for behavioral health inpatient facilities for a member that has a TPL, they will submit a BHIF prior authorization request at the same time and assist the parent or guardian with contacting the TPL to request prior authorization. Mercy RBHA will match the primary insurance authorization and review to ensure that coordination of care and proactive discharge planning is in place. Providers are required to notify Mercy RBHA at the time that the TPL has denied and to appeal all decisions if they believe the member needs further inpatient treatment. Mercy RBHA will review for continued stay determinations based on clinical information provided and medical care criteria that assess the need for the continued stay. If approved Mercy RBHA will assign a next review date based on the member's specific condition not to exceed 30 days. Providers receive notification of next review date and are responsible for requesting further stay and providing clinical information on the scheduled review date.

12.06 - Requirements for Certification of Need (CON) and Recertification of Need (RON)

A CON is a certification made by a physician that inpatient or behavioral health inpatient facility services are or were needed at the time of the member's admission. A CON is not an authorization tool designed to approve or deny an inpatient service but rather it is a federally required attestation by a physician that inpatient services are or were needed at the time of the member's admission. The decision to authorize a service that requires prior authorization is determined through the application of admission and continued stay authorization criteria.

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

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

A Recertification of Need (RON) is a re-certification made by a physician, nurse practitioner, or physician assistant that inpatient services are still needed for a member. A RON must be completed at least every 60 days for a member who is receiving services in an inpatient facility. An exception to the 60-day timeframe exists for inpatient services provided to members under the age of 21. The treatment plan (individual plan of care) for members 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.

The following documentation is needed to satisfy the requirements of a CON and RON and is maintained in the members' medical record:

- Proper treatment of the member's behavioral health condition requires services on an inpatient basis under the direction of a physician.
- The service can reasonably be expected to improve the member's condition or prevent further regression so that the service will no longer be needed;
- Outpatient resources available in the community do not meet the treatment needs of

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- the member; and
- CONs, a dated signature by a physician; and
- RONS, a dated signature by a physician, nurse practitioner, or physician assistant.

Additional CON requirements include:

- If a member becomes eligible for Title XIX or Title XXI services while receiving inpatient services, the CON must be completed and kept in the member's record.
- For members under the age of 21 receiving inpatient psychiatric services: Federal rules set forth additional requirements for completing CONs when member 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 member'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 members who are admitted and then become Title XIX or Title XXI eligible while at the facility, the team responsible for the treatment plan must complete the CON. The CON must cover any period of time for which claims for payment are made.
- Compliance with federal requirements related to the Certification of Need (CON) and Recertification of Need (RON) for Mercy RBHA authorized services including hospitals and behavioral health inpatient facilities is mandatory. The facilities will be required to complete a CON for each admission and keep the CON in the member's record.
- Physical Health Inpatient providers are required to document the above information in the medical chart.

12.07 – Discharge Planning

Mercy RBHA has developed and implemented a discharge planning process to address the post-discharge clinical and social needs of the member upon discharge. Discharge planning should take into consideration a member's unique needs and supports and involve key stakeholders such as other agencies involved with the member such as guardians, the Office of Human Rights (OHR), the Department of Children Services (DCS), the Department of Developmental Disabilities (DDD) or acute health plan care managers. As a best practice, proactively planning for discharge allows for member continuity of care by utilizing needs assessment at admission and staging discharge plans as the

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member progresses to being discharge-ready. Proactive discharge planning provides for best practice in care needs evaluation between the member, the facility, and Mercy RBHA with the goal of preventing readmission within thirty (30) days of hospital health discharge. The process is initiated by the provider utilizing a qualified healthcare professional as soon as possible before, upon, or immediately after admission and updated periodically during the inpatient admission to ensure accurate determination of continuing care needs. The discharge plan must be appropriately documented in the member's medical record and must be completed before discharge occurs.

Mercy RBHA must ensure that its subcontracted providers have a process that includes:

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

Coordination of care involving effective communication of the eligible member's treatment plan and medical history across the various outpatient providers to ensure that the member receives medically necessary services that are both timely and safe after discharge. This includes:

- Access to nursing services and therapies.
- Coordination with the member's outpatient clinical team to explore interventions to address the member's needs, such as care management, disease management, placement options, and community support services.
- Access to prescribed discharge medications.
- Coordination of care with the acute care plan, when applicable.
- Post-discharge follow up contact to assess the progress of the discharge plan according to the member's assessed clinical (physical health care) and social needs.

A discharge plan must be documented in the member's medical record.

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12.08 - Medical Necessity Criteria

To support prior and continued authorization decisions, Mercy RBHA uses nationally recognized evidence based criteria, which are applied based on the needs of individual members and characteristics of the local delivery system. Criteria is reviewed annually and approved by the Medical Management/Utilization Management Committee.

If MCG Guidelines indicate "current role remains uncertain" for the requested service, the next criteria in the hierarchy or other nationally accepted guidelines, should be consulted and applied.

For prior or continued authorization of outpatient or inpatient behavioral and physical health services, Mercy RBHA applies:

- Criteria require by AHCCCS and by the applicable state or federal regulatory agency.
- Applicable AHCCCS Medical Policy Manual (AMPM) or MCG Guidelines as the primary decision support for most medical diagnoses and conditions.
- American Society of Addiction Medicine (ASAM)
- Other nationally accepted guidelines

For services in a Behavioral Health Inpatient Facility for members under the age of 21, the following criteria will be used by Mercy RBHA and behavioral health providers:

- Prior to denials for a Behavioral Health Inpatient Facility, Mercy RBHA Medical Directors or designees will talk with the treating psychiatrist/ psychiatric nurse practitioner most familiar with the member 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 Mercy RBHA's 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, Mercy RBHA will 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, when these services will be available, and what specific behaviors will be addressed by these services. It is also expected that the

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alternative treatment plan will include what crisis situations can be anticipated and how the crisis will be addressed. Please refer to:

- Admission to Behavioral Health Hospital Facility or Behavioral Health Inpatient Facility Authorization Criteria; and
- Continued Behavioral Health Hospital Facility or Behavioral Health Inpatient Facility Authorization Criteria.

To obtain additional information on how to access or obtain practice guidelines and coverage criteria for authorization decisions, please contact Mercy RBHA Member Services at 800-564-5465.

Alternative Placement not Available upon Discharge

If a member receiving inpatient services no longer requires services on an inpatient basis under the direction of a physician, but services suitable to meet the member's behavioral health needs are not available or the member cannot return to the member'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 Mercy RBHA upon request.

12.09 - Coverage and Payment of Emergency Services

The following conditions apply with respect to coverage and payment of emergency behavioral health services for members 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 Mercy RBHA;
 - The provider is registered with AHCCCS for this service.
- Payment must not be denied when:
 - Mercy RBHA or behavioral health provider instructs a member to seek emergency behavioral health services;
 - A member 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 member (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;

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- Mercy RBHA may not refuse to cover emergency behavioral health services based on the failure of a provider to notify Mercy RBHA of a member's screening and treatment within 3 days of presentation for emergency services.
- A member 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 member; and
- The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and such determination is binding Mercy RBHA.

The following conditions apply with respect to coverage and payment of post-stabilization care services for a member who was received emergency medical or psychiatric hospitalization who is Title XIX or Title XXI eligible. Mercy RBHA is responsible for post-stabilization services and 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 Mercy RBHA for the following situations:

- Post-stabilization care services that were pre-authorized by Mercy RBHA;
- Post-stabilization care services that were not pre-authorized by Mercy RBHA or because Mercy 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
- Mercy RBHA and the treating physician cannot reach agreement concerning the member's care and a Mercy RBHA physician is not available for consultation. In this situation, Mercy 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:
 - Mercy RBHA physician with privileges at the treating hospital assumes responsibility for the member's care;
 - Mercy RBHA physician assumes responsibility for the member's care through transfer;
 - Mercy RBHA and the treating physician reach an agreement concerning the

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- member's care; or
- The member is discharged.

12.10 - Newborn Notification Process

Providers must fax a newborn notification to Mercy RBHA's dedicated fax number at 844-525-2223. Mercy RBHA will report newborn information to AHCCCS and in turn will fax back the newborn AHCCCS ID number to the provider.

Well Newborn:

- No authorization is required for vaginal delivery (2 days).
- No authorization is required for cesarean section delivery (4 days).

Sick Newborn:

- Providers will need to contact the Newborn's health plan for authorization.

12.11 - Technology

Mercy RBHA will ensure review and adoption of new technologies and/or adoption of new uses to existing technologies utilizing evidence-based research and guidelines. Adoption of evidence based research and guidelines include a meta-analysis of related peer reviewed literature.

Providers may initiate a request for coverage of new approved technologies including the usage of new applications for established technologies by submitting the proposal in writing to the Mercy RBHA Medical Director for review. The proposal must include (at a minimum):

- Medical necessity criteria;
- Documentation supporting medical necessity;
- A cost analysis for the new technology; and
- Peer reviewed literature indicating the efficacy of the new technology or the modification in usage of the existing technology.

Mercy RBHA shall participate in the review of new approved technologies, including the usage of new applications for established technologies through the Mercy RBHA Pharmacy and Therapeutics Committee and the Medical Management Committee.

Mercy RBHA shall review requests and inform the requestor and member of the decision to provide the technology in a timely manner. When the request is accompanied with a service authorization request, the decision for coverage must be completed in a timely manner - within 3 business days for an expedited request, 14 days for a standard request, with an extension of up to 14 additional days if the extension is in the best interest of the member. Discussion reflecting consideration of a new approved technology, including the usage of a new application for

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established technology and Mercy RBHA's determination of coverage shall be documented in the Pharmacy and Therapeutics Committee meeting minutes and the Medical Management Committee meeting minutes.

Mercy RBHA will notify AHCCCS of its decision to cover a new approved technology, including the usage of new applications for established technology within 30 days of reaching that determination.

Consideration for systemic implementation of the coverage of the technology will be prioritized for consideration by AHCCCS based on trends and the meta-analysis of peer reviewed literature.

12.12 – Pre-Admission Screening and Resident Review (PASRR)

The PASRR screening consists of a two-stage identification and evaluation process and is conducted to assure appropriate placement and treatment for those identified with Serious Mental Illness (SMI) and/or Mental Retardation (MR).

- PASRR Level I screenings are used to determine whether the member has any diagnosis or other presenting evidence that suggests the potential presence of SMI and/or MR.
- PASRR Level II evaluations are used to confirm whether the member indeed has SMI and/or MR. If the member is determined to have SMI and/or MR, this stage of the evaluation process determines whether the member requires the level of services in a Nursing Facility (NF) and/or specialized services (inpatient/hospital psychiatric treatment).

Medicaid certified NFs must provide PASRR Level I screening, or verify that screening has been conducted, in order to identify SMI and/or ID prior to initial admission of members to a nursing facility bed that is Medicaid certified or dually certified for Medicaid/Medicare.

PASRR LEVEL 1

Screening

See [Arizona Pre-Admission Screening and Resident Review \(PASRR\) Level I Screening Document](#).

PASRR Level I screenings can be conducted by the following professionals:

- Hospital discharge planners;
- Nurses;
- Social workers; or

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- Other NF staff that have been trained to conduct the Level I PASRR screening and make Level II PASRR referrals.

ALTCS PAS assessors or care managers may conduct Level I PASRR screenings, but it is the ultimate responsibility of the facility where the member is located to ensure that the Level I and Level II PASRR is completed prior to the member being admitted into the receiving NF.

A PASRR Level I screening is not required for readmission of members who were hospitalized and are returning to the NF, or for inter-facility transfers from another NF, if there has not been a significant change in their mental condition. The PASRR Level I screening form and PASRR Level II evaluation must accompany the readmitted or transferred member.

A PASRR Level I screening is required if a member is being admitted to a NF for a convalescent period, or respite care, not to exceed 30 days. If later it is determined that the admission will last longer than 30 days, a new PASRR Level I screening is required. The PASRR Level II evaluation must be done within 40 calendar days of the admission date.

Review

Upon completion of a PASRR Level I screening, documents are forwarded to the PASRR Coordinator within the AHCCCS Bureau of Quality Management Operations. If necessary, referrals for a PASRR Level II evaluation to determine if a member has a SMI diagnosis (See [Covered Behavioral Health Services Guide, Reference Table B4 – ICD-10 Diagnosis Codes Effective 6/15/2016](#)) (These are forwarded to the AHCCCS Office of the Medical Director.)

Alternatively, referrals for a PASRR Level II evaluation is forwarded to the Arizona Department of Economic Security/Division of Developmental Disabilities (ADES/DDD) PASRR Coordinator to determine if a member has Intellectual Disability (formerly known as mental retardation). For dually diagnosed members (both SMI and MR), referrals for a PASRR Level II evaluation are forwarded to both ADES/DDD and AHCCCS.

When a PASRR Level I screening is received by Mercy RBHA, the PASRR Coordinator reviews it and, if needed, consults with the Mercy RBHA Medical Director or designee (must be a Board-eligible or Board-certified psychiatrist and have an unrestricted, active license to practice medicine in Arizona) to determine if a PASRR Level II evaluation is necessary. If it is determined that a PASRR Level II evaluation should be conducted, the PASRR coordinator must:

- Forward copies of the PASRR Level I screening and any other documentation to AHCCCS; and
- Send a letter to the member/legal representative that contains notification of the requirement to undergo a Level II PASRR evaluation.

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PASRR LEVEL II

Evaluations

Mercy RBHA must develop an administrative process for conducting PASRR Level II evaluations and must ensure that:

- If a member is awaiting discharge from a hospital, the evaluation should be completed within 3 working days and all PASRR Level II evaluations must be completed within 5 working days of receipt of the PASRR Level I screening; and
- The criteria used to make the decision about appropriate placement are not affected by the availability of placement alternatives.

Criteria

The PASRR Level II evaluation includes the following criteria:

- The evaluation report must include the components of the [Level II PASRR Psychiatric Evaluation](#);
- The evaluation must be performed by a physician who is a Board-eligible or Board-certified psychiatrist and has an unrestricted, active license to practice medicine in Arizona;
- The evaluation can only be performed by a psychiatrist who is independent of and not directly responsible for any aspect of the care or treatment of the member being evaluated;
- The evaluation and notices must be adapted to the cultural background, language, ethnic origin, and means of communication used by the individual being evaluated;
- The evaluation must involve the individual being evaluated, the individual's legal representative, if one has been designated under state law, and the individual's family, if available and if the individual or the legal representative agrees to family participation;
- Evaluators may use relevant evaluative data, obtained prior to initiation of preadmission screening or resident reviews, if the data are considered valid and accurate and reflect the current functional status of the individual. However, in the case of individualized evaluations, to supplement and verify the currency and accuracy of existing data, the State's PASRR program may need to gather additional information necessary to assess proper placement and treatment.
- The evaluation report must include the [Pre-Admission Screening and](#)

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[Resident Review \(PASRR\) Invoice](#). (AMPM Exhibit 1220-3).

Review

The Mercy RBHA Medical Director or designee reviews all evaluations and makes final Level II placement determinations prior to the proposed/current placement.

Mercy RBHA must provide copies of the completed PASRR Level II evaluation to the referring agency, Arizona Health Care Cost Containment System, Division of Health Care Management (AHCCCS/DHCM) PASRR Coordinator, facility, primary care provider, and person/legal representative.

Cease Process and Documentation

If at any time in the PASRR process it is determined that the person does not have a SMI, or has a principal/primary diagnosis identified as an exemption in the Level I screening, the evaluator must cease the PASRR process of screening and evaluation and document such activity.

SMI Determination

Mercy RBHA reviews each person determined to have a SMI on an annual basis, or when a significant change in the resident's physical or mental condition has been noted in order to ensure the continued appropriateness of nursing home level of care and the provision of appropriate behavioral health services.

Reporting

Mercy RBHA shall report monthly to AHCCCS concerning the number and disposition of residents:

- not requiring nursing facility services, but requiring specialized services for SMI.
- residents not requiring nursing facility services or specialized services for SMI.
- any appeals activities and dispositions of appeal cases.

Discharge

Per **42 C.F.R. 483.118(b) (1 and 2)**, MERCY RBHA will work with the facility to arrange for the safe and orderly discharge of the resident. The facility, in accordance with **42 C.F.R. 483.12(a)** will prepare and orient the resident for discharge.

Per **42 C.F.R. 483.118 (c) (i-iv)**, Mercy RBHA will work with the facility to provide an alternative disposition plan for any resident who requires specialized services and who have continuously resided in a nursing facility for at least 30 months prior to the determination as defined in **42 C.F.R. 483.120**. Mercy RBHA, in consultation with the resident's family or legal

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representative and caregivers, offer the resident the choice of remaining in the facility or of receiving services in an alternative appropriate setting.

Recommendations

The [Level II PASRR Psychiatric Evaluation](#) includes the recommendations of services for lesser intensity by the evaluating Psychiatrist as per **42 C.F.R.483.120, 128(h) (i) (4 and 5)**.

The Mercy RBHA Medical Director or designee (must be a Board-eligible or Board- certified psychiatrist and have an unrestricted, active license to practice medicine in Arizona) will determine if the person requires nursing facility level of care and if specialized services are needed based on individualized evaluations or advance group determinations in accordance with **42 C.F.R. § 483.130-134**. Individual evaluations or advance group determinations may be made for the following circumstances:

- The person has been diagnosed with a terminal illness; or
- Severe physical illness results in a level of impairment so severe that the person could not benefit from specialized services. The person will be reassessed when notified by the nursing facility of an improvement in their condition; and
- Other conditions as listed in **42 C.F.R. § 483.130-134**.

Appeal and Notice Process Specific to PASRR Evaluations

Mercy RBHA shall send a written notice no later than three (3) working days following a PASRR determination in the context of either a preadmission screening or resident review that adversely affects a Title XIX/XXI eligible person.

Mercy RBHA must provide AHCCCS with any requested information, and to make available witnesses necessary to assist with the defense of the decision on appeal, in the event that a person appeals the determination of the PASRR evaluation.

Retention

Mercy RBHA must retain case records for all Level II evaluations for a period of 6 years in accordance with **A.R.S. §12-2297**.

