Mercy Maricopa Integrated Care

Provider Manual

www.MercyMaricopa.org
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CHAPTER 1 – INTRODUCTION TO MERCY MARICOPA

1.0 – Scope

Mercy Maricopa is dedicated to providing its members access to care for their behavioral and medical health (integrated care) needs. Our focus is on the whole-person 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.

Mercy Maricopa is a local not-for-profit health plan sponsored by Mercy Care Plan and Maricopa Integrated Health System (MIHS).

Mercy Care Plan is an Arizona nonprofit with a 28-year history of providing innovative Medicaid managed care administration. Mercy Care Plan is sponsored by Dignity Health and Carondelet Health Network. MIHS is a public health care system. It has served as a health care safety net for the citizens of Maricopa County for 135 years.

Mercy Maricopa is administered by Aetna Medicaid Administrators LLC (formerly Schaller Anderson). Aetna Medicaid Administrators also provides plan management for Mercy Care Plan.

The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) has developed expectations for each Tribal and Regional Behavioral Health Authority (T/RBHA) Provider Manual, which includes content specific to their geographic service areas (GSAs) and communities. The Mercy Maricopa 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
- Regional Behavioral Health Authorities.

The Mercy Maricopa Provider Manual is applicable to defined populations that may access public behavioral health/integrated care services. These populations include:

- Title XIX and Title XXI enrolled behavioral health members;
- Behavioral health members receiving emergency/crisis services;
- Non-Title XIX persons determined to have a Serious Mental Illness;
- Special populations, including persons receiving services through the Substance Abuse Block Grant (SABG);
- Non-enrolled persons participating in ADHS/DBHS prevention sponsored activities;
- Non-enrolled persons participating in ADHS/DBHS 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 Maricopa 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 Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) as well as Arizona Health Care Cost Containment System (AHCCCS) requirements, providers are required to fully understand and apply these requirements when administering covered services.


Mercy Maricopa 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.

1.1 – Introduction

OVERVIEW OF THE ARIZONA PUBLIC BEHAVIORAL HEALTH SYSTEM

The Arizona Health Care Cost Containment System (AHCCCS) is the single state Medicaid Agency and provides funding to ADHS/DBHS to administer behavioral health benefits for persons who are Title XIX and Title XXI eligible.

ADHS/DBHS contracts with Tribal and Regional Behavioral Health Authorities (T/RBHAs) who, in turn, subcontract with community providers that administer behavioral health programs and services for children and adults and their families. ADHS/DBHS is responsible for the oversight of the administration of behavioral health services for several populations funded through various sources.

Arizona state law requires ADHS/DBHS 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 ADHS/DBHS 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 Community Mental Health Services Block Grant (CMHS) supports Non-Title XIX services to children determined to have Serious Emotional Disturbance (SED) and adults determined to have Serious Mental Illness (SMI).

ADHS/DBHS administers other federal, state and locally funded behavioral health services. Individuals can get more information about ADHS/DBHS programs by visiting: [http://www.azdhs.gov/bhs](http://www.azdhs.gov/bhs)
PARTNERING WITH TRIBAL AND REGIONAL BEHAVIORAL HEALTH AUTHORITIES (T/RBHAs)
ADHS/DBHS, in partnership with the Mercy Maricopa, promote collaboration and encourage family centered, personalized and culturally relevant healthcare services that result in positive outcomes for persons. The expected outcomes include but are not limited to:

- Improved functioning;
- Reduced symptoms stemming from behavioral health conditions;
- Improved overall health, both behavioral and physical; and
- Improved quality of life for families and individuals.

TRIBAL AND REGIONAL BEHAVIORAL HEALTH AUTHORITIES (T/RBHAs)
ADHS/DBHS contracts with Regional Behavioral Health Authorities (RBHAs) to deliver behavioral health services to six Geographic Service Areas (GSAs). Each RBHA must have a network of providers to deliver all covered behavioral health services.

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OVERVIEW OF MERCY MARICOPA INTEGRATED CARE
The State of Arizona has chosen Mercy Maricopa Integrated Care, a locally owned and operated non-profit health plan, as the Regional Behavioral Health Authority (RBHA) for Maricopa County.

Under contract with Mercy Maricopa, providers are expected to follow the contents of this provider manual, Mercy Maricopa Policies and Procedures as well as fulfill the scope of the contract terms. Mercy Maricopa 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 Maricopa, its departments and their functions, please visit www.mercymaricopa.org.

ADHS/DBHS SYSTEM PRINCIPLES
All healthcare services must be delivered in accordance with ADHS/DBHS system principles. ADHS/DBHS 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 person 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 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 and use best practices;

The services system recognizes that substance abuse and other mental 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.

Cultural Competency
Cultural competence in health care demonstrates the ability of systems to provide care to persons with diverse values, beliefs and behaviors. As such, service delivery is tailored to meet the person’s social, cultural, and linguistic needs, including the needs of the deaf and hard of hearing. As healthcare providers, the goal should be to create a behavioral health system of care that fits everyone’s needs. To accomplish this goal, it is necessary to ensure that staff providing services have the skills to meet the person’s unique family, culture, natural supports, traditions, strengths and sexual orientation or gender identity when developing a person’s individual treatment plan. ADHS/DBHS endorses the following activities for ensuring a culturally competent behavioral health system:

- Healthcare service providers are recruited, trained and evaluated based upon competency in linguistic and culturally appropriate skills in responding to the individual needs of each healthcare member and family;
- Mercy Maricopa management reflects cultural diversity in values and in policies; and
- Mercy Maricopa management and behavioral health service providers strive to improve through periodic cultural self-assessment and modify individual services or the system as a whole when applicable.

Integration of Primary Health and Behavioral Healthcare
Mercy Maricopa 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 members, as well as disparities based on racial and ethnic backgrounds. Our integrated care approach includes four distinct models to provide members with choice:

1. Whole Health Clinics (WHCs) - in this model, Mercy Maricopa contracts with physical and behavioral health providers separately to provide co-located care in existing SMI clinics. By the end of the first year of our RBHA contract, we will expand Health Homes through further development of the integrated care teams, a shared electronic medical record, and shared, aligned financial incentives for
participating practices.

2. **Patient Centered Medical Homes (PCMH)** - PCMH clinics will be operated in Federally Qualified Health Centers (FQHC) or FQHC lookalikes intended to serve members in the communities where they live. We will electronically share clinical and non-clinical data with all providers involved in the member’s care through a health information exchange to further support care coordination.

3. **Patient Centered Health Care Homes (PCHCH)** – Mercy Maricopa believes that the PCHCH model is the best choice for our members. It provides fully integrated physical and behavioral health services. Care Coordination in this model is high touch and utilizes innovative health information technology, such as predictive modeling.

4. **Virtual Health Homes** – Mercy Maricopa supports members who have existing relationships with primary care providers (PCPs) to continue receiving their physical health services with that provider. Our virtual health home model allows members who have longstanding or close relationships with their PCPs to continue receiving physical health care services in a traditional office setting, but with the additional support of Care Coordination tools to facilitate integration of behavioral health services in care planning and delivery. Under this model, PCP services and behavioral health services may be provided in separate settings.

**ARIZONA CHILDREN’S PRINCIPLES**
ADHS/DBHS requires that behavioral health services be delivered to all children according to the Arizona Children’s Principles (See [12 Principles for Children’s Health](#)).

**PRINCIPLES FOR PERSONS DETERMINED TO HAVE A SERIOUS MENTAL ILLNESS (SMI)**
The service delivery system shall operate in accordance with the following principles for persons who have been determined to have SMI and their families (See [Principles for Persons with a Serious Mental Illness](#)).

**USE OF TERMS**
An attempt was made to use consistent terminology throughout the Provider Manual to the best extent possible. Persons receiving healthcare services are referred to as “behavioral health members” or simply as “persons”.

**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, ADHS/DBHS issues Policy Clarification Memorandums and posts them to the ADHS/DBHS website at [http://www.azdhs.gov/bhs/policy/memos.php](http://www.azdhs.gov/bhs/policy/memos.php). Mercy Maricopa incorporates any changes made by ADHS/DBHS 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 persons should contact the
Mercy Maricopa Network Development at 1-800-564-5465 to provide input and requests for updates.

- Providers should note that policy revisions will be available both on Mercy Maricopa’s website at www.MercyMaricopa.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.MercyMaricopa.org.

Mercy Maricopa must provide an updated copy of the Provider Manual to ADHS/DBHS on a yearly basis for approval and prior to distribution to their Provider Network. In addition, current versions of Mercy Maricopa Provider Manual policies must be posted to our website (including policies added to Section 10.0).

AHCCCS requires that ADHS/DBHS review and approve all policies pertaining to Title XIX and Title XXI eligible persons. As such, any policies developed by Mercy Maricopa that establishes requirements for the provision of behavioral health services must be submitted to the ADHS/DBHS Policy Office prior to implementation.
CHAPTER 2 – NETWORK PROVIDER/SERVICE DELIVERY REQUIREMENTS

2.0 – 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 person’s Title XIX or Title XXI eligibility.
- Next, for those persons 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 persons 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 web site allows the providers to verify eligibility and enrollment. To use the web site, providers must create an account before using the applications. To create an account, go to: [https://azweb.statemedicaid.us/Account](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, and

- **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 person’s Title XIX or Title XXI eligibility status still cannot be determined using one of the above methods, the provider must:

- Call, Mercy Maricopa Member Services at 800-564-5465 for assistance during normal business hours (8:00 am through 5:00 pm, Monday-Friday) or
o 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:
  o Provider’s identification number;
  o The member’s name, date of birth, AHCCCS identification number and social security number (if known); and
  o 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 Codes and Values (CV) 15 Reference System includes a key code index that may be used by providers to interpret AHCCCS eligibility key codes and/or AHCCCS rate codes. Mercy Maricopa 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 ADHS/DBHS Policy and Procedures Manual and the ADHS/DBHS Covered Behavioral Health Services Guide.
 There are some circumstances whereby a person may be Title XIX eligible but the ADHS/DBHS behavioral health system is not responsible for providing covered behavioral health services. This includes persons enrolled as elderly or physically disabled (EPD) under the Arizona Long Term Care System (ALTCS) Program and persons eligible for family planning services only through the Sixth Omnibus Reconciliation Act (SOBRA) Extension Program. A person who is Title XIX eligible through ALTCS must be referred to his/her ALTCS case 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 Maricopa. ALTCS-Division of Developmental Disabilities (DDD) persons’ behavioral health services are provided through the ADHS/DBHS behavioral health system.
 If the person 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 persons 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 person’s financial status.

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 person seeks or is referred for ongoing
behavioral health services.

To conduct a screening for Title XIX or other eligibility, Mercy Maricopa or provider meets with the person and completes AHCCCS eligibility screening through the Health-e Arizona PLUS online application for all Non-Title XIX persons. Documentation of AHCCCS eligibility screening must be included in a person’s comprehensive clinical record upon completion after initial screening, annual screening, and screening conducted when a significant change occurs in a person’s financial status (see Chapter 10.1 – Medical Record Standards).

Mercy Maricopa will assist providers with contact information to obtain HEAPlus assistor modules and training from AHCCCS.

Once completed, the screening tool will indicate that the person is potentially AHCCCS eligible.

Pending the outcome of the Title XIX or other eligibility determination, the person may be provided services in accordance with Chapter 8.0 – Copayments and Other Member Fees.

Upon the final processing of an application, it is possible that a person may be determined ineligible for AHCCCS health insurance. If the person is determined ineligible for Title XIX or Title XXI benefits, the person may be provided behavioral health services in accordance with Chapter 8.0 – Copayments and Other Member Fees.

If the screening tool indicates that the person does not appear Title XIX or any other AHCCCS eligibility, the person may be provided behavioral health services in accordance with Chapter 8.0 – Copayments and Other Member Fees. However, the person 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 person receiving AHCCCS eligibility and services after all.

ADHS/DBHS requires Mercy Maricopa 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 as a result of the screening;
- 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; and
- Number of applicants eligible for health coverage via the Federal Health Insurance Marketplace as a result 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 Maricopa provider relations liaison if technical assistance is needed.

**MEDICARE PART D PRESCRIPTION DRUG COVERAGE AND LOW INCOME SUBSIDY (LIS) ELIGIBILITY**

Persons must report to Mercy Maricopa or provider if they are eligible or become eligible for Medicare as it is considered third party insurance. See Chapter 9.0 - Third Party Liability and Coordination of Benefits regarding how to coordinate benefits for persons with other insurance including Medicare. If a behavioral health/integrated care recipient is unsure of Medicare eligibility, Mercy Maricopa or providers may verify Medicare eligibility by calling 800-MEDICARE (800-633-4227), with a behavioral health/integrated care recipient’s permission and needed personal information. Once a person is determined Medicare eligible, Mercy Maricopa or providers must offer assistance and provide assistance with Part D enrollment and the LIS application upon a behavioral health/integrated care recipient’s request. Mercy Maricopa and providers will be tracking Part D enrollment and LIS application status of members and reporting tracking activities, when required by ADHS/DBHS.

**Enrollment in Part D**

All persons eligible for Medicare must be encouraged to 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 Maricopa or provider must assist Medicare eligible persons in selecting a Part D plan. The Centers for Medicare and Medicaid Services (CMS) developed web tools to assist with choosing a Part D plan that best meets the person’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.

**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 person. If Mercy Maricopa or provider determines that a person may be eligible for the LIS (see Social Security Administration (SSA) website at www.ssa.gov for income and resource limits), Mercy Maricopa or provider must offer to assist the person 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 person at a SSA local office; or
By mailing a paper application to the SSA.

**Reporting Part D enrollment and LIS applications**

Mercy Maricopa 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 Maricopa or behavioral health/integrated care provider to track persons eligible for Medicare. This will assist Mercy Maricopa to ensure that Medicare eligible persons 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@mercymaricopa.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 Maricopa provider relations liaison if technical assistance is needed. Periodically, ADHS/DBHS will request Mercy Maricopa to report tracking of Part D enrollment and LIS applications.

Mercy Maricopa 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 person 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 Maricopa or provider must actively encourage the person to participate in the process of screening and applying for AHCCCS health insurance coverage or enrolling in a Medicare Part D plan.

Arizona state law stipulates that persons 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 Maricopa during their initial request for behavioral health/integrated care services or will be dis-enrolled if the person refuses to participate during an annual screening. The following conditions do not constitute a refusal to participate:

- A person’s inability to obtain documentation required for the eligibility determination;
- A person is incapable of participating as a result of their mental illness and does not have a legal guardian; and
A person 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 person 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 Maricopa or behavioral health provider must ask the person to sign the Decline to Participate in the Screening and/or Referral Process for AHCCCS Health Insurance or Medicare Part D Plan Enrollment (English / Spanish). If the person refuses to sign the form, document their refusal to sign in the comprehensive clinical record (See Chapter 10.1 – Medical Record Standards).

Special considerations for persons determined to have a Serious Mental Illness (SMI)
If a person is eligible for or requesting services as a person 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 person’s assigned case 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 person continues to refuse following a clinical consultation, Mercy Maricopa or behavioral health provider must request that the person sign the Decline to Participate in the Screening and/or Referral Process for AHCCCS Health Insurance or Medicare Part D Plan Enrollment (English / Spanish). Prior to the termination of behavioral health services for persons determined to have a SMI who have been receiving behavioral health services and subsequently decline to participate in the screening/referral process, Mercy Maricopa must provide written notification of the intended termination using Notice of Decision and Right to Appeal (see Chapter 20.3 – Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI)).

Persons who Refuse to Cooperate with AHCCCS Eligibility and/or Application Process or does not Enroll in Part D Plan
Mercy Maricopa or behavioral health provider must inform the person who they can contact in the behavioral health system for an appointment if the person chooses to participate in the eligibility and/or application process in the future. Maricopa County behavioral health recipients should contact Mercy Maricopa for assistance 1-800-564-5465.

2.1 – Appointment Standards and Timeliness of Service

Mercy Maricopa puts the member at the center of everything we do. Access to care and timely appointments are critically important to member health and wellbeing. Mercy Maricopa is committed to ensuring that contractual requirements related to Access to Care and Appointment Availability Standards are met for all children and adults in our system.

For your reference, the Arizona Health Care Cost Containment System (AHCCCS) Contractors’ Operation Manual (ACOM 417) outlines requirements regarding access to care, including the requirement that a member be seen within seven (7) days for an intake.
assessment and within 23 days for ongoing appointment.

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 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 voice mail at an agency, this will count against the agency.
- Refrain from directing members solely to Mercy Maricopa Member Services.

If an appointment cannot be offered within the required 7 days:

- Warm transfer the member to Mercy Maricopa Member Services (1-800-564-5465) 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 not 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.

**SPECIFIC BEHAVIORAL HEALTH STANDARDS**

*Appointment Availability Standards for Behavioral Health Providers for Non-Hospitalized Persons*

**Immediate:**

- **WHO:** All persons requesting assistance unless determined not to be eligible. At the time of determination that an immediate response is needed, a person’s eligibility and enrollment status may not be known. Behavioral health providers must respond to all persons 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 DES/DCS Child Referral:**

- **WHO:** Upon notification from ADES/DCYF/DCS that a child has been, or will imminently be taken into the custody of ADES/DCYF/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 DES/DCS that a child has been or will be removed from their home.

Urgent – All Other Requests

- WHO: Referrals for hospitalized persons not currently T/RBHA enrolled, all Title XIX/XXI eligible persons and all non-Title XIX/XXI persons 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:

- WHO: All Title XIX/XXI persons, all Non-Title XIX/XXI persons determined to have a Serious Mental Illness and all persons referred for determination as a person with a Serious Mental Illness
- WHAT: Includes any allowable assessment service as identified in the ADHS/DBHS 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 ADHS/DBHS credentialing requirements in order to provide assessment and evaluation services within 7 days of referral or request for behavioral health services.

- WHO: All Mercy Maricopa Integrated Care 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) days of the initial assessment.

Note: Standards for persons receiving services as part of Substance Abuse Block Grant (SABG) funding are in Chapter 2.9, Special Populations

Urgent Behavioral Health Response for Children Taken into DES/DCS Custody

For Behavioral Health Appointments for persons 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 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;
  o 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;
  o Initiate the development of the CFT for each child (see Child and Family Team Practice Protocol); and
  o Provide the ADES/DCYF/DCS Case Manager with findings and recommendations for medically necessary covered behavioral health services for the initial Preliminary Protective Hearing, which occurs within 5 to 7 days of the child’s removal (see DES/DCYF Child Welfare Timelines for more information).

- Initial Evaluation within seven calendar days after referral or request for behavioral health services
- Initial Appointment within timeframes indicated, by clinical need, but no later than 21 days after the initial evaluation
- Subsequent Behavioral Health Services within the timeframes according to the needs of the person, but no longer than 21 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.

**Appointments for Psychotropic Medications**
For persons who may need to be seen by a Behavioral Health Medical Practitioner (BHMP), it is required that the person’s need for medication be assessed immediately and, if clinically indicated, that the person be scheduled for an appointment within a timeframe that ensures:
  - The person does not run out of any needed psychotropic medications; or
  - The person is evaluated for the need to start medications to ensure that the person does not experience a decline in his/her behavioral health condition.

**Response for Referrals or Requests for Psychotropic Medications**
**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 days from the referral/initial request for services.
- **WHAT:** Screening, consultation, assessment, medication management, medications, and/or lab testing services as appropriate.
- **WHO:** All Title XIX/XXI eligible persons, all Non-Title XIX/XXI persons enrolled with a T/RBHA, all persons determined to have a Serious Mental Illness and any person 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, and/or lab testing services as appropriate.
WHO: All Title XIX/XXI eligible persons, all Non-Title XIX/XXI persons enrolled with a T/RBHA, all persons determined to have a Serious Mental Illness and any person in an emergency or crisis.

Referrals for Hospitalized Persons
Behavioral health providers must quickly respond to referrals pertaining to eligible persons not yet enrolled in the T/RBHA or Title XIX/XXI eligible persons who have not been receiving behavioral health services prior to being hospitalized for psychiatric reasons and persons previously determined to have a SMI. Upon receipt of such a referral, the following steps must be taken:

Referrals for Persons with SMI
For referrals of Title XIX/XXI eligible persons and persons 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 persons referred for eligibility determination of Serious Mental Illness:
- Initial face-to-face contact and an assessment must occur within 24 hours of the referral/request for services. Determination of SMI eligibility must be made within timeframes consistent with and in accordance with Chapter 2.5 – SMI Eligibility Determination; and
- Upon the determination that the person is eligible for services and the person is in need of continued behavioral health services, the person must be enrolled and the effective date of enrollment must be no later than the date of first contact.

Wait Times
ADHS/DBHS has established standards so that persons 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 person 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 person must not arrive sooner than one hour before his/her scheduled appointment; and
- A person 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
All referrals from a person’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 person, and the response time must help ensure that the person does not experience a lapse in necessary psychotropic medications, as described above.

Title XIX and Title XXI persons must never be placed on a “wait list” for any Title XIX/XXI covered behavioral health service. If the T/RBHA network is unable to provide medically necessary covered behavioral health services for Title XIX or Title XXI persons, it must ensure timely and adequate coverage of needed services through an alternative provider until a network provider is contracted. In this circumstance, the T/RBHA must ensure coordination with respect to authorization and payment issues. In the event that a covered behavioral health service is temporarily unavailable to a Title XIX/XXI eligible person, the behavioral health provider must adhere to the following procedure.

- Select an appropriate Mercy Maricopa contracted provider.
- Confirm that the Mercy Maricopa contracted provider can deliver the needed covered service;
- Confirm the Mercy Maricopa contracted provider can meet the timeliness of the needed service; and
- Coordinate the referral.

- If no Mercy Maricopa contracted provider can meet the timeliness of the needed service, behavioral health members must be referred to a provider outside of Mercy Maricopa’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 Maricopa 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 Maricopa 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 Maricopa at 800-564-5465
- Confirm that non-contracted provider can meet the timeliness of the needed service;
- Call Mercy Maricopa at 800-564-5465 to discuss clinical necessity for a Single Case Agreement/ad hoc; and
- 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.
**Special Populations**

ADHS/DBHS receives some funding for behavioral health services through the Federal Substance Abuse Block Grant (SABG). SABG funds are used to provide substance abuse services for Non-Title XIX/XXI eligible persons. 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 T/RBHAs receive SABG Block Grant funding through ADHS/DBHS; any providers contracted with a T/RBHA or for SABG 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:** Other injection drug users;

**Then:** Substance-using females with dependent children, including those attempting to regain custody of their child(ren); and

**Finally:** All other persons in need of substance abuse 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 person within another provider agency facility, including those in other geographic service areas. If capacity still does not exist, the person 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 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 abuse treatment (includes pregnant injection drug users and pregnant substance abusers) and Substance-using females with dependent children, including those attempting to regain custody of their child(ren)

- **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 person.
- **WHAT:** Includes any needed covered behavioral health services. Admit to a clinically
appropriate substance abuse treatment program (can be residential or outpatient based on the person’s clinical needs); if unavailable, interim services must be offered to the person. Interim services shall minimally include education/interventions with regard to 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.

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Emergency Services</th>
<th>Urgent Care</th>
<th>Routine Care</th>
<th>High Risk</th>
<th>Wait Time in Office Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP</td>
<td>Within 24 hours</td>
<td>Within 2 days</td>
<td>Within 21 days</td>
<td>Less than 45 minutes</td>
<td></td>
</tr>
<tr>
<td>Specialty Referrals</td>
<td>Within 24 hours</td>
<td>Within 3 days of request</td>
<td>Within 45 days</td>
<td>Less than 45 minutes</td>
<td></td>
</tr>
<tr>
<td>Dental Care</td>
<td>Within 24 hours</td>
<td>Within 3 days of request</td>
<td>Within 45 days</td>
<td>Less than 45 minutes</td>
<td></td>
</tr>
<tr>
<td>Maternity</td>
<td>Immediate</td>
<td>First Trimester – within 14 days and Second Trimester-within 7 days of request</td>
<td>Third Trimester – within 3 days of request</td>
<td>Within three days of identification of high risk status</td>
<td>Less than 45 minutes</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>Within 24 hours</td>
<td>Within 30 days</td>
<td></td>
<td>Less than 45 minutes</td>
<td></td>
</tr>
<tr>
<td>Non Urgent/Non-Emergent Transportation</td>
<td></td>
<td></td>
<td></td>
<td>Less than one hour before or after appointment</td>
<td></td>
</tr>
</tbody>
</table>

MONITORING OF APPOINTMENT NO-SHOW RATES
Through a series of monitoring activities, Mercy Maricopa 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. Mercy Maricopa’s Quality Management department will meet with providers to discuss their appointment no-show rates and provide technical assistance to improve performance, as needed. Corrective Action Plans (CAPs) and other forms of corrective may be taken for providers who continuously fail to meet performance expectations.
The provider is responsible for providing appropriate services so that persons understand their health care needs and are compliant with prescribed treatment plans. Providers should strive to manage persons and ensure compliance with medical treatment plans and with scheduled appointments. If you need assistance helping non-compliant persons, Mercy Maricopa’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 persons at risk. Please submit the [Provider Assistance Program Form](https://example.com) to Member Services for possible intervention.

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

### 2.2 – Referral and Intake Process

**BEHAVIORAL HEALTH REFERRAL AND INTAKE PROCESS**

To facilitate a member’s access to behavioral health services in a timely manner, Mercy Maricopa 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 Mercy Maricopa, 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 (for specific timeframes see [Chapter 2.1, Appointment Standards and Timeliness of Service](https://example.com));
- 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 (see [Chapter 6.5, Cultural Competence](https://example.com));
- 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.

**Where to Send Referrals**
In situations in which the T/RBHA does not have a single centralized intake process, provider directories will be developed and distributed by the Mercy Maricopa to the AHCCCS Health Plans, Department of Child Safety (DCS), Department of Economic Security /Division of Developmental Disabilities District Program Administrators (DES/DDD) and, upon request, to other referral sources. These directories will indicate which providers are accepting referrals and conducting initial assessments. Providers shall promptly notify the Mercy Maricopa of any changes that would impact the accuracy of the provider directory (e.g., change in telephone or fax number, no longer accepting referrals).

**Referrals for Second Opinion**

Title XIX/XXI health care member are entitled to a second opinion. Upon a Title XIX/XXI eligible healthcare recipient’s request or at the request of the treating physician, Mercy Maricopa must provide for a second opinion from a healthcare professional within the network, or arrange for the healthcare recipient to obtain one outside the network, at no cost to the member.

**Referrals Initiated by Department of Child Safety (DCS) Pending Removal of a Child**

Upon notification from DES/Division of Children, Youth and Families (DCYF) that a child has been, or is at risk of being taken into the custody of DES/DCYF/Department of Child Safety (DCS), behavioral health providers are expected to respond in an urgent manner (for additional information see [Chapter 2.1 – Appointment Standards and Timeliness of Service, Child and Family Team Practice Protocol](#) and [The Unique Behavioral Health Service Needs of Children, Youth, and Families Involved with 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. **Referral for Behavioral Health Services** can be used for information collection.

- Date and time of referral;
- Information about the referral source including name, telephone number, fax number, affiliated agency, and relationship to the person being referred;
- Name of person 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 person, 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;
- 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 other 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 person.

**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 person 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 person’s treatment or have been identified as a need by the referral source, behavioral health providers must respond as outlined in Chapter 2.1 – Appointment Standards and Timeliness of Service.

For the convenience of referral sources (e.g., AHCCCS health plans and AHCCCS primary care providers, state agencies, hospitals) ADHS/DBHS has developed ADHS/DBHS Referral for Behavioral Health Services. This form is available for use but not required. Referral sources may use any other written format or they may contact Mercy Maricopa and providers orally by calling (800) 564-5465.

In situations in which the person seeking services or his/her family member, legal guardian or significant other contacts Mercy Maricopa or provider directly about accessing behavioral health services, Mercy Maricopa or provider will ensure that the protocol used to obtain the necessary information about the person seeking services is engaging and welcoming.

When an SMI eligibility determination is being requested as part of the referral or by the person directly, Mercy Maricopa and providers must conduct an eligibility determination for SMI in accordance with Chapter 2.5 – SMI Eligibility Determination.

**Responding to Referrals**

**Follow-Up**

When a request for behavioral health services is initiated but the person does not appear for the initial appointment, the provider must attempt to contact the person and implement engagement activities consistent with Chapter 2.3 – Outreach, Engagement, Re-Engagement and Closure.

Mercy Maricopa 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 person declines behavioral health services, within 30 days of the initial request for behavioral health services, Mercy Maricopa or provider must notify the following applicable referral sources of the final disposition:

- AHCCCS health plans;
- AHCCCS PCPs;
- Arizona Department of Economic Security/Division of Children, Youth and Families (specifically Child Protective Services 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 person was seen for the initial assessment; and
- The name and contact information of the provider who will assume primary responsibility for the person’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 (See Chapter 16.0 – Confidentiality).

**Documenting and Tracking Referrals**

Mercy Maricopa 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) as defined in Chapter 2.1 – Appointment Standards and Timeliness of Service.
- 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 appointment as required in Chapter 2.3, Outreach, Engagement, Re-engagement and Closure; and
- Final disposition of the referral.

**Children’s System of Care Referral Process**

**Routine Referrals**

Expectations:
- Mercy Maricopa Member Services Department will gather the following basic information from the guardian:
  - Obtains caller/requestor information; name, relationship, address and phone number;
  - Obtains member demographic information; name, address, phone, date of birth; and
  - AHCCCS Eligibility will be verified; Will check system to ensure not a duplicate request and verify member not already enrolled.
- 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.
- The Member Service Representative will warm line transfer the call to the identified QSP with the exception of some the Same Day Access Providers. Prior to the warm line 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, AHCCCS ID number, and AHCCCS rate code.
- The QSP will gather any additional information from the caller and schedule an intake appointment within 7 days.
- For the Same Day Access Providers who have chosen not to take warm line referrals, Mercy Maricopa Member Services Department will provide the caller with information on the same day access provider including the provider’s contact information. The caller will be instructed to contact the same day access provider directly.

**DCS Rapid Response Referrals**

Expectations:

- A child is removed from their home and placed in DCS Custody.
- DCS makes a DCS Rapid Response Referral and provides appropriate documentation (generally a Temporary Custody Notice 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’s DCS Rapid Response Team to complete behavioral health and developmental screening.
  - The caregiver will be contacted by a DCS Rapid Response Team Clinician within the first 72 hours of a child being referred to RR.
  - A developmental screening and crisis assessment will be completed. The developmental checklist and warning signs will be provided to caregivers.
  - DCS Rapid Response Team will assess to determine if the youth needs HNCM services.
  - The DCS Rapid Response Team 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 or a CPNO to complete the comprehensive assessment. DCS has maintained that new referrals from Co-located DCS Sites will go to the co-located provider, unless otherwise noted. 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 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 guardian 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.
  - If no response if provided within 14 days, DCS Rapid Response Team will notify Mercy Maricopa.
- If the child is already receiving behavioral health services:
o CRN contacts the assigned behavioral health provider and DCS for coordination of care;
o The behavioral health provider will attempt to make contact with the guardian and placement within one business day; and
o The behavioral health provider will assess to determine next steps and for immediate treatment needs.

DSP and Specialty Provider Referrals
Expectations:
  • The CFT determines a referral to a Direct Support Provider or a Specialty Provider is needed.
  • The CFT must identify the Mercy Maricopa contracted provider(s) who are able to provide the needed Direct Support or Specialty Provider. Please note that referrals for MMWIA and MST services can only be made by a HNCM.
  • The CFT Facilitator and/or HNCM will complete the Direct Support or Specialty Provider Referral Form and will send the referral form (see attached referral form below) and with the following documents to the identified provider agencies:
    o CFT service plan/CFT Notes;
    o Strengths, Needs and Cultural Discovery (if CASII 4, 5, or 6);
    o Current assessment or most recent annual update;
    o Crisis/Support Plan;
    o CASII;
    o Current Psychiatric Notes and Evaluation (if applicable); and
    o MMWIA Prioritization Form for MMWIA Providers (AYFS, CFSS, Touchstone/WIT, Youth and Families First, New Hope of Arizona, Youth ETC/Project Next Step, or A New Leaf/PACT).
  • 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:
    o If the referral is accepted the guardian will be notified; and
    o 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 week, this will also include Spanish Speaking capacity to the CSOC Administrator, viamailto:DSP_SpecialtyProviders@mercymaricop.org.

Emergent Referrals
Process:
  • Hospital notifies Mercy Maricopa Member Services 1 (800) 564-5465 of youth that is currently inpatient without open episode of care.
  • Mercy Maricopa refers to Child and Family Support Services (CFSS) or Jewish Family and Children’s Services (JFCS) Child Crisis Hospital Team (CCHT) utilizing the identified
algorithm.
- CCHT will coordinate and perform assessment with 24 hours of receipt of referral.
- CCHT will refer to QSP and recommendation to HNCM as clinically appropriate.

**Eligibility Screening and Supporting Documentation**

Persons 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 person could be AHCCCS eligible (see Chapter 2.0 – Eligibility Screening for AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage and Limited Subsidy Program). Explain to the person that the supporting documentation will only be used for the purpose of assisting the person in applying for AHCCCS health care benefits. Let the person know that AHCCCS health care benefits may help pay for behavioral health services. Ask the person 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);
- For all applicants, documentation to prove United States citizenship or immigration status and identity (see Chapter 16 - 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; and
- Verification of out-of-pocket medical expenses.

**Intake**

Behavioral health providers must conduct intake interviews in an efficient and effective manner that is both “person 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, in order to best meet the needs of the person 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) in order to minimize any duplication in the information solicited from the person and his/her family.

During the intake, the behavioral health provider will collect, review and disseminate certain information to persons seeking behavioral health services. Examples can include:

- The collection of contact information, insurance information, the reason why the person is seeking services and information on any accommodations the person 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 recipient’s primary/preferred language (See Chapter 18.0 - Enrollment, Disenrollment and Other Data Submission);
- The completion of any applicable authorizations for the release of information to other parties (see Chapter 16.0 – Confidentiality);
- The dissemination of a Member Handbook to the person (see Chapter 5.0 – Member Handbook);
- The review and completion of a general consent to treatment (see Chapter 2.6 General and Informed 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 (see Chapter 2.0 – Eligibility Screening for AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage and Limited Subsidy Program and Chapter 9.0 - Third Party Liability and Coordination of Benefits);
- Advising Non-Title XIX/XXI persons determined to have a Serious Mental Illness (SMI) that they may be assessed a co-payment (see Chapter 8.0 – Copayments and Other Member Fees).
- The review and dissemination of Mercy Maricopa’s Notice of Privacy Practices (NPP) and the ADHS/DBHS HIPAA Notice of Privacy Practices (NPP) located at Chapter 2.9 Special Populations; and
- The review of the person’s rights and responsibilities as a recipient of behavioral health services, including an explanation of the appeal process.

The person and/or family members may complete some of the paperwork associated with the intake, if acceptable to the person and/or family members.

Behavioral health providers conducting intakes must be appropriately trained, approach the person 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 Maricopa 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 and refer the member to the appropriate Mercy Maricopa Participating Health Provider (PHP). Mercy Maricopa’s website includes a provider search function for your convenience. More information is available in this Provider Manual under Chapter 13.0 – Securing Services and Prior Authorization.

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 Maricopa on the date of service(s) and eligible to receive the service.
- If Mercy Maricopa’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 Maricopa network.
  - Mercy Maricopa 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 Maricopa’s policies. Both referring and receiving providers must comply with Mercy Maricopa 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 Mercy Maricopa 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 Maricopa as long as the communication between providers is documented and maintained in the members’ 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 Maricopa.
- Obtain prior authorization for services that require prior authorization or are performed by a non-PHP.
- Complete a [Specialist Referral Form](#) 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 Maricopa’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 Maricopa on the date of service, Mercy Maricopa 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 Maricopa 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, as long as the member is enrolled and eligible with Mercy Maricopa on the date of service.

**Maternity Referrals**
Referrals to Maternity Care Health Practitioners may occur in two ways:
- A pregnant Mercy Maricopa member may self-refer to any Mercy Maricopa contracted Maternity Care Practitioner.
- The PCP may refer pregnant members to a Mercy Maricopa 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 Maricopa 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 Maricopa contracted ancillary providers.

**Member Self-Referrals**
Mercy Maricopa members are allowed to self-refer to participating providers for the following covered services:
- Family Planning 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.

Mercy Maricopa’s provider directory is available online at the following website: http://www.mercymaricopa.org/find-provider

These directories will indicate which providers are accepting referrals and conducting initial assessments. It is important for providers to promptly notify Mercy Maricopa of any changes that would impact the accuracy of the provider directory (e.g., change in telephone, fax number, or no longer accepting referrals).

2.3 – Outreach, Engagement, Re-Engagement 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 Maricopa 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 persons.

Outreach activities conducted by Mercy Maricopa 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 persons 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 women/teenagers;
- Development and implementation of outreach programs that identify persons with co-morbid medical and behavioral health disorders and those who have been determined to have a Serious Mental Illness (SMI) within Mercy Maricopa’s geographic service area, including persons who reside in jails, homeless shelters, county detention facilities or other settings;
- Provision of information to mental health advocacy organizations; and
- Development and coordination of outreach programs to Native American tribes in
Arizona to provide services for tribal members.

**ENGAGEMENT**

Mercy Maricopa or their subcontracted providers will actively engage the following in the treatment planning process:

- The person and/or person’s legal guardian;
- The person’s family/significant others, if applicable and amenable to the person;
- Other agencies/providers as applicable; and
- For persons with a Serious Mental Illness who are receiving Special Assistance (see Chapter 2.12 – Special Assistance for Persons Determined to have a Serious Mental Illness), the person (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 Maricopa’s Cultural Competency Plan. Additionally, behavioral health providers must:

- Provide a courteous, welcoming environment that provides persons with the opportunity to explore, identify and achieve their personal goals;
- Engage persons 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 person’s unique family, culture, traditions, strengths, age and gender;
- Provide an environment that in which consumers 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 Chapter 6.5 – Cultural Competence);
- Be aware of and seek to gain an understanding of persons with varying disabilities and characteristics;
- Display sensitivity to, and respect for, various cultural influences and backgrounds (e.g., ethnic, racial, gender, sexual orientation and socio-economic class);
- Establish an empathic service relationship in which the person 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 person, and/or the person’s legal guardian, the person’s family members, others involved in the person’s treatment and other service providers as collaborators in the treatment planning and implementation process;
- Demonstrate the desire and ability to include the person’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 person’s motivation for recovery;
- Provide information on available services and assist the person and/or the person’s legal guardian, the person’s family, and the entire clinical team in identifying services that help meet the person’s goals; and
Provide the member with choice when selecting a provider and the services they participate in.

RE-ENGAGEMENT
Behavioral health providers must attempt to re-engage persons 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 re-engage persons 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 re-engage the person by:

- Communicating in the person’s preferred language;
- Contacting the person or the person’s legal guardian by telephone, at times when the person may reasonably be expected to be available (e.g., after work or school);
- Whenever possible, contacting the person or the person’s legal guardian face-to-face, if telephone contact is insufficient to locate the person or determine acuity and risk; and
- Sending a letter to the current or most recent address requesting contact, if 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 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 persons determined to have a Serious Mental Illness who are receiving Special Assistance (see Chapter 2.12 – Special Assistance for Persons Determined to have a Serious Mental Illness), contacting the person designated to provide Special Assistance for his/her involvement in re-engagement efforts.

If the above activities are unsuccessful, the behavioral health provider must make further attempts to re-engage persons determined to have a Serious Mental Illness (SMI), children, pregnant substance abusing women/teenagers, or any person determined to be at risk of relapse, decompensation, deterioration or a potential harm to self or others. Further attempts may include contacting the person or person’s legal guardian face to face or contacting natural supports who the member has given permission to the provider to contact. If the person 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 person to seek inpatient care voluntarily. If this is not a viable option for the person and the clinical standard is met, initiate the pre-petition screening or petition for treatment process described in Chapter 2.8 – Pre-Petition Screening, Court-Ordered Evaluation, and Court-Ordered Treatment.

All attempts to re-engage persons determined to have a Serious Mental Illness (SMI), children, pregnant substance abusing women/teenagers, or any person determined to be at risk of relapse, decompensation, deterioration or a potential 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 clinical team must attempt a telephonic contact with member, within 24 hours, following any missed appointment. If clinical team 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 Abuse (GMH/SA) services, the clinical team must attempt a telephonic contact with member, within 24 hours, following any missed appointment. If the clinical team is unable to reach telephonically on the first attempt, another telephonic attempt must be made within 72 hours, following missed appointment.

FOLLOW-UP AFTER SIGNIFICANT AND/OR CRITICAL EVENTS
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 person’s clinical needs, but no later than 7 days;
 Refusing prescribed psychotropic medications within timeframes based upon the person’s clinical needs and individual history; and
 Released from local and county jails and detention facilities within 72 hours.

Additionally, for persons to be released from inpatient care, behavioral health providers must help establish priority prescribing clinician appointments within 7 days of the person’s release to ensure client stabilization, medication adherence, and to avoid re-hospitalization.

Mercy Maricopa behavioral health providers are expected to:
 Involve recipient, 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 recipient;
 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 Mercy Maricopa Care Coordinator to provide an initial discharge plan;
 Involve the member 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 recipients have sufficient 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 Mercy Maricopa;

- 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 recipient’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 recipients 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 sufficient, 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 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 sufficient if there is evidence in the BHMP note ensuring the member/guardian understands medications; dosages, side effects and any medication changes post discharge.

### ENDING AN EPISODE OF CARE FOR PERSON IN BEHAVIORAL HEALTH SYSTEM

Under certain circumstances, it may be appropriate or necessary to disenroll a person or end an episode of care from services after re-engagement efforts described in REENGAGEMENT have been expended. Ending the episode of care can occur due to clinical or administrative factors involving the enrolled person. 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 person is disenrolled or has an episode of care ended, notice and appeal requirements may apply (see Chapter 20.0 – Title XIX/XXI Notice and Appeal Requirements and Chapter 20.3 – Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI)).

### Clinical Factors

#### Treatment Completed:

A person’s episode of care must be ended upon completion of treatment. A Non-Title XIX person would also be disenrolled at treatment completion. Prior to ending the episode of care or disenrolling a person following the completion of treatment, the behavioral health provider and the person or the person’s legal guardian must mutually agree that behavioral
health services are no longer needed.

**Further Treatment Declined:**
A person’s episode of care must be ended if the person or the person’s legal guardian decides to refuse ongoing behavioral health services. A Non-Title XIX person would also be disenrolled from services. Prior to ending the episode of care or disenrolling a person for declining further treatment, the behavioral health provider must ensure the following:

- All applicable and required re-engagement activities described in **REENGAGEMENT** have been conducted and clearly documented in the person’s comprehensive clinical record; and
- The person does not meet clinical standards for initiating the pre-petition screening or petition for treatment process described in **Chapter 2.8 – Pre-Petition Screening, Court-Ordered Evaluation, and Court-Ordered Treatment**.
- Upon receiving a request from a DCS case manager or representative to discontinue services and/or disenroll a foster child, the behavioral health provider will conduct a Child Family Team (CFT) staffing to determine if this is clinically sound.

**Lack of Contact:**
A person’s episode of care may be ended if Mercy Maricopa or behavioral health provider is unable to locate or make contact with the person after ensuring that all applicable and required re-engagement activities described in **REENGAGEMENT** have been conducted.

A Non-Title XIX individual would also be disenrolled from services.

**Administrative Factors:**
Eligibility/Entitlement Information Changes Including:

- Loss of Title XIX/XXI eligibility, if other funding is not available to continue services; and
- Persons who become or are enrolled as elderly or physically disabled (EPD) under the Arizona Long Term Care System (ALTCS) must be disenrolled 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 disenroll Non-Title XIX/XXI eligible persons for non-payment of assessed co-payments per **Chapter 8.0 – Copayments and Other Member Fees**, under the following conditions:

- The person is not eligible as a person determined to have a Serious Mental Illness (SMI) per **Chapter 2.5 – SMI Eligibility Determination**; 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 person’s comprehensive clinical record, in accordance with **Chapter 8.0 – Copayments and Other Member Fees**.

**Out-of-State Relocations:**
A person’s episode of care must be ended for a person who relocates out-of-state after appropriate transition of care. A Non-Title XIX individual would also be disenrolled. This does not apply to persons placed out-of-state for purposes of providing behavioral health treatment (see Chapter 6.6 – Out of State Placements).

Inter-T/RBHA Transfers:
A person 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 per Chapter 11.0 – Inter-RBHA Coordination of Care.

Arizona Department of Corrections Confinements:
A person age 18 or older must be disenrolled upon acknowledgement that the person 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 Mercy Maricopa prior to detainment in a county detention facility will remain in an open episode of care as long as the child remains Title XIX/XXI eligible. Mercy Maricopa and contracted providers must check the AHCCCS Pre-paid Medical Management Information System (PMMIS) 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, Mercy Maricopa is obligated to cover the services regardless of the perception of the members’ legal status.

In order 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 members’ 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 Persons:
A person’s episode of care must be ended following acknowledgement that the person is deceased, effective on the date of the death. The Non-Title XIX individual would be disenrolled from the system.

**Crisis Episodes:**
For persons who are enrolled as a result of a crisis episode, the person’s episode of care would end if the following conditions have been met:
- The behavioral health provider conducts all applicable and required re-engagement activities and such attempts are unsuccessful; or
- The behavioral health provider and the person or the person’s legal guardian mutually agrees that ongoing behavioral health services are not needed; a Non-Title XIX individual would be disenrolled from the system.

