



**Pascua Yaqui T/RBHA
CENTERED SPIRIT PROGRAM
Policy and Procedure Manual**

Section 3.14 **Securing Services and Prior Authorization**

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I. STATEMENT OF PURPOSE

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

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

Securing Most Centered Sprit Program (CSP) Services:

Most CSP services do not require prior authorization. Based upon the recommendations and decisions of the clinical team (i.e., Child and Family Team or Adult clinical team), any and all covered services that address the needs of the person and family will be secured. During the treatment planning process, the clinical team may use established tools to guide clinical practice and to help determine the types of services and supports that will result in positive outcomes for the person. Clinical teams should make decisions



based on a person's identified needs and should not use these tools as criteria to deny or limit services.

Securing Services that Need Prior Authorization:

Prior authorization is required for certain covered behavioral health services. Behavioral health services requiring prior authorization include:

- Non-Emergency admissions to an inpatient facility;
- Continued stay in an inpatient facility;
- The T/RBHA must develop and make available policies and procedures for all subcontracted providers that include these requirements and all other services that require prior authorization as approved by ADHS/DBHS.

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

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

II. REFERENCES

The following PY/CSP Provider Manual Sections can serve as additional resources for this content area:

[42 CFR 438.10 \(a\)](#)
[42 CFR 438.114](#)
[42 CFR 441](#)
[42 CFR 456](#)
[9 A.A.C 10](#)
[9 A.A.C 34](#)
[R9-22-210](#)
[R9-22-1204](#)
[R9-2122-1205](#)
[R9-31-210](#)



R9-31-1205

[3.9 Intake, Assessment and Service Planning Section](#)

3.16 Medication Formulary

[5.1 Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons Section](#)

[5.2 Member Complaints Section](#)

[5.3 Grievance and Request for Investigation for Persons Determined to have a Serious Mental Illness \(SMI\) Section](#)

[5.5 Notice and Appeal Requirements \(SMI and Non-SMI/Non-Title XIX/XXI\) Section](#)

ADHS and T/RBHA IGA

The following ADHS/DBHS also serves as a resource for this content area:

[Child and Family Team Practice Improvement Protocol](#)

[The Child and Family Team Process Technical Assistance Document](#)

[Adult Clinical Team Practice Improvement Protocol](#)

[The Arizona Vision and 12 Principles](#)

[ADHS/DBHS Policy Clarification Memorandum: Prior Authorization](#)

III. STANDARDS

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

- A. CSP follows all ADHS rules and procedures associated with prior authorization, and CONS and RONS.
- B. CSP has staff available 24 hours a day to receive requests for authorization.

It is important for a behavioral health professional to document enough information in the comprehensive clinical record to validate that the prior authorization request meets all elements of the authorization criteria.

The TRBHA may require prior authorization of behavioral health services other than inpatient services only with the prior written approval of ADHS/DBHS.

A Title XIX eligible person that is receiving services in an inpatient facility who turns age 21 may continue to receive services until the point in time in which services are no longer required or the person turns age 22, whichever comes first.

Prior authorization criteria may not include any one of the following as a sole criteria for denial of services:

- Lack of family involvement;
- Presence or absence of a particular mental health diagnosis; or
- Presence of substance use, abuse or dependence.



IV. PROCEDURES

A. Securing Services that do not require prior authorization

The clinical team is responsible for identifying and securing the service needs of each CSP recipient through the assessment and service planning processes. Rather than identifying pre-determined services, the clinical team should focus on identifying the underlying needs of the CSP recipient, including the type, intensity and frequency of supports needed.

As part of the service planning process, it is the clinical team's responsibility to identify available resources and the most appropriate provider(s) for services. This is done in conjunction with the clinical team including the CSP recipient, family, and natural supports. If the service is available through a contracted provider the person can access the service directly. If the requested service is only available through a non-contracted provider or if the clinical team requests services from a non-contracted provider, the T/RBHA must develop policies and procedures and make them available to providers to designate the T/RBHA representative who is responsible for coordinating and obtaining the requested service as outlined below.

How can services with a non-contracted provider be secured?

Sometimes it may be necessary to secure services through a non-contracted provider in order to provide a needed covered behavioral health service or to fulfill a clinical team's request. The process for securing services through a non-contracted provider is as follows:

- CSP may enter into a single case agreement with a non-contracted provider.
- The CSP Network Coordinator must secure a single case agreement with a non-contracted provider prior to services.

