Section 3.14 Securing Services and Prior Authorization

I. STATEMENT OF PURPOSE:

It is important that persons receiving Pascua Yaqui (PY) Centered Spirit Program (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, Arizona Health Care Cost Containment System (AHCCCS) requires prior authorization before accessing inpatient services in a Bureau of Medical Facility Licensed (BMFL) Level I facility (a psychiatric acute hospital, a residential treatment center for persons under the age of 21 or a sub-acute facility). In addition, the TRBHA may require prior authorization of covered behavioral health services other than inpatient services with the prior written approval of AHCCCS.

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

Securing most CSP services:

Most CSP services do not require prior authorization. Based upon the recommendations and decisions of the child and family team or clinical team, all covered services that address the needs of the person and family will be secured. During the treatment planning process, the Child and Family Team (CFT) or the Adult Services 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. CFT and Adult Services treatment 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 from the Tribal Multi-Disciplinary Review (TMDR) Team:

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

1. Non-emergency admissions to a BMFL Level I facility;

2. Continued stay in a BMFL Level I facility;

3. BMFL Level II behavioral health residential facilities (BHRFs); and

4. Admission to and continued stay in a BMFL Level II BHRF for persons under the age of 21.

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. A decision to deny a prior authorized service must be made by the TRBHA Medical Director or physician designee.

II. REFERENCES:

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

Section 3.9, Assessment and Service Planning
Section 3.16, Medication Formulary
Section 5.1, Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons
Section 5.2, Member Complaints
Section 5.3, Grievance and Request for Investigation for Persons Determined to have a Serious Mental Illness (SMI)
Section 5.5, Notice and Appeal Requirements (SMI and General)

The following AHCCCS document also serves as a resource for this content area:

AHCCCS/TRBHA Intergovernmental Agreement (IGA) 2021

III. STANDARDS:

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

A. CSP follows all AHCCCS rules and procedures associated with prior authorization, and Certification of Needs (CON) and Recertification of Needs (RON).

B. CSP has staff available 24 hours a day to receive requests for authorization.

It is important for a Behavioral Health Clinician (BHC) or Behavioral Health Technician (BHT) to document enough information in the electronic health record (EHR) to validate that the prior authorization request meets all elements of the authorization criteria.

A Title XIX eligible person that is receiving services in a Level I residential treatment center who turns age 21 may continue to receive services until the point in time in which services are no longer required or the person turns age 22, whichever comes first.

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

1. Lack of family involvement;

2. Presence or absence of a particular mental health diagnosis; or

3. Presence of substance use, abuse, or dependence.

IV. PROCEDURES:

A. Securing services that do not need prior authorization from the TMDR Team:

The CFT and Adult Services treatment teams are responsible for identifying and securing the service needs of each CSP recipient through the assessment and service planning processes. In fulfilling this responsibility, the treatment teams should focus on identifying the underlying needs of the CSP recipient, including the type, intensity and frequency of supports needed, rather than identifying pre-determined specific services.

As part of the service planning process, it is the treatment team's responsibility to identify available resources and the most appropriate provider(s) for services. This is done in conjunction with the treatment team including the CSP recipient, family, and natural supports. The treatment team seeks consultation from others which may include the Program Manager and/or the TMDR team if assistance is needed in identifying service providers. If the requested service is only available through a non-contracted provider or if a treatment team requests services from a non-contracted provider, the BHC or BHT is responsible for coordinating with the Program Manager and/or TMDR team and obtaining the requested service as outlined below.

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

1. CSP may enter into a single case agreement with a non-contracted provider.

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

3. 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).*

Utilization review process:

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

1. Detecting over and underutilization of services;

2. Defining expected service utilization patterns;

3. Facilitating the examination of BHCs, BHTs and treatment teams that are effectively allocating services; and

4. Identifying BHCs and BHTs who could benefit from technical assistance.

B. Accessing services that require prior authorization from TMDR.

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 treatment team initiates a request for a service requiring prior authorization, the request must immediately be forwarded to TMDR for making prior authorization decisions.