**One-Time Consultations:**
For persons who are in the system for the purpose of a one-time consultation as described in Chapter 11.1 – Coordination of Care with AHCCCS Health Plans, Primary Care Providers and Medicare Providers, the person’s episode of care may be ended if the behavioral health provider and the person or the person’s legal guardian mutually agrees that ongoing behavioral health services are not needed. The Non-Title XIX individual would also be disenrolled.

**Data Submission**
Behavioral health providers must follow all applicable data submission procedures as described in Chapter 18.0 - Enrollment, Disenrollment and Other Data Submission and the ADHS/DBHS Demographic and Outcome Data Set User Guide following a decision to end an episode of care or disenrollment. Please refer to 834 Transaction Data Requirements for additional information.

**SERVING PERSON PREVIOUSLY ENROLLED IN BEHAVIORAL HEALTH SYSTEM**
Some persons who have ended their episode of care or were disenrolled may need to re-enter the behavioral health system. The process used is based on the length of time that a person has been out of the behavioral health system.

For persons not receiving services for less than **one year**:
- If the person has not received a behavioral health assessment in the past 6 months, conduct a new behavioral health assessment consistent with Chapter 2.4 – Assessment and Service Planning and revise the person’s service plan as needed. If the person has received a behavioral health assessment in the last six months and there has not been a significant change in the person’s behavioral health condition, behavioral health providers may utilize the most current assessment. Review the most recent service plan (developed within the last six months) with the person, and if needed, coordinate the development of a revised service plan with the person’s clinical team (see Chapter 2.4 – Assessment and Service Planning).
- Continue the person’s SMI status if the person was previously determined to have a Serious Mental Illness (SMI) (see Chapter 2.5 – SMI Eligibility Determination).
If the person presents at a different T/RBHA or provider, obtain new general and informed consent to treatment (see Chapter 2.6 General and Informed Consent to Treatment).

If the person presents at a different T/RBHA or provider, obtain new authorizations to disclose confidential information, as applicable (see Chapter 16.0 – Confidentiality).

Submit new demographic and enrollment data (see Chapter 18.0 - Enrollment, Disenrollment and Other Data Submission).

For persons not receiving services for 6 months or longer:

- Conduct a new intake, behavioral health assessment and service plan consistent with Chapter 2.4 – Assessment and Service Planning.
- Continue the person’s SMI status if the person was previously determined to have a Serious Mental Illness (SMI) (see Chapter 2.5 – SMI Eligibility Determination).
- Obtain new general and informed consent to treatment, as applicable (see Chapter 2.6 General and Informed Consent to Treatment).
- Obtain new authorizations to disclose confidential information, as applicable (see Chapter 16.0 – Confidentiality).
- Submit new demographic and enrollment data (see Chapter 18.0 - Enrollment, Disenrollment and Other Data Submission).

2.4 – Assessment and Service Planning

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.

ADHS/DBHS does not mandate that a specific assessment tool or format be used but requires certain minimum elements. Providers must collect and submit all required demographic information in accordance with the criteria outlined in the ADHS/DBHS Demographic and Outcome Data Set User Guide (DUG) and Chapter 18.0 - Enrollment, Disenrollment and Other Data Submission.

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 assessment and meets requirements in Chapter 6.1 – Credentialing and Recredentialing. 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.

Minimum elements of the behavioral health assessment

ADHS/DBHS has established the following minimum elements that must be included in a
comprehensive behavioral health assessment and documented in the comprehensive clinical record, in accordance with [Chapter 10.1 – Medical Record Standards](#).

- 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;
- Family history;*
- 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 abuse 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) Second Edition – Revised of Patient Placement Criteria (ASAM Criteria);
- 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, past history, substance abuse, criminogenic factors, etc.;
- Brief 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

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

- REQUIRED FOR ALL TITLE XIX/XXI MEMBERS: Involvement with other agencies (e.g., Child Protective Services, Probation, Division of Developmental Disabilities).

- ONLY REQUIRED FOR CHILDREN AGE 0 TO 5: Developmental screening for children age 0-5 with a referral for further evaluation by the child’s PCP, the Arizona Early Intervention Program (AzEIP) for children age birth to three, or the public school system for children age three to five 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 persons who request SMI determination or have an SMI qualifying diagnosis and GAF score of 50 or lower) in accordance with Chapter 2.5 – SMI Eligibility Determination.

- ONLY REQUIRED FOR PERSONS DETERMINED SMI: Special Assistance assessment in accordance with Chapter 2.12 – Special Assistance for Persons Determined to have a Serious Mental Illness.

For persons 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, in accordance with Chapter 2.1 – Appointment Standards and Timeliness of Service. If the assessor is unsure regarding a person’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.

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. ADHS/DBHS 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 person’s behavioral health assessment.

If a person is in immediate or urgent need of behavioral health services (see Chapter 2.1 – Appointment Standards and Timeliness of Service), 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 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 person’s health plan, PCP.
or others involved in the care or treatment of the individual, as applicable, regarding service planning recommendations (see Chapter 11.1 – Coordination of Care with AHCCCS Health Plans, Primary Care Providers and Medicare Providers).

**Minimum elements of the service plan for Title XIX/XXI Members and for Non-Title XIX/XXI members determined to have SMI that have an assigned Case Manager**

Service plans must be completed by BHPs or BHTs who are trained on the behavioral health service plan and meet requirements in Chapter 6.1 – Credentialing and Recredentialing. In the event that a BHT completes the service plan, a BHP must review and sign the service plan within 30 days of the BHT signature.

The service plan must be documented in the comprehensive clinical record in accordance with Chapter 10.1 – Medical Record Standards, be based on the current assessment, and contain the following elements:

- The person/family vision that reflects the needs and goals of the person/family;
- Identification of the person’s/family’s strengths;
- Measurable objectives and timeframes to address the identified needs of the person/family;
- Identification of the specific services to be provided and the frequency with which the services will be provided;
- The signature of the person/guardian and the date it was signed;
- Documentation of whether or not the person/guardian is in agreement with the plan;
- The signature of a clinical team member and the date it was signed;
- The signature of the person providing Special Assistance, for persons determined to have Serious Mental Illness who are receiving Special Assistance (See Chapter 2.12 – Special Assistance for Persons Determined to have a Serious Mental Illness); and
- The Service Plan Rights Acknowledgement Template, dated and signed by the person or guardian, the person who filled out the service plan, and a BHP if a BHT fills out the service plan.

The behavioral health member must be provided with a copy of their plan. Questions regarding service plans or member rights should be directed to Mercy Maricopa’s customer service line at 1-800-564-5465.

**Minimum elements of the service plan for Non-Title XIX/XXI persons determined to have SMI that do not have an assigned Case Manager**

Service plans for Non-Title XIX/XXI persons determined to have SMI who do not have an assigned Case Manager can be incorporated into the psychiatric progress notes completed by the BHP as long as 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 persons determined to have SMI, who do not have an assigned Case 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 Case Managers; however, they should consider the member-specific needs for and expected benefits from community-based support services including, but not limited to supported 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. In the event that a person 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 person’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 person and/or legal or designated representative disagree with some or all of the Title XIX/XXI covered services included in the service plan, the person and/or legal or designated representative must be given a **Notice of Action** by the behavioral health representative on the team.

In cases that a person 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 person and/or legal or designated representative must be given a **Notice of Decision and Right to Appeal (For Individuals With a Serious Mental Illness (English/Spanish))**, by the behavioral health representative on the team.

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

**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 person’s life and how the person/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.

2.5 – Serious Mental Illness Determination

GENERAL REQUIREMENTS

This chapter applies to:

- Persons who are referred for, request or have been determined to need an eligibility determination for SMI;
- Persons who are enrolled as a person determined to have SMI for whom a review of the determination is indicated; and
- Mercy Maricopa, subcontracted providers and the ADHS/DBHS 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 persons must be evaluated for SMI eligibility by a qualified assessor, and have an SMI eligibility determination made by the Crisis Response Network, if the person:

- Requests an SMI determination; or
- Has a score of 50 or lower on the Global Assessment of Functioning Scale (GAF) and has a qualifying SMI diagnosis (see Serious Mental Illness (SMI) Qualifying Diagnoses for a list of qualifying diagnoses).

Behavioral health providers must use the GAF score as a screening mechanism for identifying persons (including enrolled children upon reaching 17.5 years of age) who may have functional impairments indicative of a SMI; however, the GAF score shall not be used as a criterion for determining or denying SMI eligibility. The GAF is completed as part of the assessment process (see Chapter 2.4 – Assessment and Service Planning).

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. Mercy Maricopa 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 Mercy Maricopa or ADHS/DBHS designee. Providers that contract with Mercy Maricopa 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. Mercy Maricopa or ADHS/DBHS 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 person will schedule an appointment for an initial meeting with the person and a qualified assessor (see Chapter 6.1 – Credentialing). This shall occur no later than 7 days after receiving the request or referral.

During the initial meeting with the person by a qualified assessor, the assessor must:
- Make a clinical assessment whether the person is competent enough to participate in an assessment;
- Obtain general consent from the person or, if applicable, the person’s guardian to conduct an assessment; and
- Provide to the person and, if applicable, the person’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 person, 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 person is SMI and obtain an authorization for the release of information, if applicable (see Chapter 16.0 – Confidentiality); 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 as a result of the qualifying diagnosis (see Serious Mental Illness (SMI) Qualifying Diagnoses for a list of qualifying diagnoses).

Functional Criteria for SMI Determination
To meet the functional criteria for SMI, a person 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 person’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 person’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; or

- Lack of a face-to-face psychiatric or psychological evaluation.

**Person with Co-occurring Substance Abuse**

For persons with co-occurring substance abuse without an established psychiatric diagnosis, the diagnostic assessment may be performed in accordance with the [DBHS Guidance Document, Co-occurring Psychiatric and Substance Disorders](#).

For persons 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
  o The assessor can demonstrate, based on a historical or prospective period of
treatment, that the functional impairment is present only when the person 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:
  o The symptoms contributing to the functional impairment cannot be attributed to
the substance abuse disorder; or
  o The functional impairment is present during a period of cessation of the co-
  occurring substance use of at least thirty (30) days; or
  o 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 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.

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 person 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 (see Chapter 6.1 – Credentialing and Recredentialing); 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
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 person 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
person’s comprehensive clinical record.

  ▪ Disagreement regarding functional impairment: Determination that the person 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 person’s comprehensive clinical record.

If there is sufficient information to determine SMI eligibility, the person 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 person agrees to the extension and:

- There is substantial difficulty in scheduling a meeting at which all necessary participants can attend;
- The person fails to keep an appointment for assessment, evaluation or any other necessary meeting (see Chapter 2.3 – Outreach, Engagement, Re-Engagement and Closure);
- The person is capable of, but temporarily refuses to cooperate in the preparation of the completion of an assessment or evaluation;
- The person or the person’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 information1 to determine SMI eligibility within the required time periods.

**Crisis Response Network must:**

- Document the reasons for the delay in the person’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 person 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 person’s current treating clinician, if any, prior to the determination of SMI, if there is insufficient information to determine the person’s

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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).
level of functioning; and

- SMI eligibility must be determined within three days of obtaining sufficient information, but no later than the end date of the extension.

If the person refuses to grant an extension, SMI eligibility must be determined based on the available information. If SMI eligibility is denied, the person 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, (in accordance with Substance Use/Psychiatric Symptomatology Table), the person shall be notified that the determination may, with the agreement of the person, be extended for up to 90 (calendar) days.²

NOTIFICATION OF SMI ELIGIBILITY DETERMINATION

If the eligibility determination results in approval of SMI status, the SMI status must be reported to the person in writing, including notice of his/her right to appeal the decision (see Chapter 20.3 – Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI)).

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 (see Chapter 20.0 – Title XIX/XXI Notice and Appeal Requirements and Chapter 20.3 – Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI)); and
- The statement that Title XIX/XXI eligible persons will continue to receive needed Title XIX/XXI covered services. In such cases, the person’s behavioral health category assignment must be assigned based on criteria in Chapter 18.0 - Enrollment, Disenrollment and Other Data Submission.

RE-ENROLLMENT OR TRANSFER

If the person’s status is SMI at disenrollment, at the end of an episode of care, or upon transfer from another T/RBHA, the person’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 person with a SMI may be initiated by Mercy Maricopa or behavioral health provider:

- As part of an instituted, periodic review of all persons determined to have a SMI; or

² This extension may be considered a technical re-application to ensure compliance with the intent of Rule. However, the person does not need to actually reapply. Alternatively, the determination process may be suspended and a new application initiated upon receipt of necessary information.
- When there has been a clinical assessment that supports that the person no longer meets the functional and/or diagnostic criteria.
- An individual currently enrolled as a person with a SMI, or their legally authorized representative, upon their request.

A review of the determination may not be requested by Mercy Maricopa 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 person is determined to no longer meet the diagnosis and functional requirements for SMI status, Mercy Maricopa must ensure that:
- Services are continued depending on Title XIX/XXI eligibility, Mercy Maricopa service priorities and any other requirements as described in Chapter 4.0 – Covered Services, Chapter 11.0 – Inter-RBHA Coordination of Care and Chapter 2.9 Special Populations.
- Written notice of the determination made on review with the right to appeal is provided to the affected person 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 Mercy Maricopa 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 Mercy Maricopa for approval. Mercy Maricopa is responsible for monitoring and validating the forms. Mercy Maricopa must keep copies of the validated Serious Mental Illness Determination Verification form in the member’s record.

2.6 – General and Informed Consent to Treatment

GENERAL REQUIREMENTS

Any person, aged 18 years and older, in need of behavioral health services must give voluntary general consent to treatment, demonstrated by the person’s or legal guardian’s signature on a general consent form, before receiving behavioral health services.

For persons 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 person aged 18 years and older or the person’s legal guardian, or in the case of persons
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 person aged 18 years and older or the person’s legal guardian, or in the case of persons 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.

Providers treating persons in an emergency situation are not required to obtain general consent prior to the provision of emergency services. Providers treating persons 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:

- 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 person’s, or if under the age of 18, the person’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 person’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 person’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**
- Persons, 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 person, must be established. If the informed consent is for psychotropic medication or telemedicine and the person, or if applicable, the person’s guardian refuses to sign an acknowledgment and gives verbal informed consent, the medical practitioner shall document in the person’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.

**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 person, 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 person, 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 [Chapter 2.7 – Pharmacy Management](#)). The use of [Informed Consent for Psychotropic Medication Treatment](#) 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 person, 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 person in research activities;
- Prior to the provision of a voluntary evaluation for a person. The use of the Application for Voluntary Evaluation (English / Spanish) is required for persons 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.

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 person, legal guardian or an appropriate court prior to the person’s admission to any medical detoxification, inpatient facility or residential program operated by a behavioral health provider.

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 person. 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 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 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 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 other person with whom the Department of Economic Security/Department of Child Safety (DES/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:

<table>
<thead>
<tr>
<th>Individual/Entity</th>
<th>Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal guardian</td>
<td>Copy of court order assigning custody</td>
</tr>
<tr>
<td>Relatives</td>
<td>Copy of power of attorney document</td>
</tr>
<tr>
<td>Other person/agency</td>
<td>Copy of court order assigning custody</td>
</tr>
<tr>
<td>DCS Placements (for children removed from the home by DCS), such as: Foster parents/Group home staff/Foster home staff/Relatives/Other person/agency in whose care DES/DCS has placed the child</td>
<td>None Required*</td>
</tr>
</tbody>
</table>

*If behavioral health providers doubt whether the individual bringing the child in for services is a person/agency representative in whose care DES/DCS has placed the child, the provider may ask to review verification, such as documentation given to the individual by DES indicating that the individual is an authorized DES/DCS placement. If the individual does not have this documentation, then the provider may also contact the child’s DES/DCS caseworker 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 or not 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 situation and can receive behavioral health care as needed for the treatment of the condition without general and, when applicable, informed consent to
INFORMED CONSENT DURING INVOLUNTARY TREATMENT
At times, involuntary treatment can be necessary to protect safety and meet needs when a person, 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 in reference to a school-based prevention program administered by ADHS/DBHS.

Substance Abuse Prevention Program and Evaluation Consent (English / Spanish) 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 ADHS/DBHS. The written 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.

Completion of the Substance Abuse Prevention Program and Evaluation Consent (English/Spanish) applies solely to consent for a survey, analysis, or evaluation only, and does not constitute consent for participation in the program itself.

2.7 – Pharmacy Management

PHARMACY MANAGEMENT
Prescription drugs may only be prescribed by Mercy Maricopa credentialed and licensed physicians, licensed physician assistants, or licensed nurse practitioners. See Chapter 6.1 – Credentialing and Recredentialing for more information regarding credentialing requirements. Prescriptions should be written to allow generic substitution whenever possible and signatures on prescriptions must be legible in order for the prescription to be dispensed. The Preferred Drug List (PDL) 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.
Updating the Preferred Drug Lists (PDLs)

Mercy Maricopa’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 PDL.
- 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.

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

Mercy Maricopa Integrated Care  
Corporate Director of Pharmacy  
4645 E. Cotton Center Blvd.  
Building 1, Suite 200  
Phoenix, AZ 85040

Notification of PDL Updates

Mercy Maricopa will not remove a medication from the PDL without first notifying providers and affected members. Mercy Maricopa will provide at least 60 days’ notice of such changes. Mercy Maricopa 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 Maricopa website. Mercy Maricopa may also notify providers of changes to the PDL via direct letter. Mercy Maricopa will notify members of updates to the PDL via direct mail and by notifying the prescribing provider, if applicable.

Prior Authorization

Prior authorization is required:

- If the drug is not included on the PDL.
For some injectable medications dispensed by a pharmacy, with the exception of heparin and insulin. Note: If the member has a primary insurance that reimburses for injectable medications, Mercy Maricopa will only coordinate benefits as the secondary payer if the Mercy Maricopa 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 1-800-564-5465 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. Peg-Intron.

Allow up to 14 calendar days 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.

**Over the Counter (OTC) Medications**

A limited number of OTC medications are covered for Mercy Maricopa 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 Maricopa 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. Brand medications can be filled if there is not an AB-rated generic available. In all other cases, brand names are listed for reference only.

**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 Maricopa:
- Anorexiants
- 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 Maricopa
- Lifestyle medications (such as medications for erectile dysfunction)
- Medications used for fertility

**Family Planning Medications and Supplies**
Family Planning Services are an available benefit for Mercy Maricopa. 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 Maricopa Fee Schedule, unless otherwise stated in the provider’s contract.
- Oral contraceptives are covered for Mercy Maricopa members.

**Requests for Non-PDL Drugs**
A physician requesting a change to Mercy Maricopa’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 Maricopa Integrated Care
Corporate Pharmacy Director
4645 E. Cotton Center Blvd.
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 (see Chapter 10.1 – Medical Record Standards).

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 (see Chapter 10.1 – Medical Record Standards).

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 person’s comprehensive clinical record per Chapter 10.1 – Medical Record Standards and must be scheduled in a timely manner consistent with Chapter 2.1 – Appointment Standards and Timeliness of Service. 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 person’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 (see Chapter 10.1 – Medical Record Standards):
- 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 person and/or legal guardian for each psychotropic medication prescribed. When obtaining informed consent, the BHP must communicate in a manner that the person 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.

The comprehensive clinical record must include documentation of the essential elements for obtaining informed consent (see [Chapter 10.1 – Medical Record Standards](#)). Essential elements for obtaining informed consent for medication are contained within the [Informed Consent for Psychotropic Medication Treatment](#) (English / Spanish). The use of [Informed Consent for Psychotropic Medication Treatment](#) (English / Spanish) 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 person’s individual comprehensive clinical record in an alternative fashion (see [Chapter 10.1 – Medical Record Standards](#)).

For more information regarding informed consent, please see [Chapter 2.6 General and Informed Consent to Treatment](#).

**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, taking into account individualized factors. At a minimum, these must include:

- **Heart Rate and Blood Pressure**: On initiation of any medication and at least every six months thereafter, or more frequently as clinically indicated.
- **Weight**: On initiation of any medication and at least every six months thereafter, or more frequently as clinically indicated.
- **Abdominal girth**: For individuals at least 18 years old, on initiation of any medication and at least every six months thereafter, or more frequently as clinically indicated.
- **Body Mass Index (BMI)**: On initiation of any medication and at least every six months thereafter, or more frequently as clinically indicated.
Abnormal Involuntary Movements (AIMS): On initiation of any antipsychotic medication and at least every six months thereafter, or more frequently as clinically indicated.

Fasting glucose: On initiation of any medication affecting this parameter 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 month of initiation of lithium or significant change in dose and at least every six months thereafter or more frequently as clinically indicated.

Thyroid functions: Within one month of initiation of lithium and at least annually thereafter or more frequently as clinically indicated.

Renal function: Within one month of initiation of lithium and at least annually thereafter or more frequently as clinically indicated.

Valproic acid level: Within one month of initiation of valproic acid or divalproex or significant change in dose and at least annually thereafter or more frequently as clinically indicated.

Carbamazepine level: Within one month 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 with regard to developing a number of 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).

ADHS/DBHS recognizes two types of polypharmacy: intra-class polypharmacy and inter-class polypharmacy. Below are ADHS/DBHS expectations regarding prescribing multiple psychotropic medications to a person 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
person’s medical record (see Chapter 10.1 – Medical Record Standards) 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 (see Chapter 10.1 – Medical Record Standards) 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 ADHS/DBHS Practice Guidelines for Children: Birth to Five Years of Age).

**Reporting Requirements**
Mercy Maricopa has established the ADHS/DBHS system requirements for monitoring the following:

- Adverse drug reactions;
- Adverse drug event; and
- Medication errors.

The above referenced events are identified, reported, tracked, reviewed and analyzed by Mercy Maricopa.

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 (see Chapter 19.2 – Reporting of Incidents, Accidents and Deaths).

**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 person or guardian, when applicable, for each CAM prescribed (see Chapter 15.0 – ADHS/DBHS Drug List). When obtaining informed consent, behavioral health medical practitioners must communicate in a manner that the person and/or legal guardian can understand and comprehend. The comprehensive clinical record must include documentation of the essential elements for obtaining informed consent (see Chapter 10.1 – Medical Record Standards). 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 (English / Spanish) 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 person’s individual
comprehensive clinical record (see Chapter 10.1 – Medical Record Standards) in an alternative fashion.

**Pharmacy Education Meetings**

The Mercy Maricopa 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 month, 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 five medications filled for the specified BHP.

2.8 – 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 person’s mental disorder when that person 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 person may be, as a result of a mental disorder:

- A danger to self (DTS);
- A danger to others (DTO);
- Persistently or acutely disabled (PAD); or
- Gravely disabled (GD).

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 person 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 person. A hearing, with the person and his/her legal representative and the physician(s) treating the person, will be conducted to determine whether the person 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 may include a combination of inpatient and outpatient treatment. Inpatient treatment days are limited contingent on the person’s designation as DTS, DTO, PAD, or GD. Persons 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 may be identified by the court to supervise the person’s outpatient treatment. In some cases, the mental health agency may be a RBHA; however, 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 Maricopa 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 these forms for all other populations:

- Application for Involuntary Evaluation;
- Application for Voluntary Evaluation (English/Spanish);
- Application for Emergency Admission for Evaluation;
- Petition for Court-Ordered Evaluation;
- Petition for Court-Ordered Treatment; and
- Affidavit, Addendum No. 1 and Addendum No. 2.

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 Assurance and Licensing Services as a court-ordered evaluation or court-ordered treatment agency must adhere to Division of Licensing Services requirements.

**PRE-PETITION SCREENING**

There is an intergovernmental agreement between Maricopa County and the Arizona Department of Health Services for these services. In-turn, ADHS/DBHS contracts with Mercy
Maricopa to provider pre-petition screening and court ordered evaluation services.

The pre-petition screening includes an examination of the person’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).
- 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 Case Manager and EMPACT Pre-Petition Team relative to AAC and ARC requirements, not intended to be instructive to provider/community members.

Pre-petition screens and Petitions for Inpatient 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 Police Mental Health Detention Information Sheet must be submitted by the behavioral health recipient’s Case Manager or the EMPACT 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 for Inpatient Court Ordered Evaluation 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 recipient brought to either the Response Recovery Center-West (RRC-W) or Urgent Psychiatric Care (UPC) for evaluation. NOTE: The Pre-Petition Screening Report 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 recipient’s Case Manager or the EMPACT pre-petition team in a secure place (such as a locked file cabinet) to ensure the behavioral health recipient’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.

**Non-emergent Process**

For behavioral health recipients receiving Clinic Services, the following steps will be completed by the PNO Clinic Clinical Team.

- For all other residents of Maricopa County (not enrolled with a Mercy Maricopa PNO Clinic), the EMPACT pre-petition team will complete these steps for petitions for COE. Any responsible individual may apply for a COE of a person 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 Mercy Maricopa PNO Clinic Services, an applicant contacts the Mercy Maricopa Customer Service Line at 800-564-5465 and requests a PAD or GD petition application be completed on an identified person in the community. 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 Maricopa PNO Clinic enrolled behavioral health recipients.

- For Mercy Maricopa PNO Clinic enrolled behavioral health recipients, the Case Management 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 recipient is determined to be in imminent danger of harming self or others, UPC or RRC-W will be contacted for assistance in evaluation and possible application for an emergency admission.

- For all Mercy Maricopa PNO Clinic enrolled or non-enrolled persons, 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 person does consent to a voluntary evaluation the Application for Voluntary Evaluation (English/Spanish) shall be used.

- During the pre-petition screening, at least three attempts to contact the behavioral health recipient should be completed. If attempts at contacting the behavioral health recipient are unsuccessful and screening is not possible, screening staff will staff 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 recipient does not consent to a voluntary outpatient evaluation or voluntary inpatient evaluation or a voluntary evaluation is not appropriate as determined by the evaluating psychiatrist, the involuntary process
shall continue.

- The Case Management Team or EMPACT Pre-Petition Team will staff the application for involuntary evaluation (Application for Involuntary Evaluation) and Pre-Petition Screening Report with a psychiatrist who will:
  - Review the report 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 person, due to a mental disorder, including 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 person, without immediate hospitalization, is likely to harm him/her or others, the psychiatrist must coordinate with the UPC/RRC-W 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 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 recipient’s Case Manager or the EMPACT 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 recipient brought to the UPC or RRC-W for evaluation. NOTE: The Petition 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 recipient’s Case Manager or the EMPACT pre-petition team in a secure place (such as a locked file cabinet) to ensure the behavioral health recipient’s confidentiality. A petition for involuntary evaluation may not be stored in the medical record if the behavioral health recipient 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 person is in
such a condition that without immediate hospitalization he/she is likely to harm himself/herself or others, an emergent petition can be filed. Only petitions 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), 903 North 2nd Street, Phoenix, AZ 85004, (602) 416-7600 or Response Recovery Center-West (RRC-W), 11361 N. 99th Ave Suite 402, Peoria AZ 85345 (602) 636-4605. Mercy Maricopa contracts with the UPC/RRC-W to assist the applicant in preparing the **Application for Emergency Admission for Evaluation** when an emergent evaluation is requested.

**Emergent process**

The applicant is a person who has, based on personal observation, knowledge of the behavioral health recipient’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-W 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-W 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 person does not require medical care beyond the capacity of UPC/RRC- W, then the UPC/RRC-W staff will immediately coordinate with local law enforcement for the detention of the person and transportation to UPC/RRC-W.
- If the Application for Emergency Admission for Evaluation is accepted by the UPC/RRC-W admitting officer and the person requires a level of medical support not available at either the UPC or RRC-W, then within 24 hours the UPC/RRC-W 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-W admitting officer, then the Mercy Maricopa Medical Director must be notified.
- An **Application for Emergency Admission for Evaluation** may be discussed by telephone with a UPC/RRC-W admitting officer, the referring physician, and a police officer to facilitate transport of the person to be evaluated at a UPC/RRC- W.
- A person proposed for emergency admission for evaluation may be apprehended and transported to the UPC/RRC-W by police officials through a written **Application for Emergency Admission for Evaluation** faxed by the UPC/RRC-W admitting officer to the police.
- A 23-Hour Emergency Admission for Evaluation begins at the time the behavioral health recipient is detained involuntarily by the Admitting Officer at UPC/RRC-W who determines there is reasonable cause to believe that the person, as a result of a mental disorder, is a DTS or DTO and that during the time necessary to complete prescreening procedures the person 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-W shall contact the County Attorney prior to filing a petition if it alleges that a person is DTO.
- The psychiatrist will complete the Release from Evaluation within 24 hours of determination that the person no longer requires involuntary evaluation.
- If the behavioral health recipient does not meet the criteria for an emergent petition but is determined to meet criteria for PAD and/or GD, UPC/RRC-W will notify the applicant of the non-emergent process.

COURT-ORDERED EVALUATION

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. The procedures for court-ordered evaluations are outlined below:

Mercy Maricopa and its subcontracted behavioral health provider must follow these procedures:

- A person being evaluated on an inpatient basis must be released within seventy-two hours if further evaluation is not appropriate, unless the person makes application for further care and treatment on a voluntary basis;
- A person 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 Mercy Maricopa’s medical director or designee; and
- Title XIX/XXI funds must not be used to reimburse court-ordered evaluation services.

Mercy Maricopa encourages the utilization of outpatient evaluation or inpatient only court orders. Mercy Maricopa 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 persons 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 person is refusing a voluntary evaluation and the psychiatrist determines the person is safe to go through an Outpatient Court Ordered Evaluation, then the Case Manager or EMPACT 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 person 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 person’s Case Manager or EMPACT PAD team in a secure place (such as a locked file cabinet) to ensure the behavioral health recipient’s confidentiality. A petition for involuntary evaluation may not be stored in the medical record if the behavioral health recipient 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 EMPACT 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 person to and from the Outpatient COE and will provide any documents requested by the psychiatrists conducting the evaluation. If the person is not enrolled at a PNO Clinic, the Mercy Maricopa Court Liaison will assist the person in arranging transportation.

If the two evaluating psychiatrists do not believe that the person is in need of COT, then the MIHS Legal Department will forward the physicians’ affidavits to the Case Manager or Pre-Petition Team with an explanation that the person has been determined not to be in need of COT.

If the two evaluating psychiatrists completing the Outpatient Court Ordered Evaluation determine the person 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 Mercy Maricopa 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 Maricopa contracted behavioral health provider that receives an application for voluntary evaluation must immediately refer the person 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 (English/Spanish) 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 Case Manager or EMPACT PAD Team is to arrange for a voluntary admission to UPC, in order for the evaluation to take place, assist the person in signing in and deliver the original notarized Application for Voluntary Evaluation (English/Spanish) to the UPC Coordinator.
- If the psychiatrist determines an outpatient voluntary evaluation is acceptable, then the Case Manager or EMPACT PAD Team will deliver the original, notarized
Application for Voluntary Evaluation (English/Spanish) to the MIHS Legal Department. An outpatient evaluation will then be scheduled at Desert Vista Hospital and the Case Manager or EMPACT PAD Team will be responsible for notifying the person 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, 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 person is in need of COT, then the MIHS Legal Department will forward the physicians’ affidavits to the Case Manager or EMPACT PAD Team with an explanation that the person has been determined not to be in need of COT.

- If the psychiatrists completing the voluntary inpatient evaluation or voluntary outpatient evaluation determine the person 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 Mercy Maricopa Court Liaison will then file a Petition for Court Ordered Treatment with the Mercy Maricopa County Superior Court within 2 business days.

- The Mercy Maricopa 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 (English/Spanish) and provide evaluation at a scheduled time and place within five days of the notice that the person 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 person 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 (see Chapter 10.1 – Medical Record Standards) must include:
    - A copy of the Application for Voluntary Evaluation (English/Spanish);
    - A completed informed consent form (see Chapter 2.6 – General and Informed Consent); and
    - A written statement of the person’s present medical condition.

When the county does not contract with the Mercy Maricopa for court-ordered evaluations Mercy Maricopa contracts with Maricopa Integrated Health Systems for inpatient Court-Ordered Evaluations and Med-Pro for 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 person’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 person nominated as guardian or conservator; and
- A copy of all petitions must be mailed to the superintendent of the Arizona State Hospital.

PERSONS WHO ARE TITLE XIX/XXI ELIGIBLE AND/OR DETERMINED TO HAVE SERIOUS MENTAL ILLNESS (SMI)

When a person referred for court-ordered treatment is Title XIX/XXI eligible and/or determined or suspected to have a Serious Mental Illness, Mercy Maricopa will:

- Conduct an evaluation to determine if the person has a Serious Mental Illness in accordance with Chapter 2.5 – SMI Eligibility Determination, and conduct a behavioral health assessment to identify the person’s service needs in conjunction with the person’s clinical team, as described in Chapter 2.4 – Assessment and Service Planning; and
- Provide necessary court-ordered treatment and other covered behavioral health services in accordance with the person’s needs, as determined by the person’s clinical team, the behavioral health member, family members, and other involved parties (see Chapter 2.4 – Assessment and Service Planning); 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 person ordered by the court to undergo treatment can be transferred from one behavioral health provider to another behavioral health provider if:

- The person 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 (see Chapter 11.0 – Inter-RBHA Coordination of Care for more details).
- In order to coordinate a transfer of a person under court-ordered treatment to ALTCS
or another RBHA, the behavioral health recipient’s clinical team will coordinate with the Mercy Maricopa Court Advocacy Department at (602) 572-5941.

- In order to coordinate a transfer of a person under COT from one PNO to another, the behavioral health recipient’s current psychiatrist will discuss the transfer with the receiving psychiatrists. If both PNOs agree that the transfer is appropriate, the receiving psychiatrist will then provide a Letter of Intent to Treat to the PNO Court Coordinator of the sending PNO. The PNO Court Coordinator will then prepare a motion to transfer treatment provider, review with PNO attorney, and file with the court. The person’s care will not be transitioned to the receiving PNO until the new treatment provider is reflected on the COT.

**COURT-ORDERED TREATMENT FOR PERSONS CHARGED WITH OR CONVICTED OF A CRIME**

Mercy Maricopa’s 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 Maricopa will cover DV services with Title XIX/XXI funds when the person 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 persons’ 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 ADHS/DBHS or Mercy Maricopa 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 person 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 Maricopa liaison(s), and tribal court representatives can be found on the ADHS/DBHS 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.

Mercy Maricopa and its providers must comply with state recognized tribal court orders for Title XIX/XXI and Non-Title XIX SMI persons. When tribal providers are also involved in the care and treatment of court ordered tribal members, Mercy Maricopa 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 Mercy Maricopa. This clinical communication and coordination with the Mercy Maricopa 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 Maricopa 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 ADHS/DBHS Tribal Court Procedures for Involuntary Commitment web page for a diagram of these different payment structures).

2.9 – Special Populations

ADHS/DBHS 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 ADHS/DBHS. ADHS/DBHS 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 persons with substance use disorders. It is used to plan, implement and evaluate activities to prevent and treat substance abuse. Grant funds are also used to provide early intervention services for HIV and tuberculosis disease in high-risk substance abusers. This section is intended to present an overview of the major Federal grants that provide ADHS/DBHS and the public behavioral health system with funding to deliver services to persons who may otherwise not be eligible for covered behavioral health services.

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 persons 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 abuse disorder, regardless of gender or route of use, (as funding is available).

Persons must indicate active substance use within the previous 12-month period to be eligible for SABG funded services.

Choice of Substance Abuse Providers

Persons receiving substance abuse 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 abuse services under the SABG must
notify persons of this right using Notification to Individuals Receiving Substance Abuse Services (English/Spanish). Providers must document that the person has received notice in the person’s comprehensive clinical record.

If a person objects to the religious character of a behavioral health provider, the provider must refer the person 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 Mercy Maricopa of the referral and ensure that the person makes contact with the alternative provider.

Upon making a referral, the provider will notify Mercy Maricopa’s General Mental Health/Substance Abuse Administrator by contacting Mercy Maricopa at 800-564-5465.

Available Services
The following services must be made available to Substance Abuse Block Grant (SABG) special populations: 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;
- Gender-specific substance abuse treatment; and
- Therapeutic interventions for dependent children

Mercy Maricopa is required to ensure the following issues do not pose barriers to access to obtaining substance abuse treatment:

- Child care;
- Case management; and
- Transportation

Mercy Maricopa is required to publicize the availability of gender-based substance abuse 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 abuse treatment services at no cost.

Subcontracted providers must notify Mercy Maricopa if, on the basis of moral or religious grounds, the provider elects to not provide or reimburse for a covered service.

Providers may call Mercy Maricopa 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 abuse, 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 ADHS 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 persons who also meet a priority population type may not be placed on a wait list (see [Chapter 2.1 – Appointment Standards and Timeliness of Service](chapter2.1)).

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 Child(ren) and Intravenous Drug Users) who are waiting for placement in a Residential Treatment Center, to the ADHS/DBHS SABG Waitlist System, or in a different format upon written approval by ADHS/DBHS.

- Title XIX/XXI persons may not be added to the wait list.
- Priority Population Members must be added to the wait list if Mercy Maricopa or its providers are not able to place the person in a Residential Treatment Center within the timeframes prescribed in [Chapter 2.1 – Appointment Standards and Timeliness of Service](chapter2.1).
  - 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 persons may be added to the waitlist if there are no available services.

**Other SABG Requirements**

Mercy Maricopa is required to designate:

- A lead substance abuse treatment coordinator who will be responsible for ensuring Mercy Maricopa 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 persons with substance abuse disorders are considered at high risk for contracting HIV-related illness, the SABG requires HIV intervention services in order to reduce the risk of transmission of this disease.
In Maricopa County, Terros, Inc., provides HIV early intervention services at substance abuse programs, case 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. For a complete list of waived Rapid HIV tests please see [http://www.fda.gov/cdrh/clia/cliawaived.html](http://www.fda.gov/cdrh/clia/cliawaived.html). 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 ADHS must be completed by Mercy Maricopa 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.

Mercy Maricopa 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 ADHS/DBHS on an annual basis, or as indicated by DBHS. The Webinar will be recorded and made available by DBHS. 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 ADHS 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
Mercy Maricopa is required to collect monthly progress reports from subcontracted providers and submit quarterly progress reports to ADHS/DBHS.

Site visits to providers offering HIV Early Intervention Services must be conducted bi-annually. The ADHS/DBHS HIV Coordinator, Mercy Maricopa 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
Mercy Maricopa 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 persons. Specific requirements apply regarding preferential access to services and the timeliness of responding to a person’s identified needs (see Chapter 2.1 – Appointment Standards and Timeliness of Service). Behavioral health providers must also submit specific data elements to identify special populations and record limited clinical information (see Chapter 18.0 - Enrollment, Disenrollment and Other Data Submission for requirements).

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, with the exception of detox services;
- To make cash payments to intended recipients 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 abuse 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; see http://grants.nih.gov/grants/policy/salcap_summary.htm; 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 population members (pregnant females, females with dependent child(ren), 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, case 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 abuse services;
• Health and behavioral health services; and
• To provide for training of providers of emergency health services regarding behavioral health.

Restrictions on Use of MHBG Funds
The State shall not expend MHBG funds on the following activities:
• To provide inpatient hospital services; with the exception of detox services
• To make cash payments to intended recipients 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 abuse 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; see http://grants.nih.gov/grants/policy/salcap_summary.htm; 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.

2.10 – Crisis Intervention Services
Crisis intervention services are provided to a person for the purpose of 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 person’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 situation.
GENERAL REQUIREMENTS
To meet the needs of individuals in communities throughout Arizona, Mercy Maricopa 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.
  - Answer calls within three (3) telephone rings (equivalent to 18 seconds), with a call abandonment rate of less than three (3)%.
  - Offer interpretation or language translation services to persons 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) to two and one-half (2-1/2) hours to a psychiatric crisis in the community.
  - If a two-person team responds, one person may be a Behavioral Health Paraprofessional, 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 abuse 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**
Connections AZ Urgent Psychiatric Care Center (UPC)
903 N. 2nd St.
Phoenix, AZ 85004
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.
Phoenix, AZ 85008
MANAGEMENT OF CRISIS SERVICES
While Mercy Maricopa must provide a standard set of crisis services to ensure the availability of these services throughout the state, Mercy Maricopa will also be able to meet the specific needs of communities located within their service area. Mercy Maricopa 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 Mercy Maricopa-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, Mercy Maricopa will use the generic medication formulary identified in the Non-Title XIX SMI benefit (see Chapter 15.0 – ADHS/DBHS Drug List).

Whenever possible, Crisis Services are to be delivered within the community at the least restrictive level of care available.

GENERAL MENTAL HEALTH/SUBSTANCE ABUSE (GMHSA) 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 on a daily basis.
- 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 RBHA Contracted Behavioral Health Providers must have 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.

EXPECTATIONS FOR OUTPATIENT PROVIDERS WITHIN 24 HOURS FOR PERSONS WITH SERIOUS
MENTAL ILLNESS (SMI) CRISIS EPISODE
When a member is medically admitted, the clinical team should provide the following information to the hospital:
 Psychiatric progress note;
 The last 3 case management progress notes;
 Face sheet;
 Points of contact for the clinical team and any other supports in the member’s life; and
 A follow up appointment with a behavioral health medical provider

Within 24 hours of admission, the clinical team needs to outreach the hospital treatment team to provide the information listed above. The clinical team is to complete at minimum one face to face contact a week while the member is inpatient and should begin ongoing discharge conversations with the hospital treatment team. Post discharge, contact should be made by the clinical team RN within 24 hours of discharge to review the discharge instructions to verify that follow up appointments with physical health providers have been scheduled and confirm that all discharge recommendations are completed (i.e. medications have been filled, appointments scheduled and attended, and etc.). If this has not been completed, the RN is to assist the member in completing these follow up needs within 24 hours of contact with the member. If the clinical team is unable to contact member post-discharge, the clinical team shall implement engagement strategies to help prevent a readmission. Follow up should be continued by the clinical team to ensure all aspects of the discharge plan have been implemented. This should include:
 The member has all medications prescribed;
 The member has seen any and all physicians required at discharge, including the primary care physician and other specialists;
 Any other discharge instructions have been completed; and
 Any durable medical equipment required has been made available.

2.11 – Housing for Individuals Determined to have Serious Mental Illness (SMI)

The Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS) and Tribal and Regional Behavioral Health Authorities (T/RBHAs) have worked collaboratively to ensure a variety of housing options and support services are available to assist persons 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 are able to live, work, learn, and participate fully in their communities. Safe, stable, and familiar living arrangements are critical to a person's ability to benefit from treatment and support services.

For persons determined to have SMI who are able to live independently, Mercy Maricopa have a number of 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.

ADHS/DBHS 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 similar to 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 have the opportunity to 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.

**ADHS/DBHS HOUSING REQUIREMENTS**

**State Funded Supported Housing Programs**

Mercy Maricopa complies with the following requirements to effectively manage limited housing funds in providing supported housing services to enrolled individuals:

- Mercy Maricopa uses supported housing allocations for individuals with a SMI and according to any restrictions pertaining to the funding source. For example, a particular allocation may require it be used for Title XIX/XXI persons, while another allocation may require it be used for Non-Title XIX persons.
- 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 Maricopa and its subcontracted providers must not actively refer or place individuals determined to have SMI in a homeless shelter, licensed supervisory care homes, unlicensed board and care homes, or other similar facilities.3
- Mercy Maricopa 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 Maricopa’s subcontracted providers must provide the tenant with a 30-day notice at the time of the tenant’s annual recertification.
- Mercy Maricopa does not use supported housing allocations for room and board charges in residential treatment settings (Level II and Level III facilities). However, Mercy Maricopa may allow residential treatment settings to establish policies, which require that persons earning income contribute to the cost of room and board.
- Mercy Maricopa may provide move-in assistance and eviction prevention services to those members in permanent housing. When move-in assistance is provided, Mercy Maricopa 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 Maricopa encourages its subcontracted providers to seek donations for necessary move-in/home furnishing items whenever possible. Mercy Maricopa does not use supported housing allocations or other funding received from ADHS/DBHS (including block grant funds) to purchase furniture.
- For appeals related to supported housing services, Mercy Maricopa and its subcontracted providers must follow the requirements in Chapter 20.3 – Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI).

Other ADHS/DBHS Housing Requirements

Mercy Maricopa submits Housing Plans and periodic reports on housing programs to ADHS, as outlined in the ADHS/Mercy Maricopa contract.

MERCY MARICOPA HOUSING PROGRAMS AND REQUIREMENTS

Mercy Maricopa’s housing programs include specialized housing units to meet the needs of persons 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 persons determined to have SMI:

- Housing for females with co-occurring disorders who are homeless;
- Apartment complexes for persons determined to have SMI with criminal backgrounds released from jail with a major biological disorder;

3 When a behavioral health member chooses to reside in an unlicensed board and care home, Mercy Maricopa and/or its subcontracted providers must report any observations of unsafe conditions or provision of services that require licensure to the local housing authority and the Division of Licensing Services (DLS) at (602) 364-2595.
- Housing for persons determined to have SMI who are hearing impaired or deaf;
- Housing for persons determined to have SMI who have sexualized behaviors and are in need of 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 persons with developmental disabilities who are determined to have SMI (joint ADHS/DBHS, DES/DD program);
- Specialized homes for polydipsia;
- Homes that specialize in dialectical behavioral therapy;
- Housing for persons determined to have SMI with limited English proficiency; and
- Housing suited to meet medical needs of persons determined to have SMI with diabetes and other chronic diseases.