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

What is the purpose of a utilization review process

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

- Detecting over and under utilization of services;
- Defining expected service utilization patterns;
- Facilitating the examination of clinicians and clinical teams that are effectively allocating services; and



- Identifying clinicians and behavioral health providers who could benefit from technical assistance.

B. Accessing services that require prior authorization.

What does prior authorization do?

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

When is prior authorization available?

Emergencies

CSP has providers available 24 hours a day, seven days a week to receive requests for any service that requires prior authorization.

Prior authorization must never be applied in an emergency situation. A retrospective review may be conducted after the person's immediate behavioral health needs have been met. If upon review of the circumstances, the behavioral health service did not meet admission authorization criteria, payment for the service may be denied. The test for appropriateness of the request for emergency services must be whether a prudent layperson, similarly situated, would have requested such services.

What is Certification of Need (CON)?

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

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

For a sample CON form, see [PM Form 3.14.1](#).

Re-certification of Need (RON)

A RON is a re-certification made by a physician, nurse practitioner or physician assistant that inpatient services are still needed for a person. A RON must be completed at least every 60 days for a person who is receiving services in an inpatient facility. An exception to the 60-day timeframe exists for inpatient services provided to persons under



the age of 21. The treatment plan (individual plan of care) for persons under the age of 21 in an inpatient facility must be completed and reviewed every 30 days. The completion and review of the treatment plan in this circumstance meets the requirement for the re-certification of need. For a sample RON form, see [PM Form 3.14.2](#).

Documentation on a CON or Recertification of Need (RON)

The following documentation is needed on a CON and RON:

- Proper treatment of the person's behavioral health condition requires services on an inpatient basis under the direction of a physician;
- The service can reasonably be expected to improve the person's condition or prevent further regression so that the service will no longer be needed;
- Outpatient resources available in the community do not meet the treatment needs of the person; and
- CONs, a dated signature by a physician;
- RONs, a dated signature by a physician, nurse practitioner or physician assistant.

Additional CON requirements

- If a person becomes eligible for Title XIX or Title XXI services while receiving inpatient services, the CON must be completed and submitted to **ADHS/DBHS** prior to the authorization of payment.

- For persons under the age of 21 receiving inpatient psychiatric services:

Federal rules set forth additional requirements for completing CONs when persons under the age of 21 are admitted to, or are receiving services in an inpatient facility. These requirements include the following:

- For an individual who is Title XIX/XXI eligible when admitted, the CON must be completed by the clinical team that is independent of the facility and must include a physician who has knowledge of the person's situation and who is competent in the diagnosis and treatment of mental illness, preferably child psychiatry;
- For emergency admissions, the CON must be completed by the team responsible for the treatment plan within 14 days of admission. **This team is defined in 42 CFR §441.156 as "an interdisciplinary team of physicians and other personnel who are employed by, or provide services to patients in the facility";** and
- For persons who are admitted and then become Title XIX or Title XXI eligible while at the facility, the team responsible for the treatment plan must



complete the CON. The CON must cover any period of time for which claims for payment are made.

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

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

- ADHS/DBHS Admission to Psychiatric Acute Hospital or Sub-Acute Facility Authorization Criteria (see [PM Attachment 3.14.1](#)); and
- ADHS/DBHS Continued Psychiatric Acute Hospital or Sub-Acute Facility Authorization Criteria (see [PM Attachment 3.14.2](#)).

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

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

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

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

What happens if a person is ready to leave an Inpatient Facility but an alternative placement is not available?



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

C. Prior authorization procedures for behavioral health providers contracted by a T/RBHA

What services must be prior authorized?

Services requiring prior authorization are:

- Non-emergency admission to and continued stay in an inpatient facility; and
- Admission and continued stay in a behavioral health facility for persons under the age of 21.

Who makes prior authorization decisions?

A behavioral health professional is required to prior authorize services unless it is a decision to deny. A decision to deny must be made by the T/RBHA Medical Director or physician designee.

How is prior authorization applied in emergency admission?

Prior authorization must never be applied in an emergency situation.

What are the considerations for denials?