Mercy RBHA must permit authorized AHCCCS personnel reasonable access to files containing the reports received and developed.

Training

Training will be provided to psychiatrists and any other medical professionals that conduct Level II evaluations as needed.

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12.13 - Retrospective Review

Mercy RBHA provides retrospective reviews for the following situations and will be reviewed within 30 days of receipt of medical record:

- Notification of stay after care has been provided due to provider's inability to ascertain member's insurer while services were being rendered.
- When a person becomes Title XIX/XXI eligible after discharge from an Inpatient (Acute or Sub- Acute) facility.

Providers may submit medical records for retrospective review to Mercy RBHA utilizing the following processes:

- SFTP: Mercy Care RBHA SFTP (Secure File Transfer Protocol) which enables registered providers to submit medical records through a secured electronic portal. Providers must register by submitting an **SFTP Connectivity Enrollment Form** to your Provider Relations Specialist/Consultant, or by mailing to:
Mercy Care RBHA
Utilization Management Department
4755 S. 44th Place
Phoenix, AZ 85040
- Claims that have been denied for no authorization are considered a Claims Appeals and must be sent to the following address:
Mercy Care RBHA
Claims Disputes
4500 E. Cotton Center Blvd
Phoenix, AZ 85040
- Grievance & Appeals must be sent to the following address:
Mercy Care RBHA
Grievance & Appeals
4500 E. Cotton Center Blvd
Phoenix, AZ 85040

Retrospective reviews are conducted by qualified staff: nurses; nurse practitioners; physicians; physician assistants; and behavioral health professionals. The reviewer monitors the appropriateness of care that was provided, the progress a recipient made, and the progress toward the recipient's discharge planning using standardized criteria.

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12.14 – Provider-Preventable Conditions

A member's health status may be compromised by hospital conditions and/or medical personnel in ways that are sometimes diagnosed as a "complication". If it is determined that the complication resulted from an Health Care-Acquired Condition (HCAC) or Other Provider-Preventable Condition (OPP), any additional hospital days or other additional charges resulting from the HCAC or OPPC will not be reimbursed.

If it is determined that the HCAC or OPPC was a result of mistake or error by a hospital or medical professional, Mercy RBHA must conduct a quality of care investigation and report the occurrence and results of the investigation to the AHCCCS Clinical Quality Management Unit.

12.15 – Inter-Rater Reliability

Inter-rater reliability testing is completed by all Mercy RBHA staff making medical necessity criteria determinations (including medical directors, nurses, physicians, behavioral health professionals, nurse practitioners, and/ or physician assistants). Medical necessity criteria determinations include, but are not limited to: conducting prior authorization, concurrent review, and retrospective review.

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RBHA CHAPTER 13 – CONTRACT COMPLIANCE

13.00 – Confidentiality

Information and records obtained in the course of providing or paying for covered health services to a member is confidential and is only disclosed according to the provisions of this policy and procedure and applicable federal and state law. In the event of an unauthorized use/disclosure of unsecured PHI, the covered entity responsible for the breach must notify all affected members. Medical records must be maintained in accordance with written protocols pertaining to their care, custody, and control as mandated by Arizona Revised Statutes Title 36, Chapter 32, Article 1 §32-3211.

Overview of Confidentiality

Mercy RBHA employees and subcontracted behavioral health providers must keep medical and behavioral health records and all information contained in those records confidential and cannot disclose such information unless permitted or required by federal or state law. The law regulates two major categories of confidential information:

- Information obtained when providing healthcare services not related to alcohol or drug abuse referral, diagnosis and treatment; and
- Information obtained in the referral, diagnosis and treatment of alcohol or drug abuse.

Protected Health Information Not Related to Alcohol and Drug Treatment

Information obtained when providing healthcare services not related to alcohol and drug abuse treatment is governed by state law and the HIPAA Privacy Rule, **45 C.F.R., Part 164, Subparts A and E, Part 160 Subparts A and B** (“the HIPAA Rule”). The HIPAA Rule permits a covered entity (health plan, healthcare provider, and healthcare clearinghouse) to use or disclose protected health information with or without patient authorization in a variety of circumstances, some of which are required and others that are permissive. Many of the categories of disclosures contain specific words and phrases that are defined in the HIPAA Rule. Careful attention must be paid to the definitions of words and phrases in order to determine whether disclosure is allowed. In addition, the HIPAA Rule may contain exceptions or special rules that apply to a particular disclosure. State law may affect a disclosure. For example, the HIPAA Rule may preempt a state law or a state law may preempt the HIPAA Rule. In addition, a covered entity must, with certain exceptions, make reasonable efforts to limit protected health information to the minimum necessary to accomplish the intended purpose of the disclosure.

In January 2013, The Department of Health and Human Services (Federal Registrar, volume 78, no. 17) substantially expanded the HIPAA Privacy and Security Rule, and affects how Mercy RBHA and health care providers are required to use and disclose protected health information. In addition, Mercy RBHA and health care providers are now required to notify each individual

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whose unsecured PHI has been impermissibly used or disclosed in accordance with the HITECH Acts Security Breach Notification requirement.

Before disclosing protected health information, it is good practice to consult the specific citation to the HIPAA Rule, state law and consult with legal counsel before disclosing an individual's protected health information. See **DISCLOSURE OF INFORMATION NOT RELATED TO ALCOHOL OR SUBSTANCE ABUSE TREATMENT** for more detail regarding the disclosure of behavioral health information not related to alcohol or drug referral, diagnosis or treatment.

Drug and Alcohol Abuse Information

Information regarding treatment for alcohol or drug abuse is afforded special confidentiality by Federal statute and regulation. This includes any information concerning a member's diagnosis or treatment from a federally assisted alcohol or drug abuse program or referral to a federally assisted alcohol or drug abuse program.

General Procedures for All Disclosures

Unless otherwise exempted by state or federal law, all information obtained about a member related to the provision of healthcare services to the member is confidential whether the information is in oral, written, or electronic format.

All records generated as a part of the Mercy RBHA grievance and appeal processes are legal records, not medical records, although they may contain copies of portions of a member's medical record. To the extent these legal records contain personal medical information, Mercy RBHA will redact or de-identify the information to the extent allowed or required by law.

List of Members Accessing Records

Providers are required to maintain a list of every member or organization that inspects a currently or previously enrolled member's records other than the member's clinical team, the uses to be made of that information and the staff member authorizing access. The access list must be placed in the enrolled member's record and must be made available to the enrolled member, their guardian or other designated representative. Providers must retain consent and authorization medical records as prescribed in **A.R.S. §12-2297**.

Disclosure to Clinical Teams

Disclosure of information to members of a clinical team may or may not require an authorization depending upon the type of information to be disclosed and the status of the receiving party. Information concerning diagnosis, treatment or referral for drug or alcohol treatment may only be disclosed to members of a clinical team with patient authorization as prescribed in this chapter. Information not related to drug and alcohol treatment may be disclosed without patient authorization to members of a clinical team for purposes of

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treatment, payment, or healthcare operations, as permitted by and in compliance with **§164.506** of the HIPAA Rule. Unless otherwise prescribed in federal regulations or statute, it is not necessary to obtain a signed release in order to share behavioral health related information with the member's parent/legal guardian, primary care provider (PCP), the member's Health Plan Behavioral Health Coordinator acting on behalf of the PCP or authorized state social service agencies. Disclosure to members of a clinical team for purposes other than treatment, payment, or healthcare operations, as permitted by and in compliance with **§164.506** of the HIPAA Rule requires the authorization of the member or the member's legal guardian or parent as prescribed in this chapter.

Disclosure to Members in Court Proceedings

Disclosure of information to members involved in court proceedings including attorneys, probation or parole officers, guardians' ad litem and court appointed special advocates may or may not require an authorization depending upon the type of information to be disclosed and whether the court has entered orders permitting the disclosure.

Disclosure of Information Not Related to Alcohol and Drug Treatment

Overview of Types of Disclosure

The HIPAA Rule and state law allow a covered entity to disclose protected health information under a variety of conditions. This is a general overview and does not include an entire description of legal requirements for each disclosure. The latter part of this chapter contains a more detailed description of circumstances that are likely to involve the use or disclosure of behavioral health information.

Below is a general description of all required or permissible disclosures:

- To the individual and the individual's health care decision maker;
- To health, mental health and social service providers for treatment, payment or health care operations;
- Incidental to a use or disclosure otherwise permitted or required by **45 C.F.R. Part 164, Subpart E**;
- To a member or entity with a valid authorization;
- Provided the individual is informed in advance and has the opportunity to agree or prohibit the disclosure:
 - For use in facility directories;
 - To members involved in the individual's care and for notification purposes;
 - When required by law;
 - For public health activities;
 - About victims of child abuse, neglect or domestic violence;
 - For health oversight activities;
 - For judicial and administrative proceedings;

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- For law enforcement purposes;
- About deceased members;
- For cadaveric organ, eye or tissue donation purposes;
- For research purposes;
- To avert a serious threat to health or safety or to prevent harm threatened by patients;
- To a human rights committee;
- For purposes related to the Sexually Violent Members program;
- With communicable disease information;
- To personal representatives including agents under a healthcare directive;
- For evaluation or treatment;
- To business associates;
- To the Secretary of Health and Human Services or designee to investigate or determine compliance with the HIPAA Rule;
- For specialized government functions;
- For worker's compensation;
- Under a data use agreement for limited data;
- For fundraising;
- For underwriting and related purposes;
- To the Arizona Center For Disability Law in its capacity as the State Protection and Advocacy Agency;
- To a third party payer to obtain reimbursement;
- To a private entity that accredits a healthcare provider;
- To the legal representative of a healthcare entity in possession of the record for the purpose of securing legal advice;
- To a member or entity as otherwise required by state or federal law;
- To a member or entity permitted by the federal regulations on alcohol and drug abuse treatment (**42 C.F.R. Part 2**);
- To a member or entity to conduct utilization review, peer review and quality assurance pursuant to **Section 36-441, 36-445, 36-2402 or 36-2917**;
- To a member maintaining health statistics for public health purposes as authorized by law; and
- To a grand jury as directed by subpoena.

Disclosure of Behavioral Health Information

Below is a description of the circumstances in which behavioral health information is likely to be required or permitted to be disclosed:

- Disclosure to an individual or the individual's health care decision maker;
- A covered entity is required to disclose information in a designated record set to an individual when requested unless contraindicated. Contraindicated means that access is reasonably likely to endanger the life or physical safety of the patient or another

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member (**A.R.S. §36-507(3); 45 C.F.R. §164.524**); A covered entity should read and carefully apply the provisions in **45 C.F.R. §164.524** before disclosing protected health information in a designated record set to an individual.

- An individual has a right of access to his or her designated record set, except for psychotherapy notes and information compiled for pending litigation (**45 C.F.R. §164.524(a)(1)** and Section 13405(e) of the HITECH Act). Under certain conditions a covered entity may deny an individual access to the medical record without providing the individual an opportunity for review (**45 C.F.R. §164.524(a) (2)**). Under other conditions, a covered entity may deny an individual access to the medical record and must provide the individual with an opportunity for review (**45 C.F.R. §164.524(a) (3)**). A covered entity must follow certain requirements for a review when access to the medical record is denied (**45 C.F.R. §164.524(a) (4)**).
- An individual must be permitted to request access or inspect or obtain a copy of his or her medical record (**45 C.F.R. §164.524(b) (1)**). A covered entity is required to act upon an individual's request in a timely manner (**45 C.F.R. §164.524(b) (2)**).
- An individual may inspect and be provided with one free copy per year of his or her own medical record, unless access has been denied.
- A covered entity must follow certain requirements for providing access, the form of access and the time and manner of access (**45 C.F.R. §164.524(c)**).
- A covered entity is required to make other information available in the record when access is denied, must follow other requirements when making a denial of access, must inform an individual of where medical records are maintained and must follow certain procedures when an individual requests a review when access is denied (**45 C.F.R. §164.524(d)**).
- A covered entity is required to maintain documentation related to an individual's access to the medical record (**45 C.F.R. §164.524(e)**).

Disclosure with Individual's or Individual's Authorization or Individual's Health Care Decision Maker

The HIPAA Rule allows information to be disclosed with an individual's written authorization.

For all uses and disclosures that are not permitted by the HIPAA Rule, patient authorization is required (**45 C.F.R. §164.502(a) (1) (iv)**); and **164.508**). An authorization must contain all of the elements in **45 C.F.R. §164.508**.

A copy of the authorization must be provided to the individual. The authorization must be written in plain language and must contain the following elements:

- A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion;
- The name or other specific identification of the member(s), or class of members,

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- authorized to make the requested use or disclosure;
- The name or other specific identification of the member(s), or class of members, to whom the covered entity may make the requested use or disclosure;
- A description of each purpose of the requested use or disclosure. The statement “at the request of the individual” is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose;
- An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure. The statement “end of the research study”. “none”, or similar language is sufficient if the authorization is for a use or disclosure of protected health information for research, including for the creation and maintenance of a research database or research repository; and
- Signature of the individual and date. If the authorization is signed by a personal representative of the individual, a description of the representative’s authority to act for the individual must also be provided.

In addition to the core elements, the authorization must contain statements adequate to place the individual on notice of all of the following:

- The individual’s right to revoke the authorization in writing, and either:
 - The exceptions to the right to revoke and a description of how the individual may revoke the authorization; or
 - A reference to the covered entity’s notice of privacy practices if the notice of privacy practices tells the individual how to revoke the authorization.
- The ability or inability to condition treatment, payment, enrollment or eligibility for benefits on the authorization, by stating either:
 - The covered entity may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs the authorization when the prohibition on conditioning of authorizations in **45 C.F.R. § 164.508 (b)(4)** applies; or
 - The consequences to the individual of a refusal to sign the authorization when, in accordance with **45 C.F.R. § 164.508 (b) (4)**, the covered entity can condition treatment, enrollment in the health plan or eligibility for benefits on failure to obtain such authorization.
- The potential for information disclosed pursuant to the authorization to be subject to re-disclosure by the member.

Disclosure to Health, Mental Health and Social Service Providers

Disclosure is permitted without patient authorization to health, mental health and social service providers involved in caring for or providing services to the member for treatment, payment or healthcare operations as defined in the HIPAA Rule. These disclosures are typically made to

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primary care physicians, psychiatrists, psychologists, social workers (including the Arizona Department of Economic Security (DES) and DES Division of Developmental Disabilities (DDD) or other behavioral health professionals. Particular attention must be paid to **45 C.F.R. §164.506(c)** and the definitions of treatment, payment and healthcare operations to determine the scope of disclosure. For example, a covered entity is allowed to disclose protected health information for its own treatment, payment or healthcare operations (**45 C.F.R. § 164.506(c) (1)**). A covered entity may disclose for treatment activities of a healthcare provider including providers not covered under the HIPAA Rule (**45 C.F.R. § 164.506(c) (2)**).

A covered entity may disclose to both covered and non-covered healthcare providers for payment activities (**45 C.F.R. § 164.506(c) (3)**). A covered entity may disclose to another covered entity for the healthcare operations activities of the receiving entity if each entity has or had a direct treatment relationship with the individual and the disclosure is for certain specified purposes in the definition of healthcare operations (**45 C.F.R. § 164.506(c)(4)**).

If the disclosure is not for treatment, payment, or healthcare operations or required by law, patient authorization is required.

The HIPAA Rule does not modify a covered entity's obligation under **A.R.S. §13-3620** to report child abuse and neglect to the DES Department of Child Safety (DCS) or disclose a child's medical records to DCS for investigation of child abuse cases.

Similarly, a covered entity may have an obligation to report adult abuse and neglect to DES Adult Protective Services (APS). See **A.R.S. §46-454**. The HIPAA Rule imposes other requirements in addition to those contained in **A.R.S. §46-454**, primarily that the individual be notified of the making of the report or a determination by the reporting member that it is not in the individual's best interest to be notified (**45 C.F.R. §164.512(c)**).

Disclosure to Other Members

A covered entity may disclose protected health information without authorization to other members including family members actively participating in the patient's care, treatment or supervision. Prior to releasing information, an agency or non-agency treating professional or that member's designee must have a verbal discussion with the member to determine whether the member objects to the disclosure. If the member objects, the information cannot be disclosed. If the member does not object, or the member lacks capacity to object, the treating professional must perform an evaluation to determine whether disclosure is in that member's best interests. A decision to disclose or withhold information is subject to review pursuant to **A.R.S. §36-517.01**.

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An agency or non-agency treating professional may only release information relating to the member's diagnosis, prognosis, need for hospitalization, anticipated length of stay, discharge plan, medication, medication side effects and short-term and long-term treatment goals (**A.R.S. § 36-509(7)**).

The HIPAA Rule imposes additional requirements when disclosing protected health information to other members including family members. A covered entity may disclose to a family member or other relative the protected health information directly relevant to the member's involvement with the individual's care or payment related to the individual's health care. If the individual is present for a use or disclosure and has the capacity to make health care decisions, the covered entity may use or disclose the protected health information if it obtains the individual's agreement, provides the individual with the opportunity to object to the disclosure and the individual does not express an objection. If the individual is not present, or the opportunity to agree or object to the use or disclosure cannot practicably be provided because of the individual's incapacity or an emergency circumstance, the covered entity may, in the exercise of professional judgment, determine whether the disclosure is in the best interests of the individual and, if so, disclose only the protected health information that is directly relevant to the member's involvement with the individual's health care (**45 C.F.R. §164.510(b)**).

Disclosure to Agent under Healthcare Directive

A covered entity may treat an agent appointed under a healthcare directive as a personal representative of the individual (**45 C.F.R. §164.502(g)**). Examples of agents appointed to act on an individual's behalf include an agent under a health care power of attorney (**A.R.S. §36-3221 et seq.**); surrogate decision makers (**A.R.S. §36-323**); and an agent under a mental health care power of attorney (**A.R.S. §36-3281**).

Disclosure to a Personal Representative

Unemancipated Minors: A covered entity may disclose protected health information to a personal representative, including the personal representative of an unemancipated minor, unless one or more of the exceptions described in **45 C.F.R. §164.502(g)(3)(i)** or **164.502(g)(5)** applies. See **45 C.F.R. §164.502(g) (1)**.