For additional information specific to Mercy Maricopa’s Housing Programs and Requirements contact a Clinical Housing Coordinator via Customer Service at: 1-800-564-5465.

**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.

Mercy Maricopa works in collaboration with the Arizona Department of Housing (ADOH) and
ADHS/DBHS 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 Maricopa 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 persons. 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 Maricopa’s Clinical Housing Coordinator via Customer Service at 800-564-5465.

### 2.12 – Special Assistance for Persons Determined to have a Serious Mental Illness

Mercy Maricopa, the Arizona State Hospital (AzSH) and subcontracted providers must identify and report to the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) Office of Human Rights (OHR) persons determined to have a Serious Mental Illness (SMI) who meets the criteria for Special Assistance. If the person’s Special Assistance needs appear to be met by an involved family member, friend, designated representative or guardian, Mercy Maricopa or behavioral health provider must still submit a notification to the OHR. Mercy Maricopa, AzSH, subcontracted providers and ADHS/DBHS Office of Grievance and Appeals (OGA) must ensure that the person designated to provide Special Assistance is involved at key stages.

**GENERAL REQUIREMENTS**

**Criteria for Identifying Need for Special Assistance**

A person who has been determined to have a SMI is in need of 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 person’s limitations are due to any of the following:
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 person 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 Maricopa or its subcontracted provider recommends a person 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 person automatically satisfies the criteria for Special Assistance.

The existence of any of the following circumstances for an individual should prompt Mercy Maricopa 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 Maricopa 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.)

**Person Qualified to Make Special Assistance Determinations**
The following may deem a person to be in need of Special Assistance:
- A qualified clinician providing treatment to the person;
- A case manager of Mercy Maricopa or subcontracted provider;
- The member’s clinical team;
- Mercy Maricopa;
- A program director of a subcontracted provider; including Arizona State Hospital (AzSH);
- The Deputy Director of ADHS/DBHS; or
- A hearing officer assigned to an appeal involving a person determined to have an SMI.

**Screening for Special Assistance**
Mercy Maricopa’s subcontracted providers must screen whether persons determined to have a SMI are in need of 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);
- 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 person’s dissatisfaction with a situation that could be addressed by one or more of these processes.

**Documentation**

Mercy Maricopa’s subcontracted providers shall document in the clinical record each time a person is screened for Special Assistance, indicating what factors were considered and the conclusion reached. If it is determined that the person is in need of Special Assistance, they must notify the Office of Human Rights (OHR) by completing [Notification of Persons in Need of Special Assistance](#) in accordance with the procedures outlined below.

Before submitting the [Notification of Persons in Need of Special Assistance](#), Mercy Maricopa’s subcontracted providers shall check if the person is already identified as in need of Special Assistance. A notation of Special Assistance designation and a completed [Notification of Persons in Need of Special Assistance](#) should already exist in the clinical record. However, if it is unclear, subcontracted providers must review Mercy Maricopa data or contact Mercy Maricopa to inquire about current status. Mercy Maricopa maintains a database on persons 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 person is not correctly identified as Special Assistance, Mercy Maricopa’s subcontracted providers must notify the Office of Human Rights (OHR) using [Notification of Persons in Need of Special Assistance (Part A)](#), within five working days of identifying a person in need of Special Assistance. If the person’s Special Assistance needs require immediate assistance, the notification form must be submitted immediately, with a notation indicating the urgency. If the person 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 Persons in Need of Special Assistance](#), 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 Maricopa subcontracted provider by completing [Notification of Persons in Need of Special Assistance, Part B](#), within five working days of receipt of notification and any necessary clarifying information from Mercy Maricopa. 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 Maricopa subcontracted providers. The Mercy Maricopa 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/person will provide Special Assistance when processing the Notification of Persons in Need of Special Assistance. When the agency/person providing Special Assistance changes, OHR will need to process an “updated Part B” to document the change. In the event the person or agency currently identified as providing Special Assistance is no longer actively involved, Mercy Maricopa or subcontracted provider must notify OHR. If an OHR advocate is also assigned, notification to the advocate is sufficient.

PERSONS NO LONGER IN NEED OF SPECIAL ASSISTANCE
The Mercy Maricopa 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 Persons in Need of Special Assistance (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 person completing the form; and
- The date the form is completed.

The following are instances that should prompt Mercy Maricopa’s subcontracted provider to submit a Part C:
- The original basis for the person meeting Special Assistance criteria is no longer applicable and the person does not otherwise meet criteria; The subcontracted provider must first discuss the determination with the person or agency providing Special Assistance to obtain any relevant input; this includes when a person is determined to no longer be a person with a SMI (proper notice and appeal rights must be provided and the time period to appeal must have expired);
- The person passes away;
- The person’s episode of care is ended with Mercy Maricopa (Non-Title XIX persons with a SMI will also be disenrolled) and the person is not transferred to another T/RBHA. (Submission of a Part C is not needed when a person transfers to another T/RBHA, as the Special Assistance designation follows the person.)

The Mercy Maricopa subcontracted providers must first perform all required re-engagement efforts, which includes contacting the person providing Special Assistance, per Chapter 2.3 – Outreach, Engagement, Re-Engagement and Closure, proper notice and appeal rights must be provided and the time period to appeal must have expired.

Upon receipt of the Notification of Persons in Need of Special Assistance, Part C, the OHR administration reviews the content to confirm accuracy and completeness and send it back to the agency that submitted it, copying Mercy Maricopa or its subcontracted provider.

REQUIREMENTS OF MERCY MARICOPA AND PROVIDERS
The Mercy Maricopa subcontracted providers must maintain open communication with the person/agency (guardian, family member, friend, OHR advocate, etc.) assigned to meet the person’s Special Assistance needs. Minimally, this involves providing timely notification to the person providing Special Assistance to ensure involvement in the following stages:

- ISP planning and review: Including any instance when the person makes a decision 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 case manager assignment); and
- ISP development and updates: Must be in accordance with Chapter 2.4 – Assessment and Service Planning;
- ITDP planning: Which includes any time the person 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 person/guardian must also be copied to the person designated to meet Special Assistance needs; and
- Investigation or grievance: Includes circumstances when initiating a request for investigation/grievance may be warranted.

In the event that such procedures are delayed in order to ensure the participation of the person providing Special Assistance, the Mercy Maricopa subcontracted provider must document the reason for the delay in the clinical record and ensure that the person receives the needed services in the interim.

Mercy Maricopa’s subcontracted providers shall provide relevant details and a copy of the original Notification of Person in Need of Special Assistance (both Parts A and B) to the receiving entity and when applicable, case manager when a person in need of Special Assistance is:

- Admitted to an inpatient facility;
- Admitted to a residential treatment setting; or
- Transferred to a different T/RBHA, case management provider site or case manager.

Subcontracted providers must periodically review whether the person’s Special Assistance needs are being met by the person or agency designated to meet those needs. If a concern arises, the Mercy Maricopa subcontracted provider should initially address the problem with the person 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 Maricopa, AzSH and subcontracted providers shall grant access to clinical records of persons in need of Special Assistance to the OHR in accordance with all federal and state confidentiality laws. (For further clarification see Chapter 16.0 – Confidentiality).

Human Rights Committee (HRCs) and their members shall safeguard the monthly list that contains the names of those persons in need Special Assistance regarding any Protected
Health Information (PHI). HRCs must inform ADHS/DBHS 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 Maricopa OGA and the ADHS/DBHS OGA must review whether the person is already identified as in need of Special Assistance.

If so, the Mercy Maricopa or ADHS/DBHS 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 Maricopa or ADHS/DBHS 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 Maricopa or ADHS/DBHS OGA shall also forward a copy of any subsequent notice of hearing.

DOCUMENTATION AND REPORTING REQUIREMENTS
Mercy Maricopa’s subcontracted providers must maintain a copy of the completed Notification of Person in Need of Special Assistance (Parts A, B and updated B, if any) in the person’s comprehensive clinical record. In the event a person was identified as no longer needing Special Assistance and a Part C of the notification form was completed, Mercy Maricopa and subcontracted providers must maintain a copy of the Notification of Person in Need of Special Assistance in the comprehensive clinical record.

Mercy Maricopa’s subcontracted providers must also clearly document in the clinical record (i.e. in the assessment, ISP, ITDP, face sheet) and case management/client tracking system if an individual is identified as Special Assistance, the person assigned currently to provide Special Assistance, the relationship, contact information of phone number and mailing address.

To support Mercy Maricopa and OHR in maintaining accurate and up-to-date information on persons in need of Special Assistance, subcontracted providers are required to follow Mercy Maricopa’s quarterly procedures for data updates about currently identified/active persons in need of Special Assistance.

Mercy Maricopa must share Special Assistance data with its subcontracted providers that provide case management to individuals determined to have a SMI and verify that a process exists at each case management provider to ensure this data is accessible by front-line provider staff (at a minimum quarterly). Mercy Maricopa must also establish a process with such providers to obtain quarterly updates on individuals currently identified as Special Assistance to support the T/RBHAs 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 Maricopa 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.

2.13 – Arizona State Hospital

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 Maricopa or other referral source has made reasonable 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 Maricopa 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 person 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 Maricopa for that geographic service area to discuss the recommendation for admission to AzSH. Mercy Maricopa must be in agreement with the other referral source that a referral for admission to AzSH is necessary and appropriate. If the candidate is not T/RBHA enrolled, Mercy Maricopa 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 Chapter 2.1 – Appointment Standards and Timeliness of Service to AzSH. The enrollment date is effective the first date of contact by Mercy Maricopa. Mercy Maricopa 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 person, if eligible in the AHCCCS Indian Health Program.
- For TRBHA (Tribal RBHA only) enrolled behavioral health members, ADHS/DBHS must also be in agreement with the referring agency that admission to AzSH is necessary and appropriate, and ADHS/DBHS must prior authorize the person’s admission (see Chapter 13.0 – Securing Services and Prior Authorization).
- Mercy Maricopa 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 (see Attachment A, AzSH Application and Attachment B, AzSH Payor Financial Information), 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 Chapter 2.12 – Special Assistance for Persons Determined to have a Serious Mental Illness 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 person for admission without copies of the necessary legal documents.
- For T-XIX enrolled persons, the Certification of Need (CON) should be included in the application for admission. Mercy Maricopa 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 Maricopa 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 Maricopa 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.
- 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 explaining why the behavioral health member is not being accepted for admission, and the referral source will be offered the opportunity to request reconsideration by submitting additional information or by conferring with the AzSH Chief Medical Officer or Acting Designee. 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, AzSH shall establish a pending list for admission. If the behavioral health member’s admission is pending for more than 15 days, 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.

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 person (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. (A.A.C. R9-21-507(B)(1)).

Hospitalization at AzSH must be the most appropriate level of care to meet the person’s treatment needs, and the person 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 ADHS/DBHS-established five principles of person-centered treatment for adult behavioral health members determined to have Serious Mental Illness (SMI).

Behavioral health members shall remain assigned to their original clinic/outpatient treatment team throughout their admission, unless the member initiates a request to transfer to a new clinic site or treatment team.

Consideration of comprehensive information regarding previous treatment approaches, outcomes and recommendations/input from Mercy Maricopa 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 in order 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 Maricopa, 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.

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 least monthly.

Any noted difficulties in collaboration with the outpatient provider treatment teams will be brought to the attention of Mercy Maricopa to be addressed. Mercy Maricopa Hospital Liaison will monitor the participation of the outpatient team and assist when necessary.

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 persons and is the contact for AzSH for all Mercy Maricopa 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). The RON will be sent to Mercy Maricopa within five (5) days of expiration of the current CON/RON. If required by Mercy Maricopa, the Utilization Manager will send to Mercy Maricopa Utilization Review staff additional information/documentation needed for review to determine continued stay.

All Mercy Maricopa decisions with regard to the approval or denial for continued stay will be rendered prior to the expiration date of the previous authorization and upon receipt of the RON for those behavioral health members. Mercy Maricopa authorization decisions are based on review of chart documentation supporting the stay and application of the ADHS/DBHS Level Continued Stay criteria. If continued stay is approved, Mercy Maricopa 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 Chapter 13.0 – Securing Services and Prior Authorization.

TRANSITION TO COMMUNITY PLACEMENT SETTING
The behavioral health member is considered to be 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 Maricopa 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 person from being placed on the 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 Maricopa must immediately take steps necessary to transition the behavioral health member into community-based treatment as soon as possible. Mercy Maricopa has up to thirty (30) days to transition the behavioral health member out of AzSH. Mercy Maricopa’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 members discharge date. This will allow sufficient 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 ADHS/DBHS.

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 persons and that coverage or payment determinations by Mercy Maricopa does not absolve AzSH or its providers of responsibility to render appropriate services to eligible persons.

AzSH must render and must ensure that contracted providers render covered services in a quality and cost effective manner pursuant to Mercy Maricopa 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 person 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 persons age 18 up to the age of twenty-one (21) years whose condition is identified as an eligible CRS diagnosis.

AzSH further agrees to comply with ADHS/DBHS policies regarding appropriate referrals to the ADES/DDD, and the AHCCCS/ALTCS programs.

The failure of AzSH to make referrals that are timely and adequate may result in denial of claims or recoupment depending upon AzSH’s method of reimbursement.

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.

GRIEVANCE AND APPEAL PROCESS
AzSH agrees, and will ensure that its contracted providers agree to abide by and cooperate with Mercy Maricopa complaint, grievance, and appeal process maintained to fairly and expeditiously resolve eligible person’s, provider’s, and AzSH’s concerns pertaining to any service provided; issues related to this chapter; and/or allow an eligible person, provider, or AzSH to appeal a determination that a service is not medically necessary; and to resolve SMI eligible person allegations of rights violations under the ADHS/DBHS rules (A.A.C. R9-21) for SMI eligible persons.

Additionally the Mercy Maricopa and provider staff must comply with the AzSH complaint, appeal and grievance processes.

DENIAL PROCESS
All decisions by Mercy Maricopa 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 Maricopa level of care criterion to each case.
The AzSH Utilization Manager will request to appeal Mercy Maricopa decision in writing and document the date and time the formal appeal was requested in the behavioral health member’s utilization management file.

**CLINICAL DISPUTE RESOLUTION PROCESS**

Any disagreements between Mercy Maricopa and AzSH should be resolved in a collaborative manner and at the lowest possible level.

Disputes regarding admission referrals may include but are not limited to:
- The patient does not have a mental disorder as defined in **A.R.S. 36-501 (26)**,
- The patient must be able to benefit from care and treatment at AzSH **(A.R.S. 36-202)**,
- AzSH level of care must be the most appropriate and least restrictive treatment option for the person **(A.R.S 36-501 (21))**, 
- The provision of appropriate, medically necessary covered behavioral health services must be consistent with treatment goals outlined on the admission application and individual needs identified in the course of treatment of individuals admitted to AzSH.

Disputes regarding discharge referrals will be dealt with through the clinical team.

If the dispute cannot be resolved within the clinical team, the AzSH treating psychiatrist will attempt to resolve the dispute through a telephonic conversation with Mercy Maricopa’s provider psychiatrist.

If the dispute continues to not be resolved, a telephonic conversation with the AzSH Chief Medical Officer (CMO) or Acting Designee and Mercy Maricopa CMO or Acting Designee will occur. As appropriate, the discharge dispute will be documented in the order identified as indicated below.
- Mercy Maricopa Chief Medical Officer (CMO) or Acting Designee or other referral source contacts AzSH CMO or Acting Designee.
- The decision is to be completed within a timely manner not to exceed three (3) working days.
- If the disagreement continues, Mercy Maricopa Chief Medical Officer or Acting designee or other referral source will contact the AzSH CEO or acting designee.
- The reconsideration decision is to be completed in a timely manner, not to exceed three (3) working days.
- If the disagreement continues to be unresolved, the ADHS/DBHS Chief Medical Officer or Acting Designee will review all pertinent information.
- ADHS/DBHS will render a final determination within three (3) working days, and the written decision will be issued to both parties.

**CLAIMS, BILLING AND REIMBURSEMENT**

*Claims*

AzSH agrees to file claims for covered services in the form and manner required by Mercy Maricopa.
AzSH agrees to cooperate with Mercy Maricopa 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 Maricopa 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 Maricopa within six (6) months after the date of service.

Payment by Mercy Maricopa 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 Maricopa within thirty/ninety (30/90) days of the Mercy Maricopa receiving the initial claim submission.

Resubmissions will be provided to Mercy Maricopa within thirty (30) days of the receipt of the denial.

**Availability of Funds**
Payments made by Mercy Maricopa to AzSH and the continued authorization of covered services are conditioned upon the receipt of funds by ADHS, and in turn, the receipt of funds to Mercy Maricopa from ADHS authorized for expenditure in the manner and for the purposes provided in this chapter.

Mercy Maricopa must not be liable to AzSH for any purchases, obligations, or cost of services incurred by AzSH in anticipation of such funding.

**Indemnification**
Mercy Maricopa 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 Maricopa, Mercy Maricopa employees, agents, directors, trustees, and/or representatives.

AzSH agrees to indemnify and to hold the Mercy Maricopa harmless from any costs, claims, judgments, losses, damages, or expenses, including attorneys’ fees, which the Mercy
Maricopa incurs because of the negligent acts or omissions of AzSH, AzSH employees, agents, directors, trustees, and/or representatives.

**Mercy Maricopa External Medical Record Review**

Mercy Maricopa utilization review specialists may obtain information from the health record of the AzSH patient to review the utilization of the hospitals services. All procedures as outlined in this chapter will be in compliance with 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).

2.14 Transfer of a SMI Member Enrolled in an Integrated RHBA to an AHCCCS Acute Care Contractor  (NEW Effective 10/1/15)

The transfer of a SMI member enrolled in Mercy Maricopa to an AHCCCS Acute Care Contractor may be granted in exceptional circumstances. Such transfer impacts physical health care services only; the member will continue to receive their behavioral health services through Mercy Maricopa.

Mercy Maricopa has developed and will maintain a process that allows SMI members to request a transfer of their physical health care services to an AHCCCS Acute Care Contractor based on the criteria outlined below.

The process must be initiated by contacting Mercy Maricopa’s Member Services, and facilitated through a centralized administrative Mercy Maricopa functional area, such as the area devoted to the resolution of Grievances and Appeals.

**CRITERIA FOR THE TRANSFER**

Upon receipt of a SMI member enrolled in Mercy Maricopa’s request to transfer to an AHCCCS Acute Care Contractor, Mercy Maricopa must explore all options to promptly resolve the member’s concerns regarding:

- The availability and accessibility of services; and/or
- The course of medical care or delivery issues; and/or
- Any policy or practice that results in the actual or perceived discriminatory or disparate treatment of the individual as a result of his/her enrollment in Mercy Maricopa.

When the efforts of Mercy Maricopa have not adequately resolved the member’s concerns, a member may be transferred to an AHCCCS Acute Care Contractor to remediate one or more of the following:

- Network limitations and restrictions that result in access to care issues for the member; and/or
- The transfer is necessary to fulfill a physician’s or provider’s course of care recommendation; and/or
The member has demonstrable evidence that due to the enrollment and affiliation with Mercy Maricopa as a person with a SMI, and in contrast to persons enrolled with an AHCCCS Acute Care Contractor, actual harm or the potential for discriminatory or disparate treatment exists with regard to one or more of the following:

- The access to, continuity, or availability of acute care covered services;
- Exercising client choice of plan;
- Privacy rights;
- Quality of services provided; or
- Client rights under Arizona Administrative Code, Title 9, Chapter 21, Article 2.

With regard to exercising client choice of plan, a member, or their representative, must demonstrate that the discriminatory or disparate treatment has already occurred or establish the plausible potential of such treatment. It is insufficient for a member to establish actual harm or the potential for discriminatory or disparate treatment solely on the basis that he/she is enrolled in Mercy Maricopa.

**PROCESS FOR TRANSFER**

The process will be initiated when the member, the member’s legal representative, or a medical provider with the member’s consent, contacts the Mercy Maricopa’s Member Services verbally or in writing to request a change in the member’s health care plan of enrollment, and the member’s concern cannot be resolved to the member’s satisfaction.

All requested plan changes will be processed as follows:

- Mercy Maricopa must enter all required information into the ADHS/DBHS Transfer of a SMI Member Enrolled in an Integrated RBHA to an AHCCCS Acute Care Contractor Form. This electronic form is located on the web based BHS Client Portal and must be submitted for each member requesting to transfer to an AHCCCS Acute Care Contractor to include the elements below:
  - Confirm and document that the member is enrolled in Mercy Maricopa.
  - If received verbally, reduce to writing the member’s assertions of actual harm or potential discriminatory or disparate treatment as a result of enrollment in Mercy Maricopa
  - Provide documentation of efforts to investigate and resolve member’s concern.
  - Include any evidence provided by the member of actual or reasonable likelihood of discriminatory or disparate treatment.
  - Review completed request packets, including all information received from the member or their designee, and recommend the approval or denial of the request.
    - The final recommendation must be approved by Mercy Maricopa Medical Director or their designee.
  - Forward the completed packet within seven (7) calendar days of receipt of the request to ADHS/DBHS for decision.
• ADHS/DBHS will issue all approval and denial decisions in writing within 10 calendar days from the date of the initial request from the member.
• For requests that are denied, ADHS/DBHS will issue a notice to the member that includes the reasons for the denial and the member’s appeal and/or hearing rights. See section 3.d for more information regarding member appeals.

For any transfer of a SMI member enrolled in Mercy Maricopa to an AHCCCS Acute Care Contractor, Mercy Maricopa must collaborate with the AHCCCS Acute Care Contractor to ensure appropriate transition and continuity of care.

Mercy Maricopa will maintain a record of all approved and denied SMI member requests to transfer to an AHCCCS Acute Care Contractor.

REQUEST FOR STATE FAIR HEARING
A Mercy Maricopa SMI member, or their designee, who is dissatisfied with the decision relating to his/her request to transfer to an AHCCCS Acute Care Contractor may request a hearing to dispute the decision to AHCCCS.

The member’s request for hearing must be in writing and received by ADHS/DBHS’ Office of Grievance and Appeals no later than thirty (30) calendar days from the date the member receives the decision.

The member may request that the hearing be expedited. The hearing shall be expedited if AHCCCS determines from the supporting documentation provided, or a provider asserts, that taking the time for a standard resolution could seriously jeopardize the member’s life, health or ability to attain, maintain or regain maximum function.

Upon receipt of a timely request for hearing, ADHS/DBHS shall, within five (5) business days, forward the following to the AHCCCS Office of Administrative Legal Services (OALS):
  • The member’s name, AHCCCS ID number, current address and current phone number (if applicable);
  • The member’s request to transfer;
  • The decision, and;
  • Any and all relevant information and/or documentation submitted by the member and any and all relevant information and/or documentation supporting the decision, including medical records.

AHCCCS will issue a Notice of Hearing if a timely request for hearing is filed.

For requests for hearing addressed pursuant to a standard resolution timeframe, AHCCCS will issue an AHCCCS Director’s Decision no later than 30 days from the date AHCCCS receives the Administrative Law Judge’s recommended decision.
For requests for hearing addressed pursuant to an expedited resolution timeframe, AHCCCS will issue an AHCCCS Director’s Decision no later than 3 business days after the date AHCCCS receives the Administrative Law Judge’s recommended decision. AHCCCS will also make reasonable efforts to provide the member verbal notice of the AHCCCS Director’s Decision.

Mercy Maricopa will fully cooperate with implementation of the AHCCCS Director’s Decision and ensure that coordination and continuity of care for the member is maintained throughout the process.

**2.15 – Provider Relations Department**

Our Provider Relations Liaisons are dedicated liaisons who are here to help you. We want you to have a positive experience with Mercy Maricopa. Your Provider Liaison will work closely with you to help you get the most out of doing business with us.

**PROVIDER RELATION LIAISONS OFFER SUPPORT SUCH AS:**
- Site visits
- Training your staff on Mercy Maricopa policies and procedures
- Providing ongoing education resources such as the provider portal and Provider Manual
- Resolving operational issues to improve health care delivery
- Being available to answer your questions

**PROVIDER RELATIONS LIAISONS HELP UTILIZE AVAILABLE TECHNOLOGY SUCH AS:**
- Secure provider web portal
- Health Information Exchange (HIE)
- Administrative functions: Claims submission (EDI), Funds Transfer (EFT), Remittance Advice (ERA)

**FIND YOUR PROVIDER RELATIONS LIAISON:**
Mercy Maricopa assigns every participating provider a liaison. You and/or your office staff will work with your provider liaison regularly. You can find your provider representative on the list [Provider Relations Assignment List](#). Call the Provider Relations Department at **1-800-564-5465** (toll-free) (TDD/TTY) **711** if you don’t see your agency listed.
CHAPTER 3 – PROVIDER RESPONSIBILITIES

3.0 – Provider Responsibilities

Providing Member Care

3.0.1 – AHCCCS REGISTRATION
Each provider must first be registered with AHCCCS and obtain an AHCCCS provider ID number.

3.0.2 – APPOINTMENT AVAILABILITY STANDARDS
Please reference Chapter 2.1 – Appointment Standards and Timeliness of Service of the Mercy Maricopa Provider Manual for detailed information regarding Appointment Availability Standards.

3.0.3 – 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 Mercy Maricopa:

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

3.0.4 – COVERING PHYSICIANS
Mercy Maricopa Provider Relations must be notified if a covering provider is not contracted or affiliated with Mercy Maricopa. This notification must occur in advance of providing coverage and Mercy Maricopa must provide authorization. Reimbursement to covering physicians is based on the Mercy Maricopa Fee Schedule. Failure to notify Mercy Maricopa of covering physician affiliations may result in claim denials and the provider may be responsible for reimbursing the covering provider.

3.0.5 – 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. Mercy Maricopa 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:
- **MercyMaricopa.org:** This information is available on the Mercy Maricopa Secure Web Portal page. You must have a confidential password to access. To register, contact your Provider Relations representative.
- **MediFax:** MediFax is an electronic product available through AHCCCS that stores key member information. Use to verify Mercy Maricopa member eligibility for pharmacy, dental, transportation and specialty care.
- **AHCCCS Interactive Voice Response (IVR):** To use, dial 602-417-7200. For providers outside of Maricopa County only please dial 1-800-331-5090.
- **Mercy Maricopa Telephone Verification:** Use as a last resort. Call Member Services to verify eligibility at 800-564-5465. 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 Mercy Maricopa, use the prompt for the providers.
- **Monthly Roster:** Monthly rosters are found on the secure website portal. Contact your Provider Relations representative for more information. Note that rosters are only updated once a month.

3.0.6 – PREVENTIVE OR ROUTINE SERVICES

Providers are responsible for providing appropriate preventive care for eligible members. Preventive health guidelines are located on the Mercy Maricopa 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; and
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program.

3.0.7 – EDUCATING MEMBERS ON THEIR OWN HEALTH CARE

Mercy Maricopa 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 in order 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.

3.0.8 – URGENT CARE SERVICES

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

Mercy Maricopa 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.

3.0.9 – EMERGENCY SERVICES
Prior authorization is not required for emergency services. In an emergency, members should go to the nearest emergency department.

Mercy Maricopa educates its members regarding the appropriate use of Emergency Services. Members are educated to obtain services from non-emergency facilities (e.g., urgent care centers) to address member non-emergency care after regular office hours or on weekends.

An emergency is a medical condition that could cause serious health problems or even death if not treated immediately. 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

3.0.10 – PRIMARY CARE PHYSICIANS (PCPS)
The primary role and responsibilities of primary care physicians participating in Mercy Maricopa Plan 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 Mercy Maricopa 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 Mercy Maricopa Plan network, as appropriate, and if necessary, referring members to out-of-network specialty providers;
- Coordinating with Mercy Maricopa Plan’s Prior Authorization Department with regard to 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 Mercy Maricopa 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

3.0.11 – 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 Mercy Maricopa 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.

3.0.12 – 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 credentialing of Locum Tenens.

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

3.0.13 – 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. If a network provider is not available, the member may obtain an appointment outside the network at no cost to the member.

3.0.14 – 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, Mercy Maricopa’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 Program Form 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 Provider Relations representative.

3.0.15 – INCORPORATING PEER AND FAMILY VOICE AND CHOICE IN INTEGRATED CARE SERVICE DELIVERY
To ensure that peers and family members are involved, providers need to conduct the following activities to engage peers and family members once an opportunity for their involvement has been identified:

- Identify the number of peers and family members needed;
- Determine the types of experience and expertise that would be most beneficial for the opportunity,
- Create an informational document that identifies the opportunity, the types of experience and expertise that would be most helpful, the time commitment required, whether or not a stipend will be offered, who to contact to express interest, and other pertinent details, as appropriate (e.g., child care, transportation);
- Contact the Arizona Peer and Family Coalition, peer operated programs, peer and family support organizations, and community organizations to advertise the opportunity;
- The staff member responsible for the activity creates a list of all individuals who responded and their contact information;
- Mercy Maricopa or subcontracted provider staff contact the peer or family member to respond to their inquiry, provide additional information, and verify their attendance;
- If the peer or family member declines participation in the activity, the staff member documents the date of the contact and the reason for the declination;
- If the staff member is unable to reach the peer or family member, the staff member attempts contact on at least 2 additional occasions;
- If the staff member is unable to reach the individual, they document the date and times of the outreach on the member input tracking log.

Mercy Maricopa maintains a list of peers and family members who express the desire and willingness to participate in committees, workgroups, community forums, or other activities. Providers may utilize this list to engage peers and family members, but are encouraged to conduct widespread recruitment as outlined above to afford all individuals with the opportunity to participate.

Providers must maintain a list of peers and family members who express interest in participating in interviews as well as other activities. Providers should refer to this list when recruiting individuals to participate in staff interviews.

To ensure that peers and family members are involved, Mercy Maricopa:
- Requires providers to demonstrate documentary evidence to show participation of at least one peer during the interview process when hiring for all direct services staff positions.
- Requires all provider sites where case management services are delivered, to establish and maintain a Clinic Advisory Council made up of individuals receiving services at that clinic, direct service staff, clinic leadership, and relevant community members/neighbors. Clinic Advisory Councils are used to provide an opportunity for individuals receiving services, their family members, the staff providing services, and interested community members to get involved in improving the delivery of services, improving the environment in which services are provided, and enhancing customer service. Clinic Advisory Councils are entrusted with the responsibility of reviewing member feedback and making recommendations for continuous improvement to the provider leadership. Provider leadership is expected to attend Clinic Advisory Council meetings as invited by the Council chair.
- Providers are required to adhere to ADHS Policy CO.1.5 Family and Youth involvement in the children’s Behavioral Health system.

**Documenting Member Care**

**3.0.16 – MEMBER MEDICAL RECORD**
For additional information, please refer to [Chapter 10.1 – Medical Record Standards](#) of the Mercy Maricopa Provider Manual.

**3.0.17 – ADVANCE DIRECTIVES**
For additional information, please refer to [Chapter 10.0 – Advance Directives](#) of the Mercy Maricopa Provider Manual.

**3.0.18 – MEDICAL RECORD AUDITS**
For additional information, please refer to [Chapter 10.1 – Medical Record Standards](#) of the Mercy Maricopa Provider Manual.
3.0.19 – 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.

3.0.20 – 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 Mercy Maricopa’s website for a member who continually misses appointments.

Mercy Maricopa encourages providers to use a recall system. Mercy Maricopa reserves the right to request documentation supporting follow up with members related to missed appointments.

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

3.0.22 – RESPECTING MEMBER RIGHTS
Mercy Maricopa is committed to treating members with respect and dignity at all times. 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 in the Mercy Maricopa website.

3.0.23 – HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPPA) OF 1997
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 http://www.hhs.gov/ocr/hipaa/. In accordance with HIPAA guidelines, providers may not interview members about medical or financial issues within hearing range of other patients.

3.0.24 – CULTURAL COMPETENCY AND HEALTH LITERACY
Cultural Competency
For additional information, please refer to Chapter 6.5 Cultural Competence of the Mercy Maricopa Provider Manual.
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 person with limited health literacy.

To increase health literacy, the National Patient Safety Foundation created the Ask Me 3™ program. Mercy Maricopa supports the Ask Me 3™ program, as it is an effective tool designed to improve health communication between patients and providers. The Ask Me 3™ website is located at:

http://www.npsf.org/for-healthcare-professionals/programs/ask-me-3/

For an Ask Me 3 poster to be displayed in your office, visit:

http://www.npsfstore.com/categories/Ask-Me-3-Products/

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 Maricopa 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 persons 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.

Health Literacy – Limited English Proficiency (LEP) or Reading Skills

See Chapter Cultural Competency for additional information. (Need to revise)

Mercy Maricopa complies with federal and state laws by offering interpreter and translation services, including sign language interpreters, to LEP members. This service affords members
access to health care and benefits by providing a range of language assistance services at no
cost to the member or provider. Mercy Maricopa strongly recommends the use of
professional interpreters, rather than family or friends. Bilingual staff members are available
in the member services department to assist LEP members and a TTY line is available for
members who are hearing impaired. Further, Mercy Maricopa 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.

To access telephone interpretation services to assist members who speak a language other
than English or who use sign language, please call Voiance directly at either of the following
phone numbers:

**Clinical Services:** 1-877-756-4839, pin 1031

**Non-Clinical Services:** 1-877-756-4839, pin 1033

Voiance provides over the telephone interpretation services in over 200 languages. This
service is available at no cost to the member. Additional information regarding Voiance is
available on the Mercy Maricopa Provider website under the **Provider Notification titled**
**Telephone Interpretation Services.** Behavioral health providers must provide their own
interpretation services.

The PCP is responsible for providing appropriate services so that members understand their
health care needs and the member is compliant.

**3.0.25 – 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.

**3.0.26 – PRIMARY CARE PHYSICIAN (PCP) ASSIGNMENTS**
Mercy Maricopa automatically assigns members to a provider upon enrollment. Members
have the right to change their provider at any time. Since member eligibility can change
frequently, providers must verify eligibility prior to delivering services.

**Provider Guidelines and Plan Details**

**3.0.27 – 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, Mercy Maricopa 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 Mercy Maricopa members in accordance with the terms of their contract and AHCCCS guidelines. See Chapter 9.0 – Third Party Liability and Coordination of Benefits for additional information.

3.0.28 – CLINICAL GUIDELINES
To help provide Mercy Maricopa 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.

Mercy Maricopa has adopted the evidence based guidelines published by the National Guideline Clearinghouse.

Behavioral health clinical guidelines can be found on the ADHS/DBHS website under Clinical Guidelines and Recommendations.

3.0.29 – OFFICE ADMINISTRATION CHANGES AND TRAINING REQUIREMENTS
Providers are responsible to notify Mercy Maricopa’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 Provider Relations representative to schedule any needed staff training.

The following trainings are required for participation in the Mercy Maricopa network:
- Medical records standards;
- Fraud and abuse training;
- PCP training regarding behavioral health referral and consultation services.

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.

3.0.30 – CONSENT FORMS
For additional information, please refer to Chapter 2.6 General and Informed Consent to Treatment of the Mercy Maricopa Provider Manual.

The following consent forms are available on the AHCCCS website:
- Certificate of Medical Necessity for Pregnancy Termination (AHCCCS Medical Policy
3.0.31 – PROVIDER SELECTION
Within the Mercy Maricopa 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 Maricopa 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 Maricopa’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.

3.0.32 – CREDENTIALING/RE-CREDENTIALING
For additional information, please refer to Chapter 6.1 – Credentialing and Recredentialing of the Mercy Maricopa Provider Manual. Please note that providers may not treat Mercy Maricopa members until they are credentialed. Providers must also be board certified. 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.

3.0.33 – 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.

3.0.34 – USE OF CORRECTIVE ACTION, NOTICE TO CURE AND SANCTIONS (Updated 02/01/16)
If a provider fails to meet contract standards or demonstrates a pattern of non-compliance, the provider will be subject to corrective action, including sanctions.
Corrective Action
When Mercy Maricopa determines that the sub-contractor is not in compliance with any term of its Contract, Mercy Maricopa will issue (CAL) to the sub-contractor. Once Mercy Maricopa issues a CAL, the sub-contractor shall develop and immediately implement a Mercy Maricopa-approved Corrective Action Plan (CAP).

Notice to Cure
When Mercy Maricopa determines that the sub-contractor is not in compliance with any term of its Contract, Mercy Maricopa will issue a Notice to cure to the sub-contractor. Upon written Notice to cure of sub-contractor noncompliance, the sub-contractor shall demonstrate compliance by the date specified in the Notice to Cure, or be subject to a financial sanction, or any other available remedy under its Contract if at the end of the specified time period, the sub-contractor has not demonstrated compliance as determined by Mercy Maricopa.

Sanctions
The sub-contractor shall be subject to financial sanctions for failure to comply with any term of its Contract, including, at a minimum:

- Substantial failure to provide required medically necessary covered services to a member.
- Charging member’s fees or co-pays in excess of those permitted under the Medicaid program, Copayments and the Mercy Maricopa Policy on Co-payments.
- Discrimination toward members on the basis of health status or need for health care services.
- Misrepresentation or falsification of information provided to Mercy Maricopa or ADHS/DBHS.
- Misrepresentation or falsification of information provided to a member, potential member, subcontractor or health care provider.
- Noncompliance with the requirements as outlined in the Provider Scope of Work in conformance with contract requirements.
- Distribution of marketing materials that have not been approved by Mercy Maricopa or that contain false or materially misleading information, directly or indirectly, through any agent or independent contractor.
- Noncompliance with financial viability standards.
- Material deficiencies in the Sub-Contractor’s provider network; Noncompliance with quality of care and quality management requirements including performance measures.
- Noncompliance with encounter submission standards.
- Noncompliance with applicable state or federal laws or regulations.
- Noncompliance with requirements to fund accumulated deficit in a timely manner.
- Noncompliance with requirements to maintain or increase the Performance Bond in a timely manner.
- Noncompliance with requirements to report third party liability coverage and recovery cases.
- Engaging in conduct which jeopardizes Federal Financial Participation.

Automatic Sanctions Protocol

Repeat Occurrences
Repeat occurrences of non-compliance meeting minimum contract standard requirements, submission of untimely, incomplete or inaccurate reports and/or deliverables will trigger an automatic sanction process. Under this process, sanction amounts will be increased, due to the
provider’s failure to remediate the problem through the Correction Action, Notice to Cure or normal Sanction processes and the resulting impact or harm to members.

Submitting untimely, incomplete or inaccurate reports, deliverables or other information requested by Mercy Maricopa:
§ Untimely Deliverable: $1,000 sanction per each business day beyond the due date. o For repeat untimely submission of the same Deliverable across reporting periods, Mercy Maricopa 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 within the corresponding contract year.
§ Incomplete and/or Inaccurate reports: $5,000 for each rejection of a Deliverable due to incomplete and inaccurate reporting.

For non-compliance with meeting minimum contract standard requirements and 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 within the Contract year. For example:
- 1st time Rejection 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 Mercy Maricopa 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@MercyMaricopa.org.

If a provider fails to meet contract standards or demonstrates a pattern of non-compliance, the provider will be subject to corrective action, including sanctions.

3.0.35 – CONTRACT ADDITIONS OR TERMINATIONS
In order 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. (See Chapter 6.2 Material Changes for additional information.)

3.0.36 – CONTRACT CHANGES OR UPDATES
Providers must report any changes to demographic information to Mercy Maricopa at least 90 days prior to the change in order to be in compliance with 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). (See Chapter 6.2 - Material Changes for additional information.)

Provider Record Updates Table

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

3.0.37 – CONTINUITY OF CARE

Providers terminating their contracts without cause are required to continue to treat Mercy Maricopa 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. Mercy Maricopa 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.

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.

You may also contact Mercy Maricopa’s Case Management Department for assistance at 800-564-5465.

### 3.0.38 – MARKETING

Providers may not market Mercy Maricopa’s name, logo or likeness without prior approval. If a provider advertisement refers to Mercy Maricopa’s name, logo or likeness, the advertising must be prior approved by ADHS/DBHS.

All external presentations and marketing materials produced by providers or subcontracted providers that contain Mercy Maricopa data or other information, or Mercy Maricopa’s name or logo, shall be submitted to Mercy Maricopa’s Network Management Department at [providerrelations@mercymaricopa.org](mailto:providerrelations@mercymaricopa.org) for approval prior to distribution.

### 3.0.39 – PROVIDER POLICIES AND PROCEDURES – HEALTH CARE ACQUIRED CONDITIONS AND ABUSE

As a prerequisite to contracting with an organizational provider, Mercy Maricopa must ensure that the organizational provider has established policies and procedures that meet AHCCCS 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 surgicenters) and the process by which the subcontractor reports at a minimum incidences of Health Care Acquired Conditions, abuse, neglect, exploitation, injuries and unexpected death to Mercy Maricopa.

### 3.0.40 – HEALTH INFORMATION EXCHANGE

Mercy Maricopa 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 Maricopa’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 Maricopa’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 Maricopa network of providers. Once connected, the provider office will have access to the system and the ability to 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 Maricopa.

Mercy Maricopa complies with all requirements of federal and state confidentiality statues, 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 H.I.E. is received at the clinics, typically during intake.

Mercy Maricopa 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.

3.0.41 – MERCY MARICOPA’S SECURE WEB PORTAL
Mercy Maricopa provides a web-based platform enabling health plans to communicate healthcare information directly with providers. Users can perform transactions, download information, and work interactively with member healthcare information. The following information can be attained from the Mercy Maricopa Secure Web Portal:

- **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 physician (PCP).
- **Provider List** – Search for a specific health plan provider by name, specialty, or location.
- **Claim(s) 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 check number, provider, claim number, or check issue/service dates. 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.
- **Submit Authorizations** – Submit an authorization request on-line. Three types of authorization types are available:
  - Outpatient
- **DME** – Rental

- **HEDIS** – Check the status of the member’s compliance with any of the HEDIS measures. “NC” means the member has measures that they are not compliant with (needs care for this measure); “--” means that member has met the requirements (does not need care for this measure).

### 3.0.42 – PSYCHIATRIC VISIT INFORMATION

The Psychiatric Visit Information Form 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.

### 3.0.43 – CASE MANAGEMENT CONTACT GUIDELINES

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>Face to Face Contact Guideline</th>
<th>Home Visit Contact Guideline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connective</td>
<td>Quarterly; Every 90 days</td>
<td>Yearly; Every 365 days</td>
</tr>
<tr>
<td>Supportive</td>
<td>Monthly; Every 30 days</td>
<td>Quarterly; Every 90 days</td>
</tr>
<tr>
<td>ACT</td>
<td>4 contacts every 7 days</td>
<td>Weekly; Every 7 days</td>
</tr>
</tbody>
</table>

### 3.0.44 – INTRA-RHBA CLINIC TRANSFERS (NEW)

**TRANSFER GUIDELINES**

- The direct care clinic (DCC) and/or agency shall implement a transfer for persons needing specialized services which are unable to be provided by the current clinic, team and/or agency, or when the person or guardian requests a transfer to a new site and/or agency. In accordance with the 9 guiding principles of person empowerment and self-determination, personal preference is given the utmost consideration and the person 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 person or guardian to discuss and attempt to resolve.

- Agencies will respect the person’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 Maricopa website. The integrated clinic will outreach to the new identified PCP to include discussion about member care, transfer of medical records, 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/case management team. The referring agency clinic shall enter a progress note in the person’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 person’s medical record.
- If the person 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@mercymaricopa.org should be contacted for assistance and notification of the delay.
- 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@mercymaricopa.org should be contacted.
- If the referring agency concludes that the requested transfer should not take place as a result of the person’s “clinical instability” and/or it would not be in the best clinical interest of the person, the agency chief medical officer can request approval from Mercy Maricopa Integrated Care’s Medical Director to delay the transfer until the risk is ameliorated. The smimemberservicesrequest@mercymaricopa.org mailbox can be utilized to start this process. The MMIC Medical Director shall issue a decision to the agency within five (5) business days. If the transfer request of the person is rejected, the clinical team shall notify all persons 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 person 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 member’s be managed within their current network and that alternate clinics within that network should be able to immediately meet all the person’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 person’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 person unable to transfer to a site initially requested will be offered the option of transferring to an alternative open clinic based on the person’s preference.
• A transfer is complete once the person has attended an initial appointment at the receiving clinic and the medical record has been delivered to the receiving clinic.
  o 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.
  o If the person 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 person has transportation to the initial appointment at the new clinic. The referring clinic retains all responsibility for the person’s care as outlined in the ISP until the completion of the transfer process.
• If the person is currently on court-ordered treatment, MMIC’s Court Liaison Administrator, needs to be notified via email once the transfer is complete. The referring clinic will send all emails to currans2@mercymaricopa.org.
• For any concerns regarding the transfer guidelines, you can contact MMIC for appropriate interventions or questions at smimemberservicesrequest@mercymaricopa.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 of the request for transfer. All transfer activities will be documented in the medical record.
• The person 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 person 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:
  o Transfer of care cover sheet
  o Part E
  o Part D
  o AUD
  o ARCP
  o Med sheet
  o Last 3 Doctor note
  o Last three progress notes
  o Face sheet
  o COT/Special Assistance or guardianship paperwork
  o A progress note indicating a conversation with the member or member’s guardian with the transfer request
• 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.
• The referring clinic shall ensure the person 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 person’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 person is appropriately designated to the desired agency/clinic.