A denial of a request for admission to or continued stay in an inpatient facility can only be made by the T/RBHA Medical Director or physician designee after verbal or written collaboration with the requesting clinician.

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

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

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



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

What documentation must be submitted to obtain a prior authorization and what are the timeframes for making a decision?

Prior to admission (for requests made Monday through Friday 8:00 a.m. to 5:00 p.m.) or within 24 hours of an admission (for requests made after 5:00 pm Monday through Friday, on weekends or State holidays) the following must be submitted to the Arizona Department of Health Services/Division of Behavioral Health Services/ Bureau of Quality Management Operations and Evaluation (Facsimile number (602) 364-4749):

Inpatient:

CON;

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

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

- Standard requests: For standard requests for prior authorization services, a decision must be made as expeditiously as the member's health condition requires, but not later than fourteen (14) calendar days following the receipt of the authorization request, with a possible extension of up to fourteen (14) calendar days if the member or provider requests an extension, or if CSP justifies a need for additional information and the delay is in the member's best interest.
- Expedited requests: An expedited authorization decision for prior authorization services can be requested if CSP or provider determines that using the standard timeframe could seriously jeopardize the member's life and/or health or the ability to attain, maintain or regain maximum function. CSP must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires but no later than three (3) working days following the receipt of the authorization request with a possible extension of up to fourteen (14) calendar days if the member or provider request an extension, or if the T/RBHA justifies a need for additional information and the delay is in the member's best interest.

Prior authorization decisions for non-emergency admissions to inpatient facilities and admission and continued stay in a Behavioral Health Residential Facility for persons under the age of 21 will be made within 24 hours of receiving the request, or if the request is received on a weekend or State holiday, the decision will be made on the next business day.



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

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

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

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

Inpatient:

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

D. Prior authorizing medications

T/RBHA must obtain approval from the ADHS/DBHS Medical Director prior to establishing prior authorization for any medication, including dosage and dispensing restrictions. For specific information on medications requiring prior authorization, see [Section 3.16, Medication Formulary](#). If T/RBHA or behavioral health provider requires prior authorization for medications, the following requirements must be met:

- Adherence to all prior authorization requirements outlined in this section, including:
 - Prior authorization availability 24 hours a day, seven days a week;
 - Standard requests: For standard requests for prior authorization services, a decision must be made as expeditiously as the member's health condition requires, but not later than fourteen (14) calendar days following the receipt of the authorization request, with a possible extension of up to fourteen (14) calendar days if the member or provider requests an extension, or if CSP justifies a need for additional information and the delay is in the member's best interest.
 - Expedited requests: An expedited authorization decision for prior authorization services can be requested if CSP or provider determines that using the standard timeframe could seriously jeopardize the member's life and/or health or the ability to attain, maintain, or regain maximum function. CSP must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires but no later than (3) working days following



the receipt of the authorization request, with a possible extension, or if CSP justifies a need for additional information and the delay in the member's best interest.

- Assurance that a person will not experience a gap in access to prescribed medications due to a change in prior authorization requirements. T/ RBHAs and behavioral health providers must ensure continuity of care in cases in which a medication that previously did not require prior authorization must now be prior authorized; and
- Incorporation of notice requirements when medication requiring prior authorization is denied, suspended or terminated.

E. Coverage and payment of emergency behavioral health services

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

- Emergency behavioral health services must be covered and reimbursement made to providers who furnish the services regardless of whether the provider has a contract with a T/RBHA;
- Payment must not be denied when:
 - A T/RBHA or behavioral health provider instructs a person to seek emergency behavioral health services;
 - A person has had an emergency behavioral health condition, including cases in which the absence of medical attention would have resulted in:
 - Placing the health of the person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
 - Serious impairment to bodily functions; or
 - Serious dysfunction of any bodily organ or part.
 - Emergency behavioral health conditions must not be limited to a list of diagnoses or symptoms;
 - A T/RBHA may not refuse to cover emergency behavioral health services based on the failure of a provider to notify the T/RBHA of a person's screening and treatment within 10 calendar days of presentation for emergency services.
 - A person who has an emergency behavioral health condition must not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the person; and



- The attending emergency physician, or the provider actually treating the person, is responsible for determining when the person is sufficiently stabilized for transfer or discharge, and such determination is binding the T/RBHA.

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

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