- The general rule is that if state law, including case law, requires or permits a parent, guardian or other member acting *in loco parentis* to obtain protected health information, then a covered entity may disclose the protected health information (See **45 C.F.R. §164.502(g)(3)(ii)(A)**).
- Similarly, if state law, including case law, prohibits a parent, guardian or other member acting *in loco parentis* from obtaining protected health information, then a covered entity may not disclose the protected health information (**45 C.F.R. §164.502(g)(3)(ii)(B)**).
- When state law, including case law, is silent on whether protected health information

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can be disclosed to a parent, guardian or other member acting *in loco parentis*, a covered entity may provide or deny access under **45 C.F.R. §164.524** to a parent, guardian or other member acting *in loco parentis* if the action is consistent with State or other applicable law, provided that such decision must be made by a licensed healthcare professional, in the exercise of professional judgment (**45 C.F.R. § 164.502(g)(3)(ii)(C)**).

Adults and Emancipated Minors: If under applicable law, a member has authority to act on behalf of an individual who is an adult or an emancipated minor in making decisions related to health care, a covered entity must treat such members as a personal representative with respect to protected health information relevant to such personal representation (**45 C.F.R. §164.502(g) (2)**). Simply stated, if there is a state law that permits the personal representative to obtain the adult or emancipated minor's protected health information, the covered entity may disclose it. A covered entity may withhold protected health information if one or more of the exceptions in **45 C.F.R. §164.502(g) (5)** applies.

Deceased Members: If under applicable law, an executor, administrator or other member has authority to act on behalf of a deceased individual or of the individual's estate, a covered entity must treat such members as a personal representative with respect to protected health information relevant to the personal representation (**45 C.F.R. §164.502(g)(4)**). A covered entity may withhold protected health information if one or more of the exceptions in **45 C.F.R. §164.502(g) (5)** applies. **A.R.S. §§ 12-2294 (D)** provides certain members with authority to act on behalf of a deceased member.

Disclosure for Court Ordered Evaluation or Treatment

An agency in which a member is receiving court ordered evaluation or treatment is required to immediately notify the member's guardian or agent or, if none, a member of the member's family that the member is being treated in the agency (**A.R.S. §36-504(B)**). The agency shall disclose any further information only after the treating professional or that member's designee interviews the member undergoing treatment or evaluation to determine whether the member objects to the disclosure and whether the disclosure is in the member's best interests. A decision to disclose or withhold information is subject to review pursuant to section **A.R.S. §36-517.01**.

If the individual or the individual's guardian makes the request for review, the reviewing official must apply the standard in **45 C.F.R. §164.524(a) (3)**. If a family member makes the request for review, the reviewing official must apply the "best interest" standard in **A.R.S. §36-517.01**.

The reviewer's decision may be appealed to the superior court (**A.R.S. §36-517.01(B)**). The agency or non-agency treating professional must not disclose any treatment information during the period an appeal may be filed or is pending.

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Disclosure for Health Oversight Activities

A covered entity may disclose protected health information without patient authorization to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions or other activities necessary for appropriate oversight of entities subject to government regulatory programs for which health information is necessary for determining compliance with program standards (**45 C.F.R. §164.512(d)**).

Disclosure for Judicial and Administrative Proceedings Including Court Ordered Disclosures

A covered entity may disclose protected health information without patient authorization in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal, provided that the covered entity discloses only the protected health information expressly authorized by the order (**45 C.F.R. §164.512(e)**). In addition, a covered entity may disclose information in response to a subpoena, discovery request or other lawful process without a court order if the covered entity receives satisfactory assurances that the requesting party has made reasonable efforts to provide notice to the individual or has made reasonable efforts to secure a qualified protective order; see **45 C.F.R. §164.512(e) (1) (iii), (iv) and (v)** for what constitutes satisfactory assurances.

Disclosure to Members Doing Research

A covered entity may disclose protected health information to members doing research without patient authorization provided it meets the de-identification standards of **45 C.F.R. §164.514(b)**. If the covered entity wants to disclose protected health information that is not de-identified, patient authorization is required or an Institutional Review Board or a privacy board in accordance with the provisions of **45 C.F.R. §164.512(i) (1) (i)** can waive it.

Disclosure to Prevent Harm Threatened by Patients

Mental health providers have a duty to protect others against the harmful conduct of a patient (**A.R.S. §36-517.02**). When a patient poses a serious danger of violence to another member, the provider has a duty to exercise reasonable care to protect the foreseeable victim of the danger (***Little v. All Phoenix South Community Mental Health Center, Inc.*, 186 Ariz. 97, 919 P.2d 1368 (1996)**). A covered entity may, consistent with applicable law and standards of ethical conduct, use or disclose protected health information without patient authorization if the covered entity, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a member or the public and is to a member or members reasonably able to prevent or lessen the threat, including the target of the threat, or is necessary for law enforcement authorities to identify or apprehend an individual (**See 45 C.F.R. §164.512(j)(1)(ii); 164.512(f)(2) and (3)** for rules that apply for disclosures made to law enforcement; see **45 C.F.R. §164.512(j)(4)** for what constitutes a good faith belief).

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Disclosures to Human Rights Committees

Protected health information may be disclosed to a human rights committee without patient authorization provided personally identifiable information is redacted or de-identified from the record (**A.R.S. §36-509(10)**) and **41-3804**). In redacting personally identifiable information, a covered entity must comply with the HIPAA Rule de-identification standards in **45 C.F.R. § 164.514(b)** and not state law. If a human rights committee wants non-redacted identifiable health information for official purposes, it must first demonstrate to Mercy RBHA that the information is necessary to perform a function that is related to the oversight of the behavioral health system, and in that case, a covered entity may disclose protected health information to the human rights committee in its capacity as a health oversight agency (**45 C.F.R. §164.512(d) (1)**).

Disclosure to the Arizona Department of Corrections

Protected health information may be disclosed without patient authorization to the state department of corrections in cases where prisoners confined to the state prison are patients in the state hospital on authorized transfers either by voluntary admission or by order of the court (**A.R.S. §36-509(5)**). The HIPAA Rule limits disclosure to correctional institutions to certain categories of information that are contained in **45 C.F.R. §164.512(k) (5)**.

Disclosure to Governmental Agency or Law Enforcement to Secure Return of Patient

Protected health information may be disclosed to governmental or law enforcement agencies if necessary to secure the return of a patient who is on unauthorized absence from any agency where the patient was undergoing court ordered evaluation or treatment. According to **A.R.S. §36-509 (6) (A)**, a covered entity may disclose limited information without patient authorization to law enforcement to secure the return of a missing member (**45 C.F.R. §164.512(f) (2) (i)**). In addition, a covered entity is permitted limited disclosure to governmental agencies to prevent or lessen a serious and imminent threat to the health or safety of a member or the public (**45 C.F.R. §164.512(j)**).

Disclosure to Sexually Violent Members (SVP) Program

Protected health information may be disclosed to a governmental agency or a competent professional, as defined in **A.R.S. §36-3701**, in order to comply with the SVP Program (**A.R.S., Title 36, Chapter 37; A.R.S. §36-509(9)**).

A "competent professional" is a member, who may be a psychologist or psychiatrist, is approved by the Superior Court and is familiar with the state's sexually violent member's statutes and sexual offender treatment programs. A competent professional is either statutorily required or may be ordered by the court to perform an examination of a member involved in the sexually violent members program and must be given reasonable access to the member in

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order to conduct the examination and must share access to all relevant medical and psychological records, test data, test results and reports (**A.R.S. §36-3701(2)**).

In most cases, the disclosure of protected health information to a competent professional or made in connection with the sexually violent members program is required by law or ordered by the court. In either case, disclosure under the HIPAA Rule without patient authorization is permitted. See **45 C.F.R. §164.512(a)** (disclosure permitted when required by law) and **45 C.F.R. §164.512(e)** (disclosure permitted when ordered by the court). If the disclosure is not required by law/ordered by the court or is to a governmental agency other than the sexually violent members program, the covered entity may have the authority to disclose if the protected health information is for treatment, payment or health care operations. See **45 C.F.R. §164.506(c)** to determine rules for disclosure for treatment, payment or healthcare operations.

Disclosure of Communicable Disease Information

A.R.S. §36-661 et seq. includes a number of provisions that address the disclosure of communicable disease information. The general rule is that a member who obtains communicable disease related information in the course of providing a health service or pursuant to a release of communicable disease related information must not disclose or be compelled to disclose that information (**A.R.S. § 36-664(A)**). Certain exceptions for disclosure are permitted to:

- The individual or the individual's health care decision maker;
- AHCCCS or a local health department for the purpose of notifying a Good Samaritan;
- An agent or employee of a health facility or a healthcare provider;
- A health facility or a healthcare provider;
- A federal, state or local health officer;
- Government agencies authorized by law to receive communicable disease information;
- Members authorized pursuant to a court order;
- The DES for adoption purposes;
- The Industrial Commission;
- The Arizona Department of Health Services to conduct inspections;
- Insurance entities; and
- A private entity that accredits a healthcare facility or a healthcare provider.

A.R.S. §36-664 also addresses issues with respect to the following:

- Disclosures to the Department of Health Services or local health departments are also permissible under certain circumstances:
 - Authorizations;
 - Re-disclosures;
 - Disclosures for supervision, monitoring and accreditation;
 - Listing information in death reports;

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- Reports to the Department; and
 - Applicability to insurance entities.
- An authorization for the release of communicable disease related the protected member must sign information or, if the protected member lacks capacity to consent, the member's health care decision maker (**A.R.S. §36-664(F)**). If an authorization for the release of communicable disease information is not signed, the information cannot be disclosed. An authorization must be dated and must specify to whom disclosure is authorized, the purpose for disclosure and the time period during which the authorization is effective. A general authorization for the release of medical or other information, including communicable disease related information, is not an authorization for the release of HIV-related information unless the authorization specifically indicates its purpose as authorization for the release of HIV-related information and complies with the requirements of **A.R.S. §36-664(F)**.
- The HIPAA Rule does not preempt state law with respect to disclosures of communicable disease information; however, it may impose additional requirements depending upon the type, nature and scope of disclosure. It is advisable to consult with the HIPAA Compliance Officer and/or legal counsel prior to disclosure of communicable disease information.
- For example, if a disclosure of communicable disease information is made pursuant to an authorization, the disclosure must be accompanied by a statement in writing which warns that the information is from confidential records which are protected by state law that prohibits further disclosure of the information without the specific written consent of the member to whom it pertains or as otherwise permitted by law. **A.R.S. §36-664(H)** affords greater privacy protection than **45 C.F.R. §164.508(c) (2) (ii)**, which requires the authorization to contain a statement to place the individual on notice of the potential for re-disclosure by the member and thus, is no longer protected. Therefore, any authorization for protected health information that includes communicable disease information must contain the statement that re-disclosure of that information is prohibited.

Disclosure to Business Associates

The HIPAA Rule allows a covered entity to disclose protected health information to a business associate if the covered entity obtains satisfactory assurances that the business associate will safeguard the information in accordance with **45 C.F.R. §164.502(e)** and the HITECH Act.

See the definition of "business associate" in **45 C.F.R. § 160.103**. Also see **45 C.F.R. §164.504(e)** and **Section 13404** of the HITECH Act for requirements related to the documentation of satisfactory assurances through a written contract or other written agreement or arrangement.

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Disclosure to the Arizona Center for Disability Law, Acting in its Capacity as the State Protection and Advocacy Agency Pursuant to 42 U.S.C. § 10805

Disclosure is allowed when:

- An enrolled member is mentally or physically unable to consent to a release of confidential information, and the member has no legal guardian or other legal representative authorized to provide consent; and
- A complaint has been received by the Center or the Center asserts that the Center has probable cause to believe that the enrolled member has been abused or neglected.

Disclosure to Third Party Payers

Disclosure is permitted to a third party payer to obtain reimbursement for health care, mental health care or behavioral health care provided to a patient (**A.R.S. §36-509(13)**).

Disclosure to Accreditation Organization

Disclosure is permissible to a private entity that accredits a healthcare provider and with whom the healthcare provider has an agreement that requires the agency to protect the confidentiality of patient information (**A.R.S. §36-509(14)**).

Disclosure of Alcohol and Drug Information

Mercy RBHA and subcontracted providers that provide drug and alcohol screening, diagnosis or treatment services that are federally assisted alcohol and drug programs must ensure compliance with all provisions contained in the Federal statutes and regulations referenced in this chapter.

Mercy RBHA and subcontracted providers must notify members seeking and/or receiving alcohol or drug abuse services of the existence of the federal confidentiality law and regulations and provide each member with a written summary of the confidentiality provisions. The notice and summary must be provided at admission or as soon as deemed clinically appropriate by the member responsible for clinical oversight of the member.

Mercy RBHA and subcontracted providers may require enrolled members to carry identification cards while the member is on the premises of an agency. A subcontracted provider may not require enrolled members to carry cards or any other form of identification when off the subcontractor's premises that will identify the member as a member of drug or alcohol services.

Mercy RBHA and subcontracted providers may not acknowledge that a currently or previously enrolled member is receiving or has received alcohol or drug abuse services without the enrolled member's authorization.

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Mercy RBHA and subcontracted providers must respond to any request for a disclosure of the records of a currently or previously enrolled member that is not permissible under this policy or federal regulations in a way that will not reveal that an identified individual has been, or is being diagnosed or treated for alcohol or drug abuse.

Release of information concerning diagnosis, treatment or referral from an alcohol or drug abuse program must be made only as follows:

- The currently or previously enrolled member or their guardian authorizes the release of information. In this case, authorization must be documented on an authorization form which has not expired or been revoked by the patient. The proper authorization form must be in writing and must contain each of the following specified items:
 - Mercy RBHA or subcontracted provider must advise the member or guardian of the special protection given to such information by federal law.
 - Authorization must be documented on an authorization form that has not expired or been revoked by the patient. The proper authorization form must be in writing and must contain each of the following specified items:
 - The name or general designation of the program making the disclosure;
 - The name of the individual or organization that will receive the disclosure;
 - The name of the member who is the subject of the disclosure;
 - The purpose or need for the disclosure;
 - How much and what kind of information will be disclosed;
 - A statement that the member may revoke the authorization at any time, except to the extent that the program has already acted in reliance on it;
 - The date, event or condition upon which the authorization expires, if not revoked before;
 - The signature of the member or guardian; and
 - The date on which the authorization is signed.

Re-Disclosure

Any disclosure, whether written or oral made with the member's authorization as provided above must be accompanied by the following written statement: "This information has been disclosed to you from records protected by federal confidentiality rules (**42 C.F.R. part 2**). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the member to whom it pertains or as otherwise permitted by **42 C.F.R. Part 2**. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

If the member is a minor, authorization must be given by both the minor and his or her parent or legal guardian.

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If the member is deceased, authorization may be given by:

- A court appointed executor, administrator or other personal representative; or
- If no such appointments have been made, by the member's spouse; or
- If there is no spouse, by any responsible member of the member's family.

Circumstances Where No Authorization Required

Authorization is not required under the following circumstances:

- **Medical Emergencies:** Information may be disclosed to medical personnel who need the information to treat a condition which poses an immediate threat to the health of any individual, not necessarily the currently or previously enrolled member, and which requires immediate medical intervention. The disclosure must be documented in the member's medical record and must include the name of the medical member to whom disclosure is made and his or her affiliation with any healthcare facility, name of the member making the disclosure, date and time of the disclosure and the nature of the emergency. After emergency treatment is provided, written confirmation of the emergency must be secured from the requesting entity.
- **Research Activities:** Information may be disclosed for the purpose of conducting scientific research according to the provisions of **42 C.F.R. §2.5**.
- **Audit and Evaluation Activities:** Information may be disclosed for the purposes of audit and evaluation activities according to the provisions of **42 C.F.R. §2.53**.
- **Qualified Service Organizations:** Information may be provided to a qualified service organization when needed by the qualified service organization to provide services to a currently or previously enrolled member.
- **Internal Agency Communications:** The staff of an agency providing alcohol and drug abuse services may disclose information regarding an enrolled member to other staff within the agency, or to the part of the organization having direct administrative control over the agency, when needed to perform duties related to the provision of alcohol or drug abuse diagnosis, treatment, or referral for treatment to a member. For example, an organization that provides several types of services might have an administrative office that has direct administrative control over each unit or agency that provides direct services.
- Information concerning an enrolled member that does not include any information about the enrolled member's receipt of alcohol or drug abuse diagnosis, treatment or referral for treatment is not restricted under this chapter. For example, information concerning an enrolled member's receipt of medication for a psychiatric condition, unrelated to the member's substance abuse, could be released as provided in *Disclosure of Information Not Related to Alcohol and Drug Treatment* of this chapter.
- **Court-ordered disclosures:** A state or federal court may issue an order that authorizes an agency to make a disclosure of identifying information that would otherwise be

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prohibited. A subpoena, search warrant or arrest warrant is not sufficient standing alone, to require or permit an agency to make a disclosure.

- **Crimes Committed by a Member on an Agency's Premises or Against Program Personnel:** Agencies may disclose information to a law enforcement agency when a member who is receiving treatment in a substance abuse program has committed or threatened to commit a crime on agency premises or against agency personnel. In such instances, the agency must limit the information disclosed to the circumstances of the incident. It may only disclose the member's name, address, last known whereabouts and status as a member receiving services at the agency.
- **Child Abuse and Neglect Reporting:** Federal law does not prohibit compliance with the child abuse reporting requirements contained in **A.R.S. §13-3620**.

A general medical release form or any authorization form that does not contain all of the elements listed in *Disclosure of Alcohol and Drug Information* above is not acceptable.

Security Breach Notification

Mercy RBHA and their subcontracted providers, in the event of an impermissible use/disclosure of unsecured PHI, must provide notification to any and all members affected by the breach in accordance with **Section 13402** of the HITECH Act.

Telemedicine

To ensure confidentiality of telemedicine sessions, providers must do the following when providing services via telemedicine:

- The videoconferencing room door must remain closed at all times;
- If the room is used for other purposes, a sign must be posted on the door, stating that a clinical session is in progress.