In all cases in which a person is being treated with medication, the transferring agency/clinic shall ensure a 30 day supply (from the date of transfer) is given to the person 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 person’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 person within 45 calendar days for supportive and connective level recipients and 21 days for ACT recipients. If the transfer timelines are not met, smimemberservicesrequest@mercymaricopa.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)
- 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 and once the transfer is complete, the receiving integrated clinic will need gather information and send a report of new members to the enrollment team MBU-MMIC_Enrollment@AETNA.com. This report will be submitted weekly.

If there are any concerns, questions, conflicts, etc., regarding the transfer process, the smimemberservicesrequest@mercymaricopa.org mailbox should be utilized for resolution if not able to resolve between the two agencies.

3.0.45 – PROVIDER FINANCIAL REPORTING (NEW)

The Provider Financial Reporting Guide has been developed to ensure that all Mercy Maricopa Integrated Care subcontracted providers and vendors develop and understand the financial requirements and responsibilities inherent in their contract with Mercy Maricopa. 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

3.1 – Provider Deliverables

There are provider deliverables required under AHCCCS and Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS). Mercy Maricopa Integrated Care produced the Provider Deliverables Matrix 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 Provider Relations representative at 602-586-1880 or 866-602-1979.

COMPLIANCE
Providers who are compliant with Deliverable’s standards require no further action until the next submission.

Providers who are “Out of Compliance” with Deliverables standards will be contacted by the Provider Relations representative to re-educate the Provider on compliance requirements related to Deliverables standards. The Provider Relations representative will continue to monitor provider compliance each month.

CORRECTIVE ACTION PLAN
Mercy Maricopa 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 Maricopa Chief Operating Officer (COO) with recommendations for further actions, which may include referral restrictions, sanctions or possible termination from the network for breach of contract.

SUBMISSION OF PROVIDER DELIVERABLES TO MERCY MARICOPA

Provider Use of SFTP
Mercy Maricopa 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 Maricopa 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 Maricopa data systems. A provider can complete the **SFTP Connectivity Enrollment Form** (in the Forms section of the Provider Manual) and submit it through their Provider Relations Liaison 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 Maricopa from the People of Color Network has this name:

CSOC_Accessstocare_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 Maricopa 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 Maricopa Provider Manual.

**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_Accessstocare_201410_POCN
The routing tag ends after the first underscore. The SFTP software is configured to use the recipient (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 recipient’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 Maricopa 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 Maricopa 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.

**3.2 – Business Continuity and Disaster Preparedness**

Mercy Maricopa 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.

**RESPONSIBILITIES**

The Facility, Provider or Vendor shall develop and maintain a Business Continuity and Incident Management Plan which assures Mercy Maricopa 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](#) 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 Maricopa are not appropriate.
• The Plan should contain, at a minimum, planning and training for:
  o Complete loss of use of the main site (e.g. major fire or flood).
  o Complete loss of systems and applications (e.g. data center disaster).
  o Loss of a critical Third Party Supplier (e.g. internet and telephones).
  o Wide-spread Severe staffing Shortage (e.g. pandemic).
  o How the Facility, Provider or Vendor will communicate with Mercy Maricopa during a business disruption. *(Plan should include Woodrow Terrell, (602) 402-8190 as the specific contact at Mercy Maricopa).* 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.
  o How Mercy Maricopa 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)*
  o 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.
• 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 Maricopa 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:

**CHAPTER 4 – COVERED SERVICES**

**4.0 – Covered Services**

**BEHAVIORAL HEALTH COVERED SERVICES**
Mercy Maricopa will cover behavioral health services consistent with the table below. *ADHS/DBHS Covered Behavioral Health Services Guide* has a complete list of covered services.

**AVAILABLE BEHAVIORAL HEALTH SERVICES***

<table>
<thead>
<tr>
<th>SERVICES</th>
<th>TITLE XIX/XXI CHILDREN AND ADULTS</th>
<th>NON-TITLE XIX/XXI PERSONS DETERMINED TO HAVE SMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioral Health Counseling and Therapy</td>
<td>Individual: Available, Not Available</td>
<td>Group: Available, Not Available</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Family: Available, Not Available</td>
</tr>
<tr>
<td>Behavioral Health Screening, Mental Health Assessment</td>
<td>Behavioral Health Screening:</td>
<td>Not Available</td>
</tr>
<tr>
<td>and Specialized Testing</td>
<td>Available</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mental Health Assessment:</td>
<td>Available</td>
</tr>
<tr>
<td></td>
<td>Available</td>
<td></td>
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<tr>
<td></td>
<td>Specialized Testing:</td>
<td>Not Available</td>
</tr>
<tr>
<td></td>
<td>Available</td>
<td></td>
</tr>
<tr>
<td>Other Professional</td>
<td>Traditional Healing:</td>
<td>Not Available with Title XIX/XXI funding**</td>
</tr>
<tr>
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<tr>
<td></td>
<td>Not Available</td>
<td></td>
</tr>
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<td></td>
<td>Auricular Acupuncture</td>
<td>Not Available with Title XIX/XXI funding**</td>
</tr>
<tr>
<td></td>
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<td></td>
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<tr>
<td></td>
<td></td>
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</table>

**REHABILITATION SERVICES**

<table>
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<tr>
<th>SERVICES</th>
<th>TITLE XIX/XXI CHILDREN AND ADULTS</th>
<th>NON-TITLE XIX/XXI PERSONS DETERMINED TO HAVE SMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skills Training and Development</td>
<td>Individual: Available, Available</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Group: Available, Available</td>
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</tr>
<tr>
<td></td>
<td>Extended: Available, Available</td>
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<tr>
<td>Cognitive Rehabilitation</td>
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<tr>
<td>Behavioral Health Prevention/Promotion Education</td>
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<tr>
<td>Psycho Educational Services and Ongoing Support to</td>
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<td></td>
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</tr>
<tr>
<td>Service</td>
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<td>Not Available</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
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<tr>
<td><strong>MEDICAL SERVICES</strong></td>
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<tr>
<td>Medication Services***</td>
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<tr>
<td>Lab, Radiology and Medical Imaging</td>
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<td>Medical Management</td>
<td>Available</td>
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</tr>
<tr>
<td>Electro-Convulsive Therapy</td>
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</tr>
<tr>
<td><strong>SUPPORT SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case Management</td>
<td>Available</td>
<td>Available</td>
</tr>
<tr>
<td>Personal Care</td>
<td>Available</td>
<td>Available</td>
</tr>
<tr>
<td>Home Care Training (Family)</td>
<td>Available</td>
<td>Available</td>
</tr>
<tr>
<td>Self Help/Peer Services</td>
<td>Available</td>
<td>Available</td>
</tr>
<tr>
<td>Home Care Training to Home Care Client (HCTC)</td>
<td>Available</td>
<td>Not Available</td>
</tr>
<tr>
<td>Respite Care****</td>
<td>Available</td>
<td>Available</td>
</tr>
<tr>
<td>Supported Housing</td>
<td>Provided based on available grant funds**</td>
<td>Provided based on available grant funds*</td>
</tr>
<tr>
<td>Sign Language or Oral Interpretive Service</td>
<td>Provided at no charge to the member</td>
<td>Provided at no charge to the member</td>
</tr>
<tr>
<td>Flex Fund Services</td>
<td>Provided based on available grant funds**</td>
<td>Provided based on available grant funds*</td>
</tr>
<tr>
<td>Transportation</td>
<td>Emergency Available</td>
<td>Limited to crisis service-related transportation</td>
</tr>
<tr>
<td>Non-Emergency</td>
<td>Available</td>
<td>Available</td>
</tr>
<tr>
<td><strong>CRISIS INTERVENTION SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crisis Intervention – Mobile</td>
<td>Available</td>
<td>Available</td>
</tr>
<tr>
<td>Crisis Intervention - Telephone</td>
<td>Available</td>
<td>Available</td>
</tr>
<tr>
<td>Crisis Intervention - Stabilization</td>
<td>Available</td>
<td>Available</td>
</tr>
<tr>
<td><strong>INPATIENT SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td>Available</td>
<td>Available but limited****</td>
</tr>
<tr>
<td>Behavioral Health Inpatient Facility</td>
<td>Available</td>
<td>Available but limited****</td>
</tr>
</tbody>
</table>
### RESIDENTIAL SERVICES

<table>
<thead>
<tr>
<th>Service</th>
<th>Title XIX</th>
<th>Title XXI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health Residential Facility</td>
<td>Available</td>
<td>Available but limited****</td>
</tr>
<tr>
<td>Room and Board</td>
<td>Not Available with TXIX/XXI funding**</td>
<td>Not Available</td>
</tr>
</tbody>
</table>

### BEHAVIORAL HEALTH DAY PROGRAMS

<table>
<thead>
<tr>
<th>Day Type</th>
<th>Title XIX</th>
<th>Title XXI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervised Day</td>
<td>Available</td>
<td>Available</td>
</tr>
<tr>
<td>Therapeutic Day</td>
<td>Available</td>
<td>Not Available</td>
</tr>
<tr>
<td>Medical Day</td>
<td>Available</td>
<td>Not Available</td>
</tr>
</tbody>
</table>

*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 ADHS/DBHS Drug List for further information on covered medications.
*****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.

### PHYSICAL HEALTH CARE SERVICES

The table below lists physical health care services available for Title XIX/XXI eligible persons determined to have a Serious Mental Illness (SMI), who are receiving both behavioral health and physical health care services from Mercy Maricopa (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

<table>
<thead>
<tr>
<th>Services</th>
<th>Title XIX</th>
<th>Title XXI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audiology</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Breast Reconstruction after Mastectomy</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Cochlear Implants</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Emergency Dental Services</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Preventative &amp; Therapeutic Dental Services</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Service Description</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Limited Medical and Surgical Services by a Dentist (for Members Age 21 and older)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dialysis</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Emergency Services – Medical</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Emergency Eye Exam</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Vision Exam/Prescriptive Lenses</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Lens Post Cataract Surgery</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Treatment for Medical Condition of the Eye</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Health Risk Assessment &amp; Screening Tests (for Members age 21 and older)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Preventive Examinations in the Absence of any Known Disease or Symptom</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>HIV/AIDS Antiretroviral Therapy</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Home Health Services</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Hospice</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Hospital Inpatient Medical</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Hospital Observation</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Hospital Outpatient Medical</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Hysterectomy (medically necessary)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Immunizations</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Laboratory</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Maternity Services</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Family Planning</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Early and Periodic Screening, Diagnosis and Treatment (Medical Services)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Other Early and Periodic Screening, Diagnosis and Treatment Services Covered by Title XIX</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Medical Foods</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Service</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Medical Supplies</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Prosthetic</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Orthotic Devices</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Nursing Facilities (up to 90 days)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Non-Physician First Surgical Assistant</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Physician Services</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Foot and Ankle Services</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Primary Care Provider Services</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Private Duty Nursing</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Radiology and Medical Imaging</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Occupational Therapy – Inpatient</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Occupational Therapy – Outpatient</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Physical Therapy – Inpatient</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Physical Therapy – Outpatient</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Speech Therapy – Inpatient</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Speech Therapy – Outpatient</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Respiratory Therapy</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Total Outpatient Parenteral Nutrition</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Non-Experimental Transplants Approved for Title XIX Reimbursement*</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Transplant Related Immunosuppressant Drugs</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Transportation – Emergency</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Transportation – Non-emergency</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Triage</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Well Exams</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*See the AHCCCS Medical Policy Manual, Chapter 300, Policy 310, 310-DD, Covered
Transplants and Related Immunosuppressant Medications.

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.

Mercy Maricopa Integrated Care 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 Maricopa, please refer to Mercy Maricopa’s Member Handbook.

Providers may arrange medically necessary non-emergent transportation for Mercy Maricopa members by calling Member Services at 800-564-5465.

Non Covered Services
Services from a provider who is NOT contracted with Mercy Maricopa (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 Maricopa;
- Prescriptions not on our list of covered medications, unless approved by Mercy Maricopa; and
- 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;
- Insulin pumps;
- Microprocessor controlled lower limbs and microprocessor controlled joints for lower limbs;
- Percussive vests;
- Services performed by a podiatrist;
- 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 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); and
- Outpatient speech and occupational therapy (except for Medicare QMB members).

MEDICARE PART D PRESCRIPTION DRUG COVERAGE
Persons 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).

TRANSPORTATION
Transportation services may be provided by:
- Non-emergency transportation providers (e.g., vans, buses, taxis) who are registered with AHCCCS as a non-emergency transportation provider and have proof of insurance, a valid driver’s license, and insurance as required by state law.
- Emergency transportation providers (e.g. air or ground ambulance) who are registered with AHCCCS as emergency transportation providers and have been granted a certificate of necessity by the Arizona Department of Health Services/Bureau of Emergency Medical Services (A.R.S. 36-2233).

In most instances, transportation services should be provided by non-emergency transportation providers.

The following applies to all providers with the exception of the Adult PNO’s:
- Funding received from Mercy Maricopa for the provision of services to covered members is inclusive of non-emergency transportation. The provider that requests/arranges for this service through an outside vendor is responsible for payment to said vendor. If a provider chooses to provide this service “in house” they may encounter for this service in accordance with their contracted fee schedule as long as no billing limitations apply. This applies to Mercy Maricopa subcontracted providers which request transport for persons from one place to another to facilitate the receipt of, or benefit from, medically necessary covered behavioral health services.

Emergency Transportation
Emergency ground and air ambulance services required to manage an emergency medical condition of a member at an emergency scene and/or to transport to the nearest appropriate facility are covered for all members. Emergency transportation is needed:
When an individual’s condition is such that the use of any other method of transportation is contraindicated and medically necessary health care services are not available in the hospital from which the person is being transported and/or;

A sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could be expected to result in:
  o Placing the member’s health in serious jeopardy
  o Serious impairment of bodily functions; or
  o Serious dysfunction of any bodily part or organ.
  o In instances of Maternal and Newborn Transportation; the Maternal Transport Program (MTP) and the Newborn Intensive Care Program (NICP) administered by ADHS provides special training and education to designated staff in the care of maternity and newborn emergencies during transport to a perinatal center. The high risk transport team is dispatched after consultation with the MTP or NICP perinatologist or neonatologist. Only MTP or NICP Contractors may provide air transport For additional information regarding the MTP or NICP transportation program, please see the ADHS High-Risk Perinatal Program/Newborn Intensive Care Program, Maternal and Neonatal Transport Services.

Emergency transportation does not require prior authorization.

For additional information regarding the amount, duration, and scope of covered emergency transportation services see the AHCCCS Medical Policy Manual 310-BB Transportation Policy.

**Non-Emergency Transportation**

Non-emergency transportation is provided for all members including persons and/or families who are unable to arrange or pay for their transportation or who do not have access to free transportation in order to access medically necessary covered health services under the following conditions:

The medical or behavioral health service for which the transportation is needed is a covered AHCCCS 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 AHCCCS registered provider.

For additional information regarding amount, duration, scope, and additional requirements for ambulance and non-ambulance providers see the AHCCCS Medical Policy Manual 310-BB Transportation Policy.

Access to non-emergency transportation may be a necessary support service for non-Title XIX/XXI SMI individuals to access other covered behavioral health services, such as medication appointments. Non-emergency transportation for non-Title XIX/XXI SMI members may be covered as a support service with the following limitations:

Transportation is covered only to and from providers of covered behavioral health services;
Transportation is covered only when no other means of transportation are available to the member to access covered behavioral health services; and

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.

Mercy Maricopa will ensure that if a member needs medically necessary transportation, that the transportation is provided and that the member arrives at his/her appointment no sooner than one hour before the appointment, and does not have to wait for more than one hour after the end of their appointment for transportation back to his/her home. For further information regarding appointment standards, please refer to Chapter 2.1 – Appointment Standards and Timeliness of Service.

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. The following elements for record-keeping are recommended for documentation of non-emergency transportation services.

- Complete Service Provider’s Name and Address
- Name and signature of the driver who provided the service
- Vehicle Identification (car, van, wheelchair van, etc.)
- Member (being transported) name
- Recipient’s AHCCCS ID
- Complete date of service, including month, day and year
- Complete address of the pick-up site
- Complete address of drop off destination
- Type of trip (round trip or one way)
- Escort (if any) must be identified by name and relationship to the member being transported
- Signature of recipient, verifying services were rendered

When a contract does not exist between a Ground Ambulance Transportation provider and Mercy Maricopa, providers are reimbursed for services according to fees established with ADHS or through the AHCCCS Capped Fee for Service Schedule. For further information regarding criteria and reimbursement processes for Ground Ambulance Transportation Reimbursement please refer to AHCCCS ACOM Policy 205, Ground Ambulance Transportation Reimbursement Guidelines for Non-Contracted Providers.

**FLEX FUNDS**

ADHS/DBHS may allocate a limited amount of grant monies to Mercy Maricopa to be utilized as flex funds.

Flex funds may only be used for non-medically necessary goods and/or services that are described in the person’s service plan that cannot be purchased by any other funding source.
Flex funds availability of services is based on availability of funding. Furthermore, the member receiving flex funds must meet the population requirements of respective Block Grant from which the funds originated. The goods and/or services to be provided using flex funds must be related to one or more of the following outcomes:

- Success in school, work or other occupation;
- Living at the person’s own home or with family;
- Development and maintenance of personally satisfying relationships;
- Prevention or reduction in adverse outcomes, and/or;
- Becoming or remaining a stable and productive member of the community.

Flex funds must not be used for:

- The purchase or improvement of land;
- The purchase, construction or permanent improvement of any building or other facility (with the exception of minor remodeling consistent with this chapter); and
- Any other prohibited activity as detailed in 45 CFR Part §96.135 et seq.
- The purchase of major medical equipment
- Not intended to be used toward payment of items relating to medical marijuana, including application fees or the drug itself.

Mercy Maricopa’s contracted providers must use flex funds for the direct purchase of goods and/or services and may not provide flex funds as direct cash payments to behavioral health members or their families. See the ADHS/DBHS Covered Behavioral Health Services Guide for additional information regarding flex funds and applicable billing limitations.

**Access to Flex Funds**

Mercy Maricopa may approve flex fund services of up to $1,525 per individual/family per year. Clinical teams may request access to flex funds by submitting the following items:

- A copy of the vendor bill
- W-9
- Member’s budget
- Progress Notes
- ISP and ISP signature page (the request must align with specific ISP requirements)
- Completed flex funds checklist
- Service Ticket

For the Adult System of Care, the PNO Regional Director will ensure that all required information, documentation and justification are provided in the request, and then forward approved requests to the Mercy Maricopa Adult System of Care Administrator for final review and approval at either the following address or fax number:

Mercy Maricopa Integrated Care
Attention: SMI Services Administrator
4350 E. Cotton Center Blvd.
Phoenix, AZ 85040
Or 1-800-564-5465
For the Children’s System of Care the QSP does not need to request approval for Flex Fund Requests under $1,525. Providers are to manage within their contract amount and report monthly to the CSOC Administrator using the SFTP, as outlined in the Deliverables Grid.

Mercy Maricopa will forward requests for approval of flex fund expenditures exceeding $1,525 per individual/family per fiscal year to flexfunds@azdhs.gov using CMHS SABG/Flex Fund Request. All documentation supporting the need and utilization of flex funds including, yet not limited to original receipts for goods or services purchased, and service plans indicating how the good or service relates to the treatment goals, must be made accessible to Mercy Maricopa and ADHS for auditing and financial tracking purposes. Mercy Maricopa has a written procedure indicating where all supporting documentation is to be stored.

**Move-In Assistance**

AHCCCS may allocate a limited one-time funding disbursement to Mercy Maricopa to be utilized for hotel assistance. Members diagnosed with a Serious Mental Illness enrolled with Mercy Maricopa may access the hotel assistance as funding is available to Mercy Maricopa.

- This assistance is one time funding and may not exceed $1,525 per lifetime per member, based on available funding and
- Each Direct Care Clinic will maintain documentation of emergency assistance funding and will provide this documentation to Mercy Maricopa at time of application and upon request.

**Operating Protocol:**

The Direct Care Clinic will assess for clinical appropriateness of requests for move in assistance based on the following:

- The member has not exhausted $1,525 lifetime allotted amount;
- The member is able to present an invoice from vendor outlining move in amount;
- The member does not have the resources to fund move in assistance;
- The member is able to demonstrate the ability to maintain finances going forward;
- The member has exhausted resources within the community, including informal supports and
- The lease or agreement must be in the Mercy Maricopa member’s name. If additional fees are needed for other individuals moving into the setting, it will not be funded by Mercy Maricopa.

The Direct Care Clinic is responsible for tracking and maintaining a list of members who have utilized and/or maximized this service

- The team will record total amounts requested per member, ensuring they do not maximize the $1525 lifetime allotted amount.
- The team will maintain these records for Mercy Maricopa Integrated Care to review upon request.
The Direct Care Clinic will submit a request for move in assistance funding to Mercy Maricopa Integrated Care to the Adult System of Care (ASOC) department for final approval, to include the following items:

- Individual Service Plan (ISP) page stating the need, vendor, amount requested, and date of fund request with signatures from the member and Behavioral Health Professional (BHP).
- Itemized vendor invoice outlining move in assistance amount as well as rent going forward
- Vendor W-9 completed for the vendor (must match billing service ticket)
- Progress note(s):
  - Explanation of the specific reasons for the request including:
    - Why move in assistance is needed;
    - The steps that are being taken to assist the recipient in the future, showing the recipient is receiving assistance with budgeting/household finances;
    - Staff need for payee services;
    - Confirmation that vendor can receive a corporate check;
    - Connections with support services for the member.
- Budget demonstrating ability to maintain going forward.
- Review and approval by regional level leadership prior to submitting to Mercy Maricopa Integrated Care.

It is the responsibility of the direct care clinic to ensure all requests do not exceed annual allotted dollar amount.

All requests will be submitted to: SMIMemberServicesRequest@mercymaricopa.org. If there are any concerns, questions, conflicts, etc. regarding the move in assistance funding process, the SMIMemberServicesRequest@mercymaricopa.org mailbox should be utilized for resolution if not able to resolve at the clinic level.

**Process**

- Mercy Maricopa Adult System of Care (ASOC) will review requests within 72 business hours to ensure all required documentation is included and will communicate any concerns to Direct Care Clinic.
- The reviewing department will submit final approved request to the finance department and notify the clinical team of available funds.
- The direct care clinic representative will obtain the check within 48 hours of check notification request. If check is not picked up during the allotted time, the check will be voided.
- The direct care clinic will submit all receipts to Mercy Maricopa within five (5) business days.

**Hotel Assistance**

AHCCCS may allocate a limited one-time funding disbursement to Mercy Maricopa to be utilized for hotel assistance. Members diagnosed with a Serious Mental Illness enrolled with Mercy Maricopa may access the hotel assistance as funding is available to the RBHA.
Hotel assistance is one time funding and may not exceed one stay per year per member.

Approved hotel stay up to $70 per night not to exceed 7 days.

Extensions for up to 7 days is available for extenuating circumstances and need to be submitted at least 48 hours prior to approved check out date.

Hotel Assistance application must come from the outpatient clinical team and be accompanied with the following:
- ISP reflecting need for hotel assistance;
- Active Plan for member to transition into independent housing;
- Documentation outlining member means to sustain housing;
- Outpatient clinical team documentation to secure support services necessary to assist member in hotel setting;
- VI-SPDAT completed to reflect ability to live independently;
- Appropriate picture identification to check into the hotel;
- If emergency situation, documentation must include clinical justification and a more permanent placement solution.

Each Direct Care Clinic will maintain documentation of previous living arrangement of member, location of member after hotel usage, and dates of hotel stay.

**Operating Protocol:**
The Direct Care Clinic will assess and screen for clinical appropriateness of requests for hotel funding based on the following:
- The member has not exhausted the one stay per member allotted amount;
- The member is able to sustain housing moving forward;
- The member is able to live independently with/without supports;
- The member is able to transition into independent housing;
- The member has exhausted resources within the community, including informal supports;
- The member does not meet residential or flex care plus/extended programming;
- The member is not transitioning into a temporary living environment such as a half-way house, supervisory care home or boarding home;
- The Direct Care Clinic is responsible for filling out the VI-SPDAT and providing with the application;
- The member has valid identification in order to check into a hotel; and
- Provided clinical justification for emergency hotel situations with transition planning.

The Direct Care Clinic is responsible for tracking and maintaining a list of members, who have utilized and/or maximized this service, including:
- Dates of stay per hotel per member;
- Total amounts requested per member;
- Previous living arrangement of the member;
- Location of member after hotel usage; and
- Support services provided to member during hotel stay.
- The team will maintain these records for Mercy Maricopa Integrated Care to review upon request.
The Direct Care Clinic is responsible for locating a hotel within the part of town of the member choosing and fits the criteria of $70 per night. The clinical team will submit a “Temporary Hotel Request” form for hotel assistance to Mercy Maricopa Integrated Care to the Adult System of Care (ASOC) department for final approval, to include the following items:

- Hotel vendor W-9
- Progress note(s):
- Explanation of specific reason for the request including:
  - Active plan to transition into independent housing;
  - Reason client is unable to pay for hotel stay;
  - The support services that are being put in place to assist the recipient while in the hotel and support for the future;
  - Confirmation that the hotel can receive a corporate check;
  - Alternative solutions that have been attempted;
  - Budget demonstrating ability to sustain housing; and
  - Review and approval by regional level leadership prior to submitting to Mercy Maricopa Integrated Care.

All requests will be submitted to: SMIMemberServicesRequest@mercymaricopa.org.

If there are any concerns, questions, conflicts, etc. regarding the emergency assistance funding process, the SMIMemberServicesRequest@mercymaricopa.org mailbox should be utilized for resolution if not able to resolve at the clinic level.

**Additional Protocol**

- The member is allotted one extension request not to exceed 7 days.
- The extension form must be submitted to SMIMemberServicesRequest@mercymaricopa.org 48 hours prior to check out.
- It is the responsibility of the direct care clinic to ensure all requests do not exceed the 7 day timeline, unless an extension is granted.
- It is the responsibility of the clinical team not to exceed the allotted dollar amount.
- It will be the responsibility of the direct care clinic to provide supportive services in order for the member to avoid property damages. It is also the responsibility that if any damage should occur during the hotel stay, the direct care clinic is responsible for payment of those damages.
- It will be the responsibility of the direct care clinic to pay the extension costs if the member stays past the allotted approved amount of time (including charges for late check out).
- The reviewing department will submit final approved request to the finance department and notify the clinical team of available funds.
- The direct care clinic representative will obtain the check within 48 hours of check notification.
- The direct care clinic will submit all receipts to SMIMemberServicesRequest@mercymaricopa.org within five (5) business days.
• It is the responsibility of the direct care clinic to ensure Mercy Maricopa 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 as described in Chapter 3.0.34 – Use of Corrective Action, Notice to Cure and Sanctions.

4.1 – Maternity and Medically Necessary Pregnancy Termination

MATERNITY CARE
Mercy Maricopa 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, Mercy Maricopa 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.

High Risk Maternity Care
In partnership with OB providers, Mercy Maricopa case managers identify pregnant women who are "at risk" for adverse pregnancy outcomes. Mercy Maricopa 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, severe mental illness (SMI) or non-compliant behaviors. Mercy Maricopa 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 case manager.

OB Case Management
Mercy Maricopa’s perinatal case management provides comprehensive care management services to high risk pregnant members, for the purpose of improving maternal and fetal birth outcomes. The perinatal case 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 case 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 case 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;
- Prescribed psychotropic drugs;
- Domestic violence;
- Non-compliance with OB appointments.

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

**OB Incentive Program**
Mercy Maricopa’s perinatal case 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.

**Obstetrical Care Appointment Standards**
Mercy Maricopa 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:

<table>
<thead>
<tr>
<th>Category</th>
<th>Appointment Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>First trimester</td>
<td>Within 14 days of the request for an appointment</td>
</tr>
<tr>
<td>Second trimester</td>
<td>Within seven days of the request for an appointment</td>
</tr>
<tr>
<td>Third trimester</td>
<td>Within three days of the request for an appointment</td>
</tr>
<tr>
<td>Return Visits</td>
<td>Return visits should be scheduled routinely after the initial visit.</td>
</tr>
<tr>
<td></td>
<td>Members must be able to obtain return prenatal visits:</td>
</tr>
<tr>
<td></td>
<td>First 28 weeks - every four weeks</td>
</tr>
<tr>
<td></td>
<td>From 28 to 36 weeks - every two to three weeks</td>
</tr>
<tr>
<td></td>
<td>From 37 weeks until delivery - weekly</td>
</tr>
<tr>
<td>High Risk Pregnancy Care</td>
<td>Within three days of identification of high risk by the Contractor or maternity care provider, or immediately if an emergency exists.</td>
</tr>
<tr>
<td></td>
<td>Return visits scheduled as appropriate to their individual needs; however, no less frequently than listed above.</td>
</tr>
<tr>
<td>Postpartum Visits</td>
<td>Postpartum visits should be scheduled routinely after delivery.</td>
</tr>
</tbody>
</table>
Routine postpartum visits should be scheduled within 21 and 60 days after delivery.

Additional Covered Related Services
ADHS/DBHS covers related services with special policy and procedural guidelines and Contractor providers include, but are not limited to:
- Home uterine monitoring technology
- Labor and delivery services provided in freestanding birthing centers
- Labor and delivery services provided in a home setting
- Licensed Midwife service
- Supplemental stillbirth payment

Home Uterine Monitoring Technology
ADHS/DBHS covers medically necessary home uterine monitoring technology for members with premature labor contractions before 35 weeks gestation, as an alternative to hospitalization.

If the member has one or more of the following conditions, home uterine monitoring may be considered:
- Multiple gestation, particularly triplets or quadruplets
- Previous obstetrical history of one or more births prior to 35 weeks gestation, or
- Hospitalization for premature labor prior to 35 weeks gestation with a documented change in cervix, controlled by tocolysis and ready to be discharged or bed rest at home.
- These guidelines refer to home uterine activity monitoring technology and do not refer to daily provider contact by telephone or home visit.

Labor and Delivery Services Provided in Freestanding Birthing Centers
For members who meet medical criteria specified in this policy, ADHS/DBHS covers freestanding birthing centers when labor and delivery services are provided by licensed physicians or certified nurse practitioners in midwifery (a.k.a. certified nurse midwives).

Freestanding birthing centers are defined as out-of-hospital, outpatient obstetrical facilities, licensed by the Arizona Department of Health Services and certified by the Commission for the Accreditation of Free Standing Birth Centers. These facilities are staffed by registered nurses to provide assistance with labor and delivery services. They are equipped to manage uncomplicated, low-risk labor and delivery. These facilities must be affiliated with, and in close proximity to, an acute care hospital for the management of complications, should they arise.

Amount, Duration and Scope
- Labor and delivery services rendered through freestanding birthing centers must be provided by a physician, (i.e., the member's primary care provider or an obstetrician with hospital admitting privileges) or by a registered nurse who is accredited/certified
by the American College of Nurse Midwives and has hospital admitting privileges for labor and delivery services.

- Only pregnant Mercy Maricopa members, for whom an uncomplicated prenatal course and a low-risk labor and delivery can be anticipated, may be scheduled to deliver at a free standing birthing center. Risk status must be determined by the attending physician or certified nurse midwife using the standardized assessment tools for high-risk pregnancies (American College of Obstetricians and Gynecologists, Mutual Insurance Company of Arizona, or National Association of Childbearing Centers). In any area of the risk assessment where standards conflict, the most stringent will apply. The age of the member must also be a consideration in the risk status evaluation; members younger than 18 years of age are generally considered high risk.

- Refer to the ADHS/DBHS Maternity Care Risk Screening Guidelines (refer to BQ&I Specifications Manual-Section D.) for more detailed explanation of what ADHS/DBHS does not consider as low-risk deliveries, nor appropriate for planned home-births or births in freestanding birthing centers.

**Labor and Delivery Services Provided in the Home Setting**

For members who meet medical criteria specified in this policy, ADHS/DBHS covers labor and delivery services provided in the home by licensed physicians, practitioners (physician assistants or certified nurse practitioners in midwifery), and licensed midwives.

**Amount, Duration and Scope**

- Only Mercy Maricopa members, for whom an uncomplicated prenatal course and a low-risk labor and delivery can be anticipated, may be scheduled to deliver in the member’s home. Refer to the ADHS/DBHS Maternity Care Risk Screening Guidelines (refer to BQ&I Specifications Manual-Section D.) for more detailed explanation of what ADHS/DBHS does not consider as low-risk deliveries, nor appropriate for planned home-births or births in freestanding birthing centers.

- Risk status must initially be determined at the time of the first visit, and each trimester thereafter, by the member’s attending physician, practitioner or licensed midwife, using the current standardized assessment criteria and protocols for high-risk pregnancies from the American College of Obstetrics and Gynecology or Mutual Insurance Company of Arizona.

- A risk assessment must be conducted when a new presenting complication or concern arises to ensure appropriate care and referral to a qualified provider, if necessary.

- Physicians and practitioners who render home labor and delivery services must have admitting privileges at an acute care hospital in close proximity to the site where the services are provided in the event of complications during labor and/or delivery.

- For each anticipated home labor and delivery, licensed midwives who render home labor and delivery services must have an established plan of action, including methods of obtaining services at an acute care hospital in close proximity to the site where services are provided. In addition, referral information to an integrated RBHA
registered physician who can be contacted immediately, in the event that management of complications is necessary, must be included in the plan.

- Upon delivery of the newborn, the physician, practitioner, or licensed midwife is responsible for conducting newborn examination procedures, including a mandatory Bloodspot Newborn Screening Panel and referral of the infant to an appropriate health care provider for a mandatory hearing screening, as well as a second mandatory Bloodspot Newborn Screening Panel and second newborn hearing screening (if infant refers on first testing). Refer the infant and/or member to an appropriate health care provider for follow-up care of any assessed problematic conditions (Refer BQ&I Specifications Manual-Section D. DBHS Maternity Care Risk Screening Guidelines).

- In addition, the physician, practitioner, or licensed midwife must notify the mother’s Mercy Maricopa or the AHCCCS Newborn Reporting Line of the birth. Notification may also be made using the AHCCCS web site reporting form. Notification must be given no later than three days after the birth in order to enroll the newborn with AHCCCS.

**Licensed Midwife Services**

ADHS/DBHS covers maternity care and coordination provided by licensed midwives for Mercy Maricopa enrolled members, if licensed midwives are included in the Mercy Maricopa’s provider network. In addition, members who choose to receive maternity services from this provider type must meet eligibility and medical criteria specified in this policy.

**Amount Duration and Scope**

- Licensed midwife services may be provided only to members for whom an uncomplicated prenatal course and a low-risk labor and delivery can be anticipated. The age of the member must be included as a consideration in the risk status evaluation. Refer to the ADHS/DBHS Maternity Care Risk Screening Guidelines (refer to BQ&I Specifications Manual-Section D.) for more detailed explanation of what ADHS/DBHS does not consider as low-risk deliveries, nor appropriate for planned home-births or births in freestanding birthing centers.

- Risk status must initially be determined at the time of the first visit, and each trimester thereafter, using the current standardized assessment criteria and protocols for high-risk pregnancies from the American College of Obstetrics and Gynecology or Mutual Insurance Company of Arizona.

- A risk assessment from the American College of Obstetrics and Gynecology or Mutual Insurance Company of Arizona must be conducted when a new presenting complication or concern arises to ensure proper care and referral to a qualified physician if necessary.

- Before providing licensed midwife services, documentation certifying the risk status of the member’s pregnancy must be submitted to the Mercy Maricopa Prior Authorization (PA) Unit. In addition, a consent form signed and dated by the member must be submitted, indicating that the member has been informed and understands the scope of services that will be provided by the licensed midwife. Members initially
determined to have a high-risk pregnancy, or members whose physical condition changes to high-risk during the course of pregnancy, must immediately be referred to an ADHS/DBHS registered physician within the provider network of the member’s Contractor for maternity care services.

- Labor and delivery services provided by a licensed midwife cannot be provided in a hospital or other licensed health care institution. Licensed midwives must have a plan of action; including the name and address of an integrated RBHA registered physician and an acute care hospital in close proximity to the planned location of labor and delivery for referral, in the event that complications should arise. This plan of action must be submitted to the integrated RBHA’s Contractor Medical Director or designee.
- Upon delivery of the newborn, the licensed midwife is responsible for conducting newborn examination procedures, including a mandatory Bloodspot Newborn Screening Panel and referral of the infant to an appropriate health care provider for a mandatory hearing screening, as well as a second mandatory Bloodspot Newborn Screening Panel and a second newborn hearing screening (if infant refers on first testing). Refer the infant and/or member to an appropriate health care provider for follow-up care of any assessed problematic conditions ((Refer to BQ&I Specifications Manual-Section D. DBHS Maternity Care Risk Screening Guidelines).
- In addition, the licensed midwife must notify the mother’s Contractor or the AHCCCS Newborn Reporting Line of the birth no later than three days after the birth, in order to enroll the newborn with AHCCCS.

**Supplemental Stillbirth Payment**
A supplemental payment package is not included in the ADHS/DBHS and Mercy Maricopa contract.

**General Obstetrical 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.
Additional Obstetrical Physician/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; include education to members on elective deliveries prior to 39 weeks and/or C-sections unless medically necessary; signs and symptoms of preterm labor; effects of smoking, diabetes, hypertension on pregnancy and/or fetus/infant; prenatal visit within first trimester or 42 days of enrollment; postpartum visit 21-60 days after delivery.
- Offer HIV/AIDS testing and confidential post testing counseling to all members.
- Remind delivery hospital of requirement to notify Mercy Maricopa on the date of delivery.
- Refer member to Mercy Maricopa case 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.
- Screen for perinatal mood and anxiety disorders and refer as necessary (e.g. postpartum depression.
- Per the AHCCCS Medical Policy Manual, all prenatal and postpartum visits are required to be recorded on claim forms and submitted to Mercy Maricopa. See Chapter 7.0 – Submitting Claims and Encounters to Mercy Maricopa for additional information.

Providers may also consult with a Mercy Maricopa medical director for members with other conditions that are deemed appropriate for perinatology referral. Please call 800-564-5465 with requests for assignment to a perinatologist.

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

Reporting High Risk and Non-Compliant Behaviors

Obstetrical physicians and practitioners must refer all “at risk” members to Mercy Maricopa’s Case Management department by calling 800-564-5465. Providers may also fax their information to 602-351-2313. The following types of situations must be reported to Mercy Maricopa 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 Mercy Maricopa Case Management Department.

**Outreach, Education and Community Resources**
Mercy Maricopa 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, but no later than within the 1st trimester or 42 days after enrollment. PCPs are expected to ask about pregnancy status when members call for appointments, report positive pregnancy tests to Mercy Maricopa 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.

Mercy Maricopa 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 Mercy Maricopa’s Case 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.

**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 18-20 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 18 through 20 years
- New patient - 99385
- Established patient - 99395

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 Mercy Maricopa if they are aware that a pregnant member is about to lose or has lost eligibility. Mercy Maricopa 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 800-564-5465 to report eligibility changes for pregnant members.

Newborn Notification Process
Providers must fax a newborn notification to Mercy Maricopa's dedicated Profax number - 1-844-525-2223. Mercy Maricopa 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:
- Authorization will be created and faxed back to provider with newborn AHCCCS ID and authorization number.

Pre-Selection of Newborn's PCP
The newborn will not be covered under Mercy Maricopa Integrated Care but will be covered by another AHCCCS contractor. 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.

MEDICALLY NECESSARY TERMINATION OF PREGNANCY
Medically necessary pregnancy termination services, including pregnancy termination use of Mifepristone 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 written informed consent must be obtained by the provider and kept in the member’s medical record for all pregnancy terminations. If the pregnant member is younger than 18 years of age, or is 18 years of age or older and considered an incapacitated person, a dated signature of the pregnant member's parent or legal guardian indicating approval of the pregnancy termination procedure is required.
- A completed and signed copy of Exhibit 410-4 - Certificate of Medical Necessity for Pregnancy Termination and the Verification of Diagnosis by Health Plan for Pregnancy Termination Request.
- Written explanation of the reason that the procedure is medically necessary. For example, it is:
  o Creating a serious physical or mental health problem for the pregnant member.
o Seriously impairing a bodily function of the pregnant member.
o Causing dysfunction of a bodily organ or part of the pregnant member.
o Exacerbating a health problem of the pregnant member.
o 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 Mifepristone is administered, the following documentation is also required:

- Duration of pregnancy in days;
- The date IUD was removed if the member had one;
- The date Mifepristone was given;
- The date Misoprostol was given, and
- Documentation that pregnancy termination occurred

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, 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.

4.2 – Family Planning

Mercy Maricopa and its contracted providers must:

- Plan and implement an outreach program to notify members of reproductive age of the specific covered family planning services available and how to request them. Notification must be in accordance with A.R.S. § 36.2904(L). A written notification on the availability of family planning services must be mailed annually to members by November 1st. If the member enrolled with Mercy Maricopa after November 1st, notification must be at the time of enrollment. The requirement for written notification is in addition to the member handbook and member newsletter. The information provided to members must include, but is not limited to:
  o A complete description of covered family planning services available;
  o Information advising how to request/obtain these services;
  o Information that assistance with scheduling is available; and
  o A statement that there is no charge for these services.

- Have policies and procedures in place to ensure that maternity care providers are educated regarding covered and non-covered services, including family planning services, available to AHCCCS members.
- Have family planning services that are:
  o Provided in a manner free from coercion or mental pressure;
o Available and easily accessible to members;
o Provided in a manner which assures continuity and confidentiality;
o Provided by, or under the direction of, a qualified physician or practitioner;
and
o Documented in the medical record. In addition, documentation must be recorded that each member of reproductive age was notified verbally or in writing of the availability of family planning.

- Provide translation/interpretation of information related to family planning in accordance with Chapter 6.5, Cultural Competence.
- Incorporate medical audits for family planning services within quality management activities to determine conformity with acceptable medical standards.
- Establish quality/utilization management indicators to effectively measure/monitor the utilization of family planning services.
- Have written practice guidelines that detail specific procedures for the provision of long-term contraceptives. These guidelines shall be written in accordance with acceptable medical standards.
- Have a process for ensuring that prior to insertion of an intrauterine or subdermal implantable contraceptives, the family planning provider has provided proper counseling to the eligible member to minimize the likelihood of a request for early removal. Counseling information is to include a statement to the member indicating if the implant is removed within two years of insertion, the member may not be an appropriate candidate for reinsertion for at least one year after removal.
- Assist contracted providers in establishing procedures for referral of those members who may lose AHCCCS eligibility to low-cost/no-cost agencies for family planning services.
- Assist contracted providers in establishing procedures for referral of those members who may lose AHCCCS eligibility with medical needs to an agency that provides low-cost/no-cost primary care services.
- Develop a process for monitoring whether referrals for low-cost/no-cost primary care services were made for members who lost AHCCCS eligibility.

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:
  o 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.
  - 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. Providers 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.

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.

STERILIZATION

The following criteria must be met for the sterilization of a member to occur:

- The member is at least 21 years of age at the time the consent is signed (see Consent for Sterilization [English/Spanish];
  - For members under the age of 21, the provider must be able to demonstrate medical necessity for the procedure with supporting documentation including Prior Authorization (PA). The medical necessity PA and supporting
documentation must be submitted to ADHS/DBHS with the Monthly Sterilization Report.

- Mental competency is determined;
- Voluntary consent was obtained without coercion; and
- Thirty (30) days, but not more than 180 days, have passed between the date of informed consent and the date of sterilization, except in the case of a premature delivery or emergency abdominal surgery. Members may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since they gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

Any member requesting sterilization must sign **Consent for Sterilization (English/Spanish)** with a witness present when the consent is obtained. Suitable arrangements must be made to ensure that the information in the consent form is effectively communicated to members with limited English proficiency or reading skills and those with diverse cultural and ethnic backgrounds, as well as members with visual and/or auditory limitations. Prior to signing the consent form, a member must first have been offered factual information that includes all of the following:

- Consent form requirements;
- Answers to questions asked regarding the specific procedure to be performed;
- Notification that withdrawal of consent can occur at any time prior to surgery without affecting future care and/or loss of federally funded program benefits;
- A description of available alternative methods;
- A full description of the discomforts and risks that may accompany or follow the performing of the procedure, including an explanation of the type and possible effects of any anesthetic to be used;
- A full description of the advantages or disadvantages that may be expected as a result of the sterilization; and
- Notification that sterilization cannot be performed for at least 30 days post consent.

Sterilization consents may **NOT** be obtained when a member:

- Is in labor or childbirth
- Is seeking to obtain, or is obtaining, a pregnancy termination; or
- Is under the influence of alcohol or other substances that affect the member’s state of awareness.

Mercy Maricopa submits a Monthly Sterilization Report (AHCCCS Exhibit 420-2) to Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) which documents the number of sterilizations performed for all members under the age of 21 years of age during the month. If no sterilizations were performed for members under the age of 21 years of age during the month, the monthly report must still be submitted to attest to that information.
Hysteroscopic tubal sterilization is not immediately effective upon insertion of the sterilization device. It is expected that the procedure will be an effective sterilization procedure three months following insertion. At the end of the three months, confirmatory testing, a hysterosalpingogram, will be performed confirming that the member is sterile and reported on the monthly sterilization report.

**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 for Family Planning Services* and fax requests 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 *Prior Authorization for Family Planning Services* and the *Consent for Sterilization (English/Spanish)*. Permanent sterilization is only covered for Mercy Maricopa members 21 years of age or older.
  - For pregnancy termination: Aetna Medicaid Administrators LLC *Prior Authorization for Family Planning Services*.

