1. PURPOSE:
   a. Prior authorization processes are used to promote appropriate utilization of behavioral and physical 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 and for accessing medications reflected as requiring prior authorization on the ADHS/DBHS Behavioral Health Drug List. In addition, a Regional Behavioral Health Authority (RBHA) may require prior authorization of covered services other than inpatient services with the prior written approval of ADHS/DBHS.

   b. The purpose of the prior authorization function is to monitor the use of designated services before services are delivered in order to confirm they are:
      i. Provided in an appropriate level of care and place of service;
      ii. Included in the defined benefits, appropriate, timely and cost effective;
      iii. Coordinated as necessary with additional departments such as Quality Management, Care Management, Medical or Behavioral Health Management;
      iv. Accurately documented in order to facilitate accurate and timely reimbursement; and,
      v. Meet ADHS/DBHS and AHCCCS requirements.

2. TERMS:
   The following terms are referenced in this section:

   - Adult Clinical Team
   - Behavioral Health Professional
   - Behavioral Health Inpatient Facility
   - Behavioral Health Residential Facility
   - Certification of Need (CON)
   - Child and Family Team
   - Clinical Teams
   - Denial
   - Emergency Behavioral Health Services
   - Expedited Authorization Request (as defined in 42 CFR 438.210)
   - Inpatient Services
   - Medically Necessary Covered Services
   - Prior Authorization
   - Prudent Layperson
   - Psychiatric Acute Hospital
   - Recertification of Need (RON)
   - Standard Authorization Request (as defined in 42 CFR 438.210)
   - Sub-Acute Facility

3. GENERAL PROCEDURES:
a. Securing services that do not require prior authorization
   i. The clinical team is responsible for identifying and securing the service needs of each behavioral health recipient through the assessment and service planning processes.
   ii. 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 behavioral health recipient, family, and natural supports. 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.
   iii. Accessing services with a non-contracted provider
      (1) The T/RBHA must have a process for their subcontracted providers for securing services through a non-contracted provider that describes the following:
          (a) The process for securing services with a non-contracted provider (e.g., single case agreement, pursuing a contract, etc.);
          (b) Information the clinical team must submit to the T/RBHA to secure services through a non-contracted provider;
          (c) The steps to take if the process for securing services with a non-contracted provider does not work (e.g. unable to establish a single case agreement); and,
          (d) How the T/RBHA ensures payment to a non-contracted provider.
   iv. In the event that a request to secure covered services through a non-contracted provider is denied, notice of the decision must be provided in accordance with Policy 1801, Title XIX and Title XXI Notice and Appeal Requirements, and Policy 1804, Notice and Appeal Requirements (SMI and Non/SMI Non-Title XIX).

b. Emergency Situations
   i. Prior authorization must never be applied in an emergency situation. A retrospective review may be conducted after the person’s immediate health needs, behavioral as well as physical, have been met. If upon review of the circumstances, the 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.

4. RBHA PROCEDURES:
   a. Accessing services that require prior authorization
      i. Prior authorization is required for certain covered behavioral and physical health services. Contractors must have Arizona licensed prior authorization staff that includes a nurse or nurse practitioner, physician or physician assistant, pharmacist or pharmacy technician, or licensed behavioral health professional with appropriate training to apply the RBHA’s prior authorization criteria or make prior authorization decisions. RBHA’s must also develop and implement a system that includes policies and procedures, coverage criteria and processes for approval of covered services.
         (1) Policies and procedures for approval of specified services must:
(a) Identify and communicate to providers and members those services that require authorization and the relevant clinical criteria required for authorization decisions. Services not requiring authorization must also be identified. Methods of communication with members include newsletters, website, and/or member handbook. Methods of communication with providers include newsletters, RBHA website, and/or provider manual. Changes in the coverage criteria must be communicated to members and providers 30 days prior to implementation of the change.

(b) Delineate the process and criteria for initial authorization of services and/or requests for continuation of services. Criteria must be made available to providers through the provider manual and RBHA website. Criteria must be available to members upon request.