Telemedicine should be restricted to dedicated utilities with built in controls to ensure that a third party is unable to intrude on the session or watch the service as it is being provided.

13.01 – Verification of U.S. Citizenship or Lawful Presence for Public Behavioral Health Benefits

Eligibility for Behavioral Health Services Verification

The following individuals are eligible for public behavioral health services:

- Members determined to be eligible for AHCCCS.
- Members not eligible for AHCCCS but determined to have a Serious Mental Illness (SMI) AND can provide documentation of citizenship/lawful presence.

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Eligibility for Behavioral Health Services without Verification

Members not eligible for AHCCCS and NOT determined as SMI but who qualify to receive behavioral health services funded through the Substance Abuse Block Grant (SABG) or the Projects for Assistance in Transition from Homelessness (PATH) Program are eligible to receive services. However, members receiving services funded by SABG or PATH must still be screened for AHCCCS eligibility.

Members presenting for and receiving crisis services are not required to provide documentation of eligibility with AHCCCS nor are they required to verify U.S. citizenship/lawful presence prior to or in order to receive crisis services.

Completing AHCCCS Eligibility Determination Screening

If a member is currently enrolled with AHCCCS and has been assigned to Mercy RBHA, verification of citizenship/lawful presence has already been completed.

For an illustration on how the verification process works, see Flowchart for the **Citizenship/Lawful Presence Verification Process Through Health-e-Arizona PLUS**.

For a list of those members who are exempt from citizenship verification, see **Members Who Are Exempt from Verification of Citizenship during the Prescreening and Application Process**.

Providers must complete an eligibility determination screening for all members who are not identified as being currently enrolled with AHCCCS using the subscriber version of the [Health-e-Arizona PLUS](#). An eligibility screening will be conducted:

- Upon initial request for behavioral health services;
- At least annually thereafter, if still receiving behavioral health services; and
- When significant changes occur in the member's financial status.

Completing Eligibility Screening using Health-e-Arizona PLUS Application for Benefits

The behavioral health provider meets with the member and completes the [Health-e-Arizona PLUS Application for Benefits](#). Once the online application screening has been completed, the Health-e-Arizona PLUS online application tool will indicate:

- If the member is potentially AHCCCS eligible the behavioral health provider must obtain, from the applicant:
 - Documentation of identification and U.S. Citizenship needed if the member claims to be a U.S. citizen (see **Documents Accepted by AHCCCS To Verify Citizenship and Identity**); or
 - Documentation needed of identification and lawful presence in the U.S. if the applicant states that he/she is not a U.S. citizen (see **Non-Citizen/Lawful Presence Verification Documents**).

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- The required U.S. citizenship/lawful presence documents are considered “permanent documents”. Permanent documents include proof of age, Social Security Number, U.S. citizenship or immigration status. These are eligibility factors that typically do not change and only need to be verified once.
- When providers use the online member verification system and enter a member’s social security number, the member’s photo, if available from the Arizona Department of Motor Vehicles (MVD), will be displayed on the AHCCCS eligibility verification screen along with other AHCCCS coverage information. The added photo image assists providers to quickly validate the identity of a member.

If the Health-e-Arizona PLUS online screening tool indicates that the member may not be eligible for AHCCCS, the member may:

- Choose to continue with the AHCCCS eligibility application, in which case the provider must assist the member in completing the application process and obtain the required identification and citizenship/lawful presence documents as indicated above or those required for Non-Title XIX Eligible individuals as outlined in **Requirement to Verify Citizenship For Non-AHCCCS Eligible Individuals (Department of Economic Security)**; or
- Decide to not continue with the online application process, the provider will need to determine if the member is eligible for behavioral health services. The provider must continue to work with the member to obtain the required citizenship/lawful presence documents whenever possible for future eligibility status need.

Required Identification or Citizenship/Lawful Presence Documents

To the extent that it is practicable, contracted providers are expected to assist applicants in obtaining required documentation of identification and citizenship/lawful presence within the timeframes indicated by Health-e-Arizona PLUS (30 days from date of application submission unless otherwise stated).

Members who are unable to provide required documentation of citizenship or lawful presence are not eligible for publicly funded behavioral health services unless they meet the criteria outline in **COMPLETING AHCCCS ELIGIBILITY DETERMINATION SCREENING**. If the member obtains the required documentation at a later date he/she may reapply for AHCCCS eligibility using Health-e-Arizona PLUS (and submit all required documentation with the reapplication, with no waiting period).

Pending the outcome of the AHCCCS eligibility determination, a member may be provided services.

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Document Requirements

Documentation of screening a member through Health-e-Arizona PLUS must be included in the behavioral health medical record, including the application summary and final determination of eligibility status notification printed from the Health-e-Arizona PLUS website.

If a member has refused to participate in the screening process, the documented refusal to participate in the screening and/or application process must be maintained.

13.02 – Reporting Discovered Violations of Immigration Status

Identification of Violations

Mercy RBHA employees and providers must refrain from conduct or actions that could be considered discriminatory behavior. It is unlawful and discriminatory to deny a member healthcare services, exclude members from participation in those services, or otherwise discriminate against any member based on grounds of race, color or national origin.

Mercy RBHA employees and providers must not use any information obtained about a member's citizenship or lawful presence for any purpose other than to provide a member with healthcare contracted services.

Factors that must **NOT** be considered when identifying a potential violation:

- The member's primary language is a language other than English;
- The member was not born in the United States;
- The member does not have a Social Security number;
- The member has a "foreign sounding" name;
- The member cannot provide documentation of citizenship or lawful presence;
- The member is identified by others as a non-citizen; and
- The member has been denied AHCCCS eligibility for lack of proof of citizenship or lawful presence.

If a member applying for healthcare services, in the course of completing the application process or while conducting business with Mercy RBHA or its healthcare providers, **voluntarily reveals** that he or she is not lawfully present in the United States, then and only then, may the Mercy RBHA employee or healthcare provider consider it to be a reportable violation.

Mercy RBHA employees and providers must not require documentation of citizenship or lawful presence from members who are not personally applying for services, but who are acting on behalf of or assisting the applicant (for example, a parent applying on behalf of a child).

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It is **not** the responsibility of Mercy RBHA to verify validity of the submitted documents. Documents must be copied for files and submitted, as requested, to the appropriate agency, as instructed through Health-e-Arizona PLUS.

The criteria for screening and applying for AHCCCS eligibility are not changed by these reporting requirements. Further, the documentation requirements for verifying or establishing citizenship or lawful presence are not changed by this process.

Mercy RBHA employees and healthcare providers must follow the expectations outlined in this policy when identifying and reporting violations. Reporting fraud to the AHCCCS Office of Inspector General is available on the AHCCCS [Report Suspected Fraud or Abuse of the Program](#) web page. The Mercy RBHA employee or provider who identifies a violation must submit an online report to AHCCCS as outlined above.

Documentation Expectations

The Mercy RBHA employee/provider must document in the member's medical record (if the provider) or in the Corporate Compliance Office (if Mercy RBHA) the following:

- Reason for making a report, including how the information was obtained and whether it was an oral or written declaration;
- The date the report was submitted to AHCCCS;
- Any actions taken as a result of the report; and

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RBHA CHAPTER 14 – DEMOGRAPHIC AND OTHER MEMBER DATA**14.00 - Enrollment, Disenrollment and Other Data Submission**

The collection and reporting of accurate, complete and timely enrollment, demographic, clinical, and disenrollment data is of vital importance to the successful operation of the AHCCCS behavioral health service delivery system. It is necessary for behavioral health providers to submit specific data on each member who is actively receiving services from the behavioral health system. As such, it is important for behavioral health provider staff (e.g., intake workers, clinicians, data entry staff) to have a thorough understanding of why it is necessary to collect the data, how it can be used and how to accurately label the data. This policy has particular relevance for those providers that conduct assessments, ongoing service planning, and annual updates.

This data in turn is used by AHCCCS to:

- Monitor and report on outcomes of individuals in active care (e.g., changes in diagnosis), employment/educational status, place of residence, substance use, number of arrests);
- Comply with federal and state funding and/or grant requirements;
- Assist with financial-related activities such as budget development and rate setting;
- Support quality management and utilization management activities; and
- Respond to requests for information.

Enrollment and Disenrollment Transaction Requirements***General Requirements***

- Arizona Health Care Cost Containment System (AHCCCS) enrolled individuals are considered enrolled with the Mercy RBHA at the onset of their eligibility. They are provided an AHCCCS identification card listing their assigned health plan. This assignment is sent daily from AHCCCS to Mercy RBHA.
- For a Non-Title XIX/XXI eligible member to be enrolled, providers must submit an enrollment transaction to Mercy RBHA.
- For a Non-Title XIX/XXI eligible member who receives a covered behavioral health service, he/she must be enrolled effective the date of first contact by a behavioral health provider.
- All members who are served through the AHCCCS behavioral health system must have an active episode of care, even if the member only receives a single service (e.g., crisis intervention, one time face-to-face consultation).
- An episode of care is the start and end of services for a behavioral health need as documented by transmission of a demographic record. For both AHCCCS enrolled and Non-Title XIX/XXI eligible individuals, the individuals must have an open episode of care starting at the first date of service and ending with the last date of service. For members that are designated as SMI, both TXIX and Non-Title XIX, please see **RBHA**

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Chapter 2 – Network Provider Service Delivery Requirements, Section 2.06 – SMI Patient Navigator.

Collection of Enrollment Information

Providers must actively secure any needed information to complete the enrollment for a Non-Title XIX/XXI eligible individual. An enrollment transaction will not be accepted by Mercy RBHA if required data elements are missing.

For AHCCCS enrolled individuals, the eligibility and enrollment information is provided to Mercy RBHA by AHCCCS daily and is available to providers on the Medicaid Web Portal.

Timeframes for Submitting Enrollment and Disenrollment Data for Non-Title XIX/XXI Eligible Individuals

The following data submittal timeframes apply to the enrollment/disenrollment transactions:

- The enrollment transaction must be submitted to Mercy RBHA within 14 days of the first contact with a behavioral health member;
- Dis-enrollments are managed and processed by Mercy RBHA.

Required Events for Submittal of an Enrollment Transaction for Non-Title XIX/XXI Eligible Individual

In addition to submitting an enrollment transaction when beginning services, a transaction must also be submitted when any of the following have changed:

- Name;
- Address;
- Date of birth;
- Gender;
- Marital status; or
- Third party insurance information.

Other considerations for both Non-Title XIX/XXI eligible and AHCCCS enrolled individuals. For an AHCCCS enrolled individual, AHCCCS will notify Mercy RBHA of changes to the above information. That information will be provided from AHCCCS to Mercy RBHA on a daily file.

When a member in an episode of care permanently re-locates from one T/RBHA's geographic area to another T/RBHA's geographic area, an inter-T/RBHA transfer must occur (see **RBHA Chapter 8 – Coordination of Care, Section 8.00 – Inter-T/RBHA Coordination of Care**). The steps that are necessary to facilitate an inter-T/RBHA transfer include the following data submission requirements:

- The home T/RBHA must submit a disenrollment transaction effective on the date of transfer and end the episode of care; and

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- The receiving T/RBHA must submit an enrollment transaction on the date of accepting the member for services and start an episode of care.
- AHCCCS will notify Mercy RBHA when a Mercy RBHA enrolled member is determined eligible for the Arizona Long Term Care System (ALTCs) Elderly and Physically Disabled (EPD) Program. This information will be passed to Mercy RBHA on a daily file.

Technical Assistance with Problems Associated with Electronic Data Submission

At times, technical problems or other issues may occur in the electronic transmission of the data from the behavioral health provider to the receiving T/RBHA. If a provider requires assistance for technical related problems or issues, please contact Mercy RBHA customer service at 800-564-5465.

Demographic and Clinical Data

Collection of Demographic and Clinical Data Timeframes

Demographic and clinical data will be collected starting at the first date of service. For both AHCCCS enrolled and Non-Title XIX/XXI eligible individuals, a demographic record must be collected within 45 days of the first service and submitted to AHCCCS within 55 days. Additional clinical data may be collected at subsequent assessment and service planning meetings with the member (e.g., education, vocation) as well as during periodic and annual updates. Demographic and clinical data recorded in the member's behavioral health medical record must match the demographic file on record with AHCCCS.

Specific Data Elements

Effective October 1, 2018, providers are required to submit demographic data directly to AHCCCS. Information on specific data elements is available at <https://www.azahcccs.gov/PlansProviders/Demographics/>

Use of Demographic and Clinical Data

Behavioral health providers are encouraged to utilize demographic and clinical data to improve operational efficiency and gain information about the members who receive behavioral health services. Providers may consider:

- Utilizing and integrating collected demographic data into the member's assessments,
- Monitoring the nature of the provider's behavioral health member population, and
- Evaluating the effectiveness of the provider's services towards improving the clinical outcomes of members enrolled in the AHCCCS system.

Technical Assistance with Demographic and Clinical Data Submission

At times, technical problems or other issues may occur in the electronic transmission of the clinical and demographic data from the behavioral health provider to the AHCCCS. Any

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questions about the portal or the data fields in the portal should be submitted to DHCM/DAR Information Management/Data Analytics Unit (IMDAU) Manager, Angela Aguayo at Angela.Aguayo@azahcccs.gov and should also include Lori Petre (Lori.Petre@azahcccs.gov), Data Analysis and Research Manager for DHCHM/DAR. If there are any technical issues with the portal contact Customer Support at either ISDCustomerSupport@azahcccs.gov or 602-417-4451.

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RBHA CHAPTER 15 – REPORTING REQUIREMENTS**15.00 – Medical Institution Reporting of Medicare Part D**

Medicare eligible members, including members 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). Medicare Part D coverage includes co-payment requirements of all members. However, Medicare Part D co-payments are waived when a dual eligible member enters a Medicaid funded medical institution for at least a full calendar month. Medical institutions must notify the AHCCCS when a dual eligible member is expected to be in the medical institution for at least a full calendar month to ensure co-payments for Part D is waived. The waiver of co-payments applies for the remainder of the calendar year, regardless of whether the member continues to reside in a medical institution. Given the limited resources of many dual eligible members and to prevent the unnecessary burden of additional co-pay costs, it is imperative that these individuals are identified as soon as possible.

To ensure that dual eligible member's Medicare Part D co-payments are waived when it is expected that dual eligible members will be in a medical institution funded by Medicaid for at least a full calendar month, AHCCCS must be notified immediately upon admittance.

Reporting must be done using the [AHCCCS Notification to Waive Medicare Part D Co-Payments for Members in a Medicaid Funded Medical Institution](#). Providers must not wait until the member has been discharged from the medical institution to submit the form.

Reporting must be done on behalf of the following:

- Members who have Medicare Part “B” only;
- Members who have used their Medicare Part “A” lifetime inpatient benefit; and
- Members who are in continuous placement in a single medical institution or any combination of continuous placements that are identified below.

Medical Institutions

Medical institutions include the following providers:

- Acute Hospital (PT 02)
- Psychiatric Hospital – IMD (PT 71)
- Residential Treatment Center – IMD (PT B1, B3)
- Residential Treatment Center – Non IMD (PT 78, B2)
- Nursing Homes – (PT 22)

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15.01 – Reporting of Seclusion and Restraint

Definitions

Drug Used As a Restraint: Means a pharmacological restraint as used in A.R.S. §36-513 that is not standard treatment for a client's medical condition or behavioral health issue and is administered to:

- Manage the client's behavior in a way that reduces the safety risk to the client or others;
- Temporarily restrict the client's freedom of movement as defined in A.A.C. R-21-101(26).

Mechanical Restraint: Means any device, article or garment attached or adjacent to a client's body that the client cannot easily remove and that restricts the client's freedom of movement or normal access to the client's body, but does not include a device, article, or garment:

- Used for orthopedic or surgical reasons; or
- Necessary to allow a client to heal from a medical condition or to participate in a treatment program for a medical condition as defined in A.A.C. R9-21-101(44).

Personal Restraint: Means the application of physical force without the use of any device for the purpose of restricting the free movement of a client's body, but for a behavioral health agency licensed as a Level 1 RTC or a Level 1 sub-acute agency according to A.A.C. R9-10-102 does not include:

- Holding a client for no longer than 5 minutes;
- Without undue force, in order to calm or comfort the client; or
- Holding a client's hand to escort the client from area to another as defined in A.A.C. R9-21-101(50).

Seclusion: Means the involuntary confinement of a behavioral health member in a room or an area from which the member cannot leave.

Seclusion of Individuals Determined to Have a Serious Mental Illness: Means the restriction of a behavioral health member to a room or area through the use of locked doors or any other device or method which precludes a member from freely exiting the room or area or which a member reasonably believes precludes his/her unrestricted exit. In the case of an inpatient facility, the grounds of the facility, or a ward of the facility does not constitute seclusion. In the case of a community residence, restricting a behavioral health member to the residential site, according to specific provisions of an Individual Service Plan or court order, does not constitute seclusion.

Reporting to Mercy RBHA

Licensed behavioral health facilities and programs, including out-of-state facilities, authorized to use seclusion and restraint must report each occurrence of seclusion and restraint and information on the debriefing subsequent to the occurrence of seclusion or restraint to Mercy RBHA's Quality Management Department within five (5) calendar days of the occurrence. The individual reports must be submitted on the **Policy 962, Attachment A, Seclusion and Restraint Individual Reporting Form**. This form is available on Mercy RBHA's website.

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In the event that a use of seclusion or restraint requires face-to-face monitoring, a report detailing face-to-face monitoring is submitted to Mercy RBHA Quality Management (QM) along with the Policy 962, Attachment A, Seclusion and Restraint Individual Reporting Form. The face-to-face monitoring form must include the requirements as per A.A.C. R9-21-204.

Each subcontracted licensed Level 1 Behavioral Health Inpatient Facility must also report the total number of occurrences of the use of seclusion and restraint for Mercy RBHA members that occurred in the prior month to Mercy RBHA QM the 5th calendar day of the month. If there were no occurrences of seclusion and restraint for Mercy RBHA members during the reporting period, the report should so indicate.