- Fax completed prior authorization form and signed consent form prior to the procedure to:
  Aetna Medicaid Administrators LLC  
  800-573-4165

Health professionals must obtain prior authorization from the Department of Economic Security, Division of Developmental Disabilities (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.

**4.3 – Dental and Vision Services**

**DENTAL SERVICES**

**DENTAL SERVICES OVERVIEW**

Mercy Maricopa has a comprehensive dental network to serve the needs of Mercy Maricopa members. The contracted network is available on Mercy Maricopa’s website under *Find a Provider*. Emergency and general dental services are described below and should be
provided in accordance with the AHCCCS Exhibit 430-1 EPSDT Periodicity Schedule available on the AHCCCS website along with the guidelines presented below. Providers should include parents or caregivers in all consultations and counseling of members regarding preventive oral health care and the clinical findings.

DENTAL EMERGENCY SERVICES
The following emergency dental services are covered:

- Treatment for pain, infection, swelling and/or injury
- Extraction of symptomatic (including pain), infected and non-restorable primary and permanent teeth, as well as retained primary teeth (extractions are limited to teeth which are symptomatic); and
- General anesthesia, conscious sedation or anxiolysis (minimal sedation, patients respond normally to verbal commands) when local anesthesia is contraindicated or when management of the patient requires it.

ADDITIONAL INFORMATION REGARDING DENTAL SERVICES
Members may select a contracted general dentist and receive preventive dental services without a referral, unless such services require prior authorization, as described below. If prior authorization is required, a provider must:

- Obtain appropriate prior authorization before rendering non-emergency services.
- Provide an oral health screening as part of an EPSDT screening and refer members for:
  - Appropriate dental services based on needs identified through the screening process.
  - Routine dental care based on the AHCCCS Exhibit 430-1 EPSDT Periodicity Schedule.
- Document evidence of referrals on the EPSDT form.
- May refer members for a dental assessment if their oral health screening reveals potential carious lesions or other conditions requiring assessment and/or treatment by a dental professional.
- Should encourage eligible members under the age of 21, to see a dentist regularly.
- Follow the AHCCCS Exhibit 430-1 EPSDT Periodicity Schedule to ensure members are referred appropriately.
- Should encourage members who call for a dental referral to obtain any routine or follow up care and document all referrals in the member’s medical record.

In addition to referrals by PCPs referrals, EPSDT members are allowed self-referral to a Mercy Maricopa contracted dentist.

Covered Dental Benefits – Summary

PREVENTIVE DENTAL SERVICES
Preventive dental services specified in the AHCCCS Exhibit 430-1A Dental Periodicity Schedule are covered benefits and include:

- Diagnostic services including comprehensive and periodic examinations.
• Mercy Maricopa covers two oral examinations and two oral prophylaxis and fluoride treatments per member per year (i.e., one every six months plus 1 day apart).

• Radiology services which are screening in nature for diagnosis of dental abnormalities and/or pathology, including panoramic or full-mouth x-rays, supplemental bitewing x-rays, and occlusal or periapical films as needed.

• Preventive services which include:
  o Oral prophylaxis performed by a dentist or dental hygienist which includes self-care oral hygiene instructions to member, if able, or to the parent/legal guardian.
  o Application of topical fluorides. Use of a prophylaxis paste containing fluoride and fluoride mouth rinses do not meet the AHCCCS standard for fluoride treatment (fluoride treatment in the PCP office is not a covered service).
  o Space maintainers for age appropriate replacement of posterior primary teeth which are lost prematurely and where unerupted, permanent posterior teeth are present.

THERAPEUTIC DENTAL SERVICES
All therapeutic dental services are covered when medically necessary but must be prior authorized by Mercy Maricopa. These services include but are not limited to:

• Periodontal procedures, scaling/root planing, curettage, gingivectomy, and osseous surgery

• Crowns:
  o When appropriate, stainless steel crowns may be used for both primary and permanent posterior teeth; composite, prefabricated stainless steel crowns with a resin window or crowns with esthetic coatings should be used for anterior primary teeth, or
  o Precious or cast semi-precious crowns may be used on functional permanent endodontic treated teeth, except third molars, for members who are 18 through 20 years old.

• Endodontic services including pulp therapy for permanent and primary teeth, except third molars (unless a third molar is functioning in place of a missing molar)

• Restoration of carious permanent and primary teeth with accepted dental materials other than cast or porcelain restorations unless the member is 18 through 20 years of age and has had endodontic treatment, and

• Dentures (both complete and partial), when medically necessary and determined to be the primary treatment of choice or an essential part of an overall treatment plan developed by both the PCP and the dentist in consultation with each other.

• Orthodontic services and orthognathic surgery are covered only when these services are necessary to treat a handicapping malocclusion. Services must be medically necessary and determined to be the primary treatment of choice or an essential part of an overall treatment plan developed by both the PCP and the dentist in consultation with each other.

ORTHODONTIC SERVICES
Orthodontic services are not covered when the primary purpose is cosmetic. Examples of
conditions that may require orthodontic treatment include the following:

- Congenital craniofacial or dentofacial malformations requiring reconstructive surgical correction in addition to orthodontic services.
- Trauma requiring surgical treatment in addition to orthodontic services.
- Skeletal discrepancy involving maxillary and/or mandibular structures.

**COVERED SERVICES FOR ELIGIBLE MEMBERS 21 YEARS OF AGE AND OVER**

Routine and emergency dental services are not covered for adults (age 21 and older), unless related to the treatment of a medical condition such as acute pain, infection, or fracture of the jaw. Covered services for adults (age 21 and older) include:

- Examination of the oral cavity
- Required radiographs
- Complex oral surgical procedures – Maxillofacial fractures
- Appropriate anesthesia
- Prescription of pain medications and antibiotics
- Pre-transplant services (Dental prophylaxis, restorations, extractions) – See below
- Prophylactic extraction of teeth for head/neck/jaw radiation

**Other Exceptions to Dental Services**

**DENTAL SERVICES NOT COVERED**

- Orthodontic treatment and extraction of non-symptomatic teeth are generally not covered services. This includes 3rd molars.
- Services or items furnished solely for cosmetic purposes are not covered by Mercy Maricopa.

**DENTAL SERVICES COVERED UNDER CERTAIN CRITERIA**

- Dentures, orthodontics and orthognathic (related to the placement of the jaw) surgery are covered only if they are determined to be medically necessary and the primary treatment of choice or an essential part of an overall treatment plan.
- Denture repair or reline to maintain serviceability of dentures is a covered benefit.
- TMJ treatment is limited to the alleviation of symptoms related to Acute, traumatic injuries only.

**DENTAL MEDICAL NECESSITY**

Medical necessity is determined by Mercy Maricopa’s medical and dental directors. The [Dental Prior Authorization Request Form](#) and medical documentation is required and must be submitted directly to Mercy Maricopa for review and prior authorization determination.

**VISION SERVICES**

**VISION OVERVIEW**

Mercy Maricopa 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 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 Maricopa’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 Maricopa’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.

**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 Maricopa's Member Services at 800-564-5465.

**4.4 – Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program**

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 members under the age of 21 as
described in 42 USC 1396d (a) and (r). However, the EPSDT program services will be provided to Mercy Maricopa Integrated Care members who are 18, 19 and 20 years of age. The EPSDT program is governed by federal and state regulations and community standards of practice.

All PCPs who provide services to Mercy Maricopa members age 18-20 are required to provide comprehensive health care, screening and preventive services, including, but not limited to:

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

A well-child visit is synonymous with an EPSDT visit and includes all screenings and services described in the AHCCCS EPSDT and Dental periodicity schedules.

Please refer to the Mercy Maricopa’s website for [Claims Coding for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) and Well-Child Visits](#) under Notices for specific claim codes.

**REQUIREMENTS FOR EPSDT PROVIDERS**

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

- Documenting immunizations 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 at: [http://azahcccs.gov/shared/Downloads/MedicalPolicyManual/Chap400.pdf](http://azahcccs.gov/shared/Downloads/MedicalPolicyManual/Chap400.pdf)
- Using current AHCCCS standardized [EPSDT Standards and Tracking Forms](#) to document services provided and compliance with AHCCCS standards.
- Sending copies of EPSDT Tracking forms to Mercy Maricopa on a monthly basis. Please send forms by mail to:
  
  4350 E. Cotton Center Blvd., Bldg. D
  
  Phoenix, AZ  85040
  
  Attn: Quality Management
  
  Or fax the forms to 860-975-3613
- 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.
- Referring Mercy Maricopa members to Children’s Rehabilitative Services (CRS) when they have conditions covered by the CRS program
- Making referrals for diagnosis and treatment when necessary and initiate follow-up services within 60 days.
- Reporting all EPSDT encounters on required claim forms, using the Preventive Medicine Codes.
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).
- 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.
- Appropriate vision and hearing/speech testing.
- Obesity screening using the BMI percentile for children.
- Anticipatory guidance.

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.

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 be viewed at the AHCCCS website, http://azahcccs.gov/shared/Downloads/MedicalPolicyManual/Chap400.pdf under Policy 430. This schedule follows the Center for Disease Control (CDC) recommendation. Children may receive additional inter-periodic screening at the discretion of the provider. Mercy Maricopa does not limit the number of well-child visits that members under age 21 receive. Claims should be billed with the following CPT/ICD-10-CM Diagnosis Codes based on age appropriateness:

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>ICD-10-CM Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>99383-99385, 99393-99395</td>
<td>Z00.21, Z00.129, Z02.89, Z00.8, Z00.5, Z00.70, Z00.71</td>
</tr>
</tbody>
</table>

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
NUTRITIONAL ASSESSMENT & NUTRITIONAL THERAPY

Nutritional assessments are conducted to assist EPSDT members whose health status may improve with nutritional intervention. AHCCCS covers the assessment of nutritional status provided by the member's primary care provider (PCP) as a part of the EPSDT screenings specified in the AHCCCS EPSDT Periodicity Schedule, and on an inter-periodic basis as determined necessary by the member’s PCP. AHCCCS also covers nutritional assessments provided by a registered dietitian when ordered by the member’s PCP. This includes EPSDT eligible members who are under or overweight. (Refer to the Centers for Disease Control and Prevention website at http://www.cdc.gov/growthcharts/for Body Mass Index (BMI) and growth chart resources.)

AHCCCS covers nutritional therapy for EPSDT eligible 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.

- Enteral nutritional therapy: Provides liquid nourishment directly to the digestive tract of a member who cannot ingest an appropriate amount of the calories to maintain an acceptable nutritional status. Enteral nutrition is commonly provided by Jejunostomy tube (J-tube), Gastrostomy Tube (G-tube) or Nasogastric (N/G) tube.
- Parenteral nutritional therapy: Provides nourishment through the venous system to members with severe pathology of the alimentary tract, which does not allow absorption of sufficient nutrients to maintain weight and strength.

Commercial Oral Supplemental Nutritional Feedings provides nourishment and increases caloric intake as a supplement to the member’s intake of other foods, or as the sole source of nutrition for the member. Nourishment is taken orally and is generally provided through commercial nutritional supplements available without prescription.

Medical necessity for commercial oral nutritional supplements must be determined on an individual basis by the member’s PCP or attending physician. The PCP or attending physician must use the approved form, “ADHS/DBHS Certificate of Medical Necessity for Commercial Oral Nutritional Supplements” to obtain prior authorization from Mercy Maricopa.

The ADHS/DBHS Certificate of Medical Necessity for Commercial Oral Nutritional Supplements must document that the PCP or attending physician has provided nutritional counseling as a part of the EPSDT services provided to the member. The documentation must specify alternatives that were tried in an effort to boost caloric intake and/or change food consistencies before considering commercially available nutritional supplements for oral feedings, or to supplement feedings.

The ADHS/DBHS Certificate of Medical Necessity for Commercial Oral Nutritional Supplements must indicate which criteria were met when assessing the medical necessity of providing commercial oral nutritional supplements. At least two of the following criteria must be met:
• The member is at or below the 10th percentile on the appropriate growth chart for their age and gender for three months or more
• The member has already demonstrated a medically significant decline in weight within the past three months (prior to the assessment)
• The member is able to consume/eat no more than 25% of his/her nutritional requirements from age-appropriate food sources
• Absorption problems as evidenced by emesis, diarrhea, dehydration, and/or weight loss and intolerance to milk or formula products has been ruled out
• The member requires nutritional supplements on a temporary basis due to an emergent condition; i.e. post-hospitalization (PA is not required for the first 30 days), or
• The member is at high risk for regression due to chronic disease or condition and there are no alternatives for adequate nutrition.

The following requirements apply:
• Nutritional therapy requires prior authorization and approval by the Mercy Maricopa Medical Director.
• Once prior authorization has been attained, a fully completed EPSDT Certificate of Medical Necessity for Commercial Oral Nutritional Supplements should be filled out and sent directly to the Durable Medical Equipment provider for handling. The form is also available on the AHCCCS website at: http://azahcccs.gov/shared/Downloads/MedicalPolicyManual/Chap400.pdf

IMMUNIZATIONS/VACCINES
EPSDT covers all child and adolescent immunizations. Immunizations must be provided according to the AHCCCS Recommended Childhood Immunization Schedules 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 Mercy Maricopa members who are 18 years of age.

Additional information can be attained by calling VFC at 602-364-3642 or by accessing their website at http://www.azdhs.gov/phs/immun/act_aipo.htm#vfc.

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 (ASIIS) that can be accessed online to obtain complete, accurate records.

The human papilloma virus (HPV) vaccine is covered for female and male EPSDT members 18, 19, and 20 years of age.

BODY MASS INDEX (BMI)
Providers should calculate each child’s BMI starting at each EPSDT visit. 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, www.cdc.gov/nccdphp/dnpa/bmi/bmi-for-age.htm.

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

<table>
<thead>
<tr>
<th>Condition</th>
<th>Percentage Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underweight</td>
<td>BMI-for-age &lt; 5th percentile</td>
</tr>
<tr>
<td>At risk of overweight</td>
<td>BMI-for-age 85th percentile to &lt; 95th percentile</td>
</tr>
<tr>
<td>Overweight</td>
<td>BMI-for-age &gt; 95th percentile</td>
</tr>
</tbody>
</table>

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

**EYE EXAMS AND PRESCRIPTIVE LENSES**
EPSDT covers eye examinations as appropriate to age according to the AHCCCS EPSDT Periodicity Schedule and as medically necessary using standardized visual tools. Prescriptive lenses are provided to correct or ameliorate defects, physical illness and conditions discovered by EPSDT screenings, subject to medical necessity.

**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 at each EPSDT visit.

**DENTAL SCREENING AND REFERRALS**
Oral health screenings are to be conducted at every EPSDT visit.

In addition to the screening, members must be referred to a dentist at least annually. 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:
- **Emergent** - (Within 24 hours) Pain, infection, swelling and/or soft tissue ulceration of approximately two weeks duration or longer
- **Urgent** - (Within three days) Decay without pain, spontaneous bleeding of the gums and/or suspicious white or red tissue areas
- **Routine** - (Within 45 days of request) none of the above problems identified.

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 are expected to 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.

In addition to PCP referrals, EPSDT members are allowed self-referral to a dentist who is included in Mercy Maricopa’s provider network.

EPSDT covers the following dental services:

- Emergency dental services including:
  - Treatment for pain, infection, swelling and/or injury
  - Extraction of symptomatic (including pain), infected and non-restorable primary and permanent teeth, as well as retained primary teeth (extractions are limited to teeth which are symptomatic), and
  - General anesthesia, conscious sedation or anxiolysis (minimal sedation, patients respond normally to verbal commands) when local anesthesia is contraindicated or when management of the patient requires it.

Preventive dental services provided as specified in the AHCCCS Dental Periodicity Schedule (see the BQ&I Specifications Manual) including, but not limited to:

- Diagnostic services including comprehensive and periodic examinations. The Integrated RBHA must allow two oral examinations and two oral prophylaxis and fluoride treatments per member per year (i.e., one every six months) for members through 18, 19 and 20 years of age
- Radiology services which are screening in nature for diagnosis of dental abnormalities and/or pathology, including panoramic or full-mouth x-rays, supplemental bitewing x-rays, and occlusal or periapical films as needed, and
  - Preventive services which include oral prophylaxis performed by a dentist or dental hygienist which includes self-care oral hygiene instructions to member, if able, or to the parent/legal guardian

All therapeutic dental services will be covered when they are considered medically necessary and cost effective but may be subject to PA by Mercy Maricopa. These services include but are not limited to:

- Periodontal procedures, scaling/root planning, curettage, gingivectomy, and osseous surgery
  - Crowns:
    - When appropriate, stainless steel crowns may be used for permanent posterior teeth; composite, prefabricated stainless steel crowns with a resin window, or
    - Precious or cast semi-precious crowns may be used on functional permanent endodontically treated teeth, except third molars, for members who are 18, 19 and 20 years old.
  - Endodontic services including pulp therapy for permanent and primary teeth, except third molars (unless a third molar is functioning in place of a missing molar)
- Restoration of carious permanent teeth with accepted dental materials other than cast or porcelain restorations unless the member is 18, 19 and 20 years of age and has had endodontic treatment.
- Removable dental prosthetics, including complete dentures and removable partial dentures, and Orthodontic services and orthognathic surgery are covered only when these services are necessary to treat a handicapping malocclusion.
  - Services must be medically necessary and determined to be the primary treatment of choice or an essential part of an overall treatment plan developed by both the PCP and the dentist in consultation with each other.
  - Orthodontic services are not covered when the primary purpose is cosmetic.
  - Examples of conditions that may require orthodontic treatment include the following:
    - Congenital craniofacial or dentofacial malformations requiring reconstructive surgical correction in addition to orthodontic services
    - Trauma requiring surgical treatment in addition to orthodontic services, or
    - Skeletal discrepancy involving maxillary and/or mandibular structures.

**COCHLEAR AND OSSEINTTEGRATED IMPLANTATION**

*Cochlear Implant*

Cochlear implantation provides an awareness and identification of sounds and facilitates communication for persons who have profound, sensorineural hearing loss (nerve deafness). Deafness may be prelingual/perilural or postlingual.

AHCCCS covers medically necessary services for cochlear implantation solely for EPSDT members. Cochlear implantation is limited to one (1) functioning implant per member. AHCCCS will not cover cochlear implantation in instances where individuals have one functioning cochlear implant.

Candidates for cochlear implants must meet criteria for medical necessity, including but not limited to, the following indications:
- A diagnosis of bilateral profound sensorineural deafness (using age-appropriate standard testing), with little or no benefit from a hearing (or vibrotactile) aid, as established by audiologic and medical evaluation;
- Presence of an accessible cochlear lumen structurally suited to implantation, with no lesions in the auditory nerve and acoustic areas of the central nervous system, as demonstrated by CT scan or other appropriate radiologic evaluation;
- No known contraindications to surgery
- Demonstrated age appropriate cognitive ability to use auditory clues, and
- The device must be used in accordance with the FDA approved labeling.

Coverage of cochlear implantation includes the following treatment and service components:
- Complete auditory testing and evaluation by an otolaryngologist, speech-language pathologist or audiologist
- Pre-surgery inpatient/outpatient evaluation by a board certified otolaryngologist
- Diagnostic procedures and studies, including CT scan or other appropriate radiologic evaluation, for determining candidacy suitability
- Pre-operative psychosocial assessment/evaluation by psychologist or counselor
- Prosthetic device for implantation (must be non-experimental/non-investigational and be Food and Drug Administration approved and used according to labeling instructions)
- Surgical implantation and related services
- Post-surgical rehabilitation, education, counseling and training
- Equipment maintenance, repair and replacement of the internal/external components or both if not operating effectively and is cost effective.
- Examples include but are not limited to: the device is no longer functional or the used component compromises the member’s safety. Documentation which establishes the need to replace components not operating effectively must be provided at the time prior authorization is sought.
- Cochlear implantation requires PA from Mercy Maricopa Medical Director.

**Osseointegrated implants (bone anchored hearing aid [BAHA])**
AHCCCS coverage of medically necessary services for osseointegrated implantation is limited to EPSDT members. Osseointegrated implants are devices implanted in the skull that replace the function of the middle ear and provide mechanical energy to the cochlea via a mechanical transducer. These devices are indicated only when hearing aids are medically inappropriate or cannot be utilized due to congenital malformation, chronic disease, severe sensorineural hearing loss or surgery. Osseointegrated implantation requires PA from Mercy Maricopa Medical Director.

**ORGAN AND TISSUE TRANSPLANTATION SERVICES**
EPSDT covers all non-experimental transplants necessary to correct or ameliorate defects, illnesses and physical conditions whether or not the particular non-experimental transplant is covered by the AHCCCS State Plan.

**CONSCIOUS SEDATION**
AHCCCS covers conscious sedation for members receiving EPSDT services. Conscious sedation provides a state of consciousness that allows the member to tolerate an unpleasant procedure while continuously maintaining adequate cardiovascular and respiratory function, as well as the ability to respond purposely to verbal command and/or tactile stimulation.

Coverage is limited to the following procedures except as specified below:
- Bone marrow biopsy with needle or trocar
- Bone marrow aspiration
- Intravenous chemotherapy administration, push technique
- Chemotherapy administration into central nervous system by spinal puncture
- Diagnostic lumbar spinal puncture, and
- Therapeutic spinal puncture for drainage of cerebrospinal fluid.

Additional applications of conscious sedation for members receiving EPSDT services will be
considered on a case by case basis and require medical review and prior authorization by
Mercy Maricopa Medical Director for enrolled members.

BEHAVIORAL HEALTH SERVICES
AHCCCS covers medically necessary behavioral health services for Mercy Maricopa members
eligible for EPSDT services. EPSDT behavioral health services include the services listed in
Federal Law 42 USC 1396d(a) necessary to correct or ameliorate mental illnesses and
conditions discovered by the screening services whether or not the services are covered
under the AHCCCS State Plan.

Mercy Maricopa contracted PCPs, within the scope of their practice, who wish to provide
psychotropic medications and medication adjustment and monitoring services may do so for
members diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder,
depressive (including postnatal depression) and/or anxiety disorders. The BQ & I
Specifications Manual provides clinical guidelines, including assessment tools and algorithms
for each of the three named diagnoses. The clinical guidelines are to be used by the PCPs as
an aid in treatment decisions.

RELIGIOUS NON-MEDICAL HEALTH CARE INSTITUTION SERVICES
AHCCCS covers medically necessary services provided in religious nonmedical health care
institutions or nursing facilities for EPSDT members who need nursing care 24 hours a day,
but do not require hospital care under the daily direction of a physician. The religious non-
medical health care institutions are exempt from licensure or certification requirements.

CARE MANAGEMENT SERVICES
AHCCCS covers care management services as appropriate for Mercy Maricopa members
eligible for EPSDT services. In EPSDT, care management involves identifying the health needs
of a member, ensuring necessary referrals are made, maintaining health history, and
initiating further evaluation/diagnosis and treatment when necessary.

CHIROPRACTIC SERVICES
AHCCCS covers chiropractic services to Mercy Maricopa members eligible for EPSDT services
when ordered by the member’s PCP and approved by Mercy Maricopa in order to ameliorate
the member’s medical condition.

PERSONAL CARE SERVICES
AHCCCS covers personal care services, as appropriate, for Mercy Maricopa members eligible
for EPSDT services.

INCONTINENCE BRIEFS
Incontinence briefs, including pull-ups, are covered in order to prevent skin breakdown and
to enable participation in social, community, therapeutic and educational activities under the
following circumstances:

- The member is 18, 19 or under 20 years old
- The member is incontinent due to a documented disability that causes incontinence of bowel and/or bladder
- The PCP or attending physician has issued a prescription ordering the incontinence briefs
- Incontinence briefs do not exceed 240 briefs per month unless the prescribing physician presents evidence of medical necessity for more than 240 briefs per month for a member diagnosed with chronic diarrhea or spastic bladder
- The member obtains incontinence briefs from providers in Mercy Maricopa’s network
- Prior authorization has been obtained as required by Mercy Maricopa.

**MEDICALLY NECESSARY THERAPIES**
AHCCCS covers medically necessary therapies including physical therapy, occupational therapy and speech therapy necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services. Therapies are covered under both an inpatient and outpatient basis when medically necessary.

**TUBERCULIN SKIN TESTING**
Tuberculin skin testing should be performed as appropriate to age and risk. Members at increased risk of tuberculosis (TB) include those who have contact with persons:
- Confirmed or suspected of TB;
- In jail during the last five years;
- Living in a household with an HIV-infected person or the member is infected with HIV;
- Traveling/emigrating from, or having significant contact with persons indigenous to, endemic countries.

**RESPONSIBILITIES OF PRIMARY CARE PROVIDERS (PCPS) PROVIDING EPSDT SERVICES**

**EPSDT Screening and Documentation**
- PCPs that provide primary care services to members 18, 19 and 20 years of age are to conduct EPSDT assessments in accordance with the most current AHCCCS EPSDT Periodicity Schedule (see the BQ & I Specification Manual).
- PCPs are encouraged to take advantage of all clinical visits to conduct EPSDT screenings.
- Each assessment performed is to be documented on the AHCCCS EPSDT Tracking Form. The PCP or a licensed health professional under the PCP's direction is to interpret each EPSDT assessment and follow up with diagnosis, treatment, and referral if indicated.

**Referrals and Follow-up**
If an EPSDT screen reveals a condition requiring treatment or services outside the PCP's scope of practice, the PCP is to refer the member according to the provisions listed below.
- Members who require covered services, that can be obtained within Mercy Maricopa network; are to be referred to the participating Mercy Maricopa health professional (including dental services in accordance with the most current AHCCCS periodicity table) according to Mercy Maricopa referral procedures outlined in Mercy Maricopa’s
prior authorization policy.

- Members who require treatment or services for a confirmed diagnosis that is medically eligible for coverage by the Children's Rehabilitative Services (CRS) are to be referred to CRS. For further information and to access the CRS application form, please refer to the AHCCCS CRS webpage.

- Members who require services that are not covered by AHCCCS or CRS may receive services from Mercy Maricopa, if the member is eligible, or should be referred to providers or community agencies that will provide the services such as Woman, Infants and Children Supplemental Nutrition Programs (WIC).

- Mercy Maricopa and its contracted providers require PCPs to establish procedures for tracking and following up on referrals made during EPSDT visits. Additionally, PCPs will ensure that members are notified when dental or medical appointments are due as specified in the periodicity schedules.

**Immunizations**

- EPSDT covers all age appropriate immunizations as specified in the Recommended Childhood Immunization Schedules (see the BQ & I Specifications Manual). All age appropriate immunizations must be provided to establish and maintain up-to-date immunization status for each EPSDT member.

- Mercy Maricopa will require PCPs to implement the United States Office of Health and Human Services, Centers for Disease Control (CDC) Standards for Immunization Practices. The standards include the following recommendations to:
  - Assess the member's immunization status during each EPSDT or episodic care visit;
  - Take advantage of all opportunities to vaccinate;
  - Identify and minimize barriers to vaccine administration;
  - Assess for and follow only medically accepted contraindications to vaccination; and
  - Educate the member or parent/guardian of the benefits and risks of vaccination in a culturally appropriate manner and easy to understand language.

- ADHS/DBHS and AHCCCS require PCPs who are providing immunizations to members 18 years of age to enroll with the ADHS Vaccines for Children Program (VFC) and to re-enroll annually. PCPs that choose not to participate in the program will not have eligible members 18 years of age assigned to their panel by Mercy Maricopa. PCPs that lose eligibility with VFC will have their EPSDT eligible members 18 years of age removed from their panel. To allow members the right to choose from available service providers, an EPSDT member 18 years of age may receive EPSDT services from a nonparticipating or excluded VFC provider. These providers will refer their EPSDT members 18 years of age to a county health department or community based clinic for immunizations.

- Arizona State law requires reporting of all immunizations administered to children under 19 years of age. Immunizations must be reported timely to ADHS. Mercy Maricopa must require practitioners who are providing immunizations to members 18 years of age to enroll and report using the ASIIS (Arizona State Immunization
Information System) registry and maintain each EPSDT member’s immunization records in ASIIS in accordance with A.R.S. Title 36, Section 135. Reported immunizations in ASIIS can be accessed by practitioners to document all vaccines given and to view a member's immunization record. Mercy Maricopa is required to educate the provider network about these requirements and the use of this resource.

Compliance with Standards
PCPs are to comply with the Mercy Maricopa Minimum Medical Record Standards, based upon AHCCCS and any applicable accrediting agency requirements and other medical requirements under the law. PCPs will cooperate with Mercy Maricopa’s periodic reviews of the EPSDT Program services, which may include member record reviews supported by the ADHS/DBHS Quality Management Department to assess compliance to the standards.

Reporting EPSDT Encounters
PCPs are to report EPSDT visits by indicating the applicable Current Procedural Terminology (CPT) Preventive Medicine Codes on the contractually required claim form.

RESPONSIBILITIES OF MERCY MARICOPA
Mercy Maricopa must develop policies and procedures to identify the needs of EPSDT members, inform members of the availability of EPSDT services, coordinate their care, conduct adequate follow up, and ensure that members receive timely and appropriate treatment.

Mercy Maricopa must:
- Develop policies and procedures to monitor, evaluate, improve and increase EPSDT participation;
- Employ sufficient numbers of appropriately qualified personnel in order to meet the health care needs of members and fulfill Federal and State EPSDT requirements as well as to achieve contractual compliance.
- Inform all participating primary care providers (PCPs) about EPSDT requirements.
- This must include informing PCPs of Federal, State and AHCCCS policy requirements for EPSDT and updates of new information as it becomes available.
  - Develop, implement, and maintain a program to inform members about EPSDT services within 30 days of enrollment with Mercy Maricopa. This information must include:
    - The benefits of preventive health care;
    - Information that an EPSDT visit is a “well visit”;
    - A complete description of the services available as described in this policy
    - Information on how to obtain these services and assistance with scheduling appointments;
    - Availability of care management assistance in coordinating EPSDT covered services;
    - A statement that there is no co-payment or other charge for EPSDT screening and resultant services, and
    - A statement that assistance with medically necessary transportation and
• scheduling appointments is available for a member to obtain EPSDT services.
  ▪ Provide EPSDT information, defined in #3 above, in a second language, in addition to English, in accordance with the requirements of Chapter 6.5, Cultural Competency.
  ▪ Develop and implement processes to assist members and their families regarding community health resources, including but not limited to WIC.
  ▪ Participate in community and/or quality initiatives to promote and support best local practices and quality care within the communities served by Mercy Maricopa.
  ▪ Attend EPSDT related meetings when requested by ADHS/DBHS and/or AHCCCS Administration.
  ▪ Develop, implement, and maintain a procedure for ensuring timeliness of re-screening and treatment for all conditions identified as a result of examination, screening, and diagnosis. Treatment, if required, must occur on a timely basis and generally no longer than 6 months beyond the request for screening services (refer to contractor requirements in this chapter). Develop and implement a process for monitoring that providers use the most current EPSDT Tracking Forms at every EPSDT visit (if an electronic medical record is utilized the electronic medical record must include all of the elements of the most current age appropriate EPSDT Tracking Form) and that all age appropriate screening and services are conducted during each EPSDT visit.
  ▪ Develop, implement and maintain a procedure to notify all members/caretakers prior to visits required by the AHCCCS EPSDT and Dental Periodicity Schedules. This procedure must include:
    ○ Notification of members or responsible parties regarding due dates of each periodic screen. If a periodic screening visit has not taken place, a second written notice must be sent.
    ○ Notification of members or responsible parties regarding due date of an annual dental visit. If a dental visit has not taken place, a second notice must be sent.
  ▪ Develop and implement processes to reduce no-show appointment rates for EPSDT services.
  ▪ Provide targeted outreach to those members who did not show for appointments.
  ▪ Implement processes to print two part carbonless EPSDT Tracking Forms (a copy for the medical record and a copy for providers to send to the Mercy Maricopa EPSDT Coordinator).
  ▪ Distribute or provide the EPSDT Tracking Forms to contracted providers.
• Require the use of the AHCCCS EPSDT and Dental Periodicity Schedules and AHCCCS approved, standardized EPSDT Tracking Forms (see the BQ & I Specifications Manual) by all contracted providers. The AHCCCS EPSDT and Dental Periodicity Schedules give providers necessary information regarding timeframes in which age-related required screenings and visits must be rendered by providers.

• Mercy Maricopa must require contracted providers to complete all of the following requirements:
  o Use the AHCCCS EPSDT Tracking Forms (or electronic equivalent) at every EPSDT visit
  o Perform all age appropriate screening and services during each EPSDT visit in accordance with the AHCCCS EPSDT and Dental Periodicity Schedules, see the BQ & I Specifications Manual;
  o Sign EPSDT Tracking Forms and place them in the member’s medical record (if an electronic medical record is used an electronic signature must be used). Send copies of the EPSDT Tracking Forms (or electronic equivalent) to Mercy Maricopa.
  o Providers are not required to submit EPSDT Tracking Forms to ADHS/DBHS or AHCCCS Administration.

• Submit to ADHS/DBHS, within 15 days of the end of each reporting quarter, a detailed progress report that describes the activities of the quarter and the progress made in reaching the established goals of the plan in accordance with the Mercy Maricopa contract. Quarterly reports must include documentation of monitoring and evaluation of EPSDT requirements, and implementation of improvement processes. The quarterly report must include results of Mercy Maricopa’s ongoing monitoring of performance rates in a format that will facilitate comparison of rates in order to identify possible need for interventions to improve or sustain rates. The reports must also identify Mercy Maricopa established goals. (See the BQ & I Specifications Manual for the report template and requirements/instructions).

• Have a written EPSDT plan including oral health, which addresses the objectives, monitoring and evaluation activities of their program.

• Participate in an annual review of EPSDT requirements conducted by ADHS/DBHS including, but not limited to, Mercy Maricopa results of on-site visits to providers and medical record audits.

• Include language in PCP contracts that requires PCPs to:
  o Provide EPSDT services for all members 18, 19 and 20 years of age. Services must be provided in accordance with the AHCCCS EPSDT and Dental Periodicity Schedules, and
  o Agree to utilize the standardized AHCCCS EPSDT Tracking Forms or, if electronic medical records are utilized, they must contain all the elements of the current AHCCCS EPSDT Tracking Forms.
  o Implement procedures to ensure compliance by PCPs with all EPSDT standards and contract requirements.
  o Implement protocols to ensure that health problems are diagnosed and treated early, before they become more complex and the treatment more costly (including follow-up related to tuberculosis screening).
o Implement protocols for coordinating care and services with the appropriate state agencies for EPSDT eligible members, and ensure that members are referred to support services, as well as other community-based resources to support good health outcomes.
CHAPTER 5 – COMMUNICATION AND MEMBER INFORMATION

5.0 – Member Handbook

Mercy Maricopa is responsible for the Member Handbook. Providers can request member handbooks by completing the Member Handbook Order Form in its entirety and submit to MercyMaricopaProviderRelations@aetna.com. Handbooks are packaged 40 handbooks to one box. There is a minimum order of one box.

Member handbooks must be distributed to persons receiving services as follows (see AHCCCS ACOM Chapter 400, Policy 404 for more information):

- Members diagnosed with SMI who are enrolled with Mercy Maricopa 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 Mercy Maricopa 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 for the minimum requirements to document members’ receipt of the handbook.

Member Handbooks will be available and easily accessible at all provider sites and is available on the Mercy Maricopa 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.

Persons receiving healthcare services have the right to request and obtain a Member Handbook at least annually. Mercy Maricopa notifies persons of their right to request and obtain a Member Handbook at least annually by publishing this information using notices or newsletters accessible on Mercy Maricopa’s website.

ADHS/DBHS may require Mercy Maricopa to revise the Member Handbook and distribute it to all current enrollees if there is a significant program change. ADHS/DBHS determines if a change qualifies as significant.

Member Handbooks are reviewed annually, and if needed, updated by the ADHS/DBHS and Mercy Maricopa.
CHAPTER 6 – NETWORK REQUIREMENTS

6.0 – Provider Network Development and Management (REVISED: 05/15/15)

To ensure that Mercy Maricopa 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 Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) standards and requirements.

NETWORK DEVELOPMENT

Mercy Maricopa 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 Maricopa 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 persons 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.

NETWORK MANAGEMENT
Mercy Maricopa as the RBHA must:

- Monitor network compliance with all policies and rules of AHCCCS and the Contractor, including:
  - ADHS 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;
  - 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 Maricopa tracks and trends provider inquiries/complaints/requests for information and take systemic action as necessary and appropriate
  - Mercy Maricopa 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 ADHS/DBHS or AHCCCS).
  - Mercy Maricopa 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 Maricopa procedures for initiating provider contracts or AHCCCS provider registration;
    - Claim submission methods and resources (see Chapter 7.0 - Submitting Claims and Encounters to Mercy Maricopa);
    - Claim dispute and appeal procedures (Chapter 20.4 – Contractor and Provider Claims Disputes);
    - Identifying and referring quality of care issues; and
    - Fraud, waste, and program abuse reporting requirements in accordance with Chapter 17.0, Corporate Compliance.

Mercy Maricopa as the Integrated RBHA’s 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 Maricopa 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.

6.1 – Credentialing and Recredentialing

APPLICATION PROCESS
Providers wishing to contract with Mercy Maricopa may fax a letter of interest along with required information to fax 860-902-8370. ATTN: Network Development and Contracting. Contract requests will be reviewed and the requesting provider will be notified of contract status. To determine the status of a contract request, please call your provider relations representative at 602-586-1880 or 866-602-1979. Additional information and application forms can be located on the Mercy Maricopa website at mercymaricopa.org.

GENERAL PROCESS FOR CREDENTIALING/REcredentialing
The Credentialing Committee (comprised of both network peer physicians and Mercy Maricopa medical directors) reviews all credentialing information and forwards their recommendations to the chief medical officer (CMO) who presents the information to the Quality Management Oversight Committee and the Mercy Maricopa’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) with the exception of references, recommendations or other peer-review protected information.
- To correct erroneous information submitted by another source. Mercy Maricopa 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.
- To ensure Mercy Maricopa does not discriminate against a provider solely on the basis of the professional’s license or certification; or due to the fact that the provider serves high-risk populations and/or specializes in the treatment of costly conditions.

Streamlining Process
Mercy Maricopa is dedicated to improving and streamlining credentialing processes and timelines for those providers credentialed and re-credentialed directly through Mercy Maricopa. In addition, contractual relationships have been developed to delegate credentialing and re-credentialing activities to approved, qualified outside entities throughout the Mercy Maricopa region (GSA-6). 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 Mercy Maricopa members.

Providers’ credentialed/re-credentialed through a delegated entity must still be approved through the Mercy Maricopa 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 Mercy Maricopa Special Needs Unit (SNU) coordinates care and services with the carve-out programs for Mercy Maricopa members enrolled in one or more of the following programs:

- ADHS Division of Children’s Rehabilitation Services (CRS) and
- AZ Department of Economic Security, Division of Developmental Disabilities.

**Notification Requirement**

Mercy Maricopa has procedures for reporting (in writing) to appropriate authorities (Arizona Department of Health Services/Division of Behavioral Health Services, Arizona Health Care Cost Containment System (AHCCCS), the provider’s regulatory board or agency, Office of the Attorney General (OAG), etc.) any serious quality deficiencies that could result in a provider’s suspension or termination from Mercy Maricopa’s network. If the issue is determined to have criminal implications, a law enforcement agency must also be notified. Mercy Maricopa:

- Maintains documentation of implementation of the procedure, as appropriate;
- Has an appeal process for instances in which Mercy Maricopa chooses to alter the provider’s contract based on issues of quality of care and/or service; and
- Will inform the provider of the appeal process.

Providers must immediately notify AHCCCS-OIG and ADHS/DBHS-OPI of any confirmed instances of an excluded provider, employee or subcontractor that is or appears to be in a prohibited relationship with Mercy Maricopa or its sub- contractors.

**TEMPORARY/PROVISIONAL CREDENTIALING PROCESS**

Mercy Maricopa 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 Mercy Maricopa’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.

**CREDENTIALING REQUIREMENTS FOR INDIVIDUALS NOT LICENSED OR CERTIFIED**

Individuals who are not licensed or certified must be included in the credentialing process and profiled as outlined in [A.A.C. R9-20-204](#).

**RE-CREDENTIALING**

Mercy Maricopa will ensure that all credentialed providers are re-credentialed. The re-credentialing process must:
Occur at least every three years; and
Update information obtained during the initial credentialing process with the exception of:
  - History of loss of license and/or felony convictions;
  - Minimum five-year work history; and
  - Board certification, if the provider is Board certified.

The re-credentialing of individual providers must include a process for ongoing monitoring and intervention and if appropriate, provider sanctions, complaints and quality issues, which include, at a minimum, reviews of:
- Medicare/Medicaid sanctions;
- State sanctions or limitations on licensure;
- Member concerns including grievances (complaints) and appeals information;
- Utilization management information (such as: hospital length of stay, pharmacy utilization);
- Performance improvement and monitoring (such as performance measure rates);
- Results of any medical record review audits; and
- Quality of care issues (including trend data). If an adverse action is taken with a provider due to a quality of care concern, Mercy Maricopa must report the adverse action to the ADHS/DBHS Clinical Quality Management Unit.

COMMUNITY SERVICE AGENCIES – TITLE XIX CERTIFICATION
Community Service Agencies (CSAs) were developed by ADHS/DBHS, in collaboration with the Arizona Health Care Cost Containment System (AHCCCS), to provide rehabilitation, support and transportation services to behavioral health recipients. CSAs are a unique provider type that allow behavioral health recipients to participate in programs and activities in community settings (such agencies could include churches, after school programs or other agencies that serve the general public). CSAs provide services that enhance or supplement behavioral health services that persons receive through other, licensed agencies. Agencies operating licensed programs that provide services or intend to provide services as Tier I or Tier II services must capture these services under their license. Licensed agencies must not apply for Title XIX Certification. ADHS/DBHS policy provides a standardized process for Title XIX Certification of CSAs, describes the certification application process and Mercy Maricopa and ADHS/DBHS review process for approval of CSAs, specifies requirements for the continued operation of CSAs, and establishes Mercy Maricopa responsibilities in auditing and ongoing monitoring of CSAs. See ADBS Policy Section 1, Chapter 406, Community Service Agencies for additional information.

ADDITIONAL CREDENTIALING STANDARDS FOR HOSPITALS AND BEHAVIORAL HEALTH FACILITIES
Hospitals and behavioral health facilities licensed by DLS, outpatient clinics and ADHS/DBHS Title XIX certified Community Service Agencies) must ensure the following:
- The provider is licensed/certified to operate in Arizona as applicable and is in compliance with any other applicable state or federal requirements; and
- The provider is reviewed and approved by an appropriate accrediting body, or if not
Initial Assessment of Organizational Providers

As a prerequisite to contracting with the provider, Mercy Maricopa must ensure that the organizational provider has established policies and procedures that meet AHCCCS requirements. The requirements described in this chapter must be met for all providers included in Mercy Maricopa network (including, but not limited to, hospitals, home health agencies, attendant care agencies, group homes, nursing facilities, behavioral health facilities, dialysis center, transportation companies, dental and medical schools, and free standing surgi-centers; see AHCCCS Medical Policy Manual, Chapter 950).

Prior to contracting with the provider, Mercy Maricopa must:

- Confirm that the provider has met all the state and federal licensing and regulatory requirements (a copy of the license or letter from the regulatory agency will meet this requirement);
- Confirm that the provider is reviewed and approved by an appropriate accrediting body as specified by the Centers for Medicare and Medicaid Services (CMS) (a copy of the accreditation report or letter from the accrediting body will meet this requirement). Mercy Maricopa must state in policy which accrediting bodies it accepts;
- Conduct an onsite quality assessment if the provider is not accredited. Mercy Maricopa must develop a process and utilize assessment criteria for each type of unaccredited organizational provider for which it contracts which must include, but is not limited to, confirmation that the organizational provider has the following:
  - A process for ensuring that they credential their practitioners;
  - Liability insurance;
  - Business license; or
  - CMS certification or state licensure review/audit may be substituted for the required site visit. In this circumstance, Mercy Maricopa must obtain the review/audit documentation from CMS or the state licensing agency and verify that the review/audit was conducted and that the provider meets Mercy Maricopa’s standards. A letter from CMS that states the organizational provider was reviewed/audited and passed inspection is sufficient documentation when Mercy Maricopa has documented that they have reviewed and approved the CMS criteria and they meet Mercy Maricopa’s standards.
  - Review and approve the provider through Mercy Maricopa’s credentialing committee.

Reassessment of Organizational Providers

Mercy Maricopa must reassess organizational providers at least every three years. The reassessment must include the following components and all information utilized by Mercy
Maricopa must be current:

- Confirmation that the organizational providers remain in good standing with State and Federal bodies, and, if applicable, are reviewed and approved by an accrediting body. To meet this component, Mercy Maricopa must validate that the organizational provider meets the conditions listed below:
  - Federal requirements as applicable; and
  - Is licensed to operate in the State, and is in compliance with any other State requirements. If an organization provider is not accredited or surveyed or licensed by the State, an on-site review must be conducted;

- Assess data available to Mercy Maricopa including:
  - The most current review conducted by the ADHS Division of Licensing and/or summary of findings (please include date of review);
  - Record of on-site inspection of non-licensed organizational providers to ensure compliance with service specifications.