(c) Authorize services in a sufficient amount, duration or scope to achieve the purpose for which the services are furnished.

(d) Specify timeframes for responding to requests for initial and continuous determinations for standard and expedited authorization requests as defined in this policy and 42 C.F.R. 438.210.

(e) Provide for consultation with the requesting provider when appropriate.

(f) Specify the policies and procedures followed if an authorization request is denied that is inclusive of issuance of notice. Notice must be provided in accordance with Policy 1801, Title XIX/XXI Notice and Appeal Requirements.

(g) Review all prior authorization requirements for services, items or medications annually. The review will be reported through the RBHA MM Committee and will include the rationale for changes made to prior authorization requirements. A summary of the prior authorization requirement changes and the rationale for those changes must be included in the annual RBHA MM/UM Plan submission.

(2) Criteria for decisions on coverage and medical necessity must be clearly documented, based on reasonable medical evidence or a consensus of relevant health care professionals.

(a) RBHAs may not arbitrarily deny or reduce the amount, duration or scope of a medically necessary covered service solely because of the setting, diagnosis, type of illness or condition of the member.

(b) RBHAs may place appropriate limits on services based on a reasonable expectation that the amount of service to be authorized will achieve the expected outcome, and

(c) RBHAs must have in place criteria to make decisions on coverage when the Contractor receives a request for service involving Medicare or other third party payers. The fact that the RBHA is the secondary payer does not negate the Contractor's obligation to render a determination regarding coverage within the timeframes established within this policy. Refer to Policy 701, Third Party Liability and Coordination of Benefits for additional information regarding payment and cost sharing responsibilities.
(3) Integrated RBHAs must include the following in their wheelchair service request analysis and delivery tracking reporting and analysis:
   (a) Timeliness of prior authorization and average time frame from the approval to delivery;
   (b) Timeliness of wheelchair repairs and average time frame from approval to completion; and
   (c) Ongoing evaluation of wheelchair denials against clinical criteria.

ii. Prior Authorizing Medications
   (1) DBHS has developed a behavioral health drug list for use for all contractors. This list denotes all drugs that require prior authorization. These prior authorization criteria have been developed by the statewide DBHS pharmacy and therapeutics committee, and must be used by all non-tribal contractors. TRBHAs may choose to participate in implementing these prior authorization criteria. Medications or other prior authorization criteria may not be added to any contractor’s medication list. For specific information on medications requiring prior authorization, see Policy 1301, ADHS/DBHS Drug List. The approved prior authorization criteria are posted on the ADHS/DBHS Behavioral Health Drug List and Prior Authorization Guidance Documents website.

(2) For implementation of this process for prior authorization the following requirements must be met:
   (a) Prior authorization availability 24 hours a day, seven days a week;
   (b) Assurance that a person will not experience a gap in access to prescribed medications due to a change in prior authorization requirements;
   (c) 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
   (d) Incorporation of notice requirements when medication requiring prior authorization is denied, suspended, or terminated.

4. TRBHA PROCEDURES:
   a. Prior authorization procedures for behavioral health providers contracted by a Tribal RBHA:
      i. Services requiring prior authorization are:
         (1) Non-emergency admission to and continued stay in an inpatient facility; and
         (2) Admission and continued stay in a Behavioral Health Residential Facility for persons under the age of 21.
      ii. The TRBHA behavioral health professional is required to prior authorize services unless it is a decision to deny. A decision to deny must be made by the ADHS/DBHS Medical Director or physician designee.
   iii. Prior authorization must never be applied in an emergency situation.
   iv. A denial of a request for admission to or continued stay in an inpatient facility can only be made by the ADHS/DBHS Medical Director or physician designee after verbal or written collaboration with the requesting clinician.
(1) For Title XIX/XXI covered services requested by persons who are Title XIX/XXI eligible or who have been determined to have a serious mental illness, ADHS/DBHS must provide the person(s) requesting services with a Notice of Action (see Policy 1801, Title XIX and Title XXI Notice and Appeal Requirements, Form 1801.1) following:
   (a) The denial or limited authorization of a requested service, including the type or level of service;
   (b) The reduction, suspension, or termination of a previously authorized service; and,
   (c) The denial in whole or in part, of payment for a service.