In order to maintain consistency, all seclusion and restraint reported events for Mercy RBHA members are to be submitted via email directly to MMIC@Aetna.com or via fax to 1-855-224-4908.

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RBHA CHAPTER 16 – GRIEVANCE SYSTEM AND MEMBER RIGHTS

16.00 – Title XIX/XXI Notice and Appeal Requirements

General Requirements

“Day” is defined as any calendar day unless otherwise specified.

Computation of Time

Computation of time for appeals begins the day after the act, event or decision and includes the final day of the period. For purposes of computing all timeframes, except for the standard service authorization time frames and extensions thereof, if the final day of the period is a weekend day (Saturday or Sunday) or legal holiday, the period is extended until the end of the next day that is not a weekend day or a legal holiday.

For a standard service authorization with or without an extension, if the final day of the period is a weekend day or legal holiday the period is shortened to the last working day immediately preceding the weekend day or legal holiday.

Computation of time in calendar days includes all calendar days. Computation of time in workdays includes all working days, i.e., non-weekend.

Language and Format Requirements

Mercy RBHA is responsible for sending notice to Title XIX/XXI eligible members must ensure that:

- Notice and written documents related to the appeals process must be available in each prevalent, non-English language spoken within Mercy RBHA’s Geographic Service Area;
- As applicable, Mercy RBHA must provide free oral interpretation services to explain information contained in the notice or as part of the appeal process for all non-English languages;
- Notice and written documents related to the appeals process must be available in alternative formats, such as Braille, large font or enhanced audio and take into consideration the special communication needs of the member; and
- Notice and written documents must be written using an easily understood language and format.

Delivery of Notices

All notices identified herein, including those provided during the appeal process, shall be mailed to the required party at their last known residence or place of business. If it may be unsafe to contact the member at his or her home address, or the member has indicated that he or she does not want to receive mail at home, the alternate methods identified by the individual for communicating notices shall be used.

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Prohibition of Punitive Action

Mercy RBHA or Providers must not take punitive action against a Title XIX/XXI eligible member who decides to exercise their right to appeal. Mercy RBHA does not take punitive action against member or member's legal guardian who requests an expedited resolution to an appeal or who supports a Title XIX/XXI eligible member's appeal.

Notice of Adverse Benefit Determination (NOA)

For Title XIX/XXI covered services, notice must be provided 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;
- The denial, in whole or in part, of payment for a service that is not TXIX/XXI covered; and
- The denial of the Title XIX/XXI member's request to obtain services outside the network.

Complex Case Request

Mercy RBHA is responsible for sending all Notices of Adverse Benefit Determination (NOA) to Title XIX/XXI eligible members. Providers who determine an action may be required shall complete a **Complex Case Review Form**, available on our [Forms Library](#) web page, and forward their request to Mercy RBHA Medical Management at ComplexCase@MercyCareAZ.org for review. Providers must include the following information in their email request:

- Member name, date of birth, AHCCCS ID number, services request, type of request, whether the request is immediate or routine
- Brief description of the reason for the notice with any applicable dates
- The name of the requestor, their title, email address, fax and phone number

Non-Prior Authorized Level of Care

Providers are expected to work with the member regarding clinical and service needs. Providers will review needs of the member and determine if the member/guardian is in agreement regarding services. If a member/guardian is not in agreement, the provider will complete the following actions:

- Utilize staffing to address member needs
- Include the right support system
- Update the ISP to support member outcomes
- If unable to come to agreement, the provider will complete the **Complex Case Review Form**, available on our [Forms Library](#) web page, and submit it to Mercy RBHA at email: ComplexCase@MercyCareAZ.org.

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- Mercy RBHA will respond and coordinate next steps on complex cases that can't be resolved at the provider level. If the provider is unable to support the member in the current setting and needs subject matter expert support from the plan level.
- Mercy RBHA will respond and coordinate next steps in accordance with timeframes below:
 - Within one business day on immediate resolution requests
 - Within 5 business days on routine resolution requests

The provider does not complete an NOA for member closures. The provider needs to follow the guidelines in Provider Manual RBHA **Chapter 2 – Network Provider Service Requirements, Section 2.03, Outreach, Engagement, Re-engagement and Closure** for the following areas:

- Engagement
- Reengagement
- No Show Policy
- Follow-Up After Significant and/or Critical Events
- Ending an Episode of Care for Person in Behavioral Health System
- Further Treatment Declined
- Lack of Contact

Authorized Level of Care

When a provider has determined they are not clinically able to support the member in current setting, they will:

- Outreach the assigned Mercy RBHA Utilization Review staff, and
- Mercy RBHA UM staff reviews the case with the medical director (MDR) to determine if the member still meets medical necessity.
 - If the member still meets medical necessity, the UM team will coordinate a transfer to another provider at the same level of care.
 - If the member no longer meets medical necessity, the MDR completes a denial and Mercy RBHA issues the NOA in accordance with applicable policies.

AHCCCS sends notices to Title XIX/XXI eligible members enrolled with a Tribal RBHA (TRBHA) following:

- The denial or limited authorization of a requested service, including the type or level of service (see **RBHA Chapter 12 – Service Authorizations, Section 12.00 - Securing Services and Prior Authorization**); and
- The reduction, suspension or termination of a previously authorized service. AHCCCS sends notices to Title XIX/XXI eligible members who have been adversely affected by a

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PASRR determination in the context of either a preadmission screening or a resident review.

Communication of Notice to Title XIX/XXI Eligible Members

The use of **Notice of Adverse Benefit Determination**, available on our **Forms Library** web page, is required when providing notice regarding an action concerning a Title XIX/XXI member. (Please see the [AHCCCS Contractors Operations Manual \(ACOM\) 414](#) for guidance in preparation of this form). **Notice of Adverse Benefit Determination**, available on our [Forms Library](#) web page, will include the following:

- The requested service;
- The reason/purpose of that request in layperson terms;
- The action taken or intended to be taken (denial, limited authorization, reduction, suspension or termination) with respect to the service request;
- The effective date of the action;
- The reason for the action, including member specific facts;
- The legal basis for the action;
- Where members can find copies of the legal basis;
- The right to and process for appealing the decision; and
- Legal resources for members for help with appeals, as prescribed by AHCCCS

Delivery of Notices

The **Notice of Adverse Benefit Determination**, available on our **Forms Library** web page, must be mailed to the Title XIX/XXI eligible member and, when applicable, their legal representative or designated representative (e.g., Department of Economic Security/Division of Children, Youth and Families/Department of Child Safety (DCS) Specialist and/or advocate for SMI members requiring special assistance). For Title XIX/XXI eligible members under the age of 18, the **Notice of Adverse Benefit Determination**, available on our **Forms Library** web page, must be mailed to their legal or custodial parent or a government agency with legal custody of the Title XIX/XXI eligible member.

All notices must be mailed to all parties at their last known residence or place of business. If it may be unsafe to contact a member at his or her home address, or the member does not want to receive mail at home, alternate methods identified by the member for communicating notice must be used.

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Notice of Adverse Benefit Determination Timeframes***Notice of Adverse Benefit Determination for Service Authorization Requests***

For service authorization requests, the following timeframes for sending **Notice of Adverse Benefit Determination**, available on our **Forms Library** web page, are in effect (See **RBHA Chapter 12.0 – Service Authorizations, Section 12.00 – Securing Services and Prior Authorization** for required timeframes for decisions regarding prior authorization requests):

- For an authorization decision related to a service requested by or on behalf of a Title XIX/XXI eligible member, Mercy RBHA must send a **Notice of Adverse Benefit Determination**, available on our **Forms Library** web page, within 14 days following the receipt of the member's request;
- For an authorization request in which Mercy RBHA indicates or determines, that the 14 calendar day timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function, the responsible entity must make an expedited authorization decision and send the **Notice of Adverse Benefit Determination**, available on our **Forms Library** web page, as expeditiously as the member's health condition requires, but no later than three working days after receipt of the request for service;
- If the Title XIX/XXI eligible member requests an extension of either timeframe above, the Mercy RBHA must extend the timeframe up to an additional 14 days;
- If Mercy RBHA needs additional information and the extension is in the best interest of the member, Mercy RBHA shall extend the 14-calendar day or the three working day timeframe up to an additional 14 days. If Mercy RBHA extends the timeframe, Mercy RBHA must:
 - Give the Title XIX/XXI eligible member written notice of the reason for the decision to extend the timeframe using [Notice of Extension of Timeframe for Service Authorization Decision Regarding Title XIX/XXI Services](#), and inform the member of the right to file a complaint if the member disagrees with the decision; and
 - Issue and carry out the determination as expeditiously as the member's condition requires and no later than the date the extension expires.
 - For service authorization decisions not reached within the maximum timeframes outlined above, the authorization shall be considered denied on the date that the timeframe expires.
 - Mercy RBHA shall provide the requesting provider written notification of a decision to deny a service authorization.

Notice of Adverse Benefit Determination for Service Termination, Suspension or Reduction

For service terminations, suspensions or reductions, the following timeframes are in effect:

- Mercy RBHA must send the **Notice of Adverse Benefit Determination** at least 10 days before the date of the action with the following exceptions. Mercy RBHA may send the

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Notice of Adverse Benefit Determination no later than the date of the action if:

- Mercy RBHA has factual information confirming the death of a Title XIX/XXI member;
- Mercy RBHA receives a clear written statement signed by the Title XIX/XXI member or their legal representative that the member no longer wants services or gives information to Mercy RBHA that requires termination or reduction of services and indicates that the member understands that this will be the result of supplying that information;
- The Title XIX/XXI member is an inmate of a public institution that does not receive federal financial participation and the member becomes ineligible for TXIX/XXI;
- The Title XIX/XXI member's whereabouts are unknown and the post office returns mail to Mercy RBHA indicating no forwarding address;
- The Title XIX/XXI eligible member's whereabouts are unknown and the post office returns mail, directed to the Title XIX/XXI eligible member, to Mercy RBHA or the provider, indicating no forwarding address;
- Mercy RBHA establishes the fact that the Title XIX/XXI member has been accepted for Medicaid by another state. Mercy RBHA may shorten the period of advance notice to five days before the date of action if Mercy RBHA has verified facts indicating probable fraud; or
- Mercy RBHA may shorten the period of advance notice to five (5) working days before the date of action if there are verified facts indicating probable fraud by the Title XIX/XXI eligible member.

Notice of Adverse Benefit Determination for Denial of Claim for Payment

Mercy RBHA is designated to authorize services and shall send a **Notice of Adverse Benefit Determination** to the Title XIX/XXI eligible member if they deny a claim for payment to the provider for a service that is not Title XIX/XXI covered.

Title XIX/XXI Appeal and State Fair Hearing Process

A Title XIX/XXI eligible member may appeal the following actions with respect to Title XIX/XXI covered services:

- The denial or limited authorization of a requested service, including the type or level of service;
- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service that is not TXIX/XXI covered;
- The failure to provide TXIX/XXI services in a timely manner;
- The failure to act within the timeframes required for standard and expedited resolution of appeals and standard disposition of grievances; and

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- The denial of a TXIX/XXI enrollee's request to obtain services outside the Mercy RBHA's provider network.

A Title XIX/XXI eligible member adversely affected by PASRR determination in the context of either a preadmission screening or a resident review may file an appeal under this policy.

Responsibility

Mercy RBHA is responsible for processing appeals and does not delegate this function to a provider. AHCCCS processes appeals related to actions initiated by a Tribal RBHA or one of their subcontracted providers. Any responsibilities attributed to Mercy RBHA are the responsibility of AHCCCS if the action relates to a Tribal RBHA or one of their subcontracted providers or relates to an appeal concerning a PASRR determination. Information gathered during the appeal process is considered confidential and the member's rights to privacy are protected throughout the process.

The following information is provided to familiarize providers with the Title XIX/XXI appeal process.

Filing an Appeal or Request a State Fair Hearing

The following members or authorized representative(s) may file an appeal or request a State Fair Hearing regarding an action:

- A Title XIX/XXI eligible member;
- A legal or authorized representative, (e.g., Department of Economic Security/Division of Children, Youth and Families/Department of Child Safety (DCS) Specialist and/or advocate for SMI members requiring special assistance), including a provider, acting on behalf of the member, with the member's or legal representative's written consent.
- A Title XIX/XXI eligible member adversely affected by a PASRR determination in the context of either a preadmission screening or a resident review.

Standard and Burden of Proof

The standard of proof on all issues on appeal shall be the preponderance, or the greater weight, of the evidence. The burden of proof for all issues on appeal is on the complainant (individual or agency) appealing.

Denial of Request for Appeal

In the event Mercy RBHA refuses to accept a late appeal or determines that the decision being appealed does not constitute an action subject to these appeal requirements, Mercy RBHA must inform the appellant in writing by sending a Notice of Appeal Resolution.

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Timeframe for Filing Standard Appeal

A Title XIX/XXI eligible member has up to 60 days after the date of the **Notice of Adverse Benefit Determination** to file a standard appeal. The appeal may be filed orally or in writing.

Timeframes for MERCY RBHA to Resolve a Standard Appeal

Mercy RBHA resolves standard appeals and mails written Notice of Appeal Resolution no later than 30 days from the date of receipt of the appeal, unless an extension is in effect.

Extension of Timeframe for Standard Appeal Resolution

If a Title XIX/XXI eligible member requests an extension of the 30-day timeframe, Mercy RBHA will extend the timeframe up to an additional 14 days. If Mercy RBHA needs additional information and the extension is in the best interest of the member, Mercy RBHA may extend the 30-day timeframe up to an additional 14 days.

Expedited Appeal

Mercy RBHA conducts an expedited appeal if:

- Mercy RBHA receives a request for an appeal from a Title XIX/XXI eligible member and determines that taking the time for a standard appeal resolution could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function;
- Mercy RBHA receives a request for an expedited appeal from a Title XIX/XXI eligible member supported with documentation from the provider that taking the time for a standard resolution could seriously jeopardize the member's life or health, or ability to attain, maintain or regain maximum function; or
- Mercy RBHA receives a request for an expedited appeal directly from a provider, with the Title XIX/XXI eligible member's written consent, and the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life or health, or ability to attain, maintain or regain maximum function.

Denial of Expedited Appeal

If Mercy RBHA denies a request for expedited resolution of an appeal from a Title XIX/XXI eligible member, Mercy RBHA will resolve the appeal within the standard resolution timeframe and make reasonable efforts to give the member prompt oral notice of the denial. Within two calendar days, Mercy RBHA follows up with written notice of the denial.

Timeframes for MERCY RBHA to Resolve an Expedited Appeal

Mercy RBHA must resolve expedited appeals and mail a written Notice of Appeal Resolution within 72 hours after the day Mercy RBHA receives the appeal, unless an extension is in effect.

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Extension of Expedited Appeal Resolution Timeframe

If a Title XIX/XXI eligible member requests an extension of the 72-hour timeframe, Mercy RBHA will extend the timeframe up to an additional 14 days. If Mercy RBHA needs additional information and the extension is in the best interest of the member, Mercy RBHA extends the three working day timeframe up to an additional 14 days.

Filing Appeals

All appeals must be submitted in writing, along with substantiating documentation to:

Mercy Care RBHA
Attn: Grievance and Appeals
4755 S. 44th Place
Phoenix, AZ 85040
Fax: 602-351-2300

A member can also file an appeal orally by contacting:

Mercy Care RBHA
Grievance and Appeals
Phone: 602-586-1719
866-386-5794

Requesting a State Fair Hearing

A Title XIX/XXI eligible member, legal or authorized representative may request a State Fair Hearing following Mercy RBHA's resolution of an appeal. The request must be in writing and submitted to:

Mercy Care RBHA
Attn: Grievance and Appeals
4755 S. 44th Place
Phoenix, AZ 85040
Phone: 602-586-1719
866-386-5794
Fax: 602-351-2300

The request must be received by Mercy RBHA no later than 120 days after the date that the member received the Notice of the Appeal Resolution.

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Assistance to Title XIX/XXI Eligible Members in Filing an Appeal and/or Requesting a State Fair Hearing

Mercy RBHA provides reasonable assistance to Title XIX/XXI eligible members in completing forms and other procedural steps. Reasonable assistance includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD (teletypewriter/telecommunications device for the deaf and text telephone) and interpreter capability. Reasonable assistance may be offered by a provider or referred to Mercy RBHA by contacting the Grievance and Appeals department at 602-453-6098 or 866-386-5794.

AHCCCS Timeframe for Resolution of a State Fair Hearing

AHCCCS will send a Notice of State Fair Hearing according to **ARS §41-1092.05** if a timely request for a State Fair Hearing is received.

For appeals resolved pursuant to the standard resolution timeframes, AHCCCS will send an AHCCCS Director's decision to the Title XIX/XXI member no later than 30 days after the date of the Administrative Law Judge's recommended decision and within 90 days after the date that the appeal was filed with Mercy RBHA, not including the number of days the Title XIX/XXI eligible member took to file for a State Fair Hearing, and days for continuances granted at the Title XIX/XXI eligible member's request.

For appeals resolved pursuant to the expedited resolution timeframes, within three working days after the date AHCCCS receives the case file and information from Mercy RBHA concerning an expedited appeal resolution, AHCCCS will send the Title XIX/XXI eligible member the AHCCCS Director's decision which results from the State Fair Hearing and the Administrative Law Judge's Recommended Decision. AHCCCS will make reasonable efforts to provide oral notice of the AHCCCS Director's decision.

Continuation of Services during Appeal or State Fair Hearing Process

For the purposes of this chapter, if the following criteria are met, services shall be continued based on the authorization that was in place prior to the denial, termination, reduction or suspension of services that has been appealed. A Title XIX/XXI eligible member's services can continue during the appeal and State Fair Hearing process, unless continuation of services would jeopardize the health or safety of the member or another member, if:

- The member files the appeal timely*;
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment or the appeal involves a denial if the provider asserts the denial represents a necessary continuation of a previously authorized service;
- The services were ordered by an authorized provider; and
- The member requests continuation of services.

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*Timely filing means filing on or before the later of the following:

- Within 10 days after the date that Mercy RBHA or the subcontracted provider mails or delivers the **Notice of Adverse Benefit Determination**; or
- The effective date of the action as indicated in the **Notice of Adverse Benefit Determination**.