- Evaluate organizational provider specific information including, but not limited to, the following:
  - Member concerns which include grievances (complaints);
  - Utilization management information (if applicable);
  - Performance improvement and monitoring (if applicable);
  - Results of medical records review audits (if applicable);
  - Quality of care issues and, if an adverse action is taken with a provider due to a quality of care concern, Mercy Maricopa must report the adverse action to the ADHS/DBHS Clinical Quality Management Unit; and
  - Onsite assessment.
  - Review and approval by Mercy Maricopa’s credentialing committee with formal documentation that includes any discussion, review of thresholds, and complaints or grievances.

Notice of Requirements (Limited to Providers)

Mercy Maricopa must have procedures for reporting (in writing) to appropriate authorities (ADHS/DBHS, AHCCCS, the provider’s regulatory board or agency, OAG, etc.) any known serious issues and/or quality deficiencies. If the issue/quality deficiency results in a provider’s suspension or termination from Mercy Maricopa’s network, it must be reported. If the issue is determined to have criminal implications, a law enforcement agency must also be notified.

- Mercy Maricopa must maintain documentation of implementation of the procedure, as appropriate;
- Mercy Maricopa must have an appeal process for instances in which Mercy Maricopa chooses to alter the provider’s contract based on issues of quality of care and/or service; and
- Mercy Maricopa must inform the provider of the appeal process.

6.2 – Material Changes

Mercy Maricopa must ensure the timely and accurate reporting of material changes to the network, affecting behavioral health members to the Arizona Department of Health Services,
Division of Behavioral Health Services (ADHS/DBHS). Mercy Maricopa also ensures that all subcontracted providers adhere to the requirements of this chapter.

Mercy Maricopa 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 Maricopa:

- 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 MARICOPA RESPONSIBILITIES**

During the material transition process, Mercy Maricopa 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-ADHS/DBHS NOTIFICATIONS**

*For all Mercy Maricopa Provider Changes:*

Notify Mercy Maricopa 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](#) form is required. The completed form must be submitted electronically to Mercy Maricopa Network Management to your assigned Provider Relations Liaison using email [materialchanges@mercymaricopa.org](mailto:materialchanges@mercymaricopa.org).

Mercy Maricopa will notify ADHS/DBHS in writing within one (1) day of knowledge of any unexpected network material change, see form for specific requirements.

Mercy Maricopa 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 ADHS/DBHS Policy Office before it is printed, posted or disseminated to members.
Mercy Maricopa may require subcontracted providers to submit a **Network Material Change Transition Grid** 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 Maricopa will provide the Transition Grid and specific monthly reporting requirements. The Transition Grid will be submitted for a period to be determined by Mercy Maricopa.

Mercy Maricopa 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 Maricopa members of any material network change described in this chapter to subcontracted providers.

### 6.3 – Training Requirements

Mercy Maricopa monitors and implements training activities and requirements listed in this chapter. In addition, Mercy Maricopa annually evaluates the impact of the training requirements and activities in order to develop a qualified, knowledgeable and culturally competent workforce.

Mercy Maricopa’s comprehensive training content is adult-learning focused, intensive and aligned with company guidelines, the Substance Abuse and Mental Health Services Administration (SAMHSA) core competencies for workforce development, 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 Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS)
- Arizona Health Care Cost Containment System (AHCCCS)
- Arnold v. ADHS and JK v. Humble settlement agreements
- Maricopa County Superior Court

**REQUIRED TRAINING FOR PROVIDERS AND THEIR STAFF**

Mercy Maricopa providers must ensure the following are completed within 90 days of the staff person’s hire date, as relevant to each staff person’s job duties and responsibilities and annually as applicable. Any staff person hired for temporary services working less than 90 days are required to attend applicable training at the discretion of the Provider. See **REQUIRED TRAINING SPECIFIC TO PROFESSIONAL FOSTER HOMES PROVIDING HCTC SERVICES** for training requirements applicable to Home Care Training to Home Care Client (HCTC) providers and **REQUIRED TRAINING SPECIFIC TO COMMUNITY SERVICE AGENCIES** for training requirements applicable to Community Service Agencies.

**Section 1**

- Fraud and program abuse recognition and reporting requirements and protocols, including but not limited to training on the Federal False Claims Act and administrative remedies for false claims and statements, state laws relating to civil
and criminal penalties for false claims and statements, and whistleblower protections under such laws;

- Managed care concepts, including information on Mercy Maricopa and the public healthcare system;
- Screening for eligibility, enrollment for covered services (when eligible), and referral when indicated;
- Overview of the Arizona system policies and procedures in the Arizona Vision and 12 Principles in the children’s system;
- Overview of Arizona’s system policies and procedures in the 9 Guiding Principles for Recovery Oriented Adult Behavioral Health Services and Systems;
- Overview of partnership with Department of Economic Services/Rehabilitative Services Administration (DES/RSA);
- Cultural competency; including Cultural Competency 101: Embracing Diversity (ADHS/DBHS curriculum);
- Interpretation and translation services;
- Demographic Data Set, including required timeframes for data submission and valid values; and
- Identification and reporting of quality of care concerns and the quality of care concerns investigation process.

Section 2

- Use of assessment and other screening tools (e.g., substance-related, crisis/risk, developmental, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program etc.), including the Birth-to-Five Assessment depending upon population(s) served;
- Use of effective interview and observational techniques that support engagement and are strengths-based, recovery-oriented, and culturally sensitive;
- Application of diagnostic classification systems and methods depending upon population(s) served;
- Best practices in the treatment and prevention of behavioral health disorders;
- Service planning and implementation which includes family vision and voice, developed in collaborations with the individual/family needs as identified through initial and ongoing assessment practices;
- Covered services (including information on how to assist persons in accessing all medically necessary covered services regardless of a person’s behavioral health category assignment or involvement with any one type of service provider);
- Overview of Substance Abuse Block Grant (SABG): priority placement criteria, interim service provision, consumer wait list reporting, and expenditure restrictions of the SABG in accordance with requirements in Chapter 2.9 – Special Populations, Chapter 2.1 – Appointment Standards and Timeliness of Service and 45 CFR Part 96;
- Providers should receive training on the ADHS/DBHS National Practice Guidelines and Clinical Guidance Documents with required elements before providing services, but must receive training within six months of the staff person’s hire date. (Protocol training is only required if pertinent to populations served).
- Clinical training as it relates to specialty populations including but limited to
conditions based on identified need;

- Information regarding the appropriate clinical approaches when delivering services to children in the care and custody of the Arizona Department of Economic Security/Division of Children Youth and Families (ADES/DCYF); and

- Understanding behavioral and environmental risk factors, nonphysical interventions, the safe use of seclusion or restraint and responding to emergency situations in accordance with Chapter 19.1 – Reporting and Monitoring the Use of Seclusion and Restraint.

### Section 3

- Medical record documentation requirements (see Chapter 10.1 – Medical Record Standards);
- Confidentiality/Health Information Portability and Accountability Act (HIPAA);
- Sharing of treatment/medical information;
- Coordination of service delivery for persons with complex needs (e.g. persons at risk of harm to self and others, court ordered to receive treatment); Rights and responsibilities of eligible and enrolled behavioral health recipients, including rights for persons determined to have Serious Mental Illness (SMI);
- Appeals, grievances and requests for investigations;
- Complaint process (see Chapter 20.1 – Complaint Resolution);
- Customer service;
- Coordination of care requirements with Primary Care Providers (PCPs) (see Chapter 11.1 – Coordination of Care with AHCCCS Health Plans, Primary Care Providers and Medicare Providers);
- Third party liability and coordination of benefits (see Chapter 9.0 - Third Party Liability and Coordination of Benefits);
- Other involved agencies and government entities see Chapter 11.2 – Coordination of Behavioral Health Care with Other Governmental Entities;
- Claims/encounters submission process (see Chapter 7.0 – Submitting Claims and Encounters to Mercy Maricopa);
- Advance Directives (see Chapter 10.0 – Advance Directives);
- Identification and reporting of persons in need of Special Assistance for individuals who have been determined to have a Serious Mental Illness (SMI) and ensuring involvement of persons providing Special Assistance (See Chapter 2.12 – Special Assistance for Persons Determined to have a Serious Mental Illness);
- Providers delivering services through distinct programs (e.g., Assertive Community Treatment teams, Dialectical Behavioral Therapy, Multi-Systemic Therapy, developmental disabilities, trauma, substance abuse, children age birth to five, and inpatient facilities);
- Member benefit options trainings: such as Medicare Modernization Act (MMA) Department of Economic Security/Rehabilitation Services Administration (DES/RSA) Substance Abuse Block Grant (SABG).
- 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 behavioral health system (e.g., the Balanced
Budget Act (BBA), Medicaid Modernization Act (MMA), the Affordable Care Act (ACA)

- PCP training regarding behavioral health referral and consultation services;
- Behavioral health step therapy for members with depression, post-partum depression, anxiety, and attentive deficit/hyperactivity disorder (ADHD) in compliance with the AHCCCS medical policy manuals.

**MERCY MARICOPA REQUIRED TRAININGS**

Mercy Maricopa requires the following additional training classes for providers:

- Welcome to RELIAS Learning Management System
- Mercy Maricopa Integrated Care Overview
- Cultural Competency – 101 Embracing Diversity
- Introduction to AHCCCS

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;
- Complaints;
- Utilization management;
- Grievance and appeals;
- System of care data;
- Quality of care data; and
- Court system data;

**ANNUAL AND ONGOING TRAINING REQUIREMENTS**

In addition to training required within the first 90 days of hire, all Mercy Maricopa behavioral health providers are required to undergo and provide ongoing training for the following content areas:

- ADHS/DBHS Demographic Data Set, including required timeframes for data submission, valid values and as changes occur;
- Monthly trainings concerning procedures for submissions of encounters as determined by ADHS/DBHS;
- Annual cultural competency and linguistically appropriate training updates for staff at all levels and across all disciplines respective to underrepresented/underserved populations;
- Identification and reporting of Quality of Care Concerns and the Quality of Care Concerns investigations process;
- Inter-rater reliability;
- American Society of Addiction Medicine (ASAM) Criteria;
- Child and Adolescent Service Intensity Instrument (CASII);
- Ticket to Work/Disability Benefits 101;
- Peer, family member, peer-run, family-run and parent-support training and coaching;
Identification and reporting of persons in need of Special Assistance for individuals who have been determined to have a Serious Mental Illness (SMI) and ensuring involvement of persons providing Special Assistance (see Chapter 2.12 – Special Assistance for Persons Determined to have a Serious Mental Illness);

- Workforce Development trainings specific to hiring, support, continuing education and professional development; and
- Homeless clinic training on availability of assistance with administrative issues such as obtaining prior authorization and resolving claims issues.

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;
- Complaints;
- Utilization management;
- Grievance and appeals;
- System of care data;
- Quality of care data; and
- Court system data;

DIVISION OF LICENSING SERVICES (DLS) REQUIRED TRAINING
Training must be completed and documented in accordance with the Bureau of Medical Facilities Licensing (BMFL) / Bureau of Residential Facilities Licensing (BRFL) requirements. http://www.azdhs.gov/als/medical/
http://www.azdhs.gov/als/residential/

REQUIRED TRAINING SPECIFIC TO PROFESSIONAL FOSTER HOMES PROVIDING HCTC SERVICES

Children
Medicaid reimbursable Home Care Training to Home Care Client (HCTC) services for children are provided in professional foster homes licensed by the Arizona Department of Economic Security/Office of Licensing, Certification and Regulation which must comply with training requirements as listed in R6-5-5850. All agencies that recruit and license professional foster home providers must provide and credibly document the following training to each contracted provider:

- CPR and First Aid Training; and
- 18 hours of pre-service training utilizing the Arizona Home Care Training to Client Service Curriculum.

The provider delivering HCTC services must complete the above training prior to delivering services. In addition, the provider delivering HCTC services for children must complete and credibly document annual training as outlined in R6-5-5850, Special Provisions for a
Professional Foster Home.

Adults
Medicaid reimbursable HCTC services for adults are provided in Adult Therapeutic Foster Homes licensed by ADHS Division of Licensing, and must comply with training requirements as listed in R9-20-1502:

- Protecting the person’s rights;
- Providing behavioral health services that the adult therapeutic foster home is authorized to provide and the provider delivering HCTC services is qualified to provide;
- Protecting and maintaining the confidentiality of clinical records;
- Recognizing and respecting cultural differences;
- Recognizing, preventing or responding to a situation in which a person:
  - May be a danger to self or a danger to others;
  - Behaves in an aggressive or destructive manner;
  - May be experiencing a crisis situation; or
  - May be experiencing a medical emergency;
- Reading and implementing a person’s treatment plan; and
- Recognizing and responding to a fire, disaster, hazard or medical emergency

In addition, providers delivering HCTC services to adults must complete and credibly document annual training as required by R9-20-1502.

REQUIRED TRAINING SPECIFIC TO 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 ADHS/DBHS’s Policy 406, Community Service Agencies-Title XIX Certification.

TRAINING EXPECTATIONS FOR CLINICAL AND RECOVERY PRACTICE PROTOCOLS
Under the direction of the ADHS/DBHS Chief Medical Officer, the Department publishes national practice guidelines and clinical guidance documents to assist Mercy Maricopa providers. These documents, some with required elements can be accessed at: http://azdhs.gov/bhs/guidance/index.htm

Mercy Maricopa providers providing services to children and families involved with Department of Child Safety (DCS) will be required to attend:

- “Unique Needs of Children Involved with DCS” training that is offered by Mercy Maricopa on a regular basis.
- Training on Child and Family Team (CFT) practice, depending on the population(s) served (see ADHS/DBHS Practice Protocol Child and Family Team Practice).

Training curriculums will be differentiated based on the role (BHP, BHT, Coaches, Family
Support Partners, Supervisors, etc.) of training participation provided in CFT Practice. All providers training curricula and certification processes shall be approved by Mercy Maricopa and ADHS/DBHS.

REPORTING AND TECHNOLOGY USAGE

- All Mercy Maricopa providers must be set up to use the RELIAS learning management system within Mercy Maricopa’s enterprise site to report all training activities for their staff to include but not limited to:
  - Attendance, course completion and training content for face to face training
  - Attendance, course completion and training content for online technology based training
  - Attendance, course completion and training content for web conferencing training
  - Attendance, course completion and training content/agenda’s for training seminars

- All Mercy Maricopa providers must use the RELIAS Learning Management system to upload all course content developed by their organization to meet the Mercy Maricopa Chapter 6.3 – Training Requirements, if equivalent courses not developed by Mercy Maricopa are used. Any training requirement equivalency used by individual providers is subject to review to determine if the training content satisfies the Chapter 6.3 – Training Requirements.

TRAINING REQUESTS

For additional training requests and/or technical assistance specific to the trainings listed above and /or identified area of need, contact Mercy Maricopa’s training department by calling customer services at (800)-564-5465 or by email at MercyMaricopa_LP@mercymaricopa.org.

- All training requests for onsite training will be reviewed and responded to within 5-7 business days with recommendations for scheduling onsite at a provider location or through an alternative mode of delivery
  - Onsite training can only be provided if a minimum of 10 individuals are registered for the training, requests for less than 10 individuals will be not be scheduled.
  - The penalty for cancelling an onsite training request hosted by Mercy Maricopa are as follows:
    - A provider must notify Mercy Maricopa Learning and Performance (MercyMaricopa_LP@mercymaricopa.org) at minimum 48 hours before the scheduled onsite training activity; in the event the provider has not canceled within this timeframe the opportunity to gain onsite training in the future could be limited.

- All 1:1 technical assistance, training consultation, coaching and mentoring for providers will answered in the order received and a response will be generated no more than 5 business days after the submission of the request.
  - The penalty for cancelling an onsite technical assistance, training consultation, coaching and mentoring scheduled activity are as follows:
A provider must notify Mercy Maricopa Learning and Performance (MercyMaricopa_LP@mercymaricopa.org) at minimum 24 hours before the scheduled activity; in the event the provider has not canceled within this timeframe the opportunity for onsite 1:1 technical assistance could be limited.

All requests for training and technical assistance will be completed using online forms/tools provided by Mercy Maricopa when they become available.

WORKFORCE DEVELOPMENT

Training Experts
Mercy Maricopa employs training experts/contacts as key personnel and point of contact to implement and oversee compliance with the training requirements, develop a training plan, and participate in the Training Coordinators committees.

Training Development Plan
Mercy Maricopa develops, implements, and submits an Annual Training Plan that provides information and documentation of all trainings. The training plan and training curriculums will be submitted annually, forty-five days after fiscal year end.

Training Quarterly Updates
Mercy Maricopa submits a Workforce Development Quarterly Update that includes information specific to initiatives and activities specific to training to ADHS, as required.

ADHS/DBHS Ownership of any intellectual property
This chapter will serve as disclosure of ownership of any intellectual property created or disclosed during the course of the service contract such as educational materials created for classroom training and/or learning programs.

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 Maricopa 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 contractor educational pursuits.

6.4 – Peer/Recovery Support Training, Certification and Supervision Requirements

PEER/RECOVERY SUPPORT SPECIALIST QUALIFICATIONS
Individuals seeking to be certified and employed as Peer/Recovery Support Specialists must:
- Be self-disclosed 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 certified as a Peer/Recovery Support Specialist by completing training and passing a competency test through an ADHS/DBHS approved Peer Support Employment Training Program. ADHS/DBHS will oversee the approval of all certification materials including curriculum and testing tools. Certification through an ADHS/DBHS approved Peer Support Employment Training Program is applicable statewide.

Some agencies may wish to employ individuals prior to the completion of certification through a Peer Support Employment Training Program. However, certain trainings must be completed prior to delivering behavioral health services (see PEER SUPPORT EMPLOYMENT TRAINING PROGRAM APPROVAL PROCESS). An individual must be certified as a Peer/Recovery Support Specialist or currently enrolled in an ADHS/DBHS-approved Peer Support Employment Training Program under the supervision of a qualified individual prior to billing Peer Support Services.

PEER SUPPORT EMPLOYMENT TRAINING PROGRAM APPROVAL PROCESS
A Peer Support Employment Training Program must submit their 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 ADHS/DBHS, and ADHS/DBHS will issue feedback or approval of the curriculum, competency exam and exam scoring methodology in accordance with PEER SUPPORT EMPLOYMENT TRAINING CURRICULUM STANDARDS.

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 their curriculum or if there is an addition to required elements (see PEER SUPPORT EMPLOYMENT TRAINING CURRICULUM STANDARDS) during this three year period, the program must submit the updated curriculum to ADHS/DBHS for review and approval.

ADHS/DBHS will base approval of the curriculum, competency exam and exam scoring methodology only on the elements included in this chapter. If a Peer 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 Support Specialist/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 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 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 Support Employment Training Program may require that the individual repeat or complete additional training prior to taking the competency exam again.

PEER SUPPORT EMPLOYMENT TRAINING CURRICULUM STANDARDS
A Peer 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 person-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:
    - Professional boundaries & 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, as described in Chapter 6.3 – Training Requirements. Peer 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 role in the public healthcare system and instructional for peer interactions.

For a list of references to assist in developing a curriculum that addresses the topics listed in the Curriculum Standards, see Suggested Curriculum Development References.

SUPERVISION OF CERTIFIED PEER/RECOVERY SUPPORT SPECIALIST

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. (For more information, see DBHS Practice Protocol, Clinical Supervision.)

Mercy Maricopa must develop and make available to the providers policies and procedures regarding resources available to agencies for establishing supervision requirements and any expectations for agencies regarding Mercy Maricopa monitoring/oversight activities for this requirement.

PROCESS FOR SUBMITTING EVIDENCE OF CERTIFICATION

While peer support employment training programs must not duplicate training required of licensed agencies or CSAs, it is possible that licensed agencies and/or CSAs may consider training completed as part of the peer support employment training program as meeting the agencies’ training requirements.
Agencies employing Peer Support Specialists/Recovery Support Specialists who are providing peer support services are responsible for keeping records of required qualifications and certification. Mercy Maricopa ensures that Peer Support Specialists/Recovery Support Specialists meet qualifications and have certification, as described in this chapter.

6.5 – Cultural Competence

ADHS/DBHS CULTURAL COMPETENCY FRAMEWORK

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.

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.

ADHS/RBHA contracts, ADHS/TRBHA Intergovernmental Agreements (IGAs) and T/RBHA Annual Cultural Competence plans require adherence to all areas of the CLAS standards.

Language Access Services (LAS):
To comply with the LAS requirements, Mercy Maricopa 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 10 in order 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 person 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 Arizona Health Care Cost Containment System (AHCCCS) eligible persons and persons determined to have a Serious Mental Illness (SMI); and
- Mercy Maricopa 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.

To access telephone interpretation services to assist members who speak a language other than English or who use sign language, please call Voiance directly at either of the following phone numbers:

**Clinical Services:** 1-877-756-4839, pin 1031

**Non-Clinical Services:** 1-877-756-4839, pin 1033

The determination between clinical vs. non-clinical is made on 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 consider non-clinical interpretation.

Voiance provides over the telephone interpretation services in over 200 languages. This service is available at no cost to you or the member. Additional information regarding Voiance is available on the Mercy Maricopa Provider website under the Provider Notification titled [Telephone Interpretation Services](#).

**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**, T/RBHAs and their subcontracted providers must make oral interpretation services available to persons with Limited English Proficiency (LEP) at all points of contact. Oral interpretation services are provided at no charge to AHCCCS eligible persons and Non-Title XIX/XXI persons determined to have a Serious Mental Illness (SMI). Members must be provided with information instructing them how to access these services:

- All Mercy Maricopa 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 Maricopa providers may contract with any interpretation vendor approved by Mercy Maricopa to provide this service for members.
- The interpretation vendor will bill the Mercy Maricopa provider for the service.
- The Mercy Maricopa provider will pay the interpretation vendor directly for their service.
- Mercy Maricopa providers may submit a claim to Mercy Maricopa for reimbursement of this service.
- Interpretive services must be billed using the following criteria:

**Interpretive Services Billing**

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

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1013</td>
<td></td>
<td>Qualified staff delivering services is also interpreting.</td>
</tr>
<tr>
<td>T1013</td>
<td>Q6</td>
<td>Separate but employed qualified staff is interpreting.</td>
</tr>
<tr>
<td>T1013</td>
<td>CR</td>
<td>External vendor used.</td>
</tr>
</tbody>
</table>

**Accessing Interpretation Services for the Deaf and the Hard of Hearing**

Mercy Maricopa 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 person;
- 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 makingaurally delivered materials available to persons 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. (Arizona Commission for the Deaf and the Hard of Hearing http://www.acdhh.org or (602) 542-3323 (V/TTY)).

Mercy Maricopa has a TTY line in the member services department for members who are hearing impaired at 1-866-796-5598 (TTY/TDD) 711.

Translation of Written Material
Mercy Maricopa and their subcontracted providers will make written translated materials available, when Mercy Maricopa is aware that a language is spoken by 3,000 or 10% (whichever is less) of Mercy Maricopa’s members, to the commonly encountered LEP groups who are AHCCCS eligible and to persons determined to have a Serious Mental Illness (SMI).

All vital materials will be translated when Mercy Maricopa is aware that a language is spoken by 1,000 or 5% (whichever is less) of the Mercy Maricopa’s members who also have LEP. 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 recipient;
- Grievance notices; and
- Member Handbooks.

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

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

Mercy Maricopa 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, Mercy Maricopa and subcontracted providers must:
- 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. Providers with direct care responsibilities must complete mandated Cultural Competency training (see Chapter 6.3 – Training Requirements).

Assessment
If the behavioral health recipient requests a copy of the assessment, those documents must be provided to the behavioral health recipient in his/her primary/preferred language. Documentation in the assessment must also be made in English; both versions must be maintained in the recipient’s record. This will ensure that if any persons, who must review the member’s record for purposes such as coordination of care, emergency services, auditing and data validation, have an English version available.

**Individual Service Plan (ISP) and Inpatient Treatment and Discharge Plan (ITDP)**
The ADHS/DBHS Individual Service Plan (ISP) is intended to fulfill several functions, which include identification of necessary behavioral health services (as evaluated during the assessment and through participation from the person and his/her team), documentation of the person’s agreement or disagreement with the plan, and notification of the person’s right to a Notice of Action (see Chapter 20.0 – Title XIX/XXI Notice and Appeal Requirements) or Notice of Decision and Right to Appeal (see Chapter 20.3 – Notice and Appeal Requirements, SMI and Non-SMI/Non-Title XIX/XXI), if the person does not agree with the plan.
ADHS/DBHS provides the service plan templates in both English and Spanish. The individual service plan is a vital document as defined in the AHCCCS/ADHS contract and ADHS/ Mercy Maricopa contracts.

Service plans specifically incorporate a person’s rights to disagree with services identified on the plan. If the plan is not in the person’s preferred language, the person 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 recipient 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 recipient’s primary/preferred language for his/her signature. Mercy Maricopa 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. A sample of the decline attestation can be found at mercymaricopa.org under forms.

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

**ORGANIZATIONAL SUPPORTS FOR CULTURAL AND LINGUISTIC NEED**
Under ADHS/DBHS guidance, and to comply with the Organizational Supports for Cultural Competence Mercy Maricopa 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 Maricopa 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 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 Maricopa 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 Maricopa and Mercy Maricopa subcontracted providers with a goal of health and wellness for all.

Cultural Competence Administrator
Mercy Maricopa 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 Maricopa has developed and implemented an Annual Cultural Competence Plan based on current initiatives in the field of cultural 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 must be submitted to the ADHS/DBHS Cultural Competence Manager each year as required.

Annually, Mercy Maricopa will develop and/or modify initiatives based on the identified needs of their GSAs, with a goal of eliminating health disparities.

Cultural Competence Reporting
ADHS/DBHS 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 Maricopa 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 ADHS/DBHS Cultural Competence Manager in accordance with Mercy Maricopa’s contract.
  - **Semi-Annual Language Services Report:** Mercy Maricopa will submit semi-annual reports to the ADHS/DBHS Cultural Competence Manager. The report captures linguistic need (primary language, Deaf and Hard of Hearing, sign language services, interpretive services, translation services, traditional healing services, and mental health services) and provides comprehensive lists of translator language abilities and billing unit usage.

**Workforce Development**

Mercy Maricopa 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 recipients with diverse cultural needs;
- Recruit, retain and promote, at all levels of the organization, a culturally competent, diverse staff and leadership;
- Maintain full compliance with all mandatory trainings; (See *Chapter 6.3 – Training Requirements*); and
- Develop and implement cultural-related trainings/curriculums as determined by ADHS/DBHS, Mercy Maricopa, Cultural Competence Committees, policies, and contract requirements.

**LAWS ADDRESSING DISCRIMINATION AND DIVERSITY**

Mercy Maricopa 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 on the basis of race, color, and national origin in programs and activities receiving federal financial assistance.
• **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 persons 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 persons 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 persons 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.

• **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 persons 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.

• **Section 504 of the Rehabilitation Act** prohibits discrimination on the basis of disability in delivering contract services.

• **The Americans with Disabilities Act** prohibits discrimination against persons who have a disability. Providers are required to deliver services so that they are readily accessible to persons with a disability. Mercy Maricopa and their subcontracted providers who employ less than fifteen persons and who cannot comply with the accessibility requirements without making significant changes to existing facilities may refer the person with a disability to other providers where the services are accessible. Mercy Maricopa or its subcontracted provider who employs fifteen or more persons is required to designate at least one person to coordinate its efforts to comply with federal regulations that govern anti-discrimination laws.

### 6.6 – Out of State Placements

**GENERAL REQUIREMENTS**

When Mercy Maricopa considering an out-of-state placement for a child or young adult, the following conditions apply:

- The CFT or ART will consider all applicable and available in-state services and determine that the services do not adequately meet the specific needs of the person;
The person’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 placement;
The out-of-state placement is registered as an AHCCCS provider;
The out-of-state placement meets the Arizona Department of Education Academic Standards; and
A plan for the provision of non-emergency medical care must be established.

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 placement is made:
All less restrictive, clinically appropriate approaches have either been provided or considered by the CFT or ART and found not to meet the person’s needs,

- The CFT or ART has been involved in the service planning process and is in agreement with the out-of-state placement;
- The CFT or ART has determined how they will remain active and involved in service planning once the out-of-state placement has occurred;
- A proposed ISP that includes a discharge plan has been developed that addresses the needs and strengths of the person (see Chapter 2.4 – Assessment and Service Planning);
- All applicable prior authorization requirements have been met (see Chapter 13.0 – Securing Services and Prior Authorization);
- 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 person;
- Coordination has occurred with other state agencies involved with the person, including notification to the DDD Medical Director when the individual is enrolled DD eligible;
- The person’s AHCCCS Health Plan Behavioral Health Coordinator or heath 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 Provider Network Organization (PNO) in coordination with the family/legal guardian will coordinate with the AHCCCS Health Plan to make arrangements and document all contacts and arrangements;
- Cultural considerations have been explored and incorporated into the ISP; and
- In the event that a person has been placed out-of–state secondary to an emergency situation or unforeseen event, Mercy Maricopa must address all above conditions as soon as notification of the out-of-state placement is received.

THE INDIVIDUAL SERVICE PLAN (ISP)
For a person placed out-of-state, the ISP developed by the CFT or ART must require that:

- Discharge planning is initiated at the time of referral or notification of admission, 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 possible or proposed in-state residence where the person will be
The recommended services and supports required once the person returns from the out-of-state placement;

- What needs to be changed or arranged to accept the person for subsequent in-state placement that will meet the person’s needs;

- How effective strategies implemented in the out-of-state placement will be transferred to the persons’ subsequent in-state placement; and

- The actions necessary to integrate the person into family and community life upon discharge.

- The CFT or ART actively reviews the person’s progress with clinical staffing occurring at least every 30 days. Clinical staffing must include the staff of the out-of-state facility;

  - The person’s family/guardian is involved throughout the duration of the placement. This may include family counseling in person or by teleconference or videoconference;

  - The CFT or ART must ensure that essential and necessary health care services are provided; and

  - Home passes are allowed as clinically appropriate and in accordance with the ADHS/DBHS 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 ADHS/DBHS OFFICE OF MANAGEMENT
Mercy Maricopa is required to obtain approval from the ADHS/DBHS Office of Medical Management prior to an out-of-state placement and upon discovering that a Mercy Maricopa enrollee is in an out-of-state placement using Out-of-State Placement Form. Prior authorization must be obtained before making a referral for out-of-state placement; in accordance with Mercy Maricopa criteria (see Chapter 13.0 – Securing Services and Prior Authorization). Mercy Maricopa may ask that providers assist with supplying the information required on the form and with providing copies of supporting clinical documentation.

Process for Initial Notification to ADHS/DBHS
For behavioral health providers contracted with Mercy Maricopa, the provider needs to notify Mercy Maricopa of the intent to make a referral for out-of-state placement as follows:

For children/adolescent and adults under the age of 21, the QSP Clinical Leadership is expected to follow Chapter 13.0 – Securing Services and Prior Authorization.

If a child/adolescent or adult under age 21 is approved for an inpatient placement, 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 Maricopa for assistance in resolution.

- When the QSP Clinical Leadership and key stakeholders agree on the placement, the
QSP Clinical Leadership will complete the **Out of State Placement Form** and submit it to the Mercy Maricopa, Care Management Department.

- The Mercy Maricopa Care Management Department will review the form and forward by email to the ADHS/DBHS Office of Medical Management at **DBHSMEDICALMANAGEMENT@azdhs.gov** for review and approval prior to placing the child or young adult.
- When the out of state placement is approved ADHS/DBHS, Mercy Maricopa will notify the QSP Clinical Leadership and direct them to complete the out of state placement process.

Prior to placing the child or young adult or upon discovering that a Mercy Maricopa enrollee has been admitted to an out-of-state placement, Mercy Maricopa or behavioral health provider must complete **Out-of-State Placement Form** and submit to ADHS/DBHS Office of secure e-mail to **DBHSMEDICALMANAGEMENT@azdhs.gov** for approval of the out-of-state placement request.

**PERIODIC UPDATES TO ADHS/DBHS OFFICE OF MEDICAL MANAGEMENT**

In addition to providing initial notification, updates are required to be submitted every 30-days regarding the person’s progress in meeting the identified criteria for discharge from the out-of-state.

Once completed, Mercy Maricopa must submit the form to ADHS/DBHS Office of Medical Management secure e-mail to **DBHSMEDICALMANAGEMENT@azdhs.gov** every 30-days the person continues to remain in out-of-state placement. The 30-day update timelines will be based upon the date of admission to the out-of-state placement as reported by Mercy Maricopa to ADHS/DBHS via email to **DBHSMEDICALMANAGEMENT@azdhs.gov**.

Every 30 days, Mercy Maricopa requires the High Needs case manager to complete the **Out-of-State Placement Form**. The QSP Clinical Leadership faxes the completed form to Mercy Maricopa’s Care Management Department at 602-351-2300. Mercy Maricopa reviews the form for completeness and submits it to the ADHS/DBHS Office of Utilization Management.

Additionally, Mercy Maricopa must submit notification to DBHS within forty-eight (48) hours of Mercy Maricopa being notified when an Out of State placement is discontinued.

**6.7 – Family and Youth Involvement in the Children’s Behavioral Health System**

(Formerly Partnerships with Families and Family-Run Organizations 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 Maricopa 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 delivery.
- Provide culturally and linguistically relevant services that appropriately respond to a family’s unique needs (see Chapter 6.5 – Cultural Competence).
- 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 Maricopa, and ADHS/DBHS at intake and throughout the CFT process.
- Work with Mercy Maricopa to develop training in family engagement and participation, roles and partnerships for provider staff, parents/caregivers, youth and young adults (see DBHS Practice Protocol, Family and Youth Involvement in the Children’s Behavioral Health System for more information on these roles).

RESPONSIBILITIES OF MERCY MARICOPA 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 Maricopa 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; and
- 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 (see Chapter 2.6 - General and Informed Consent).
- Provide contact information and allow contact with all levels of personnel within the agency for families, youth and young adults.
- Make a Family Support Partner (FSP) available to the family when requested by the CFT.
RESPONSIBILITIES OF MERCY MARICOPA

- Support family, youth and young adults in roles that have influence and promote shared responsibility and active participation.
- 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 Maricopa 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 person experience.
- Providing compensation that values first-person 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.
- 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;
- Other sources as required by the ADHS/RBHA contracts or Mercy Maricopa IGAs.

6.8 – Use of Telemedicine

Mercy Maricopa 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 Maricopa will ensure that all prescribing of controlled substance through telemedicine will conform to all federal and state regulations.

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 Maricopa.

Mercy Maricopa 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 recipient 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 person and/or legal guardian can understand and comprehend. See [Chapter 2.6 – General and Informed Consent](#) for a list of specific elements that must be provided.

Exceptions to this consent requirement include:

- If the telemedicine interaction does not take place in the physical presence of the patient;
- In an emergency situation in which the patient or the patient’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.

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; 
• A statement of the person’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 person receiving the recorded service; and
• For persons 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 and Chapter 10.1, Medical Record Standards. Mercy Maricopa 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 person, other than those agreed to by the person 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 in accordance with Chapter. 16.0 – Confidentiality for more information on Disclosure of Behavioral Health information and telemedicine.

**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 person’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 ADHS/DBHS.

**6.9 – Parent/Family Support Provider Training, Certification and Supervision Requirements**
PARENT /FAMILY SUPPORT PROVIDER AND TRAINER QUALIFICATIONS

- Individuals seeking certification and employment as a 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 abuse needs; and
  - Meet the requirements to function as a behavioral health professional, behavioral health technician, or behavioral health paraprofessional.
- Individuals seeking certification and employment as a 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, behavioral health technician, or behavioral health paraprofessional.

PARENT/FAMILY SUPPORT PROVIDER TRAINING PROGRAM TRAINING PROCESS

A Parent/Family Support Provider Training Program must submit their 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 ADHS/DBHS. ADHS/DBHS will issue feedback or approval of the curriculum, competency exam, and exam-scoring methodology in accordance with training curriculum standards outlined below.

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 their curriculum or if there is an addition to required elements (see competency exam below) during this three-year period, the program must submit the updated content to ADHS/DBHS for review and approval no less than 60 days before the changed or updated curriculum is to be utilized.

ADHS/DBHS will base approval of the curriculum, competency exam, and exam-scoring methodology only on the elements included in this policy. If a 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 family support certification based on the additional elements or standards.

COMPETENCY EXAM

Individuals seeking certification and employment as a Parent/Family Support Provider must complete and pass a competency exam with a minimum score of 80% upon completion of required training. Each 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 in the training curriculum standards outlined below. Agencies employing Parent/Family Support Providers who are providing family care should ensure that these standards are met.
support services are required to ensure that their employees are competently trained to work with their population.

Individuals certified in another state may obtain certification after passing a competency exam. If an individual does not pass the competency exam, the Parent/Family Support Provider Training Program shall require that the individual complete additional training prior to taking the competency exam again.

PARENT/FAMILY SUPPORT PROVIDER EMPLOYMENT TRAINING CURRICULUM STANDARDS
A Parent/Family Support Provider Employment Training Program curriculum must include the following core elements for persons working with both children and adults:

- Communication Techniques:
  - Person 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;
  - Using self-disclosure effectively; sharing one’s story when appropriate.

- 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;
    - Individual Service Planning (ISP); tailored to meet the individual needs;
    - Rights of the caregiver/enrolled member; complaints, grievances and the appeal processes; life planning guardianship, powers of attorney, special needs trusts, mental health advanced directives;
    - 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;
    - Integrated health care services/integrated care;
    - Trauma Informed Care.
  - Introduction to adult and child serving systems: Department of Child Safety (DCS); Division of Developmental Disabilities (DDD), Juvenile Probation and the Juvenile Justice System; Justice System, Court Ordered Treatment (COT), Mental Health Court, Corrections, Probation, Parole; Adult Protective Services; Social Security;
  - Overview of confidentiality laws and information sharing; Health Insurance Portability and Accountability Act (HIPAA); mandated reporting requirements;
Professional responsibilities regarding disclosure and sharing of information and records unique to adult family support;
• Codes of Ethics;
• Overview of Individualized Education Programs (IEP); Section 504;
• Overview of documentation and billing requirements.

 Building Collaborative Partnerships and Relationships:
  • Engagement; Identifies and utilizes strengths;
  • Utilize and model conflict resolution skills, interest-based negotiation skills, problem solving skills, and shared decision making;
  • Cultural diversity; cultural awareness; understanding individual and family culture; social culture; biases; perceptions; system’s cultures;
  • The ability to identify, build and connect individuals and families, including families of choice to natural, community and informal supports;
  • Family finding techniques;
  • Family-Driven/youth-guided care.

 Crisis Prevention, Intervention and Safety Planning:
  • Positive behavioral reinforcement, stabilization and de-escalation techniques;
  • Overview of suicide prevention;
  • Overview of crisis planning;
  • Overview of 24-hour safety planning

 Goal Setting and Empowerment:
  • Coaching family members and other supports to identify their needs, develop goals and promote self-reliance;
    • Identify and understand stages of change;
    • Identify and use natural supports;
    • Ability to identify unmet needs when progress is not being made.
  • Understanding developmental milestones for infants, children, adolescents and adults;
  • Understand how to assist individual or family member to access information related to diagnoses or treatments including the use of medications;
  • Attributes of meaningful involvement: Access, voice and ownership.

 Wellness:
  • The Substance Abuse and Mental Health Services Administration (SAMHSA) Eight (8) Dimensions of Wellness:
  • Understanding the stages of grief and loss; and
  • Understanding self-care and stress management;
  • Addressing stigma;
  • Understanding compassion fatigue, burnout, and trauma;
  • Resiliency and recovery;
  • Planning and managing for personal safety;
  • Healthy personal and professional boundaries.

Some curriculum elements include concepts that are part of ADHS/DBHS required training, as described in Chapter 6.3 – Training Requirements. 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 must be specific to the Family Support role in the public behavioral health system and instructional for family support interactions.

For a list of references to assist in developing a curriculum that addresses the topics listed in the Curriculum Standards, see Suggested Curriculum Development References. Mercy Maricopa has developed and made available policies and procedures as well as additional resources for development of curriculum, including Mercy Maricopa staff contacts for questions or assistance.

SUPERVISION OF CERTIFIED PARENT/FAMILY SUPPORT PROVIDERS
Agencies employing 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 Parent/Family Support Provider 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 Parent/Family Support Providers. (For more information, see DBHS Practice Protocol, Clinical Supervision.)

Mercy Maricopa has developed and made available to the providers policies and procedures regarding resources available to agencies for establishing supervision requirements and any expectations for agencies regarding Mercy Maricopa monitoring/oversight activities for this requirement.

PROCESS OF CERTIFICATION
Mercy Maricopa must ensure that Parent/Family Support Providers meet qualifications and have certification, as described in this policy. Agencies employing Certified Parent/Family Support Providers who are providing family support services are responsible for keeping records of required qualifications and certification.

Mercy Maricopa must develop and make available to providers policies and procedures that describe monitoring and auditing/oversight activities where personnel files of Parent/Family Support Provider are reviewed.

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While Parent/Family Support Provider Employment Training Programs must not duplicate training required of licensed agencies or CSAs, it is possible that licensed agencies and/or CSAs may consider training completed as part of the family support employment training program as meeting the agencies’ training requirements.
CHAPTER 7 – SUBMITTING CLAIMS AND ENCOUNTERS

7.0 – Submitting Claims and Encounters to Mercy Maricopa

Mercy Maricopa subcontracted providers are required to submit claims or encounters in conformance the ADHS/DBHS Office of Program Support Operations and Procedures Manual, the ADHS/DBHS Covered Behavioral Health Services Guide, the ADHS/DBHS Financial Reporting Guide for GSA 6, the Client Information System (CIS) File Layouts and Specifications Manual requirements and in accordance with HIPAA for each covered service delivered to a member.

The Mercy Maricopa claims department is responsible for claims adjudication; resubmissions, claims inquiry/research and provider encounter submissions to ADHS/DBHS.

All providers who participate with Mercy Maricopa 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.

BEHAVIORAL HEALTH VERSUS MEDICAL – DETERMINING PLAN RESPONSIBILITY

When determining financial responsibility for a claim that contains both behavioral health diagnoses and medical diagnoses, Mercy Maricopa, in accordance with AHCCCS guidelines, determines financial responsibility by the primary diagnosis that appears on a claim. This is defined as the principal diagnosis on a UB-04 claim from a facility or the first-listed diagnosis on a 1500 (02/12) claim from a physician. A listing of principal behavioral health diagnoses is available in the Covered Behavioral Health Services Guide under Appendix B-4 – ICD-10 Diagnosis Codes Effective 10-01-2015.

There may be times where a facility or physician claim may have a combination of both medical and behavioral health services listed on the claim. Mercy Maricopa’s determination of plan responsibility when the claim is initially submitted is as follows:

- If the primary diagnosis listed is a medical diagnosis, the financial responsibility to process the claim the AHCCCS medical plan.
- If the primary diagnosis listed is a behavioral health diagnosis and the Acute member has a Medicare Prime plan or Mercy Care Advantage, the financial responsibility to process the claim would be AHCCCS medical plan.
- If the primary diagnosis listed is a behavioral health diagnosis and the member does not have a Medicare Prime plan or Mercy Care Advantage, the financial responsibility to process the claim would be Mercy Maricopa’s.

BILLING REQUIREMENTS

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.

Mercy Maricopa members may NOT be billed for covered services or for services not reimbursed due to the failure of the provider to comply with MERCY MARICOPA’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. In particular, 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:

- Charge, submit a claim to, or demand or collect payment from a person claiming to be AHCCCS eligible; or
- Refer or report a person claiming to be an eligible person to a collection agency or credit reporting agency”

Mercy Maricopa 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 Mercy Maricopa for these amounts and Mercy Maricopa will coordinate benefits. Unless otherwise stated in contract, Mercy Maricopa adjudicates payment using the lesser of methodology and members may not be billed for any remaining balances due to the lesser of methodology calculation.

Prior Period Coverage
On occasion, ADHS/DBHS eligible members are enrolled retrospectively into Mercy Maricopa. The retrospective enrollment is referred to a Prior Period of Coverage (PPC). Members may have received services during PPC and Mercy Maricopa 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 Mercy Maricopa 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, Mercy Maricopa may, at its discretion, retroactively review medical records to determine medical necessity. If such services are deemed not medically necessary, Mercy Maricopa reserves the right to recoup payment, in full, from the provider. The provider may not bill the member.

ENCOUNTER SUBMISSION REQUIREMENTS

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, ADHS/DBHS requires the submission of claims and encounters for all services provided to enrolled members. Fines and penalties are levied against Mercy Maricopa for failure to
correctly report encounters in a timely manner. Mercy Maricopa may pass along these financial sanctions to a provider that fails to comply with encounter submissions.

When to File an Encounter
Encounters should be filed for all services provided, even those that are capitated or paid under a block purchase arrangement. Mercy Maricopa uses the encounter information to determine if care requirements have been met and establish rate adjustments.

How to File an Encounter
Encounters should be billed on the same forms as claims. For additional information on how to submit encounter submission, see CLAIM SUBMISSION REQUIREMENTS.

In order to comply with federal reporting requirements, ADHS/DBHS conducts data validation 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 ADHS/DBHS. If services do not coincide, claims will be reversed and monies recouped. If providers do not properly report all encounters, Mercy Maricopa may be assessed monetary penalties for 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.

CLAIM SUBMISSION REQUIREMENTS
When to File a Claim
All claims and encounters must be reported to Mercy Maricopa, including prepaid services.