(2) Notice must be provided in accordance with Policy 1801, Title XIX and Title XXI Notice and Appeal Requirements. Before a final decision to deny is made, the person’s attending physician can ask for reconsideration and present additional information.

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

v. Documentation required to obtain a prior authorization and the timeframes for making a decision
   (1) 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 ADHS/DBHS Bureau of Quality & Integration (BQ&I) (Facsimile number (602) 364-4697):
      (a) Inpatient:
         (i) Certification of Need (CON) (see Policy Form 1101.1, Certification of Need (CON) for Inpatient Facilities);
         (ii) TRBHA prior authorization request form (see Policy Form 1101.3, TRBHA Prior Authorization Request Form); and
         (iii) The person’s service plan (see Policy 105, Assessment and Service Planning).

vi. Decisions to prior authorize inpatient admission must be made according to these guidelines:
   (1) 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 the TRBHA justifies a need for additional information and the delay is in the member’s best interest.
   (2) Expedited requests: An expedited authorization decision for prior authorization services can be requested if the TRBHA 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. The TRBHA 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 requests an extension, or if the TRBHA justifies a need for additional information and the delay is in the member’s best interest.

vii. 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.

viii. A provider may also telephone the BQ&I 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.

ix. 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&I by the next business day following the person’s Title XIX or Title XXI eligibility determination.

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

   (1) Inpatient:
      (a) Re-certification of Need (RON) (see Policy Form 1101.2, Re-certification of Need for Inpatient Facilities); and
      (b) The person’s service plan (Behavioral Health Inpatient Facility only) (see Policy 105, Assessment and Service Planning).

b. Criteria used to determine whether to approve or deny a service that requires prior authorization:

   i. For services in a psychiatric acute hospital or a behavioral health inpatient facility, ADHS/DBHS has developed the following criteria to be used by all TRBHAs and behavioral health providers:

      (2) ADHS/DBHS Admission to Psychiatric Acute Hospital or Behavioral Health Inpatient Facility Authorization Criteria (see Policy Attachment 1101.1, Admission to Psychiatric Acute Hospital or Behavioral Health Inpatient Facility); and

      (3) ADHS/DBHS Continued Psychiatric Acute Hospital or Behavioral Health Inpatient Facility Authorization Criteria (see Policy Attachment 1101.2, Continued Psychiatric Acute Hospital or Behavioral Health Inpatient Facility Authorization Criteria).

   ii. 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 TRBHAs and behavioral health providers:

      (1) Prior to denials for Behavioral Health Inpatient Facility, TRBHA 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 TRBHA Medical Director or designee to obtain the professional opinion of a behavioral health clinician.

(2) In addition, if a denial is issued for admission to a Behavioral Health Inpatient Facility, the TRBHA 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.

(3) ADHS/DBHS Admission to Behavioral Health Inpatient Facility Authorization Criteria (see Policy Attachment 1101.3, ADHS/DBHS Behavioral Health Inpatient Facility Admission Authorization Criteria); and


(5) The RBHA must develop and make available to its subcontracted providers specific references to and ability to access ADHS/DBHS approved authorization and continued authorization criteria for all other services subjected to prior authorization.

iii. If a person in a Behavioral Health Inpatient no longer requires services on an inpatient basis, but an alternative placement cannot be provided, services may continue to be authorized as long as there is an 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.

5. REFERENCES:
   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
   R9-22-1205
R9-31-210
R9-31-1205
AHCCCS/ADHS Contract
ADHS/RBHA Contract
ADHS/T/RBHA IGAs
Policy 105, Assessment and Service Planning
Policy 1301, ADHS/DBHS Drug List
Policy 1801, Title XIX and Title XXI Notice and Appeal Requirements
Policy 1802, Complaint Resolution
6. APPROVED BY:

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Date 4/15/15

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Chief Medical Officer
Arizona Department of Health Services
Division of Behavioral Health Services

Date 4/3/15