If a member wishes services to continue during appeal, they must request the continuation of services when the appeal is initially filed **and** at the time of requesting a State Fair Hearing.

Discontinuation of Services during Appeal or State Fair Hearing Process

Mercy RBHA is required to continue services until one of the following occurs:

- The Title XIX/XXI eligible member withdraws the appeal;
- The Title XIX/XXI eligible member makes no request for continued benefits within 10 days of the delivery of the Notice of Appeal Resolution or
- The AHCCCS Administration issues a State Fair Hearing decision adverse to the Title XIX/XXI eligible member.

Upheld Appeal

If the AHCCCS Director's decision upholds Mercy RBHA's action, Mercy RBHA may recover the cost of the services furnished to a Title XIX/XXI eligible member while the appeal is pending if the services were furnished solely because of the requirements above.

Overtured Appeal

If Mercy RBHA or AHCCCS Director reverses a decision to deny, limit, or delay authorization of services, and the member received the disputed services while an appeal was pending, Mercy RBHA will process a claim for payment from the provider in a manner consistent with the Mercy RBHA or Director's Decision and applicable statutes, rules, policies, and contract terms. (See **ARS §36-2904**).

Mercy RBHA is required to provide the disputed services that were not provided during the appeal or State fair hearing process no later than 72 hours from the date it overturns the appeal (if appeal is overturned) (438.424(a)).

The provider will have 90 days from the date of the reversed decision to submit a clean claim to Mercy RBHA for payment. For all claims submitted because of a reversed decision, Mercy RBHA is prohibited from denying claims as untimely if they are submitted within the 90-day timeframe.

Mercy RBHA is also prohibited from denying claims submitted by providers because of a reversed decision because the member chose not to request continuation of services during the

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appeals/hearing process. A member's failure to request continuation of services during the appeals/hearing process is not a valid basis to deny the claim.

16.01 – Complaint Resolution

General Requirements

Mercy RBHA develops and provides training to staff responsible for taking complaints. The training plan is submitted to AHCCCS and updated annually on an ad hoc basis as modified. The training must include information regarding the complaint (member grievance) process; appeals, SMI grievances and requests for investigations; and customer service requirements. These trainings must be provided to new employees per **RBHA Chapter 5 – Network Requirements, Section 5.02 - Training Requirements**.

Individuals responsible for taking complaints must provide assistance as indicated by the following:

- An action that is subject to appeal through the Title XIX/XXI Member Appeal process shall be treated as an appeal pursuant to **RBHA Chapter 16 – Grievance System and Member Rights, Section 16.00 - Title XIX/XXI Notice and Appeal Requirements** to establish the earliest possible filing date for the appeal.
- For members determined to have SMI who are appealing a decision regarding SMI eligibility, or Non-TXIX/XXI members appealing the need for a covered service, see **RBHA Chapter 16 – Grievance System and Member Rights, Section 16.03 - Notice and Appeal Requirements (SMI and Non-Title XIX/XXI)**.
- For allegations of rights violations concerning members determined to have SMI see **RBHA Chapter 16 – Grievance System and Member Rights, Section 16.02 - Conduct of Investigations Concerning Members with Serious Mental Illness**.

In the event a complainant is dissatisfied with the resolution to a complaint, the issue(s) in dispute may still be referred to applicable appeal and grievance processes.

Mercy RBHA shall not route or otherwise encourage the direct filing of complaints with AAHCCCS unless the member is AHCCCS or Arizona Long Term Care Services (ALTCs) eligible and enrolled and the complaint is specific or directly relates to the acute care health plan/provider.

There are no time limits placed on filing a complaint.

Mercy RBHA Requirements for Handling Complaints

Responsibilities for resolving complaints pursuant to requirements of this policy shall not be delegated by Mercy RBHA to provider agencies.

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Regardless of who within the organization receives a complaint or whether it is filed orally or in writing, Mercy RBHA shall have a centralized complaint resolution process and designated individuals to whom all complaints shall be referred.

Complaints may be made to Mercy RBHA orally or in writing by members or those seeking covered services, their families or legal guardian(s), authorized representatives, other agencies, or the public.

- For oral complaints: Call Mercy RBHA at 602-586-1841
- To submit a written complaint: Mail the complaint to:
Mercy Care RBHA
Attn: Complaints
4755 S. 44th Place
Phoenix, AZ 85040

All complaints will be acknowledged. Complaints filed orally shall be considered acknowledged at the time of filing. Written complaints must be acknowledged to the complainant within 5 working days of receipt by Mercy RBHA but acted upon in accordance with the urgency of the concern. If verbal acknowledgment is not achieved, a written acknowledgement letter must be sent within the 5-day timeframe. The letter will include a contact name and a phone number.

When information is received, either orally or in writing, that the individual has Limited English Proficiency (LEP) or any other communication need; Mercy RBHA must follow requirements outlined in **MC Chapter 4 – Provider Requirements, Section 4.24 Cultural Competency, Health Literacy and Linguistic Services**, regarding oral interpretation services, translation of written materials, and services for the deaf and hard of hearing:

- For all individuals with LEP, the provider must make available oral interpretation services.
- For individuals needing translation in the prevalent non-English language within the region, Mercy RBHA shall provide a written translation in accordance with the requirements of **MC Chapter 4 – Provider Requirements, Section 4.24 – Cultural Competency, Health Literacy and Linguistic Services**.
- For individuals who need translation in a language that is not considered a prevalent non-English language within the region or who require alternative formats (such as TTY/TTD), Mercy RBHA shall provide oral interpretation of written materials or make alternative communication formats available as indicated.
- Mercy RBHA must follow up on each complaint as expeditiously as the member's condition requires.

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Mercy RBHA must address the identified issues as expeditiously as the member's condition requires. Complaints involving or asserting an immediate need such as a crisis service or assessment, access to medication, or health and safety concerns require immediate follow up.

Mercy RBHA is required to dispose of each complaint and provide oral or written notice to affected parties as quickly as possible and in conformance with confidentiality requirements. If a member requests a written explanation of the complaint resolution, the complaint resolution response must be mailed within 10 days.

Most complaints should be resolved within 10 business days of receipt, but in no case longer than 90 days.

Mercy RBHA is responsible for investigating the complaint and issuing a resolution decision and shall ensure that:

- Individuals who make decisions regarding complaints are not involved in any previous level of review or decision-making; and
- Individuals making decisions about complaints that involve the denial of an expedited resolution of an appeal, or that involve clinical issues must be health care professionals with the appropriate clinical expertise in treating the member's condition.

If the complainant is dissatisfied with Mercy RBHA's resolution of their complaint, Mercy RBHA will advise the complainant that they may contact AHCCCS for additional review. AHCCCS will review the complaint and Mercy RBHA's efforts to resolve the complaint and intervene as indicated by the review.

In the event Mercy RBHA receives a complaint referred from AHCCCS, Mercy RBHA will provide AHCCCS with a written summary that describes the steps taken to resolve the complaint, including the findings, plan for resolution, and any plan for correction, within the timeframe specified by AHCCCS. Mercy RBHA will acknowledge receipt of AHCCCS referred complaints expeditiously and according to the urgency and response timeframe identified by AHCCCS.

Mercy RBHA shall ensure that any specific corrective action or other action directed by AHCCCS is implemented.

Mercy RBHA shall:

- Maintain individual complaint records that include adequate, dated documentation, including but not limited to:
 - Copies of communication generated during the resolution process;
 - Documentation of actions taken to ensure that immediate health care needs are met;

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- Documentation of all steps taken to resolve the concern, including the date the complaint was acknowledged and the date the complainant was notified of the resolution;
- Documentation of the plans for resolution;
- Documentation of plans for correction;
- Evidence that the resolution and any plans for correction have been implemented; and
- Evidence that identified issues are referred for additional follow up as indicated, including referrals to Quality Management, Network Management, Grievance and Appeals, Fraud and Abuse, and/or regulatory agencies.
- For complaints taking greater than 10 business days to resolve from the date of filing, the reason for the delay.
- Maintain a log of all complaints received utilizing a set of fields which documents the following information:
 - The enrollee's first and last name;
 - The date the complaint was made;
 - Title XIX/XXI eligibility status;
 - The source of the complaint;
 - A description of the complaint;
 - Any identified communication need (e.g., need for translator);
 - The outcome reached;
 - The length of time for outcome as indicated in Section G.1.h. of this policy;
 - Covered service category;
 - Treatment setting; and
 - Behavioral health category.
- Routinely review the data collected through the complaint process as part of the Mercy RBHA's quality improvement strategy and network sufficiency review.

16.02 – Conduct of Investigations Concerning Members with Serious Mental Illness***General Requirements***

Members requesting or receiving services shall be notified of their right to file grievances or request investigations according to the requirements set forth in **RBHA Chapter 16 – Grievance System and Member Rights, Section 16.03 - Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI)**. Mercy RBHA and the AzSH, shall respond to grievances and requests for investigations in accordance with this policy and the requirements and timelines contained in **9 A.A.C. 21, Article 4**.

Computation of Time – In computing any period prescribed or allowed by this policy, the period begins the day after the act; event or decision occurs and includes all calendar days and the final day of the period. If the final day of the period is a weekend or legal holiday, the period is

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extended until the end of the next day that is not a weekend or a legal holiday. If the period is not designated as calendar days and is less than 11 days, then intermediate Saturdays, Sundays and legal holidays must not be included in the computation.

Mercy RBHA or the AzSH shall use the unique Docket Number each appeal filed. The file and all correspondence generated shall reference the Docket Number.

Agency Responsible for Resolving Grievances and Requests for Investigation

Grievances involving an alleged rights violation, or a request for investigation involving an allegation that a condition requiring investigation exists, which occurred in an agency operated by Mercy RBHA, one of its subcontracted providers or the AzSH, and which does not involve a client death or an allegation of physical or sexual abuse, shall be filed with and investigated by Mercy RBHA or the AzSH.

Grievances or requests for investigation involving physical or sexual abuse or death that occurred in the AzSH, an agency which is operated by Mercy RBHA or one of its subcontracted providers or because of an action of a member employed by Mercy RBHA or one of its subcontracted providers shall be addressed and investigated by AHCCCS.

Grievances involving a rights violation, or a request for investigation involving an allegation that a condition requiring investigation exists and which occurred in an agency that is not AzSH, Mercy RBHA or one of their subcontracted providers, shall be addressed to the appropriate regulatory division or agency.

The AHCCCS Deputy Director, or designee, the Mercy RBHA Chief Executive Officer (CEO), or the Chief Executive Officer of the AzSH, before whom a grievance or request for investigation is pending, shall immediately take whatever action may be reasonable to protect the health, safety and security of any client, complainant or witness.

Grievance/Request for Investigation Process Timeliness and Method for Filing Grievances

Grievances or a request for investigation must be submitted to AzSH or Mercy RBHA, orally or in writing, no later than 12 months from the date the alleged violation or condition requiring investigation occurred. This timeframe may be extended for good cause as determined by the AHCCCS Deputy Director, or designee, Mercy RBHA Director, or CEO of AzSH, before whom the grievance or request for investigation is pending.

All grievances or requests for investigation must be submitted orally or in writing to:

Mercy Care RBHA
Attn: Grievances and Appeals

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4755 S. 44th Place
Phoenix, AZ 85040
Fax Number: 602-351-2300
Phone: 602-586-1719 or 866-386-5794

Within five days of receipt of a grievance or request for investigation, AzSH or Mercy RBHA must inform the member filing the grievance or request for investigation, in writing, that the grievance or request has been received.

Any employee or contracted staff of AzSH, Mercy RBHA or its subcontracted provider, shall, upon request, assist a member receiving services, or their legal guardian, in making an oral or written grievance or request for investigation or direct the member to an available supervisory or managerial staff who shall assist the member to file a grievance or request for investigation.

All oral grievances and requests for investigation must be accurately reduced to writing by AzSH, Mercy RBHA or its subcontracted provider that receives the grievance or request, on the **Appeal or SMI Grievance Form**, available on our [Forms Library](#) web page.

Preliminary Disposition

Summary Disposition – AzSH, Mercy RBHA Director or designee, may summarily dispose of a grievance or request for investigation, which shall not include any notice or right for further review or hearing, when:

- The alleged violation occurred more than one year prior to the date of request; or
- The grievance request is primarily directed to the level or type of mental health treatment provided and can be fairly and efficiently addressed through the service planning or appeal process as described in **9 A.A.C. 21, Articles 3 and 4**.

Disposition without Investigation

Within seven days of receiving a grievance or request for investigation, AzSH, Mercy RBHA Director or designee, may resolve the matter without conducting a full investigation when:

- The matter involves no material dispute as to the facts alleged in the grievance or request for investigation;
- The allegation is frivolous, meaning that it:
 - Involves conduct that is not within the scope of Title 9, Chapter 21;
 - Is impossible on its face; or
 - Is substantially like conduct alleged in two previous grievances or requests for investigation within the past year and which have been determined to be unsubstantiated.
- Is resolved fairly and efficiently within seven days without a formal investigation.

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Within seven days of the grievance or request for investigation, AzSH, Mercy RBHA's Director or designee, shall prepare a written dated decision which shall explain the essential facts as to why the matter may be appropriately resolved without investigation, and the resolution. The written decision shall contain a notice of appeal rights, and information to request assistance from the AHCCCS Office of Human Rights (OHR) and the State Protection and Advocacy System. Copies of the decision shall be sent to the member filing the grievance or request for investigation and to the AHCCCS OHR for members who need special assistance.

Conducting Investigation of Grievances

AzSH, and Mercy RBHA shall conduct the investigation pursuant to **A.A.C. R9-21-406**.

If an extension of any time frame related to the grievance process in **A.A.C. R9-21, Article 4** is needed; it must be requested and approved in compliance with **A.A.C. R9-21-410(B)**.

Specifically:

- Mercy RBHA investigator or any other official responsible for responding to grievances must address their extension request to Mercy RBHA Director or designee.
- The Mercy RBHA investigator or any other Mercy RBHA official responsible for responding to grievances must address their extension request to the AHCCCS Deputy Director or designee; and
- A Mercy RBHA request for an extension to complete an investigation for grievances remanded pursuant to **A.A.C. R9-21-407(B)(2)** or any other period established by AHCCCS decisions relating to a grievance shall be addressed to the AHCCCS Deputy Director or designee.

Grievance Investigations – Allegations of Rights Violations or Physical Abuse

The investigator shall:

- Interview the member who filed the grievance and the member receiving services who is identified as the subject of the violation or abuse (if different) prior to interviewing the member alleged to be the perpetrator of the rights violation, or physical or sexual abuse.
- If the member who is the subject of the investigation needs special assistance, the investigator shall contact the member's advocate; or if no advocate is assigned, the member shall contact AHCCCS OHR, and request that an advocate be present to assist the member during the interview and any other part of the investigation process.
- Request assistance from the AHCCCS OHR if the member identified as the subject needs assistance to participate in the interview and any other part of the investigation process.
- Prepare a written report that contains at a minimum:
 - A summary for each individual interviewed of information provided by the individual during the interview conducted;
 - A summary of relevant information found in documents reviewed;

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- A summary of any other activities conducted as a part of the investigation;
- A description of any issues identified during the investigation that, while not related to the allegation or condition under investigation, constitutes a rights violation or condition requiring investigation;
- A conclusion, based on the facts obtained in the investigation, that the alleged violation or abuse is either substantiated or not substantiated based on a preponderance of the evidence. The conclusion must describe those findings and/or factors that led to this determination; and
- Recommended actions or a recommendation for required corrective action, if indicated.

Decisions

Within 5 days of receipt of the investigator's report, AHCCCS' Deputy Director or designee, Mercy RBHA Director, or the CEO of AzSH shall review the investigation case record, and the report, and issue a written, dated decision which shall either:

- Accept the report and state a summary of findings and conclusions and any action or corrective action required of AzSH, Mercy RBHA Director, and send copies of the decision, subject to confidentiality requirements provided for in **RBHA Chapter 13 – Contract Compliance, Section 13.00 Confidentiality** to the investigator, AzSH, Mercy RBHA Director, the member who filed the grievance, the member receiving services identified as the subject of the violation or abuse (if different), and the AHCCCS Office of Human Rights for members deemed in need of Special Assistance. The decision sent to the grievant and the member who is the subject of the grievance (if different) shall include a notice of the right to request an administrative appeal of the decision within 30 days from the date of receipt of the decision. The decision must be sent to the grievant by certified mail or by hand- delivery.
- Reject the report for insufficiency of facts and return the matter for further investigation. The investigator must complete the further investigation and deliver a revised report to AHCCCS' Deputy Director or designee, Mercy RBHA Director, or the Chief Executive Officer of the AzSH within 10 days.

Actions

AHCCCS' Deputy Director or designee, Mercy RBHA Director, or the CEO of the AzSH may identify actions to be taken, as indicated above, which may include:

- Identifying training or supervision for or disciplinary action against an individual found to be responsible for a rights violation or condition requiring investigation identified during investigation of a grievance or request for investigation;
- Developing or modifying a mental health agency's practices or protocols;
- Notifying the regulatory entity that licensed or certified an individual according to **A.R.S. Title 32, Chapter 33** of the findings from the investigation; or

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- Imposing sanctions, which may include monetary penalties, according to the terms of a contract, if applicable.

Disagreement with Decision

A grievant or the client who is the subject of the grievance, who disagrees with the final decision of Mercy RBHA or AzSH, may file a request for an administrative appeal within 30 days from the date of their receipt of the Mercy RBHA or AzSH decision. The request for administrative appeal must specify the basis for the disagreement. Failure to specify the basis for the disagreement may result in a summary determination in favor of the Mercy RBHA or AzSH decision.