Timely Filing of Claims Submission
In accordance with contractual obligations, claims for services provided to a Mercy Maricopa member must be received in a timely manner. Mercy Maricopa’s timely filing limitations are as follows:

- New Claim Submissions – Claims must be filed on a valid claim form within **180 days** (6 months) from the date services were performed or from the date of eligibility posting, whichever is later, unless there is a contractual exception. For hospital inpatient claims, date of service means the date of discharge of the patient.
- Claim Resubmission - Claim resubmissions must be filed within **365 days** (1 year) from the date of provision of the covered service or eligibility posting deadline, whichever is later. The only exception to this is if a claim is recouped, the provider is given an additional 60 days from the recoupment date to resubmit a claim. Please submit any additional documentation that may effectuate a different outcome or decision.

Failure to submit claims and encounter data within the prescribed time period may result in
payment delay and/or denial.

**Mercy Maricopa as a Secondary Payer**
Mercy Maricopa 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 Mercy Maricopa is secondary.

- File an initial claim with Mercy Maricopa 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 in order to preserve your claim dispute rights.
- Upon the receipt of payment or denial by the other insurer, you should then submit your claim to Mercy Maricopa, 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. **If billing electronically, the other insurer’s payment information must be included on the 837 transaction.**
- When a member has other health insurance, such as Medicare, a Medicare HMO or a commercial carrier, Mercy Maricopa will coordinate payment of benefits.
- In accordance with requirements of the Balanced Budget Act of 1997, Mercy Maricopa will pay co-payments, deductibles and/or coinsurance for AHCCCS Covered Services up to the lower of either Mercy Maricopa’s fee schedule or the Medicare/other insurance allowed amount.

Claims should be 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 submitted within one year from the last date of service or six months from the date of the other insurance explanation of benefits, whichever is later, once the other insurance explanation of benefits is received.

Claims can be submitted electronically when Mercy Maricopa is the secondary payer. The appropriate electronic loops for primary payer need to be completed or the claim will deny.

**Dual Eligibility Mercy Maricopa Advantage (MMA) Cost Sharing and Coordination of Benefits (MMA terminated as of 12/31/15)**
For Mercy Maricopa Advantage members enrolled in both Mercy Maricopa and Mercy Maricopa Advantage, any cost sharing responsibilities will be coordinated between the two payers. For the most part, providers only need to submit one claim to Mercy Maricopa Advantage and Mercy Maricopa benefits will be automatically coordinated. There may be exceptions to this, which are covered in this chapter under **INSTRUCTION FOR SPECIFIC CLAIM TYPES.**

**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 in order for Mercy Maricopa 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.

HOW TO FILE A CLAIM

1) **Select the appropriate claim form (refer to table below).**

<table>
<thead>
<tr>
<th>Service</th>
<th>Claim Form/Electronic Format</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and professional services, including behavioral health</td>
<td>CMS 1500 Form (02-12)/837P</td>
</tr>
<tr>
<td>Family planning services – medical</td>
<td>CMS 1500 Form (02-12)/837P</td>
</tr>
<tr>
<td>Family planning services – hospital inpatient, outpatient or emergency</td>
<td>CMS 1500 Form (02/12)/837P</td>
</tr>
<tr>
<td>Obstetrical care</td>
<td>CMS 1500 Form (02/12)/837P</td>
</tr>
<tr>
<td>*Should be billed using Complete Obstetrical Care Package</td>
<td></td>
</tr>
<tr>
<td>Hospital inpatient, including all behavioral health inpatient services, outpatient, skilled nursing facility and emergency room services</td>
<td>CMS UB-04 Form/837I</td>
</tr>
<tr>
<td>General dental services</td>
<td>ADA 2006 Claim Form (02/12)/837D</td>
</tr>
<tr>
<td>Dental, services that are considered medical services (oral surgery, anesthesiology)</td>
<td>CMS 1500 Form/837P</td>
</tr>
</tbody>
</table>

Instructions on how to fill out the each of the claim form can be found by linking on the below link:

- **Form 1500 (02-12) Completion Instructions**
- **UB-04 (CMS 1450) Form Completion Instructions**
- **ADA Dental Claim Form Completion Instructions**

2) **Complete the claim form.**

   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).** 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 Mercy Maricopa 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 Mercy Maricopa uses are as follows:
  - Emdeon
  - Southwestern Provider Services (SPSI)
  - Relay Health
- Contact your software vendor directly for further questions about your electronic billing.
- Contact your Provider Relations representative for more information about electronic billing.
- All electronic submission shall be submitted in compliance with applicable law including HIPAA regulations and Mercy Maricopa policies and procedures.
- Dates of Service must not span a contract year. If a service spans a contract year, the claim must be split and submitted in two different date segments, with the appropriate number of units for each segment so the dates of service do not span a contract year.

b) Through the Mail

<table>
<thead>
<tr>
<th>Claim Address Table</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims</td>
</tr>
<tr>
<td>Medical and Behavioral Health</td>
</tr>
<tr>
<td>Dental</td>
</tr>
<tr>
<td>Refunds</td>
</tr>
</tbody>
</table>

**Correct Coding Initiative**

Mercy Maricopa, ADHS/DBHS 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 at: https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html?redirect=/NationalCorrectCodInitEd/.
Mercy Maricopa 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/societies.

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.

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 in order to use an additional code when one higher level, more comprehensive code is appropriate.

Modifiers
Appropriate modifiers must be billed in order to reflect services provided and for claims to pay appropriately. Mercy Maricopa 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).

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. Mercy Maricopa 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. Mercy Maricopa 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.”


**Medical Claims Review**
To ensure medical appropriateness and billing accuracy, any inpatient and outpatient outlier claims are sent for Medical Claims Review. An outlier is identified on the claim with a condition code of 61 and is used to identify claims with extraordinary cost per day. For inpatient outlier claims, this includes those that are greater than $60,000 billed if covered costs per day exceed the statewide average cost threshold.

**Checking Status of Claims**
Providers may check the status of a claim by accessing Mercy Maricopa’s Secure Website or by calling the Claims Inquiry Claims Research (CICR) department.

**Online Status through Mercy Maricopa’s Secure Website**
Mercy Maricopa encourages providers to take advantage of using online status, as it is quick, convenient and can be used to determine status for multiple claims. To register, go to [http://www.mercymaricopa.org/providers/portal](http://www.mercymaricopa.org/providers/portal).

**Calling**
Claims Inquiry Claims Research Department can be reached at 800-564-5465. 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 particular 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,
Please be prepared to give the service representative the following information:
- Provider name and AHCCCS provider number with applicable suffix if appropriate.
- 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.

**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.

Resubmissions and reconsiderations should be submitted electronically, however, we are unable to accept electronic attachments at this time.

If billing a resubmission electronically, you must submit with:
- **CMS 1500 Form (02-12)** - A status indicator of 7 in the submission form location and the Original Claim ID field need to be filled out.
- **UB-04** – In the Bill Type field, the last number of the 3 digit code should be a 7.

If billing a resubmission on a paper claim:
- **CMS 1500 Form (02-12)** - A status indicator of 7 must be indicated in Block 22 on the claim form.
- **UB-04** – 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 filing resubmissions or reconsiderations on paper (which should only be done if there is an attachment), please include the following information:
- Use the [Claims Resubmission Form](#).
- An updated copy of the claim. All lines must be rebilled or a copy of the original claim (reprint or copy is acceptable).
- 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 the Claim Address Table,
• 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.

INSTRUCTION FOR SPECIFIC CLAIM TYPES
Mercy Maricopa claims are always paid in accordance with the terms outlined in the healthcare provider’s contract. Prior authorized services from Non-contracted healthcare providers will be paid in accordance with AHCCCS processing rules.

Skilled Nursing Facilities (SNFs)
Providers submitting claims for SNFs should use the CMS UB-04 Form.
The following applies to acute stays in a Skilled Nursing Facility:

Levels of Care
• The appropriate level of care will be determined by the Mercy Maricopa Concurrent Review Nurse utilizing Mercy Maricopa criteria.
• All Covered Therapy Services are included in the per diem rate. The SNF shall arrange or provide Covered Therapy Services for members while residing in its facility.
• Pharmacy is not included in the per diem rate. The SNF shall use a contracted pharmacy to obtain medications.
• Daily documentation in the medical chart of continued need for sub-acute level of care is required.
• The SNF must notify Mercy Maricopa staff within 24 hours when a member no longer requires sub-acute level of care services.

Levels of Care Defined
• **Level I - Custodial.** Member must be pending ALTCS eligibility. Additionally, the member must be awaiting surgery, on tube feeding or oxygen dependent (or identified as new occurrence of need). Level I may include up to one hour per day of therapy (PT/OT/ST).
• **Level II - Sub-Acute.** This includes all components of Level I plus any combination of the following must be provided; simple wound care, administration of IV fluids or antibiotics, small volume nebulizer (at 5 or greater) or any therapy up to 2 hours per day (PT/OT/ST). Please note that Level II or greater may go to a Level III.
• **Level III - Intensive Sub-Acute.** This includes all components of Level I and II, plus any combination of the following must be provided: complex wound care/decubitus, total parenteral nutrition or tracheotomy care or any therapy up to 3 hours per day (PT/OT/ST). An RN charge nurse is required to be on the station where the Level III members are located 24 hours a day.
• **Level IV - Vent Care/Dialysis.** This includes all components of Level I, II and III, plus ventilator with tracheotomy care or dialysis on site.

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>Revenue Code</th>
</tr>
</thead>
</table>
| Level IV - Vent Care/Dialysis. This includes all components of Level I, II and III, plus ventilator with tracheotomy care or dialysis on site.
Dental Claims

- Claims for dental services should be submitted on the standard American Dental Association form - ADA 2006 Claim Form.
- Services provided by an anesthesiologist or medically related oral surgery procedure should be submitted on CMS 1500 Form.

Family Planning Claims

- Claims for medical services will only be accepted on CMS 1500 Form.
- Inpatient hospitalizations, outpatient surgery and emergency department facility claims should be filed on CMS UB-04 Form.
- See the Covered Family Planning Services and Appropriate Billing Codes on the Mercy Maricopa website 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.
- A separate claim must be submitted for each date of service.

Members may request services, such as infertility evaluations and abortions, from providers, whether or not 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.

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

**Obstetrical Claims**

**Complete Obstetrical Care Package**
Reimbursement for obstetrical care is dependent upon the provider’s contract with Mercy Care. 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 **CMS 1500 Form**.

**Fee for Service**
For additional information regarding fee for service billing, please refer to **Obstetrical Billing** found under Notices on Mercy Maricopa’s website. 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
- 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.

**Trimester of Entry into Prenatal Care**
Claims for obstetrical services are submitted on [CMS 1500 Form](#). Health providers must bill Evaluation and Management codes with the date span, and zero charges on one line and the total OB service charges on another. The health professional must then list out each pre- and post-natal visit using an E&M code 99213 with a $0.00 amount billed and 1 unit of service. For additional detail regarding appropriate billing, please refer to [Obstetrical Billing](#) under Notices on the Mercy Maricopa website.

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 are measured and monitored by Mercy Maricopa and AHCCCS as part of the Quality Management Program.

**Behavioral Health**
Pseudo identification numbers are only applicable to behavioral health providers under contract with Mercy Maricopa.

On very rare occasions, usually following a crisis episode, basic information about a behavioral health recipient may not be available. When the identity of a behavioral health recipient is unknown, a behavioral health provider may use a pseudo identification number to register an unidentified person. This allows an encounter to be submitted to ADHS/DBHS, allowing Mercy Maricopa and the provider to be reimbursed for delivering certain covered services. Covered services that can be encountered/billed using pseudo identification numbers are limited to:

- Crisis Intervention Services (Mobile);
- Case Management; and
- Transportation

Pseudo identification numbers must only be used as a **last option** when other means to obtain the needed information have been exhausted. Inappropriate use of a pseudo identification number may be considered a fraudulent act. For a list of available pseudo identification numbers, see [Pseudo Identification Numbers](#).
PAYMENT OF CLAIMS
Mercy Maricopa processes and records the payment of claims through a Remittance Advice. Providers may choose to receive checks through the mail or electronically. Mercy Maricopa 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 Provider Relations representative for further information on how to receive ERA. Remittance Advice samples are available on the Mercy Maricopa website.

Provider Remittance Advice
Mercy Maricopa 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 Provider Relations representative if you are interested in receiving electronic remittance advices. Additional information can be attained on Mercy Maricopa website under the notice titled Electronic Tools.

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.

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 Mercy Maricopa 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 Mercy Maricopa 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 Mercy Maricopa 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:
  o Member/Patient Name
  o ID
  o Birth Date
  o Account Number,
  o Authorization ID, if Obtained
  o Provider Name,
  o Claim Status,
  o Claim Number
  o Refund Amount, if Applicable

• 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 on the Mercy Maricopa website at [www.mercymaricopa.org](http://www.mercymaricopa.org) or click on the attachment listed below:

- Mercy Maricopa Remit Format for Check
- Mercy Maricopa Remit Format for EFT
- Aetna FPS Remit Format for Check
- Aetna FPS Remit Format for EFT

An electronic version of the Remittance Advice can be attained. In order 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 Provider Relations Representative to assist you with this process.

**Electronic Funds Transfer**

Through Electronic Funds Transfer (EFT), providers have the ability to direct funds to a designated bank account. Mercy Maricopa 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 EFT Enrollment Form and submitting the form along with a voided check to process the request. It is very important to note that the form must be submitted to the fax number indicated on the form so that it gets submitted to our Finance Department directly. Please allow at least 30 days for EFT implementation. Your Provider Relations representative will assist you with this.

Additional information can be attained by accessing Notices at the Mercy Maricopa Provider website.
CHAPTER 8 – COPAYMENTS AND OTHER MEMBER FEES

8.0 – Copayments and Other Member Fees

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 Maricopa 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 recipients for covered behavioral health services and reported to ADHS/DBHS in the encounter.

The collection of copayments is an administrative process, and as such, copayments must not be collected in conjunction with a person’s treatment. All efforts to resolve non-payment issues, as they occur, must be clearly documented in the person’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 persons:
- 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. Persons 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 on the basis 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 person is exempt from Medicare copayments.

**Copayments are never charged for the following services for anyone:**

- 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.

**Nominal (Low) Copays for Some AHCCCS Programs**

Individuals eligible for AHCCCS through any of the following programs are subject to nominal copayments. Nominal copayments are also referred to as optional copayments. Individuals with nominal (optional) copayments are not charged copayments if they are in a population or category or for a service listed above. Providers are prohibited from refusing services to members who have nominal (optional) copayments if the member states he or she is unable to pay the copayment.

Persons 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;
- 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 Maricopa’s Secure Web Portal. Most people who get AHCCCS benefits are asked to pay the following nominal copayments for medical services:

<table>
<thead>
<tr>
<th>Nominal Copay Amounts for Some Medical Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service</td>
</tr>
<tr>
<td>Prescriptions</td>
</tr>
<tr>
<td>Out-patient services for physical, occupational and speech therapy</td>
</tr>
<tr>
<td>Doctor or other provider outpatient office visits for evaluation and management of your care</td>
</tr>
</tbody>
</table>

**Mandatory Copayments for Certain AHCCCS Members**

Persons 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).

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 are listed below:

<table>
<thead>
<tr>
<th>Mandatory Copayments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service</td>
</tr>
<tr>
<td>Prescriptions</td>
</tr>
<tr>
<td>Doctor or other provider outpatient office visits for evaluation and management of care. This excludes emergency room/emergency department visits</td>
</tr>
<tr>
<td>Physical, Occupational and Speech Therapies</td>
</tr>
<tr>
<td>Outpatient non-emergent or voluntary surgical procedures. This excludes emergency room/emergency department visits</td>
</tr>
</tbody>
</table>

**5% Aggregate limit for nominal (optional) and mandatory copayments**
The total aggregate amount of copayments for persons 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 persons determined to have a Serious Mental Illness (SMI)**

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Last Revised: July 1, 2016
ADHS/DBHS Copayments for Non-Title XIX/XXI eligible persons who are determined to have a Serious Mental Illness (SMI)

- For individuals who are Non-Title XIX/XXI eligible persons determined to have a SMI, ADHS/DBHS 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.
- Persons 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 person in his/her comprehensive clinical record.
- Copayments assessed for Non-Title XIX/XXI persons 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 person’s behavioral health treatment.
- Clearly document in the person’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. RBHAs must establish 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 person for AHCCCS eligibility; and
  - Present other payment options, such as payment plans or payment deferrals, and discuss additional payment options as requested by the person.

**OTHER PAYMENT SOURCES**

If a person has third party liability coverage, Mercy Maricopa and their providers must follow
the requirements set forth in Chapter 9.0 - Third Party Liability and Coordination of Benefits.

**Medicare Part D Prescription Drug Coverage**

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

Persons 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 persons’ cost sharing requirements are paid for by the federal government. Dual eligibles on a Medicare Savings Program through AHCCCS (QMB, SLMB, or QI-1) are automatically eligible for the LIS program. Other persons have to apply for the LIS program. Title XIX/XXI funds are not available to pay any cost sharing of Medicare Part D. Mercy Maricopa may utilize Non-Title XIX/XXI funds for cost sharing of Medicare Part D copayments for Non-Title XIX/XXI persons determined to have SMI.
CHAPTER 9 – THIRD PARTY LIABILITY AND COORDINATION OF BENEFITS

9.0 - Third Party Liability and Coordination of Benefits

DETERMINING OTHER HEALTH INSURANCE COVERAGE
Behavioral health/integrated care providers must inquire about a person’s other health insurance coverage during the initial appointment or intake process (See Chapter 2.2 – Referral and Intake Process). When behavioral health/integrated care providers attempt to verify a person’s Title XIX or Title XXI eligibility, information regarding the existence of any third party coverage is provided through the automated systems described in Chapter 2.0 – Eligibility Screening for AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage and Limited Subsidy Program. If a person is not eligible for Title XIX or Title XXI benefits, they will not have any information to verify through the automated systems. Therefore, the existence of third party payers must be explored with the person during the screening and application process for AHCCCS health insurance.

DETERMINING SERVICES OTHER HEALTH INSURANCE COVERS
Mercy Maricopa 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 Mercy Maricopa is secondary. The third party health insurance coverage may cover all or a portion of the behavioral health/integrated care services rendered to a person. Behavioral health/integrated care providers must contact the third party directly to determine what coverage is available to the person. At times, Mercy Maricopa may incur the cost of copayments or deductibles for a Title XIX/XXI eligible person or person determined to have a Serious Mental Illness, while the cost of the covered service is reimbursed through the third party payer. Title XIX/XXI funds cannot be used to pay for cost sharing of Medicare Part D Prescription Drug coverage.

BILLING REQUIREMENTS
Upon determination that a person has third party coverage, a behavioral health/integrated care provider must submit proper documentation to demonstrate that the third party has been assigned responsibility for the covered services provided to the person. For specific billing instructions, see the ADHS/DBHS Office of Program Support Operations and Procedures Manual and AHCCCS IHS/Tribal Billing Manual. The following guidelines must be adhered to by behavioral health/integrated care providers regarding third party payers:

- Mercy Maricopa must be the payers of last resort for Title XIX/XXI and Non-Title XIX/XXI covered services. Payment by another state agency is not considered third party and, in this circumstance, Mercy Maricopa are not the payer of last resort.
- Benefits must be coordinated so that costs for services funded by Mercy Maricopa are cost avoided or recovered from a third party payer. Providers must bill claims for any covered services to any third party payer when information on that third party payer is available. Documentation that such billing has occurred must accompany the claim when submitted for payment. Such documentation includes a copy of the Remittance Advice or Explanation of Benefits from the third party payer. The only exceptions to this billing requirement are:
When a response from the third party payer has not been received within the timeframe established by Mercy Maricopa for claims submission or, in the absence of a subcontract, within 120 days of submission;

When it is determined that the person had relevant third party coverage after services were rendered or reimbursed; or

When a behavioral health/integrated care recipient eligible for both Medicaid and Medicare (dual eligible) receives services in an inpatient sub-acute facility that is not Medicare certified. Non-Medicare certified facilities should only be utilized for dual eligibles when a Medicare certified facility is not available.

In an emergency situation, the provider must first provide any medically necessary covered behavioral health/integrated care services and then coordinate payment with any potential third party payers.

Providers must cost avoid all claims or services that are subject to third party payment. Mercy Maricopa may deny payment to a provider if a provider is aware of third party liability and submits a claim or encounter to Mercy Maricopa. However, if the provider knows that the third party payer will not pay for or provide a medically necessary covered service, then the provider must not deny the service nor require a written denial letter. If the provider does not know whether a particular medically necessary covered service is covered by the third party payer, the provider must contact the third party payer rather than requiring the person receiving services to do so. Providers must refer to the formulary of the behavioral health/integrated care recipients’ Medicare Part D plan to determine if a specific drug will be covered under Medicare Part D. The Medicare Part D plan formularies are available at www.medicare.gov.

**DISCOVERY OF THIRD PARTY LIABILITY AFTER SERVICES RENDERED/REIMBURSED**

If it is determined that a person has third party liability after services were rendered or reimbursed, providers must identify all potentially liable third party payers and pursue reimbursement from them. In instances of post-payment recovery, the behavioral health/integrated care provider must submit an adjustment to the original claim, including a copy of the Remittance Advice or the Explanation of Benefits. AHCCCS and/or ADHS/DBHS may refer cases to Mercy Maricopa for Title XIX and Title XXI persons in the following circumstances:

- Uninsured/under-insured motorist insurance
- Tortfeasors
- Special Treatment Trusts
- Adoptions
- Worker’s compensation
- Estates

The provider is responsible to report any cases involving the above circumstances to Mercy Maricopa. Behavioral health/integrated care providers may be asked to cooperate with AHCCCS and/or ADHS/DBHS in third party collection efforts.
COPAYMENTS, PREMIUMS, COINSURANCE AND DEDUCTIBLES
If a third-party insurer requires a person to pay a copayment, coinsurance or deductible, Mercy Maricopa is responsible for covering those costs for Title XIX/XXI eligible persons (see Third Party Liability and Coordination of Benefits, Title XIX/XXI Eligible Persons).

The ADHS/DBHS co-payment assessed for non-Title XIX/XXI persons determined SMI is intended to be payment by the member for services covered in the medication only benefit (e.g., psychiatric assessments, medication management, medications), but co-payments are only collected at the time of the psychiatric assessment and psychiatric follow up appointments. Non-Title XIX/XXI persons determined to have a Serious Mental Illness may be assessed the ADHS/DBHS co-payment in accordance with Chapter 8.0 – Copayments and Other Member Fees, or may be assessed co-payments, premiums, coinsurance and/or deductibles for services covered by the third party insurer. When a Non-Title XIX/XXI person determined to have SMI is assessed the ADHS/DBHS co-payment, he/she will pay the ADHS/DBHS co-payment or the co-payment required by the third party insurer, whichever is less (see Third Party Liability and Coordination of Benefits, Non-Title XIX/XXI Eligible Persons Determined to have a Serious Mental Illness). Additionally, when a Non-Title XIX/XXI person determined to have SMI is assessed a co-payment for a generic medication that is also on the ADHS/DBHS Non-Title XIX/XXI Formulary, he/she will pay the ADHS/DBHS co-payment or the co-payment required by the third party insurer, whichever is less. Mercy Maricopa is responsible for covering the difference between the ADHS/DBHS co-payment and the third party co-payment when the third party co-payment is greater than the ADHS/DBHS co-payment. Behavioral health recipients are responsible for third party co-payments for services that are not services that ADHS/DBHS covers and third party premiums, coinsurance and deductibles, if applicable. When Non-Title XIX/XXI persons determined to have SMI have difficulty paying co-payments, the provider must re-screen the individual for Title XIX/XXI eligibility.

TRANSPORTATION
Behavioral health/integrated care providers must provide and retain fiscal responsibility for transportation for Title XIX and Title XXI persons in order for the person to receive a covered behavioral health/integrated care service reimbursed by a third party, including Medicare.

NON-TITLE SMI MEMBERS
Mercy Maricopa and their contracted providers must educate and encourage Non-Title SMI members to enroll in a qualified health plan through the federal health insurance exchange and offer assistance for those choosing to enroll during open enrollment periods and qualified life events. The following applies for members who enroll in a qualified health plan through the Federal Health Insurance Marketplace:
Members enrolled in a qualified health plan through the Federal Health Insurance Marketplace continue to be eligible for Non-Title XIX covered services that are not covered under the exchange plan.

Non-Title XIX funds may not be used to cover premiums or co-pays associated with qualified health plans through the Federal Health Insurance Marketplace or other third party liability premiums or co-pays other than Medicare Part D for SMI members.

Mercy Maricopa must issue approval prior to any utilization of Non-Title XIX funding for services otherwise covered under a qualified plan through the Federal Health Insurance Marketplace.

**MEDICAID ELIGIBLE PERSONS WITH MEDICARE PART A AND PART B**

A Title XIX eligible person may receive coverage under both Medicaid (AHCCCS) and Medicare. These persons are sometimes referred to as “dual eligibles”. In most cases, providers are responsible for payment of Medicare Part A and Part B coinsurance and/or deductibles for covered services provided to dual eligible persons. However, there are different cost-sharing responsibilities that apply to dual eligible persons for a variety of situations. In the event that a Title XIX eligible person also has coverage through Medicare, behavioral health providers must ensure adherence with the requirements described in this chapter.

Persons who are eligible for Medicare benefits can receive services through one of the following arrangements:

- Fee-for-service Medicare system; or
- Enroll in a Medicare Advantage Plan.

A Medicare Advantage Plan is a managed care entity that has a Medicare contract with the Centers for Medicare and Medicaid Services (CMS) to provide services to Medicare beneficiaries.

**Medicare Part A and Part B Cost Sharing Responsibilities for Medicare Advantage Plan Enrollees**

Mercy Maricopa is the payer of last resort. Therefore, if a behavioral health/integrated care recipient is enrolled with a Medicare Advantage Plan, the behavioral health/integrated care recipient must be directed to that plan as their primary payer. However, if the Medicare Advantage Plan does not authorize a Title XIX covered behavioral health/integrated care service, the behavioral health/integrated care provider/ACO must:

- Review the requested service;
- Determine if the service is a medically necessary covered service; and
- When determined, provide the Title XIX covered behavioral health service not covered by Medicare Part A or B.

Behavioral health/integrated care providers/ACO have cost sharing responsibility for all Title XIX covered services provided to behavioral health/integrated care recipients by a Medicare

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Advantage Plan. For those Medicare services that have benefit limits, the behavioral health/integrated care provider/ACO must reimburse all Title XIX and Medicare covered services when the behavioral health/integrated care recipient reaches the Medicare Advantage Plan’s benefit limits.

Behavioral health/integrated care providers/ACO only have cost sharing responsibility for the amount of the behavioral health/integrated care recipient’s coinsurance, deductible or copayment. Behavioral health/integrated care providers/ACO have no cost sharing obligation if the Medicare payment exceeds the behavioral health providers/ACO contracted rate for the services. The behavioral health/integrated care provider/ACO liability for cost sharing plus the amount of Medicare’s payment must not exceed the behavioral health/integrated care provider’s/ACO contracted rate for the service. With respect to copayments, the behavioral health/integrated care provider/ACO may pay the lesser of the copayment or their contracted rate.

**Qualified Medicare Beneficiaries (QMB) duals Enrolled in Medicare Advantage Plan**

QMB duals are entitled to:
- All Title XIX covered services;
- Medicare Part A covered services; and
- Medicare Part B covered services.

In addition to Title XIX covered services, QMB duals may receive Medicare services that are not covered under Title XIX, or differ in scope or duration. When a behavioral health/integrated care member is enrolled in a Medicare Advantage Plan, the behavioral health/integrated care provider/ACO is responsible for cost sharing for Medicare Part A and Part B services that are not covered under Title XIX, or differ in scope or duration. These behavioral health Medicare services include:
- Inpatient psychiatric services (Medicare has a lifetime benefit maximum);
- Other behavioral health services such as partial care; and
- Any services covered by/added to the Medicare Program not covered under Title XIX.

**Non-QMB Duals Enrolled in Medicare Advantage Plan**

Behavioral health provider/ACO is responsible for Part A and Part B cost sharing for Title XIX only covered services for Non-QMB duals.

**Note:** CMS issued a memo dated September 17, 2008, ("CMS Guidance") providing guidance regarding balance billing by providers of certain individuals enrolled in both Medicare Advantage plans and a State Medicaid plan ("Dual Eligible beneficiaries"). More specifically, this CMS Guidance states that providers are prohibited from balance billing Dual Eligible beneficiaries who are classified as QMB for Medicare Parts A and B cost sharing amounts. The CMS Guidance explains that providers must accept Medicare and Medicaid payment(s), if any, as payment in full. A QMB has no legal liability to make payment to a provider or Medicare Advantage plan for Medicare Part A or B cost sharing, and a provider may not treat a QMB as “private pay patient” in order to bill a QMB patient directly. In addition, the CMS Guidance states that federal regulations require a provider treating an individual enrolled in a State Medicaid plan, including QMBs, to accept Medicare assignment. Providers
participating in Medicare networks are required to comply with all of the requirements set forth in this CMS Guidance.

**Prior Authorization for Medicare Advantage Plan Enrollees**

If Mercy Maricopa’s contract with a behavioral health provider requires the behavioral health provider to obtain prior authorization before rendering services and the behavioral health provider does not obtain prior authorization, Mercy Maricopa is not obligated to pay the Medicare Part A or Part B cost sharing for Title XIX covered services, except for emergency services.

If the Medicare Advantage Plan determines that a service is medically necessary, the behavioral health provider/ACO is responsible for Medicare Part A and Part B cost sharing, even if the behavioral health provider/ACO determines otherwise. If the Medicare Advantage Plan denies a service requiring prior authorization for lack of medical necessity, the ADHS/DBHS, Mercy Maricopa or behavioral health provider/ACO must apply its own authorization criteria and may not use the Medicare Advantage Plan’s decision as the basis for denial.

**Out of Network Services for Medicare Advantage Plan Enrollees**

If an out of network referral is made by a contracted behavioral health/integrated care provider and Mercy Maricopa specifically prohibits out of network referrals in the provider contract, then the behavioral health/integrated care provider may be considered to be in violation of the contract and Mercy Maricopa has no Part A or Part B cost sharing obligation. The behavioral health/integrated care provider who referred the behavioral health/integrated care recipient to an out of network provider is obligated to pay any Part A or Part B cost sharing. The behavioral health/integrated care recipient must not be responsible for the Medicare Part A or Part B cost sharing, unless the behavioral health/integrated care recipient has been advised of Mercy Maricopa’s network and elects to go out of the network. In this case, the behavioral health/integrated care recipient is responsible for paying the Medicare Part A and Part B cost sharing amount, unless the service is an emergency, pharmacy (not Medicare Part D) or other physician ordered service.

If the Medicare Advantage Plan and Mercy Maricopa have networks for the same service that have no overlapping providers and Mercy Maricopa chooses not to have the service performed in its own network, then Mercy Maricopa is responsible for Part A and Part B cost sharing for that service. If the overlapping providers have closed their panels and the behavioral health/integrated care recipient goes to an out of network provider, then Mercy Maricopa is also responsible for Part A and Part B cost sharing.

**Medicare Part A and Part B Pharmacy/Physician Ordered Services Medicare Advantage Plan Enrollees**

The requirements described under this heading are for informational purposes only. Behavioral health/integrated care providers may or may not have direct responsibilities related to these activities.
For purposes of this chapter, “in Mercy Maricopa network” refers to the provider who supplies the prescription, not the prescribing provider. Mercy Maricopa must cover pharmacy copayments for medications prescribed by both contracted and non-contracted providers as long as the prescriptions are filled at a contracted pharmacy. However, if a provider prescribes a non-formulary medication, then Mercy Maricopa may opt to not reimburse for the prescription copayment. Mercy Maricopa may choose not to cover the copayment if prior authorization was not obtained.

If a behavioral health/integrated care recipient exceeds their pharmacy benefit limit, Mercy Maricopa must cover all prescription costs for the person. These prescriptions are subject to Mercy Maricopa’s formulary, prior authorization and pharmacy network requirements.

If the Medicare Advantage Plan does not offer a pharmacy benefit, then Mercy Maricopa may require that the prescribing physician be in Mercy Maricopa’s network for prescription benefit coverage. This requirement extends to all prescribed services (e.g., laboratory services).

**Cost Sharing under Medicare Fee-for-Service Program**

A Medicare beneficiary may elect to receive Medicare services through providers authorized to deliver Medicare services. Behavioral health/integrated care providers/ACO have Part A and Part B cost sharing responsibility for Title XIX covered services provided to behavioral health/integrated care recipients by fee-for-service behavioral health/integrated care providers in Mercy Maricopa’s network. Behavioral health/integrated care providers/ACO have no Part A and Part B cost sharing obligation if the Medicare payment exceeds the behavioral health/integrated care provider’s/ACO contracted rate for the services. The behavioral health/integrated care provider’s/ACO liability for Part A and Part B cost sharing plus the amount of Medicare’s payment must not exceed the behavioral health/integrated care provider’s/ACO contracted rate for the service. For those Medicare services for which prior authorization is not required, but is also covered under Title XIX, there is no Part A or Part B cost sharing obligation if Mercy Maricopa has a contract with the provider and the provider’s contracted rate includes Medicare Part A and Part B cost sharing as specified in the contract.

**QMB Duals under Medicare Fee-for-Service Program**

QMB duals are entitled to:

- All Title XIX covered services;
- Medicare Part A covered services; and
- Medicare Part B covered services.

Behavioral health/integrated care providers/ACO are responsible for the payment of the Medicare Part A and Part B deductible and coinsurance for Title XIX covered services. In addition to Title XIX covered services, QMB duals may receive Medicare services that are not covered under Title XIX, or differ in scope or duration. The services must be provided regardless of whether the behavioral health/integrated care provider is in Mercy Maricopa’s network. These Medicare services include:
- Inpatient psychiatric services (Medicare has a lifetime benefit maximum);
- Other behavioral health services such as partial care; and
- Any services covered by or added to the Medicare Program not covered under Title XIX.

**Non-QMB Duals Receiving Services under Medicare Fee-for-Service Program**

Behavioral health/integrated care provider/ACO is responsible for the payment of the Medicare Part A and Part B deductible and coinsurance for Title XIX covered services that are rendered on a fee-for-service basis by a Medicare behavioral health/integrated care provider within the Mercy Maricopa network. Behavioral health/integrated care providers/ACO are not responsible for Medicare Part A and Part B services not covered under Title XIX.

**Prior Authorization for Persons Receiving Services under Medicare Fee-for-Service Program**

If Mercy Maricopa’s contract with a behavioral health/integrated care provider requires the behavioral health provider to obtain prior authorization before rendering services and the behavioral health provider does not obtain prior authorization, Mercy Maricopa is not obligated to pay the Medicare Part A and Part B cost sharing for Title XIX covered services, except for emergency services. Mercy Maricopa cannot require prior authorization for Medicare Part A and Part B only services.

If the Medicare provider determines that a service is medically necessary, the behavioral health/integrated care provider/ACO is responsible for Medicare Part A and Part B cost sharing, even if the behavioral health/integrated care provider/ACO determines otherwise. If Medicare denies a Part A or Part B service requiring prior authorization for lack of medical necessity, the ADHS/DBHS, Mercy Maricopa or behavioral health/integrated care provider must apply its own authorization criteria. If the criterion supports the provision of the Part A or Part B service, the behavioral health/integrated care provider/ACO must cover the cost of the service.

**Out of network Services for Persons Receiving Services under Medicare Fee-for-Service Program**

If an out of network referral is made by a contracted behavioral health/integrated care provider and Mercy Maricopa specifically prohibits out of network in the provider contract, then the behavioral health/integrated care provider may be considered to be in violation of the contract and Mercy Maricopa has no Part A or Part B cost sharing obligation. The behavioral health/integrated care recipient who referred the behavioral health/integrated care recipient to an out of network provider is obligated to pay any Part A or Part B cost sharing. The behavioral health/integrated care recipient must not be responsible for the Medicare Part A or Part B cost sharing, unless the behavioral health/integrated care recipient has been advised of Mercy Maricopa’s network and elects to go out of the network. In this case, the behavioral health/integrated care recipient is responsible for paying the Medicare Part A and Part B cost sharing amount, unless the service is an emergency, pharmacy (not Medicare Part D) or other physician ordered service.

**Medicare Part A and Part B Pharmacy/Physician Ordered Services for Persons Receiving**
**Services under Medicare Fee-for-Service Program**
The requirements described under this heading are for information purposes only. Behavioral health/integrated care providers may or may not have direct responsibilities related to these activities.

Mercy Maricopa must cover prescriptions and other ordered services that are both prescribed and filled by in network providers. If a provider prescribes a non-formulary prescription, then Mercy Maricopa may opt to not reimburse for the prescription. Mercy Maricopa may also require prior authorization.

For information on prior authorization, refer to Chapter 13.0 – Securing Services and Prior Authorization.

**MEDICARE PART D PRESCRIPTION DRUG COVERAGE**
All persons eligible for Medicare Part A or enrolled in Medicare Part B are for Medicare Part D Prescription Drug coverage. Dual eligible persons (eligible for Medicaid and Medicare) no longer receive prescription drug coverage through Medicaid. To access Medicare Part D coverage, persons 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 persons 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).

Persons 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 persons’ cost sharing requirements are paid for by the federal government. Dual eligibles on a Medicare Savings Program through AHCCCS (QMB, SLMB, or QI-1) are automatically eligible for the LIS program. Other persons have to apply for the LIS program. Title XIX/XXI funds are not available to pay any cost sharing of Medicare Part D. Mercy Maricopa may utilize Non-Title XIX/XXI funds for cost sharing of Medicare Part D copayments for Non-Title XIX/XXI persons determined to have SMI.
CHAPTER 10 – COVERED SERVICES REQUIREMENTS

10.0 – Advance Directives

Advance directives not only identify services a person would desire if he or she becomes unable to make a decision, 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.

If changes occur in State law regarding advance directives, adult persons 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 person the right to designate another adult person to make health care treatment decisions on his or her behalf. The designee may make decisions on behalf of the adult person 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 health treatment of the adult person 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 person the right to designate another adult person to make behavioral health care treatment decisions on his or her behalf. The designee may make decisions on behalf of the adult person 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 person 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 person or by court order;
 Has the same right as the adult person to receive information and to review the adult person’s medical records regarding proposed healthcare treatment and to receive, review, and consent to the disclosure of medical records relating to the adult person’s treatment;
 Must act consistently with the wishes of the adult person as expressed in the health care power of attorney or mental health care power of attorney. If, however, the
adult person’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 person’s best interest; and

- May consent to admitting the adult person 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.

REQUIREMENTS FOR ADULT PERSON AT TIME OF ENROLLMENT

At the time of enrollment, all adult persons, 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 person’s rights, in writing, regarding advance directives under Arizona State law;
- A description of the applicable state law (summarized in 3.12.7-A and 3.12.7-B above); 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 person is no longer incapacitated and ensure that the information is given to the person directly.

ASSISTANCE FOR ADULT PERSON TO DEVELOP ADVANCE DIRECTIVE

Healthcare providers must assist adult persons who are interested in developing and executing an advance directive. Mercy Maricopa can offer the Advanced Directives Form (English/Spanish).

OTHER REQUIREMENTS FOR HEALTHCARE PROVIDERS

Healthcare providers must:

- Document in the adult person’s clinical record whether or not the adult person was provided the information and whether an advance directive was executed;
- Not condition provision of care or discriminate against an adult person 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 person’s executed advanced directive, or documentation of refusal, to the PCP for inclusion in the person’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 to provide services.

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

10.1 – Medical Record Standards

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 person altering the record. Correction fluid or tape is not allowed; and
- 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:
  o The date and time of entries in a medical record as noted by the computer’s internal clock;
  o The personnel authorized to make entries using provider established policies and procedures;
  o The identity of the person making an entry; and
  o 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 recipients 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.);
    - Members’ 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 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 recipients, 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.

- Mercy Maricopa communicates documentation standards listed in **Chapter 4.0, Covered Services** 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 Mercy Maricopa, AHCCCS or any government agency upon request.

When a recipient changes his or her PCP, the provider must forward the member’s medical
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. (See Chapter 11.1, Coordination of Care with AHCCCS Health Plans, Primary Care Providers and Medicare Providers for more information; see the ADHS/DDD Interagency Service Agreement Amendment 9).
- Mercy Maricopa and subcontracted providers must provide each member who makes a request one copy of his or her medical record free of charge annually.
- Mercy Maricopa and subcontracted providers must allow, upon request, recipients to view and amend their medical record as specified in 45 C.F.R. § 164.524, 164.526 and A.R.S. § 12-2293.

COMPREHENSIVE CLINICAL RECORD

Mercy Maricopa shall ensure the development and maintenance of a comprehensive clinical record for each recipient. Comprehensive clinical records, whether electronic or paper, should contain all information contributed by any service provider involved with the care and treatment of the member.

The comprehensive clinical record must include the following information to the fullest extent possible:

- Member identification information on each page of the record (i.e., recipient’s name and AHCCCS /Client Information System (CIS) identification number);
- Identifying demographics including 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/behavioral health history, social history and laboratory screenings (the initial history of a member under age 21 should also include prenatal care and birth history of the mother while pregnant with the member);
- Past medical/behavioral health 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;
- Current presenting concerns; and
- Any review of behavioral health record information by any person or entity (other than members of the clinical team) that includes the name and credentials of the person reviewing the record, the date of the review, and the purpose of the review.

HEALTH RISK ASSESSMENT
The Health Risk Assessment (HRA) is a best practice approach and key component of Mercy Maricopa’s integrated care model. The standardized, 16-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 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 provide 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 Maricopa 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 Maricopa. 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 Maricopa 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.

**PHYSICAL HEALTH INFORMATION**
All providers must adhere to national medical record documentation standards. Below are the minimum medical record documentation and coordination requirements. The following requirements are taken directly from the AHCCCS Medical Policy Manual 940.1:
- 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 medical and behavioral health problem list;
Current physical and behavioral health medications;
Current and complete EPSDT forms (required for all members age 18 through 20 years)
Documentation in the comprehensive medical record must be initialed and dated by the member's PCP, to signify review of diagnostic information including:
- Laboratory tests and screenings
- Radiology reports
- Physical examination notes
- Other pertinent data;
Reports from referrals, consultations and specialists;
Documentation that reflects assessments, requests, referrals and issuance of medically necessary medical supplies, durable medical equipment and orthotic/prosthetic devices;
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;
Documentation as to whether or not 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.

BEHAVIORAL HEALTH RECORD
For General Mental Health/Substance Abuse (GMH/SA), 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 recipient’s right to receive services from a provider to whose religious character the recipient does not object to (see Chapter 2.9 – Special Populations);
  - Documentation of recipient’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:
  - Documentation of all information collected in the behavioral health assessment, any applicable addenda 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 Persons in Need of Special Assistance (see Chapter 2.12 – Special Assistance for Persons 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.

- Treatment and service plans documentation that includes:
  - The recipient’s treatment and service plan;
  - Child and Family Team (CFT) documentation;
  - 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 person 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;
  - 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 recipient’s treatment plan;
  - In the event that more than one provider simultaneously provides the same service to a recipient, 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 recipient’s response to service; and
  - For recipients 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), (see Chapter 13.0 – Securing Services and Prior Authorization) when applicable.

▪ Reports from other agencies that include:
  o Reports from providers of services, consultations, and specialists;
  o Emergency/urgent care reports; and
  o Hospital discharge summaries.

▪ Paper or electronic correspondence that includes:
  o 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 recipient’s health care;
  o Documentation of any requests for and forwarding of behavioral health record information.

▪ Financial documentation that includes:
  o Documentation of the results of a completed Title XIX/XXI screening as required in Chapter 2.0, Eligibility Screening for AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage and Low Income Subsidy Program; and,
  o Information regarding establishment of any copayments assessed, if applicable (see Chapter 8.0, Copayments).

▪ Legal documentation including:
  o Documentation related to requests for release of information and subsequent releases
  o Copies of any advance directives or mental health care power of attorney as defined in Chapter 10.0, Advance Directives, if applicable, including:
    ▪ Documentation that the adult person 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 person to make health care decisions (not including mental health) on behalf of the person 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 person to make behavioral health care decisions on behalf of the person if they are found to be incapable of making these decisions. Documentation of general and informed consent to treatment pursuant to Chapter 2.6, General and Informed Consent to Treatment and Chapter 2.7, Pharmacy Management;
    ▪ Authorization to disclose information pursuant to Chapter 16.0, Confidentiality; 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 recipient and his/her legal guardian or authorized representative, if applicable (see Chapter 20.0, Title XIX/XXI Notice and Appeal Requirements).
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 Mercy Maricopa, 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 Mercy Maricopa that the member should receive care through the behavioral health system for evaluation and/or continued medication management services, Mercy Maricopa 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. (See Chapter 11.1, Coordination of Care with AHCCCS Health Plans, Primary Care Providers and Medicare Providers.)

MEDICAL RECORD AUDITS
Mercy Maricopa conduct routine medical record audits to assess compliance with established standards. Medical records may be requested when Mercy Maricopa is responding to an inquiry on behalf of a member or provider, administrative responsibilities quality of care issues, and/or DBHS monitoring and validation audits 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/DBHS for quality review upon request. Mercy Maricopa shall have access to medical records for the purpose of assessing quality of care, conducting medical evaluations and audits, and performing utilization management functions.