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. 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.

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:

1. For persons age 21 or older, within 72 hours of admission; and

2. For persons under the age of 21, within 14 days of admission.

3. 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 a Level I facility. An exception to the 60-day timeframe exists for inpatient services provided to persons under the age of 21. The treatment plan (individual plan of care) for persons under the age of 21 in a Level I facility must be completed and reviewed every 30 days. 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:

1. Proper treatment of the person's behavioral health condition requires services on an inpatient basis under the direction of a physician:

2. 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;

3. Outpatient resources available in the community do not meet the treatment needs of the person; and

4. CONs, a dated signature by a physician; and/or

5. 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 TMDR 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 a Level I facility. These requirements include the following:

For an individual who is Title XIX/XXI eligible when admitted, the CON must be completed by the clinical team that is independent of the facility and must include a physician who has knowledge of the person's situation and who is competent in the diagnosis and treatment of mental illness, preferably child psychiatry;

1. 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

2. 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 happens if a person is ready to leave a Level I Facility but there is not an alternative placement 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.

C. Prior authorization procedures by TMDR for behavioral health providers contracted by a TRBHA:

What services must be prior authorized?

Services requiring prior authorization are:

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

Who makes prior authorization decisions?

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

How is prior authorization applied in emergency admission?

Prior authorization must never be applied in an emergency.

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 TRBHA 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, TRBHA must provide the person(s) requesting services with a Notice of Action (see PM Form 5.1.1) following:

1. The denial or limited authorization of a requested service, including the type or level of service;
2. The reduction, suspension, or termination of a previously authorized service; and
3. 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 TRBHA 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 or Tribal holidays) the following must be submitted to the CSP Director of Behavioral Health:

Level I:

CON:

TRBHA prior authorization request form (see PM Form 3.14.3); and

The person's service plan (see *Section 3.9, Assessment and Service Planning).*

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

TRBHA prior authorization request form (see PM Form 3.14.3); and

The person's service plan (see *Section 3.9, Assessment and Service Planning).*

Prior authorization decisions for non-emergency admissions to Level I facilities and Level II facilities for persons under the age of 21 will be made within 24 hours of receiving the request.

Authorization will not be provided without all the required documentation. For services provided after hours, on weekends or on State or Tribal holidays, prior authorization must be obtained on 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 CSP Director of Behavioral Health 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 CSP Director of Behavioral Health:

Level I:

RON; and

The person's service plan (RTC only) (see *Section 3.9, Assessment and Service Planning).*

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

TRBHA prior authorization request form (see PM Form 3.14.3); and

The person's service plan (see *Section 3.9, Assessment and Service Planning).*

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

Psychiatric acute hospital and sub-acute facility: The initial authorization is valid for 72 hours. A request for continued stay authorization (see PM Form 3.14.3) must be submitted within the initial 72 hours. All subsequent continued stay authorizations must be made prior to expiration of the last authorization;

Level I residential treatment centers: The initial authorization is valid for 30 days. A request for continued stay authorization (see PM Form 3.14.3) must be submitted two weeks prior to the expiration of the current authorization; and

Level II facilities (for persons under the age of 21): The initial authorization is valid for 60 days. A request for continued stay authorization (see PM Form 3.14.3) must be submitted two weeks prior to the expiration of the current authorization.

D. 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 TRBHA.

A TRBHA may not refuse to cover emergency behavioral health services based on the failure of a provider to notify the TRBHA 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 TRBHA.

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 TRBHA 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 TRBHA for the following situations:

- Post-stabilization care services that were pre-authorized by the TMDR;

- Post-stabilization care services that were not pre-authorized by the TMDR or because the TRBHA 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 TRBHA and the treating physician cannot reach agreement concerning the member's care and a TRBHA physician is not available for consultation. In this situation, the TRBHA 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 TRBHA physician with privileges at the treating hospital assumes responsibility for the person's care;

- A TRBHA physician assumes responsibility for the person's care through transfer;

- The TRBHA and the treating physician reach an agreement concerning the person's care; or

- The person is discharged.