Administrative Appeal

In the event an administrative appeal is filed, Mercy RBHA or AzSH, shall forward the full investigation case record, which includes all elements in **A.A.C. R9-21-409(D)(1)**, to AHCCCS' Deputy Director or designee through the AHCCCS OGA. The failure of Mercy RBHA or AzSH to forward a full investigation case record that supports the Mercy RBHA or AzSH decision may result in a summary determination in favor of the member filing the administrative appeal. Mercy RBHA or AzSH shall prepare and send with the investigation case record, a memo in which Mercy RBHA states:

- Any objections AzSH or Mercy RBHA has to the timeliness of the administrative appeal;
- AzSH's or Mercy RBHA's response to any information provided in the administrative appeal that was not addressed in the investigation report; and
- AzSH or Mercy RBHA understands the basis for the administrative appeal.

Within 15 days of the filing of the administrative appeal, AHCCCS' Deputy Director or designee, will review the appeal and the investigation case record and may discuss the matter with any of the members involved or convene an informal conference, and prepare a written, dated decision which shall either:

- Accept the investigator's report with respect to the facts as found, and affirm, modify or reject the decision of the agency director with a statement of reasons. The decision, along with a notice of the right to request an administrative hearing within 30 days from the date of receipt of the decision, shall be sent to the appealing party, with copies of the decision provided to the AzSH or Mercy RBHA Director, as indicated; the OHR; and the applicable human rights committee; or
- Reject the investigator's report for insufficiency of facts and remand the matter with instructions to Mercy RBHA or AzSH for further investigation and decision. Mercy RBHA or AzSH shall conduct further investigation and complete a revised report and decision to AHCCCS' Deputy Director or designee within 10 days. Upon receipt of the report and decision, AHCCCS shall render a final decision consistent with the procedures described above; or;

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- Reject Mercy RBHA's decision and remand the matter with instructions to Mercy RBHA or AzSH to conduct an investigation, or to conduct further investigation, issue an initial or revised, decision, and include a notice of the right of the grievant or client who is the subject of the grievance to request an administrative appeal to AHCCCS of the decision within 30 days from the date of receipt of the decision, consistent with the requirements in **A.A.C. R9-21-406, et. seq.**

A grievant or member who is the subject of the grievance who is dissatisfied with the decision of AHCCCS' Deputy Director, or designee may request an administrative hearing before an administrative law judge within 30 days of the date of the decision.

Upon receipt of a request for a hearing, the hearing shall be scheduled and conducted according to the requirements in **A.R.S. §41-1092 et seq.**

After the expiration of the time frames for administrative appeal and administrative hearing as described above, or after the exhaustion of all appeals regarding outcome of the investigation, Mercy RBHA or AzSH Director, or the Deputy Director, or designee of AHCCCS, shall take any corrective action required and add to the record a written, dated report of the action taken. A copy of the report shall be sent to the AHCCCS OHR for members in need of Special Assistance.

Unless an investigation request is made pursuant to **A.A.C. R9-21-403(A)** or **R9-21-403(B)**, investigations into the deaths of members receiving services shall be conducted as described in **RBHA Chapter 15 – Reporting Requirements, Section 15.02 - Reporting of Incidents, Accidents and Deaths.**

Grievance Investigation Records and Tracking System

AHCCCS, AzSH, and Mercy RBHA will maintain records in the following manner:

- All documentation received and mailed related to the grievance and investigation process will be date stamped on the day received;
- AHCCCS, AzSH, and Mercy RBHA will maintain a grievance investigation case record for each case. The record shall include:
 - The docket number assigned;
 - The original grievance/investigation request letter and the **Appeal or SMI Grievance Form**;
 - Copies of all information generated or obtained during the investigation;
 - The investigator's report which will include a description of the grievance issue, documentation of the investigative process, names of all members interviewed, written documentation of the interviews, summary of all documents reviewed, the investigator's findings, conclusions and recommendations; and

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- A copy of the acknowledgment letter, final decision letter and any information/documentation generated by an appeal of the grievance decision;
- AHCCCS, AzSH, and Mercy RBHA will maintain all grievance and investigation files in a secure designated area and retain for at least 5 years;

Other Matters Related to Grievance Process

Pursuant to the applicable statutes, AzSH and Mercy RBHA shall maintain confidentiality and privacy of grievance matters and records at all times.

Notice shall be given to a public official, law enforcement officer, or other member, as required by law, that an incident involving death, abuse, neglect, or threat to a member receiving services has occurred, or that a dangerous condition or event exists.

AzSH or Mercy RBHA shall notify the Deputy Director or designee of AHCCCS when:

- A member receiving services files a complaint with law enforcement alleging criminal conduct against an employee;
- An employee or contracted staff files a complaint with law enforcement alleging criminal conduct against a member receiving services;
- An employee, contracted staff, or member receiving services is charged or convicted of a crime related to a rights violation, physical or sexual abuse, or death of a member receiving services.

16.03 – Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI)

General Requirements for Notice and Appeals

Behavioral health providers must be aware of general requirements guiding notice and appeal rights for the populations covered in this chapter. Behavioral health providers may have direct responsibility for designated functions (i.e., sending notice) as determined by Mercy RBHA and/or may be asked to provide assistance to members who are exercising their right to appeal.

Time Computed

In computing any time prescribed or allowed in this chapter, the period begins the day after the act, event or decision occurs. If the period is 11 days or more, the period must be calculated using calendar days, which means that weekends and legal holidays are counted. If, however, the period is less than 11 days, the period is calculated using working days, in which case, weekends and legal holidays must not be included in the computation. In either case, if the final day of the period is a weekend or legal holiday, the period is extended until the end of the next day that is not a weekend or a legal holiday.

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Language, Format and Comprehensive Clinical Record Requirements

Notice and related forms must be available in each prevalent, non-English language spoken in Mercy RBHA's geographic service area (GSA). As designated by Mercy RBHA, behavioral health providers must provide free oral interpretation services to all members who speak non-English languages for purposes of explaining the appeal process and/or information contained in the notice. Mercy RBHA is responsible for providing oral interpretation services at no cost to the member receiving such services.

Notice and other written documents pertaining to the appeal process must be available in alternative formats, such as Braille, large font or enhanced audio and must take into consideration any special communication needs of the member applying for or receiving behavioral health services. Mercy RBHA is responsible for ensuring the availability of these alternative formats.

The provision of notice must be documented by placing a copy of the notice in the member's comprehensive clinical record.

Delivery of notices and appeal decisions

All notices and appeal decisions must be personally delivered or mailed by certified mail to the required party, at their last known residence or place of business. If it may be unsafe to contact the member at his or her home, or the member has indicated that he or she does not want to receive mail at home, the alternate methods identified by the member for communicating notices must be used.

Notice Requirements for Members with Serious Mental Illness

For actions (see definition) related to Title XIX/XXI covered services, see **RBHA Chapter 16 – Grievance System and Member Rights, Section 16.00 - Title XIX/XXI Notice and Appeal Requirements**.

The following provisions apply to notice requirements for members determined to have a SMI and for members for which an SMI eligibility determination is being considered.

Members who are evaluated for an SMI eligibility determination must receive **the Appeal or SMI Grievance Form**, available on our [Forms Library](#) web page, at the time of determination.

The Notice of Decision and Right to Appeal (for Individuals with a Serious Mental Illness), available on our [Forms Library](#) web page, must be provided to members determined to have a Serious Mental Illness or to members applying for SMI services when:

- Initial eligibility for SMI services is determined. The notice must be sent within 3 days of the eligibility determination;

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- A decision is made regarding fees or waivers;
- The assessment report, service plan or individual treatment and discharge plan is developed, provided or reviewed;
- A decision is made to modify the service plan, or to reduce, suspend or terminate any service that is a covered service funded through Non-Title XIX funds 6F1. In this case, notice must be provided at least 30 days prior to the effective date unless the member consents to the change in writing or a qualified clinician determines that the action is necessary to avoid a serious or immediate threat to the health or safety of the member receiving services or others;
- A decision is made that the member is no longer eligible for SMI services; and
- A Pre-Admission Screening and Resident Review (PASRR) determination in the context of either a preadmission screening or an annual resident review, which adversely affects the member.

Additional Notices

The following additional notices must be provided to members determined to have a Serious Mental Illness or members applying for SMI services:

- The **Notice of Legal Rights for Members with Serious Mental Illness**, available on our [Forms Library](#) web page, must be given at the time of admission to a behavioral health provider agency for evaluation or treatment. The member receiving this notice must acknowledge in writing the receipt of the notice and the behavioral health provider must retain the acknowledgement in the member's comprehensive clinical record. All behavioral health providers must post **Notice of Legal Rights for Members with Serious Mental Illness**, available on our [Forms Library](#) web page, in both English and Spanish, so that it is readily visible to behavioral health members and visitors;
- The **Notice of Discrimination Prohibited**, available on our [Forms Library](#) web page, posted in English and Spanish so that it is readily visible to members visiting the agency, and a copy provided at the time of discharge from the behavioral health provider agency.

Provider Notice Responsibility

Following a decision requiring notice to a behavioral health member, Mercy RBHA will ensure the communication of a notice to the member.

Notice Requirements for Non-Title XIX/XXI/Non-SMI Population

Notice is not required to members who are not eligible for Title XIX/XXI or SMI services under this policy.

¹ Actions or decisions that deny, suspend, reduce, or terminate a member's or member's services or benefits to avoid exceeding the state funding legislatively appropriated for those services or benefits do not require Notice.

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Appeal Requirements

Appeals that are related to Mercy RBHA or one of their contracted behavioral health providers' decisions must be filed with Mercy RBHA.

Title XIX/XXI eligible members applying for or who have been determined to have a SMI and who are appealing an action affecting Title XIX/XXI covered services may elect to use either the Title XIX/XXI appeal process (see **RBHA Chapter 16 – Grievance System and Member Rights, Section 16.0 - Title XIX/XXI Notice and Appeal Requirements**) or the appeal process for members determined to have a SMI described in **RBHA Chapter 16 – Grievance System and Member Rights, Section 16.3 - Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI)**.

Types of Appeal

There are two appeal processes applicable to this section:

- Appeals of members applying for an eligibility determination or who have been determined to have a SMI; and
- Appeals for other covered service related issues.

Filing Members and Entities

The following members and entities may file an appeal:

- An adult applying for or receiving behavioral health services, their legal guardian, guardian ad litem, designated representative or attorney if Special Assistance, or the member meeting Special Assistance needs;
- A legal guardian or parent who is the legal custodian of a member under the age of 18 years;
- A court appointed guardian ad litem or an attorney of a member under the age of 18 years;
- A state or governmental agency that provides behavioral health services through an Interagency Service Agreement/Intergovernmental Agreement (ISA/IGA) with AHCCCS, but which does not have legal custody or control of the member, to the extent specified in the ISA/IGA between the agency and AHCCCS; and
- A provider, acting on the behavioral health member's behalf and with the written authorization of the member.

Timeframes for Appeals

Appeals must be filed orally or in writing with Mercy RBHA when required, within 60 days from the date of the decision being appealed. Late appeals must be accepted upon showing good cause.

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Where to Appeal

- Mercy RBHA
 - Oral Appeal: Call (800) 564-5465
 - Fax Appeal: Fax to (602) 351-2300
 - Written appeal:
 - Mercy Care RBHA
 - Attn: Appeals
 - 4755 S. 44th Place
 - Phoenix, AZ 85040

Appeal Process of Members with Serious Mental Illness

An appeal may be filed concerning one or more of the following:

- Decisions regarding the member's SMI eligibility determination;
- Sufficiency or appropriateness of the assessment;
- Long-term view, service goals, objectives or timelines stated in the Individual Service Plan (ISP) or Inpatient Treatment and Discharge Plan (ITDP);
- Recommended services identified in the assessment report, SP or ITDP;
- Actual services to be provided, as described in the ISP, plan for interim services or ITDP;
- Access to or prompt provision of services;
- Findings of the clinical team about the member's competency, capacity to make decisions, need for guardianship or other protective services or need for Special Assistance;
- Denial of a request for a review of, the outcome of, a modification to or failure to modify, or termination of an SP, ITDP or portion of an ISP or ITDP;
- Application of the procedures and timeframes for developing the ISP or ITDP;
- Implementation of the ISP or ITDP;
- Decision to provide service planning, including the provision of assessment or care management services to a member who is refusing such services, or a decision not to provide such services to the member;
- Decisions regarding a member's fee assessment or the denial of a request for a waiver of fees;
- Denial of payment of a claim;
- Failure of Mercy RBHA to act within the timeframes regarding an appeal; or
- A PASRR determination, in the context of either a preadmission screening or an annual resident review, which adversely affects the member.

Standard Appeal Process

Within 5 working days of receipt of an appeal, Mercy RBHA must inform the appellant in writing that the appeal has been received and of the procedures that will be followed during the appeal.

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In the event Mercy RBHA refuses to accept a late appeal or determines that the issue may not be appealed, Mercy RBHA must inform the appellant in writing that they may, within 10 days of their receipt of Mercy RBHA's decision, request an Administrative Review of the decision with the AHCCCS OGA.

If a timely request for Administrative Review is filed with AHCCCS regarding Mercy RBHA's decision, AHCCCS shall issue a final decision of within 15 days of the request (for members requiring Special Assistance, see **RBHA Chapter 2 – Network Provider Service Delivery Requirements, Section 2.10 – Special Assistance for Members Determined to have a Serious Mental Illness**).

Informal Conference with MERCY RBHA

Within 7 days of receipt of an appeal, Mercy RBHA shall hold an informal conference with the member, guardian, any designated representative, care manager or other representative of the service provider, if appropriate.

Mercy RBHA must schedule the conference at a convenient time and place and inform all participants in writing, two days prior to the conference, of the time, date and location, the ability to participate in the conference by telephone or teleconference, and the appellant's right to be represented by a designated representative of the appellant's choice.

The informal conference shall be chaired by a representative of Mercy RBHA with authority to resolve the issues under appeal, who shall seek to mediate and resolve the issues in dispute.

Mercy RBHA representative shall record a statement of the nature of the appeal, the issues involved, any resolution(s) achieved, the date by which the resolution(s) will be implemented and identify any unresolved issues for further appeal.

If the issues in dispute are resolved to the satisfaction of the member or guardian, if applicable, Mercy RBHA shall issue a dated written notice to all parties, which shall include a statement of the nature of the appeal, the issues involved, the resolution achieved and the date by which the resolution will be implemented.

If the issues in dispute are not resolved to the satisfaction of the member or guardian and the issues in dispute do not relate to the member's eligibility for behavioral health services, the member or guardian shall be informed that the matter will be forwarded for further appeal to AHCCCS for informal conference, and of the procedure for requesting a waiver of the AHCCCS informal conference.

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If the issues in dispute are not resolved to the satisfaction of the member or guardian and the issues in dispute relate to the member's eligibility for SMI services or the member or guardian has requested a waiver of the AHCCCS informal conference in writing, Mercy RBHA shall:

- Provide written notice to the member or guardian of the process to request an administrative hearing.
- Determine at the informal conference whether the member or guardian is requesting Mercy RBHA to request an administrative hearing on behalf of the member or guardian and, if so, file the request with AHCCCS within 3 days of the informal conference.
- For a member who needs special assistance, send a copy of the appeal, results of information conference and notice of administrative hearing to the Office of Human Rights (OHR).
- In the event the member appealing fails to attend the informal conference and fails to notify Mercy RBHA of their inability to attend prior to the scheduled conference, Mercy RBHA shall reschedule the conference. If the member appealing fails to attend the rescheduled conference and fails to notify Mercy RBHA of their inability to attend prior to the rescheduled conference, Mercy RBHA will close the appeal docket and send written notice of the closure to the member appealing.
 - In the event the appellant requests the appeal be re-opened due to not receiving the informal conference notification and/or due to good cause, Mercy RBHA can re-open the appeal and proceed with the informal conference.
- For all appeals unresolved after an informal conference with Mercy RBHA, Mercy RBHA must forward the appeal case record to the AHCCCS OGA within three days from the conclusion of the informal conference.

AHCCCS Informal Conference

Unless the member or guardian waives an informal conference or the issue on appeal relates to eligibility for SMI services, AHCCCS shall hold a second informal conference within 15 days of the notification from Mercy RBHA that the appeal was unresolved.

- At least 5 days prior to the date of the second informal conference, AHCCCS shall notify the participants in writing of the date, time and location of the conference.
- The informal conference shall be chaired by a representative of AHCCCS with authority to resolve the issues under appeal who shall seek to mediate and resolve the issues in dispute.
- The AHCCCS representative shall record a statement of the nature of the appeal, the issues involved, any resolution(s) achieved, the date by which the resolution(s) will be implemented and identify any unresolved issues for further appeal.
- If the issues in dispute are resolved to the satisfaction of the member or guardian, AHCCCS shall issue a dated written notice to all parties, which shall include a statement of the nature of the appeal, the issues involved, the resolution achieved and the date by which the resolution will be implemented.

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- For a member in need of Special Assistance, AHCCCS shall send a copy of the informal conference report to the OHR.
- If the issues in dispute are not resolved to the satisfaction of the member or guardian, AHCCCS shall:
 - Provide written notice to the member or guardian of the process to request an administrative hearing.
 - Determine at the informal conference whether the member or guardian is requesting AHCCCS to request an administrative hearing on behalf of the member or guardian and, if so, file the request within 3 days of the informal conference.
 - For a member who needs Special Assistance, send a copy of the notice to the OHR.
 - In the event the member appealing fails to attend the informal conference and fails to notify AHCCCS of their inability to attend prior to the scheduled conference, AHCCCS may issue a written notice, within 3 working days of the scheduled conference, which contains a description of the decision on the issue under appeal and which advises the appellant of their right to request an Administrative Hearing.
 - In the event the appellant requests the appeal be re-opened due to not receiving the informal conference notification and/or due to good cause, AHCCCS can re-open the appeal and proceed with the informal conference.

Requests for Administrative Hearing

A written request for hearing filed with AHCCCS must contain the following information:

- Case name (name of the applicant or member receiving services, name of the appellant and the docket number);
- The decision being appealed;
- The date of the decision being appealed; and
- The reason for the appeal.

In the event a request for administrative hearing is filed with Mercy RBHA, Mercy RBHA shall ensure that the written request for hearing, appeal case record and all supporting documentation is received by the AHCCCS OGA within 3 days from such date.

Administrative hearings shall be conducted and decided pursuant to **A.R.S. §41-1092 et seq.**

Expedited appeals

A member, or a provider on the member's behalf, may request an expedited appeal for the denial or termination of crisis or emergency services, the denial of admission to or the

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termination of a continuation of inpatient services, if inpatient services are a covered benefit, or for good cause.

Within 1 day of receipt of a request for an expedited appeal, Mercy RBHA must inform the appellant in writing that the appeal has been received and of the time, date and location of the informal conference; or

Issue a written decision stating that the appeal does not meet criteria as an expedited appeal and that the appellant may request an Administrative Review from AHCCCS of this decision within 3 days of the decision. The appeal shall then proceed according to the standard process described in this chapter.

Expedited Informal Conference

Within 2 days of receipt of a written request for an expedited appeal, Mercy RBHA shall hold an informal conference to mediate and resolve the issues in dispute.

AHCCCS Expedited Informal Conference

Within two days of notification from Mercy RBHA, AHCCCS shall hold an informal conference to mediate and resolve the issue in dispute, unless the appellant waives the conference at this level, in which case the appeal shall be forwarded within one day to the AHCCCS Director to schedule an administrative hearing.

Within one day of the informal conference with AHCCCS, if the conference failed to resolve the appeal, the appeal shall be forwarded to the AHCCCS Director to schedule an administrative hearing.

Requests for Administrative Hearing

A written request for hearing filed with AHCCCS must contain the following information:

- Case name (name of the applicant or member receiving services, name of the appellant and the docket number);
- The decision being appealed;
- The date of the decision being appealed; and
- The reason for the appeal.

In the event a request for administrative hearing is filed with Mercy RBHA, Mercy RBHA shall ensure that the written request for hearing, appeal case record and all supporting documentation is received by the AHCCCS OGA within 3 days.

Administrative hearings shall be conducted and decided pursuant to **A.R.S. §41-1092 et seq.**

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Continuation of Services during Appeal Process

For members determined to have a SMI, the member's behavioral health services will continue while an appeal of a modification to or termination of a covered behavioral health service is pending unless:

- A qualified clinician determines the modification or termination is necessary to avoid a serious or immediate threat to the health or safety of the member or another individual; or
- The member or, if applicable, the member's guardian, agrees in writing to the modification or termination.

Appeals for Non-Title XIX/XXI/Non-SMI Population

Based on available funding, a member who is Non-Title XIX/XXI and Non-SMI may file an appeal of a decision that is related to a determination of need for a covered service (e.g., modification to previously authorized services for a non-Title XIX/XXI eligible member). In these circumstances, there is no continuation of services available during the appeal process.

Mercy RBHA in processing the appeal must:

- Inform the appellant in writing within 5 working days of receipt that the appeal has been received and of the procedures that will be followed during the appeal;
- Provide the appellant a reasonable opportunity to present evidence and allegations of fact or law in member and in writing; and
- Provide a written decision no later than 30 days from the day the appeal is received. The decision shall include a summary of the issues involved, the outcome of the appeal, and the basis of the decision. For appeals not resolved wholly in favor of the appellant, Mercy RBHA shall advise the appellant in writing of their right to request an administrative hearing with AHCCCS no later than 30 days from the date of Mercy RBHA's decision, and how to do so.

Requests for Administrative Hearing

A written request for hearing filed with AHCCCS must contain the following information:

- Case name (name of the applicant or member receiving services, name of the appellant and the docket number);
- The decision being appealed;
- The date of the decision being appealed; and
- The reason for the appeal.

In the event a request for administrative hearing is filed with Mercy RBHA, Mercy RBHA shall ensure that the written request for hearing, appeal case record and all supporting documentation is received by AHCCCS OGA within 3 days.

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Behavioral Health Provider Responsibilities

While providers are not directly responsible for the resolution of appeals, they are required to actively participate in the process as follows:

- Provide information deemed to be necessary by Mercy RBHA, AHCCCS or the Office of Administrative Hearings (e.g., documents and other evidence); and
- Cooperate and participate as necessary throughout the appeal process.

Behavioral health providers must be available to assist a member in the filing of an appeal. For members determined to have a SMI, the Office of Human Rights may be available to assist the member in filing as well as resolving the appeal.

Behavioral health providers must not retaliate against any member who files an appeal or interfere with a member's right to file an appeal. Additionally, no punitive action may be taken against a behavioral health provider who supports a member's appeal.

16.04 –Provider Claim Disputes

The provider claim disputes process affords providers the opportunity to challenge a decision by Mercy RBHA that impacts the provider for issues involving:

- A payment of a claim;
- The denial of a claim;
- The recoupment of payment of a claim; and
- The imposition of sanctions.

Providers will initially submit a claim dispute to Mercy RBHA when:

- Challenging a decision of Mercy RBHA; or
- Disputing a claim payment issue for services provided to members enrolled with Mercy RBHA.

Once Mercy RBHA makes a decision regarding a provider claim dispute, the provider may request another review of the decision, referred to as an administrative hearing.

Many times, disagreements between a provider and Mercy RBHA can be resolved through an informal process. Providers are encouraged to try and solve issues at the informal level before initiating the formal provider claim dispute process. However, providers should be aware that the formal process contains very specific timeframes within which to file for a review and/or hearing and resolving issues through an informal process does not suspend or postpone these timeframes.

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The intent of this chapter is to describe the options available to providers to resolve issues and other events related to a decision of Mercy RBHA. The chapter is organized to delineate the process for filing a claim dispute:

- For providers disputing a decision of Mercy RBHA; and
- The process for requesting an administrative hearing in the event a provider does not agree with the claim dispute decision of Mercy RBHA.

Prior to Filing an Initial Claim Dispute

All providers are encouraged to seek informal resolution of a concern by first contacting the appropriate entity responsible for the decision. For concerns regarding claims, it is important for providers to understand why the claim was denied before initiating a claim dispute. Denied claims may be the result of filing errors or missing supporting documentation, such as an explanation of benefits (EOB) or an invoice. Resubmitting claims with the requested information or corrections can result in resolution of the issue and full payment of the claim. To get assistance with the informal resolution of a decision, please contact:

Mercy Care RBHA
4755 S. 44th Place
Phoenix, AZ 85040
Phone: 800-564-5465

General Requirements

Computation of Time - A written claim dispute is considered filed when it is received by Mercy RBHA established by a date stamp or other record of receipt. Providers must use the following methodology in computing any period described in this chapter:

- Computation of time for calendar day begins the day after the act, event or decision and includes all calendar days and the final day of the period.
- If the final day of the period is a weekend or legal holiday, the period is extended until the end of the next day that is not a weekend or a legal holiday.

If an issue is unable to be resolved informally, providers may dispute the decision by filing a written claim dispute. For all provider claim disputes related to decisions of Mercy RBHA, the provider must file the claim dispute with Mercy RBHA at:

Mercy Care RBHA
Attn: Appeals Department
4755 S. 44th Place
Phoenix, AZ 85040

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Mercy RBHA must utilize a unique Docket Number for each claim dispute filed. The Docket Number is established as follows:

- The Mercy RBHA letter code (see **T/RBHA Codes for Docket Numbers** form, available on our [Forms Library](#) web page);
- The date of receipt of the claim dispute using the MMDDYY format;
- The letter code "P" which designates the case as a claim dispute;
- A four-digit sequential number, which begins on January 1 of each year as 0001.

All documentation received during the claim dispute resolution process must be date stamped upon receipt.

All claim dispute case records must be filed in secured locations and retained for five years after the most recent decision has been rendered.

All decisions shall be personally delivered or mailed by certified mail to the party at their last known residence or place of business.

Claim Dispute Log

The Office of Grievance and Appeals database shall maintain the log of all claim disputes initiated under this policy. Mercy RBHA is responsible for entering all information related to the claim dispute resolution process necessary for the accurate and timely maintenance of the log. The log shall contain:

- A unique Docket Number;
- A substantive but concise description of the claim dispute including whether the claim dispute is related to the provision of Title XIX or Title XXI covered services;
- The date the claim dispute was received;
- The nature, date, and outcome of all subsequent decisions, appeals, or other relevant events; and
- A substantive but concise description of the final decision, the action taken to implement the decision and the date the action was taken.

Notification of Right to File Claim Dispute

Mercy RBHA must provide an affected provider a remittance advice that includes provider's right to file a claim dispute and how to do so, upon the payment, denial or recoupment of payment of a claim. Mercy RBHA must notify an affected provider of the right to file a claim dispute and how to do so when a decision is made to impose a sanction.

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Initiate Claim Dispute

It is important for providers to ensure the claim dispute is submitted in writing and contains all required information and is filed within the required timeframes. Failure to do so will result in the denial of the claim dispute.

The notice of claim dispute must specify the statement of the factual and legal basis for the claim dispute and the relief requested. Claim disputes may be denied if the filing party has failed to provide a comprehensive factual or legal basis for the dispute.

Timeframes for Initiating Claim Dispute

The claim dispute must be filed within the following established timeframes:

- Within 60 days of the date of notice advising that a sanction will be imposed, or
- For challenges to the payment, denial or recoupment of a claim, the later of the following:
 - 12 months of the date of delivery of the service;
 - 12 months after the date of eligibility posting; or
 - Within 60 days after the payment or denial of a timely claim submission, or the recoupment of payment, whichever is later.

Claim Disputes of Mercy RBHA Decisions

Within 5 days of receipt of a claim dispute, Mercy RBHA shall send written acknowledgment that the claim dispute has been received, will be reviewed and that a decision will be issued within 30 days of receipt of the claim dispute, absent extension of the timeline.

If Mercy RBHA determines that it was not responsible for the claim dispute, they must immediately forward the claim dispute to the responsible RBHA or to AHCCCS with an explanation of why the claim dispute is being forwarded.

- A copy of the transmittal shall be sent by Mercy RBHA to the party filing the claim dispute.
- The receiving RBHA must ensure that a decision is rendered within 30 days of Mercy RBHA's receipt of the notice of claim dispute, unless an extension has been granted pursuant to 3.g. of this policy.

Mercy RBHA Notice of Decision

Mercy RBHA shall issue a written, dated decision which must be mailed by certified mail to all parties no later than 30 days after the provider files a claim dispute with Mercy RBHA, unless the provider and Mercy RBHA have agreed to a longer period. The Decision must include and describe in detail, the following:

- The nature of the claim dispute;
- The issues involved;

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- Mercy RBHA's decision and the reasons supporting decision, including references to applicable statute, rule, applicable contractual provisions, policy and procedures;
- The provider's right to request a hearing by filing a written request for hearing to AHCCCS no later than 30 days after the date the provider receives Mercy RBHA's decision;
- The provider's right to request an informal settlement conference prior to hearing; and
- If the claim dispute is overturned, the requirement that Mercy RBHA must reprocess and pay the claim(s), with interest, when applicable, in a manner consistent with the decision within 15 business days of the date of the decision.

Extension of Time

To request an extension of the 30-day timeframe, the provider must submit to Mercy RBHA prior to the expiration of the original time limit, a written request including the reasons for the extension and a proposed new timeframe that does not unreasonably postpone final resolution of the matter. A representative of Mercy RBHA may also request an extension. In either case, the provider and Mercy RBHA must agree to the extension in writing. Documentation of the agreement to the extension of time must be maintained in the claim dispute case record.

Requests for Administrative Hearing

If the party filing a claim dispute is dissatisfied with the Mercy RBHA Notice of Decision or if a Notice of Decision is not received within 30 days after the claim dispute is filed, absent an extension of time; a request for an administrative hearing may be filed, in writing, with a request to the AHCCCS Office of Grievance and Appeals.

Timeframes for Requesting an Administrative Hearing

The provider's request for a hearing must be filed in writing and received by AHCCCS no later than 30 calendar days of the date of receipt of the Mercy RBHA Notice of Decision, absent of an extension of time. A written request for hearing is considered filed when received by the AHCCCS Office of Grievance and Appeals established by a date stamp or other record of receipt.

Requirements for a Request for Administrative Hearing

The request for an administrative hearing to AHCCCS must include:

- Provider name, AHCCCS identification Number, address, phone number and the docket number;
- Member's name and AHCCCS identification number;
- The date of receipt of the claim dispute;
- The issue to be determined at the administrative hearing; and
- A summary of Mercy RBHA actions undertaken to resolve the claim dispute and basis of the determination.

PLAN SPECIFIC TERMS

Scheduling of an Administrative Hearing

Pursuant to **A.R.S. §41-1092.03**, upon receipt of a request for hearing, the AHCCCS Office of Grievance and Appeals must request that AHCCCS schedule an administrative hearing pursuant to **A.R.S. §41-1092.05**.

If the AHCCCS or Mercy RBHA decision regarding a claim dispute is reversed through the claim dispute or hearing process, AHCCCS or Mercy RBHA shall reprocess and pay the claim(s) with interest, when applicable, in a manner consistent with the decision within 15 business days of the date of the decision unless a different timeframe is specified.

Administrative Process

The Administrative Hearing Process shall be conducted according to **A.R.S. Title 41, Chapter 6, Article 10**.

Appeal of AHCCCS Director's decisions:

- For Title XIX and Title XXI covered services, an appellant aggrieved by the Director's decision may appeal the decision to AHCCC by filing a written notice of appeal within 30 calendar days of receipt of the decision to:
AHCCCS
Office of Administrative Legal Services
701 E. Jefferson St., MD-620
Phoenix, AZ 85034

Detecting Fraud and Program Abuse

Mercy RBHA tracks, trends and analyzes claim disputes for purposes of detecting fraud and program abuse. Mercy RBHA reports all suspected fraud, waste and/or program abuse involving any Title XIX/XXI funds to the AHCCCS Office of the Inspector General (OIG) within ten (10) business days of discovery.

PLAN SPECIFIC TERMS

SOW CHAPTER 1 – SCOPE OF WORK SUMMARY

1.00 – Scope of Work Summary

In addition to the services that every provider is expected to render within their scope of licensure, certain providers and agencies have entered into contractual agreements to provide special programs and services which are governed by specific Scopes of Work. Your contract will list any such programs within the Schedule and Compensation pages. You may locate and review the requirements of any program through the [Mercy Care Web Portal](#) or the [Mercy Care RBHA Web Portal](#). After logging in you may review these documents under the Provider Documents section.

1.01 – Scopes of Work

Below are the Scopes of Work available for both MCCC and Mercy RBHA:

- Access Point
- ACT with PCP Partnership
- Acute Level 1 Specialized for Children and Adolescents with High Needs
- Adult Family Support Partner
- Adult Inpatient Peer Transition Team
- Adult Jail Transition Team
- Adult MAT PDOA
- Adult MAT
- Adult Outpatient Services
- Adult SMI Clinic
- Alcohol and or Drug Services, Intensive Outpatient Program
- Applied Behavioral Analysis (ABA) for Adult Outpatient Services
- Arizona Behavioral Health Corporation Coordinated Entry Subsidy
- Arizona Behavioral Health Corporation Housing (HUD)
- Arizona Behavioral Health Corporation Scattered Site
- Assertive Community Treatment (ACT)
- Behavioral Health Residential Facility – Adult
- Behavioral Health Residential Facility – Children's
- Behavioral Health Residential Facility Adult Substance Abuse Treatment
- Behavioral Health Residential Facility Basic 24 SMI Adult
- Behavioral Health Residential Facility Co-Occurring SMI Adult
- BH Eating Disorder Residential Facility 24 Hour – Adult
- Birth to Five
- Bride to Permanency
- CASS Partnership

PLAN SPECIFIC TERMS

- CASS Shelter Provider
- Center of Excellent – Family Center
- Child – Adolescent Specialty Provider
- Child Hospital Team
- Child Protective Services Crisis Stabilization Services
- Child Protective Services Rapid Response Children
- Child-Adolescent Youth to Adulthood Transition Team
- Children’s Direct Support Provider “DSP”
- Children’s RTC Level 1 Secure and Non-Secure
- Cognitive Enhancement Therapy
- Community Housing – Housing Provider
- Community Service Agency (CSA)
- Comprehensive Community Health Program (CCHP)
- Cooperative Agreement to Benefit Homeless Individuals (CABHI) Program
- CPR SMI Evaluations
- Crisis Transition Navigator Services
- CRN Crisis Call Center
- DCS Co-location Provider
- Developmental Disabilities Mobile Crisis Team
- Employment Rehabilitation Provider
- Family Psychoeducation
- Family Support Partner Program Adult SMI
- First Episode Center Adult SMI
- First Episode Center Evidence Based Practices Center of Excellence
- First Episode Clinic Qualified Service Provider (QSP)
- Forensic ACT with PCP Partnership
- Forensic Assertive Community Treatment (FACT)
- Generalist Direct Support Provider (MMWIA)
- GMHSU Whole Health Integrated Care
- Home Care Training (HCTC)
- Hospital Rapid Response
- Housing – On-Site Services – Community Living
- Housing – Transition Living Program (TLP)
- Housing Provider
- Housing Temporary Assistance Program
- Information and Referral
- Integrated Health Home – Family Support Services
- Integrated Health Home SOW Exhibit B
- Integrated Health Home

PLAN SPECIFIC TERMS

- Intensive Day Treatment Program (IDTP)
- Level 1 Hospital with Detoxification Unit Freestanding
- Level 1 Hospital with Psychiatric Unit
- Level 1 Residential Treatment Center – Secure and Non-Secure
- MAT Services Center of Excellence
- MAT Services COE
- Medical Assertive Community Treatment (M-ACT)
- Methadone Clinic
- Mobile Crisis Service
- Multi-Systemic Therapy (MST)
- Peer and Family Operated Organization
- Peer Attempt Survivor Skills Group
- Peer Warm Line
- Permanent Supportive Housing – Housing Provider
- Permanent Supportive Housing Services – Service Provider
- Pregnancy Program – Healthy Connections for Moms to Be
- Prevention Provider
- Qualified Service Provider (QSP)
- Start Up Boxes
- Sub-Acute Facilities – Level I with 24 Hour
- Sub-Acute Facilities – Level I Without 24 Hour
- Supported Employment
- Transition-Age Youth Specialty Provider
- Tribal Community Mobile Crisis
- Whole Health Clinic