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 (see Chapter 11.0 – Inter-RBHA Coordination of Care for additional information on Inter-T/RBHA transfers), it is important to ensure that there is minimal disruption to the behavioral health recipient’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 see Chapter 16.0 – Confidentiality for other situations that 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 recipient. 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 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 Maricopa 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 recipient. The minimum written requirement for each behavioral health recipient’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 person providing the service;
- The recipient’s CIS identification number and AHCCCS identification number;
- Mercy Maricopa conducts routine audits to ensure that services provided by the agency/provider are reflected in the behavioral health recipient’s service plan. CSAs, HCTC Providers and Habilitation Providers must keep a copy of each behavioral health recipient’s service plan in the recipient’s record; and
- Daily documentation of the service(s) provided and monthly summary of progress toward treatment goals.
Community Service 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 recipient’s clinical team for inclusion in the comprehensive clinical record.

ADEQUACY AND AVAILABILITY OF DOCUMENTATION
Mercy Maricopa 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 Maricopa 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 ADHS/DBHS and Mercy Maricopa, 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 Maricopa’s failure to prepare, retain and provide to ADHS/DBHS 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 Maricopa.

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.
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.

CHAPTER 11 – COORDINATION OF CARE

11.0 – Inter-RBHA Coordination of Care (formerly Transitions of Persons)

GENERAL PROVISIONS
Computation of Time – In computing any period of time 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 of time 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 (persons 18 years and older), the T/RBHA jurisdiction is determined by the
person’s current place of residence, except persons who are unable to live independently
must not be transferred to another T/RBHA with the exception of persons who are unable to
live independently but are involved with Arizona Department of Economics 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 person 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 (ALTCS)/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.

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 person’s discharge from an inpatient or residential setting.

OUT-OF-AREA SERVICE PROVISION
Crisis Services
Crisis services must be provided without regard to the person’s enrollment status. When a
person presents for crisis services the T/RBHA will:
- Provide needed crisis services;
- Ascertain the person’s enrollment status with all T/RBHAs and determine whether the person’s residence is temporary or permanent.
  - If the person is enrolled with another T/RBHA, notify the home T/RBHA within 24 hours of the person’s presentation. The home T/RBHA or their contracted providers is fiscally responsible for crisis services and must:
    - Make arrangements with the T/RBHA at which the person presents to provide needed services, funded by the home T/RBHA;
    - Arrange transportation to return the person to the home T/RBHA area; or
    - Determine if the person intends to live in the new T/RBHA and if so, initiate a transfer. Persons 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 make arrangements for housing and consider this a temporary placement for three months. After three months, if the person continues to clearly express an intent/desire to remain in this new service area, the inter-T/RBHA transfer can proceed.
  - If the person is not enrolled with any T/RBHA, lives in GSA 6 and has presented for services, behavioral health providers must notify the Mercy Maricopa to initiate an enrollment. Providers should notify Mercy Maricopa at 1-800-564-5465
  - If the person is not enrolled with any T/RBHA, lives outside of GSA 6 and is presenting for crisis services, Mercy Maricopa must enroll the person, provide needed crisis services and initiate the inter-T/RBHA transfer.
  - In the event that T/RBHA or provider receives a referral regarding a hospitalized person whose residence is located outside the T/RBHA or provider must immediately coordinate the referral with the person’s designated T/RBHA.

**Non-Emergency Services**
If the person 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 person’s residence within 24 hours of the person’s presentation. The designated T/RBHA must proceed with the person’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 persons.

**Courtesy Dosing of Methadone**
A person receiving methadone administration services who is not a recipient of take-home medication may receive up to two courtesy doses of methadone from a T/RBHA while the person 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 person 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 person returns to the home T/RBHA’s area.

**INTER-T/RBHA**

A transfer will occur when:

- An adult person voluntarily elects to change their place of residence to an independent living setting from one T/RBHA’s area to another.
- Persons 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 make arrangements for housing and consider this to be a temporary placement for 3 months. After 3 months, if the person continues to clearly express an intent/desire to remain in this new service area, the inter-RBHA transfer can proceed.
- Persons who are unable to live independently and are involved with ADES/DDD can be transferred to another T/RBHA. Persons 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
- The court of jurisdiction of a dependent child changes to another T/RBHA’s area.

Inter-T/RBHA transfers are not to be initiated when a person is under pre-petition screening or court ordered evaluation (see [Chapter 2.8 – Pre-Petition Screening, Court-Ordered Evaluation, and Court-Ordered Treatment](#)).

**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 person will move to the new area; or
- If the planned move is in less than 30 days, immediately upon learning of the person’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 person’s comprehensive clinical record,
- Consents for release of information pursuant to [Chapter 16.0 Confidentiality](#):
For Title XIX eligible persons between the ages of 21 and 64, the number of days the person has received services in an IMD in the contract year (July 1 – June 30), and
- The number of hours of respite care the person has received in the contract year (July 1 – June 30);
- 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 making arrangements 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 person. The meeting must include:
  - The person or the person’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 team;
  - Other involved agencies; and
  - Any other relevant participant at the person’s request or with the consent of the person’s guardian.
- Establish a transition plan that includes at least the following:
  - The person’s projected moving date and place of residence;
  - Treatment and support services needed by the person 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 person 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 person’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 person’s behavioral health provider in the receiving T/RBHA’s GSA, including information on how to contact the behavioral health provider;
  - Identification of the person at the receiving T/RBHA who is responsible for coordination of the transfer, if other than the person’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 person is taking medications prescribed for a behavioral health issue, the location and date of the person’s first appointment with a practitioner who can prescribe medications. There must not be a gap in the availability of prescribed medications to the person.

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 person 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 person, the T/RBHAs must collaborate to ensure appropriate re-engagement activities occur (see Chapter 2.3 Outreach, Engagement, Re-Engagement and Closure) and proceed with the inter-T/RBHA transfer, if appropriate. Each T/RBHA must designate a contact person responsible for the resolution of problems related to enrollment and disenrollment.

When a person presents for crisis services, providers must first deliver needed behavioral health services and then determine eligibility and T/RBHA enrollment status. Persons enrolled after a crisis event may not need or want ongoing behavioral health services through the T/RBHA. Providers must conduct re-engagement efforts as described in Chapter 2.3 Outreach, Engagement, Re-Engagement and Closure however; persons who no longer want or need ongoing behavioral health services must be disenrolled (i.e., closed in the CIS) and an inter-T/RBHA transfer must not be initiated. Persons 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 person presented for crisis services in a GSA other than where the person resides.

Timeframes specified above cover circumstances when behavioral health recipients inform their provider or T/RBHA prior to moving to another service area. When behavioral health recipients 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 of the documentation from the previous T/RBHA before scheduling services for the behavioral health member.

COMPLAINT RESOLUTION
A person 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 as provided for in Chapter 20.0 – Title XIX/XXI Notice and Appeal Requirements.

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, person being transferred, or the person’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 person, and
- Any other issue that delays the person’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 person’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.
- 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 the DBHS.

**Third Level**

- The Deputy Director of the DBHS, 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 person 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 the DBHS.

Second Level
• The Deputy Director of the DBHS, 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.

11.1 – 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 person’s primary care provider (PCP) is unknown, subcontracted providers must contact the Acute Health Plan or the Behavioral Health Coordinator of the person’s designated health plan to determine the name of the person’s assigned PCP. See the AHCCCS Contracted Health Plans Behavioral Health Coordinators 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 Maricopa Member Services to determine the name and contact information for the member’s PCP. T/RBHA enrolled persons 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 persons should also be prompted to visit their PCP for routine medical examinations annually or more frequently if necessary.
• Mercy Maricopa subcontracted providers should request medical information from the person’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. Mercy Maricopa encourages subcontracted providers to use the Request for Information from PCP or Medicare Plan/Provider. If the PCP does not respond to the request, the subcontracted provider should contact the health plan’s Behavioral Health Coordinator for assistance.
• Mercy Maricopa 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 Maricopa Acute Health Plan and Provider Coordinator via Customer Services at 800-564-5465.

MERCY MARICOPA ACUTE HEALTH PLAN AND PROVIDER COORDINATOR
Mercy Maricopa has designated an Acute Health Plan and Provider Coordinator who gathers, reviews and communicates clinical information requested by PCPs, Acute Care Plan Behavioral Health Coordinators and other treating professionals or involved stakeholders (see T/RBHA Acute Health Plan and Provider Coordinator Contact Information).

Mercy Maricopa maintains a designated and published phone number for the Acute Health Plan and Provider Coordinator or a clearly recognized prompt on an existing phone number that facilitates prompt access to the Acute Health Plan and Provider Coordinator and that is staffed during business hours. The phone number is (800) 564-5465.

Mercy Maricopa provides Acute Health Plan and Provider Coordinators with training, which includes, at a minimum, the following elements:
- Provider inquiry processing and tracking (including resolution timeframes);
- Mercy Maricopa procedures for initiating provider contracts or AHCCCS provider registration;
- Claim submission methods and resources (see Chapter 7.0 - Submitting Claims and Encounters to Mercy Maricopa);
- Claim dispute and appeal procedures (Chapter 20.4 – Contractor and Provider Claims Disputes); and
- Identifying and referring quality of care issues.

SHARING INFORMATION WITH PCPS, AHCCCS ACUTE 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 persons to the assigned PCP, AHCCCS Acute 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 Maricopa health information exchange
Mercy Maricopa’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 persons 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, (for more information on the referral process, see Chapter 2.2 – Referral and Intake Process);
- Coordinate the placement of persons in out-of-state treatment settings as described in Chapter 6.6 – Out of State Placements.
- Notify, consult with or disclose information to the assigned PCP regarding persons with 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 recipient’s medical record; and
- Notify, consult with or disclose other events requiring medical consultation with the person’s PCP.

Upon request by the PCP or member, information for any enrolled member must be provided to the PCP consistent with requirements outlined in Chapter 16.0 – Confidentiality.

When contacting or sending any of the above referenced information to the person’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 Maricopa 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 of the required elements contained in the Communication Document.

Mercy Maricopa tracks/logs all the requests received from PCPs, AHCCCS Acute Health Plans, other treating professionals and other involved stakeholders, (T/RBHA Acute Health Plan
and Provider Inquiry Monthly Log). Mercy Maricopa will submit the completed form to ADHS/ DBHS by the 30th day after the end of the month. Mercy Maricopa works with its subcontracted providers, AHCCCS Acute Health Plans, and other system stakeholders to resolve systemic issues.

RESPONSIBILITY FOR FEE-FOR-SERVICE PERSONS
It is the responsibility of Mercy Maricopa to provide fee-for-service behavioral health services to Title XIX/XXI eligible persons not enrolled with an AHCCCS Health Plan.

Mercy Maricopa is responsible for providing all inpatient emergency behavioral health services for fee-for-service persons with psychiatric or substance abuse diagnoses.

Mercy Maricopa is responsible for behavioral health services to Native American Title XIX and Title XXI eligible persons referred by an Indian Health Services (IHS) or tribal facility for emergency services rendered at non-IHS facilities.

RESPONSIBILITY FOR PERSONS ENROLLED IN AHCCCS HEALTH PLAN
Mercy Maricopa 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 Maricopa provider network.

Emergency Behavioral Health Services
When a Title XIX or Title XXI eligible person presents in an emergency room setting, the person’s AHCCCS Health Plan is responsible for all emergency medical services including triage, physician assessment, and diagnostic tests.

Mercy Maricopa, 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 persons enrolled with Mercy Maricopa.

Mercy Maricopa is responsible for providing all non-inpatient emergency behavioral health services to Title XIX and Title XXI eligible persons. Examples of non-inpatient emergency services include assessment, psychiatric evaluation, mobile crisis, peer support and counseling.

Mercy Maricopa is responsible for providing all inpatient emergency behavioral health services to persons with psychiatric or substance abuse diagnoses for all Title XIX and Title XXI eligible persons.
Mercy Maricopa is responsible for Emergency transportation of a Title XIX or Title XXI eligible person to the emergency room (ER) when the person has been directed by Mercy Maricopa or a subcontracted provider to present to this setting in order to resolve a behavioral health crisis. Mercy Maricopa or the subcontracted provider directing the person to present to the ER must notify the emergency transportation provider of Mercy Maricopa’s fiscal responsibility for the service.

Emergency transportation of a Title XIX or Title XXI eligible person 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 person’s AHCCCS Health Plan.

For information on emergency services for Non-Title XIX/XXI persons see Chapter 2.1 – Appointment Standards and Timeliness of Service.

**Non-emergency Behavioral Health Services**

For Title XIX and Title XXI eligible persons, Mercy Maricopa is responsible for the provision of all non-emergency behavioral health services.

If a Title XIX or Title XXI eligible person is assessed as needing inpatient psychiatric services by Mercy Maricopa or a subcontracted provider prior to admission to an inpatient psychiatric setting, Mercy Maricopa is responsible for authorizing and paying for the full inpatient stay, as per Chapter 13.0 – Securing Services and Prior Authorization.

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 Maricopa 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 person to an initial behavioral health intake appointment is the responsibility of Mercy Maricopa.

**Medical Treatment for Persons in Behavioral Health Treatment Facilities**

When a Title XIX or Title XXI eligible person 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/SA or children. For recipients determined to have a Serious Mental Illness, Mercy Maricopa 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 recipient’s PCP to obtain prior authorization, as needed.

If a non-SMI, Title XIX or Title XXI eligible person 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 person requires inpatient medical services that are not available at the inpatient psychiatric facility, the person 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 person is enrolled with Mercy Maricopa. For recipients determined to have a Serious Mental Illness, Mercy Maricopa retains responsibility for all medically-necessary medical and behavioral health services provided while the recipient 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
- Anxiety disorders.

*The “Agreed Conditions”*

Certain requirements and guiding principles regarding medications for psychiatric disorders have been established for persons under the care of both a health plan PCP and Mercy Maricopa subcontracted provider simultaneously. The following conditions apply:

- Title XIX and Title XXI enrolled persons must not receive medications for psychiatric disorders from the health plan PCP and behavioral health provider simultaneously. If a person is identified to be simultaneously receiving medications from the health plan PCP and Mercy Maricopa 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 person’s behavioral health condition.

- Medications prescribed by providers within the behavioral health system must be filled by Mercy Maricopa 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 Maricopa and the person’s AHCCCS Health Plan. Mercy Maricopa and contracted providers must take active steps to ensure that prescriptions written by providers by Mercy Maricopa providers are not charged to the person’s AHCCCS Health Plan.

*Transitions of Persons 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, as long as the member, their guardian or parent and the PCP agree to this treatment transition. Mercy Maricopa 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 regime;
  - A medication sheet or list of medications currently prescribed by the Mercy Maricopa Behavioral Health Medical Practitioner (BHMP);
  - A psychiatric evaluation;
  - Any relevant psychiatric progress notes that may assist in the ongoing treatment of the member; and
  - A discharge summary outlining the member’s care and any adverse responses the member has had to treatment or medication.

- 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 Maricopa 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.

- Each month, Mercy Maricopa will complete Recipient Transition from RBHA to PCP Tracking Log and submit it to ADHS/DBHS in order to monitor the transition process.

**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 person 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 person upon his/her PCP’s request in accordance with Chapter 2.1 – Appointment Standards and Timeliness of Service.

A one-time face-to-face evaluation is used to answer PCPs specific questions and provide clarification and evaluation regarding a person’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 person 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 Maricopa 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 Maricopa 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 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; acute members with Medicare Prime plans or Medicare Advantage as their primary payor will be realigned for General Mental Health/Substance Abuse (GMHSA) benefits from their current Regional Behavioral Health Authority (RBHA) to their acute plans. Prior to October 1, 2015, this coverage is facilitated by the Mercy Maricopa Integrated Care in Maricopa county.

Mercy Maricopa Integrated Care dual eligible members will continue to receive their care through Mercy Maricopa.

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). These plans provide Medicare Part A, Part B and Part D benefits in addition to Medicaid services for dual eligible persons 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 payor. Mercy Maricopa implements cost sharing responsibilities and billing for inpatient psychiatric services in accordance with Chapter 9.0 - Third Party Liability and Coordination of Benefits and Chapter 7.0 – Submitting Claims and Encounters to Mercy Maricopa.

Mercy Maricopa will coordinate inpatient care and discharge planning care with the inpatient team for Medicare recipients receiving inpatient services with Medicare providers as described in Chapter 9.0 - Third Party Liability and Coordination of Benefits.

Outpatient Behavioral Health Services
Medicare provides some outpatient behavioral health services that are also ADHS/DBHS covered behavioral health services. Mercy Maricopa implements cost sharing responsibilities
and billing for outpatient behavioral health services in accordance with Chapter 9.0 - Third Party Liability and Coordination of Benefits and Chapter 7.0 – Submitting Claims and Encounters to Mercy Maricopa.

Mercy Maricopa will coordinate outpatient care with Medicare providers for Medicare recipients receiving covered behavioral health services as described in Chapter 9.0 - Third Party Liability and Coordination of Benefits.

**Prescription Medication Services**

Medicare eligible behavioral health recipients 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 recipients enrolled in PDPs. Some MA-PDs may contract with Mercy Maricopa or subcontracted providers to provide the Part D benefit to Medicare eligible behavioral health recipients.

While PDPs and MA-PDs are responsible for ensuring prescription drug coverage to behavioral health recipients 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 Maricopa is responsible for covering non-covered or excluded Part D behavioral health prescription medications listed on the Mercy Maricopa formulary, in addition to Part D cost sharing, in accordance with Chapter 9.0 - Third Party Liability and Coordination of Benefits.

11.2 – Coordination of Behavioral Health Care with Other Governmental Entities

**ARIZONA DEPARTMENT OF ECONOMIC SECURITY/DIVISION OF CHILDREN, YOUTH AND FAMILIES (ADES/DCYF)**

When a child receiving behavioral health services is also receiving services from ADES/DCYF, 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 DCYF initiated referrals for children who have been removed from their homes (see Chapter 2.1 – Appointment Standards and Timeliness of Service).
- 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) (see Chapter 2.4 – Assessment and Service Planning).
- 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 (as appropriate) for the purpose of 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 DCYF.
- Provide behavioral health services during the reunification process and/or other permanency plan options facilitated by DCYF. 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 DCYF planning and facilitates adherence to DCYF established timeframes (see Practice Protocol, The Unique Behavioral Health Service Needs of Children, Youth, and Families Involved with DCS) and Practice Protocol, Transition to Adulthood.

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 ADES/DCYF/DCS and the ADES/FAA Jobs Program. ADHS/DBHS participates in statewide implementation of the program with ADES (see A.R.S. 8-881). Mercy Maricopa 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 persons and families referred through AFF and provide services, if eligible (see Chapter 2.9 – Special Populations);
- Ensure that services made available to persons 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 ADES/DCYF/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 Maricopa 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 DES/DCYF/DCS
must be family centered, provide for sufficient support services and must be provided in a timely manner (see Chapter 2.1 – Appointment Standards and Timeliness of Service).

ARIZONA DEPARTMENT OF EDUCATION (ADE), SCHOOLS OR OTHER LOCAL EDUCATIONAL AUTHORITIES
ADHS/DBHS has delegated the functions and responsibilities as a State Placing Agency to Mercy Maricopa for members in Maricopa County. Mercy Maricopa 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 (see Chapter 16.0 – Confidentiality);
- 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 (see Chapter 2.4 – Assessment and Service Planning);
- 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 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)
Persons 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:

<table>
<thead>
<tr>
<th>Type of DDD Eligibility</th>
<th>What behavioral health services are available?</th>
<th>Who is responsible for providing the behavioral health services?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title XIX and eligible for ALTCS</td>
<td>All Title XIX covered services</td>
<td>Mercy Maricopa and subcontracted providers</td>
</tr>
<tr>
<td>Title XIX and not eligible for ALTCS</td>
<td>All Title XIX covered services</td>
<td>Mercy Maricopa and subcontracted providers</td>
</tr>
</tbody>
</table>
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;
- Providing assistance to 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 recipient’s clinical team (see Chapter 2.4 – Assessment and Service Planning);
- 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 Maricopa and DDD, please see the collaborative protocol available on www.mercymaricopa.org.

**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 (see Chapter 2.1 –
Appointment Standards and Timeliness of Service);

- Ensuring that, if an AzEIP team has been formed for the child, the behavioral health provider will coordinate team functions so as to avoid duplicative processes between systems; and
- Coordinating enrollment in Mercy Maricopa’s children’s system of care when a child transfers to the children’s DDD system.

Mercy Maricopa and the Arizona Department of Economic Security Arizona Early Intervention Program (ADES/AzEIP) have an established mutually agreed upon protocol to ensure effective and efficient delivery of behavioral health services. The Collaborative Protocol between Mercy Maricopa and Arizona Department of Economic Security/ Arizona early Intervention program (ADES/AzEIP) defines the respective roles and responsibilities of each party.

COURTS AND CORRECTIONS
Mercy Maricopa 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), or
- 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 person’s release (see Chapter 2.0 – Eligibility Screening for AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage and Limited Subsidy Program, Chapter 2.2 – Referral and Intake Process, and Chapter 2.5 – SMI Eligibility Determination).

Mercy Maricopa 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 Maricopa and Arizona Department of Corrections (ADC) defines the respective roles and responsibilities of each party.

Mercy Maricopa 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 Maricopa and Arizona
Department of Juvenile Corrections defines the respective roles and responsibilities of each party.

Mercy Maricopa and the Arizona Superior Court have an established mutually agreed upon protocol 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 Maricopa and Administrative Office of the Courts (AOC) defines the respective roles and responsibilities of each party.

Additional data sharing agreements have been developed with the City of Glendale Municipal Court and the City of Mesa Municipal Court

These collaborative protocols are available on the Mercy Maricopa website at www.mercymaricopa.org.

ARIZONA COUNTY JAILS
In Maricopa County, when a member receiving behavioral health services has been determined to have, or is perceived to have, a Serious Mental Illness (see Chapter 2.5 – SMI Eligibility Determination) and is detained in a Maricopa 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 and in accordance with Chapter 16.0 – Confidentiality; and
- Determining whether the member is eligible for the Jail Diversion Program.

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 Maricopa enrolled members who are incarcerated, please contact the Court Liaison Department through customer service at 1-800-564-5465, or visit www.mercymaricopa.org.

ARIZONA DEPARTMENT OF ECONOMIC SECURITY/REHABILITATION SERVICES ADMINISTRATION (ADES/RSA)
The purpose of RSA is to work with individuals with disabilities to achieve increased independence or gainful employment through the provision of comprehensive rehabilitative and employment support services.
Supportive employment services available through Mercy Maricopa are distinct from vocational services available through RSA. Please refer to the Behavioral Health Services Guide for more details.

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:

- Working in collaboration with the vocational rehabilitation (VR) counselors 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 (see Chapter 10.1 – Medical Record Standards);
- Inviting RSA staff to be involved in planning for day programming to ensure that there is coordination and consistency with the delivery of vocational services;
- Participating and cooperating with RSA in the development and implementation of a Regional Vocational Service Plan; and
- Allocating space and other resources for VR counselors or employment specialists working with enrolled members who have been determined to have a Serious Mental Illness.

Mercy Maricopa and Arizona Department of Economic Security/Rehabilitation Services Administration (ADES/RSA) have an established mutually agreed upon 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 Maricopa and Arizona Department of Economic Security/Rehabilitation Services Administration (ADES/RSA) defines the respective roles and responsibilities of each party. The collaborative protocol is available on the Mercy Maricopa website at www.mercymaricopa.org.

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 Maricopa enrolled members who are seeking Assisted Living services, please call customer service at 1-800-564-5465, or visit www.mercymaricopa.org.

Providers, members, and community stakeholders should contact the Mercy Maricopa Housing Department through customer service at 1-800-564-5465 to report unsafe conditions.
11.3 – 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 M-ACT staff 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 PNO/provider, adult recovery team (ART)/children and family team (CFT ), where applicable, and with Mercy Maricopa.
- Will document coordination and participation in discharge planning efforts with PNO/provider, ART/CFT (where applicable), and with Mercy Maricopa.

COORDINATION OF CARE FOR MEMBERS WITH A SERIOUS MENTAL ILLNESS

Mercy Maricopa’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, sharing information on the member’s progress, and reviewing services and medications the member is receiving.

11.4 – 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.

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 (GMHSA) system, but for young adults who do, providers must ensure a smooth transition. In order 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 actually 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.
- Identifying the need for transportation to appointments and other necessary activities.
- Identifying special needs that the young adult may have and/or whether or not 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 ADHS/DBHS Clinical and Recovery Practice Protocol, Transition to Adulthood.
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, assuming that continuation of these services is the choice of the young person 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, according to Mercy Maricopa procedures included in Section 6.2 Submitting Claims and Encounters to Mercy Maricopa.

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 GMHSA. Services include case management services and all other covered services that the person’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 pursuant to Chapter 2.5 – SMI Eligibility Determination.

When a young adult receiving behavioral health services reaches 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.
- Address any new authorization requirements for sharing protected health information due to the young adult turning 18 (as described in Section 4.1, Disclosure of Behavioral Health Information) to ensure that the clinical team can continue to share information;
- Ensure that the young adult’s behavioral health category assignment is changed consistent with Section 7.5, Enrollment, Disenrollment and other Data Submission. 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 in Section 3.2, Appointment Standards and Timeliness of Services; and
- Upon turning 18 years of age, if the person is not eligible for services as a person determined to have a Serious Mental Illness or the person has been determined...
ineligible for Title XIX or Title XXI services, behavioral health providers can continue to provide behavioral health services consistent with Section 3.4, Co-payments.
CHAPTER 12 - QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT

12.0 – Quality Management
Mercy Maricopa works in partnership with providers to continuously improve the care given to our enrollees. The Mercy Maricopa 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 Maricopa adopts DBHS 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 Maricopa Provider website.

QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT PLAN
Under the leadership of the Chief Medical Officer, Mercy Maricopa’s Quality Management department has developed a written Annual QM Plan that addresses Mercy Maricopa’s proposed methodology to meet or exceed ADHS/DBHS 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 Maricopa must measure performance using measurement tools specified by CMS and AHCCCS and report its performance to CMS/AHCCCS. Mercy Maricopa 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.

PROCEDURES FOR HEDIS/CLINICAL PERFORMANCE MEASURE IMPROVEMENT
All contracted providers are expected to meet MPS as established by AHCCCS and/or Mercy Maricopa. 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 Maricopa’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
  - 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
  - Increasing utilization of annual EPSDT visits

CHRONIC CARE IMPROVEMENT PROGRAM
Mercy Maricopa 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 contracting 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 ADHS/DBHS sources (e.g., Customer Service, the Office of the Deputy Director), and external sources (e.g., behavioral health members; providers; other stakeholders; Incident, Accident, and Death reports). Upon receipt of a QOC concern, ADHS/DBHS follows the procedures below. As participants in the QOC process, Mercy Maricopa 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 ADHS/DBHS areas:
  - 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

- 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 ADHS/DBHS 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 standalone process and shall not be combined with other agency meetings or processes. This process is also outlined in the ADHS/DBHS Desktop Protocol – Quality of Care and Peer Review (See the [BQ&I Specifications Manual](#)).

- ADHS/DBHS and Mercy Maricopa, as active participants, complete 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;
  - 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.
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 recipient’s behavioral health care. Substantiated allegations require a level of intervention such as 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.

**ADHS/DBHS and Mercy Maricopa, as active participants in the process, use 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 recipient and/or other recipients, an allegation that is unsubstantiated or unable to be substantiated when the QOC is closed.
- **Level 1** – Concern that MAY potentially impact the recipient and/or other recipients if not resolved.
- **Level 2** – Concern that WILL LIKELY impact the recipient and/or other recipients if not resolved promptly.
- **Level 3** – Concern that IMMEDIATELY impacts the recipient and/or other recipients and is considered potentially life threatening or dangerous.
- **Level 4** – Concern that NO LONGER impacts the recipient. Death or an issue no longer has an immediate impact on the recipient, an allegation that is substantiated when the QOC is closed.

**ADHS/DBHS and Mercy Maricopa, as active participants in the process, report issues to the appropriate regulatory agency including Adult Protective Services, AHCCCS, Department of Child Safety, the Attorney General’s Office, law enforcement 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. Referral to the Peer Review Committee shall not be a substitute for implementing interventions (see**
Chapter 12.2, Peer Review.

- If an adverse action is taken with a provider due to a quality of care concern, ADHS/DBHS will report the adverse action to the AHCCCS Clinical Quality Management Unit (CQM) as well as to the National Practitioner Data Bank. Mercy Maricopa, as active participants in the process, must notify ADHS/DBHS 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, ADHS/DBHS will provide written notification to the appropriate regulatory/licensing board or and AHCCCS. Mercy Maricopa, as active participants in the process, are required to notify ADHS/DBHS of the same.
- When the review of a quality of care concern is complete, ADHS/DBHS will submit a closing letter to AHCCCS Clinical Quality Management (CQM). T/RBHAs, as active participants in the process, are expected to submit a closing letter to ADHS/DBHS. 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
ADHS/DBHS 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 Maricopa, as an active participant in the QOC process, also track and trend QOC data and report trends and potential systemic problems to ADHS/DBHS.

The data from the QOC database will be analyzed and evaluated to determine any trends related to the quality of care or service in the each T/RBHA’s service delivery system or provider network, and aggregated for the state. When problematic trends are identified through this process, ADHS/DBHS will incorporate the findings in determining systemic interventions for quality improvement. Mercy Maricopa, as active participants in the QOC process, incorporate trended data into systemic interventions.

- As evaluated trended data is available, ADHS/DBHS will prepare and present analysis of the QOC tracking and trending information for review and consideration of action by the ADHS/DBHS Quality Management Committee and Chief Medical Officer, as Chairperson 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, ADHS/DBHS 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.

ADHS/DBHS 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 either ADHS/DBHS or Mercy Maricopa. As Mercy Maricopa receive delayed autopsy results, they will use them to confirm the resolution of the QOC concern. If the cause and manner of death gives reason to change the findings of the QOC concern, Mercy Maricopa is expected to notify ADHS/DBHS and resubmit a revised resolution report. Mercy Maricopa is expected to send a cause and manner of death report to ADHS/DBHS monthly, including the results of all reports received during the past month. ADHS/DBHS will also revise closing letters to AHCCCS if the cause and manner of death changes the findings of a QOC investigation. ADHS/DBHS and Mercy Maricopa, as active participants in the QOC process, 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 Healthcare Acquired Conditions (HAC). 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.

Provider-Preventable Conditions
If a Health Care Acquired Condition (HCAC) or Other Provider-Preventable Condition (OPPC) is identified, ADHS/DBHS will conduct a quality of care investigation and report the occurrence and results of the investigation to the AHCCCS Clinical Quality Management Unit.

12.1 – Performance Improvement Projects

Mercy Maricopa Integrated Care (Mercy Maricopa) is committed to establishing high quality healthcare services. One method for achieving this is through adherence to the standards and guidelines set by the Centers for Medicare and Medicaid Services (CMS). Mercy Maricopa adheres to CMS standards and guidelines and, in turn, promotes improvement in the quality of healthcare provided to recipients 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 recipients;
- 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 that come to the attention of Mercy Maricopa in part through:
  - Data from Mercy Maricopa 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;
  - Quality Management/Utilization Management data analysis and reporting; and
  - Member and/or provider satisfaction surveys and feedback.

Mercy Maricopa contracted healthcare providers play an integral role in the implementation of the ADHS/DBHS 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 recipients 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 recipient has stopped taking
medication and has experienced a crisis which resulted in hospitalization), or a status (e.g., a recipient 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 recipient 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 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 Maricopa 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 Maricopa, other providers, stakeholders, and community members to implement recommended improvement strategies that are developed as a...
result of an identified performance improvement project.

12.2 – Peer Review

ADHS/DBHS PEER REVIEW

ADHS/DBHS has established and maintains a Peer Review Committee. The Peer Review Committee serves as the primary entity responsible for ensuring Mercy Maricopa and subcontracted providers adhere to a clinically appropriate peer review process. The ADHS/DBHS Bureau of Quality and Integration may submit a matter for peer review to the Chair of the ADHS/DBHS 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.

ADHS/DBHS Peer Review Committee membership will include:

- The ADHS/DBHS Chief Medical Officer (Chair);
- The ADHS/DBHS Deputy Chief Medical Officer;
- The ADHS/DBHS Office Chief of Quality of Care; and
- ADHS/DBHS Quality of Care Reviewers
- Non-voting Members:
  - ADHS/DBHS Deputy Director
  - ADHS/DBHS Assistant Director of BQ&I; and
  - Licensed Practitioners, internal and external, when necessary

The ADHS/DBHS 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 ADHS/DBHS Peer Review Committee will examine selected peer review outcomes from Mercy Maricopa’s and information made available through the quality management process to monitor Mercy Maricopa’s peer review process. As a result of the review, the ADHS/DBHS Peer Review Committee will make recommendations to Mercy Maricopa’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 ADHS/DBHS Peer Review Committee and ADHS/DBHS Quality Management Committee must review its monitoring process and corresponding guidance documents annually.

The ADHS/DBHS Peer Review Committee may also make recommendations for Mercy Maricopa Chief Medical Officers to refer cases to the Arizona Health Care Cost Containment System (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 Maricopa must implement recommendations made by the ADHS/DBHS Peer Review Committee. Some ADHS/DBHS Peer Review recommendations may be appealable agency actions under Arizona law. A Mercy Maricopa 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 the ADHS/DBHS 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 ADHS/DBHS Peer Review Committee must sign an ADHS/DBHS confidentiality and conflict of interest statement at the initiation of each peer review committee meeting.

PROCEDURES FOR MERCY MARICOPA 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 Maricopa, or other federal, state, or local government agencies.

The Mercy Maricopa Peer Review Committee is chaired by the Chief Medical Officer (CMO) and the membership includes Administrators and Managers of other departments within Mercy Maricopa and representation of healthcare professionals from local communities in which Mercy Maricopa has enrolled members (including physical health care Primary Care Physicians (PCPs and or Specialist). Mercy Maricopa’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 chairperson 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 Maricopa’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.

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 Maricopa 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 adjusting 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 Maricopa 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 Maricopa 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 Maricopa.
  - **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 Maricopa reduce, restrict, suspend, terminate, or not renew the healthcare professional’s Mercy Maricopa 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.

### 12.3 – Behavioral Health Recipient Satisfaction Survey

This chapter outlines the process for Mercy Maricopa and behavioral health providers that deliver covered behavioral health services to Title XIX or Title XXI eligible persons receiving services in the public behavioral health system.

The surveys request independent feedback from Title XIX/XXI adult recipients/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:

- General Satisfaction
- Access to Services
- Service Quality/Appropriateness
- Participation in Treatment
- Outcomes
- Cultural Sensitivity
- Improved Functioning
- Social Connectedness

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. The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) has the statewide oversight responsibility for implementation and analysis of the survey data. MMIC is responsible for ensuring that providers strictly adhere to the Consumer Survey protocol. The providers are primarily responsible for the survey administration. The two Mental Health Statistics Improvement Program (MHSIP) surveys instruments used the Adult Consumer Survey and the Youth Services Survey for Families (YSS-F). These surveys are administered annually statewide to a sample of enrolled TXIX/XXI behavioral health recipients and/or parents/guardians of enrolled recipients.
Annually, ADHS/DBHS, Mercy Maricopa and providers jointly conduct a statewide Behavioral Health Recipient Satisfaction Survey with the participation of Mercy Maricopa providers.

The survey gives TXIX/XXI enrolled behavioral health recipients aged 18 and over and family members or guardians of persons under age 18 receiving behavioral health services, an opportunity to provide direct feedback about their experiences while receiving services in the public behavioral health system.

SURVEY DEVELOPMENT AND REPORTING
All Tribal and Regional Behavioral Health Authorities (T/RBHAs) and T/RBHA contracted providers are required to participate in and collaborate with ADHS/DBHS in planning, implementation, data analysis and results reporting for the annual statewide behavioral health recipient surveys.

Each T/RBHA conducts an in-depth analysis of the survey data results and develops a report. Copies of the report may be obtained from Mercy Maricopa. The results of the survey are used to initiate performance improvement efforts and activities statewide. Mercy Maricopa is responsible for submitting corrective action plans (CAPs) for those domains that consistently fall below 70%, and/or that are not sustained over time. CAPs are submitted to and monitored by ADHS/DBHS.

The adult survey is administered to adult behavioral health members. If the individual requests assistance, a guardian may complete the questionnaire on the behavioral health recipient’s behalf. The YSS-F is administered to the parent/guardian of the child receiving services.

ADHS/DBHS utilizes survey data submitted by the T/RBHAs to complete a statewide report of findings. The results of the statewide Behavioral Health Recipient Satisfaction Survey are public information and are available on the ADHS/DBHS Web site: ADHS/DBHS Annual Consumer Survey Report.
CHAPTER 13 – SERVICE AUTHORIZATION

13.0 – Securing Services and Prior Authorization

GENERAL REQUIREMENTS
When it is necessary for a Mercy Maricopa 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 complete the ADHS/DBHS Referral for Behavioral Health Services and refer the member to the appropriate Mercy Maricopa provider. Mercy Maricopa’s website includes a provider search function for your convenience. See Chapter 2.2 – Referral and Intake Process for additional information.

Securing Services do Not Require Authorization
The clinical team is responsible for identifying and securing the service needs of each behavioral health 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 Maricopa’s network of Participating Healthcare Providers (PHP). This is done in conjunction with the clinical team, the behavioral health recipient, family, and natural supports. If the service is available through a contracted provider, the 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 Maricopa to obtain the requested service as outlined below.

Although Adult HCTC is not a prior authorized service, Mercy Maricopa requires the submission of the Adult HCTC Application in order to access this service.

Accessing Services with Non-Contracted Providers
If Mercy Maricopa’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 if:

- The services required are not available within the Mercy Maricopa network.
- Mercy Maricopa 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 Maricopa’s policies. Both referring and receiving providers must comply with Mercy Maricopa’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 request to Mercy Maricopa for these services with an AHCCCS registered provider. Mercy Maricopa requires the following information in order to activate the prior authorization:

- Requested services (including covered service codes)
- Provider demographic information (name, license, address, phone number, AHCCCS ID)
- Copy of the service plan indicating needed services have been documented
- Reason for the need to refer to a non-contracted provider (e.g., specialty not available in network)
- Reason this service is the only medically viable alternative for member

The process for securing services through a non-contracted provider is as follows:

- **Behavioral Health Adult & Children’s Services:**
  - Mercy Maricopa 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 Maricopa 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 can be found at www.mercymaricopa.org/providers/forms; Provider Manual Forms on the Mercy Maricopa website.
    - 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 agreements will be at the AHCCCS rate unless CMDP service providers for SCA agreements will be reimbursed at 130% of the AHCCCS rate?
- **Physical health providers requesting SCA for all services, excluding DME/Medical Supplies, Home Health, PT, OT and ST:**
  - The Physical Health Prior Authorization Standard Request Form should be used.
  - All requests for SCAs are required to be faxed to the Prior Authorization Department –fax number (860) 975-1040
  - Non-contracted providers need to be AHCCCS-registered
  - Times for response:
    - Mercy Maricopa Expedited Request: Three days;
    - Standard Request: Fourteen days.
  - Upon execution of the SCA, the provider will receive a copy of the SCA via email from Mercy Maricopa Contracts and/or via fax from Mercy Maricopa.

- 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
Chapter 20.0 – Title XIX/XXI Notice and Appeal Requirements and Chapter 20.3 – Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI).

In order to expedite payment of a Single Case Agreement, be sure to include a copy of the SCA with the claim.

**Purpose of Utilization Review Process**

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
- Identifying providers and/or clinicians who could benefit from technical assistance
- Facilitating the examination of clinicians and clinical teams that are effectively allocating services.

In order to expedite payment of a Single Case Agreement, be sure to include a copy of the SCA with the claim.

**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 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.

**Services requiring prior authorization are:**

- Non-emergency admission to and continued stay in an inpatient facility;
- Admission to and continued stay in a behavioral health inpatient facility (level I);
- Admission to and continued stay in a behavioral health residential facility (BHRF);
- 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 Maricopa;
- Non-emergency services outside the Mercy Maricopa contracted Provider Network;
- Psychological, psychosexual and neuropsychological testing;
- Specific pharmacy practices;
- Electroconvulsive therapy (ECT); and
- Non-emergency out of network single case agreements

Mercy Maricopa employs licensed clinicians to review and make prior authorization decisions. Any decision to deny must be made by a Mercy Maricopa medical director or physician designee.

A denial of a request for admission to or continued stay in an inpatient facility can only be
made by a Mercy Maricopa medical director or physician designee after an offer of verbal or written collaboration with the requesting clinician. If the offer is declined, a decision can be made based on the available information.

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, the provider must provide the person(s) requesting services with a Notice of Action 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 (this is Mercy Mariopa’s responsibility).

Notice must be provided in accordance with Chapter 20.0 – Title XIX/XXI Notice and Appeal Requirements. Before a final decision to deny is made, the person’s attending psychiatrist can ask for reconsideration and present additional information.

Mercy Maricopa ensures 24-hour access to a delegated psychiatrist or other physician designee for any denials of inpatient admission.

The following documentation is required in order to obtain prior authorization:

- Prior to a non-emergent admission to an inpatient psychiatric acute hospital or sub-acute facility, a Certification of Need (CON) must be completed
- Request for authorization to a non-emergent Adult Behavioral Health Residential Facility must submit a Referral for Behavioral Health Residential Facility Services for Adults application via fax to: 855-825-3165. A decision will be made within three days for urgent, and fourteen days for standard requests for a behavioral health inpatient facility for persons under the age of 21. Authorization cannot be provided without all the requested documentation.
- Request for authorization to a non-emergent child/adolescent behavioral health inpatient facility must submit a Therapeutic Residential Service Request for Children and Adolescents via fax to: 1-855-825-3165. A decision will be made within three days for urgent, and fourteen days for standard requests for a behavioral health inpatient facility for persons under the age of 21. Authorization cannot be provided without all the requested documentation.
- If an adoptive parent, DCS Group home, or foster parent requests residential treatment, Mercy Maricopa will treat this as an urgent referral and respond within seventy-two hours.
- Approval for child/adolescent behavioral health inpatient facility is valid for up to forty-five days and must be accompanied by submission of the Child and Adolescent 45 Day Clinical Review for Continued Prior Authorization of Residential Facility. If a person becomes Title XIX/XXI-eligible after discharge from an inpatient (acute or sub-acute) facility, the rendering provider may request a retrospective authorization. For a retrospective authorization to occur, the provider must submit a copy of the
medical record to Mercy Maricopa via secure mail to 4350 E. Cotton Center Blvd. Phoenix, AZ 85040 (attention: Utilization Management Department).

- Prior to admission to an adult or child and adolescent behavioral health residential facility or Child HCTC, the appropriate form (Referral for Behavioral Health Residential Facility Services for Adults, Adult HCTC Application or Therapeutic Residential Service Request for Children and Adolescents) must be faxed to Mercy Maricopa at 855-825-3165 followed by telephonic notification to Mercy Maricopa Utilization Management via Mercy Maricopa’s Member Services Department at 1-800-564-5465. **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 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 must be faxed to Mercy Maricopa at 855-825-3165.

- Electroconvulsive therapy (ECT) requires prior authorization. Complete the ECT Prior Authorization Request Form located at www.mercymaricopa.org/providers/forms; Provider Manual Forms using the Electroconvulsive Therapy Criteria fax to 844-424-3976; or for urgent requests call 800-564-5465 to review with Mercy Maricopa’s Utilization Management Department.

- Prior authorization requests for Behavioral Health psychological, psychosexual and neuropsychological testing complete the Behavioral Health Request for Psychological Testing Preauthorization and fax it to Mercy Maricopa’s Utilization Management Department at 844-424-3976. Request related to physical health complete Physical Health Prior Authorization Standard Request Form.

- For requests for prior authorizations for medications, Mercy Maricopa contracted prescribing clinicians shall refer to Chapter 15.0 – ADHS/DBHS Drug List. Formulary medications do not require prior authorization. Prior Authorization Criteria can be found under Prior Authorization Guidelines and the Prior Authorization Requests can be found under Prior Authorization Request Forms.

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 Mercy Maricopa 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 Mercy Maricopa or the 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. Mercy Maricopa will 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 Mercy Maricopa justifies a need for additional information and the delay is in the member’s best interest.

When Mercy Maricopa receives an expedited request for a service authorization and the requested service is not of an urgent medical nature, Mercy Maricopa may downgrade the expedited authorization request to a standard request. If the request is downgraded, Mercy Maricopa will notify the provider immediately of the decision by contacting the requestor via telephone and/or email. If the provider disagrees with Mercy Maricopa’s decision, they can submit a written request for appeal to the prior authorization department; which will be reviewed and responded to in no more than 24 hours.

Decisions to prior authorize other services are made within the following timeframes:

- Within 14 calendar days of the request for ECT;
- Within 14 calendar days of the request for psychological and neuropsychological testing;
- Within 24 hours or the next business day of the request for authorization for a specific medication scenario that requires prior authorization. Formulary medications do not require prior authorization and most PA requests will receive a response in less than 24 hours
- For requests for continued stay, Mercy Maricopa contracted Level of Care providers must call Mercy Maricopa’s Utilization Management Department at (800)-564-5465 to make the request for ongoing care within the following timeframes:
- Requests for continuing care within an inpatient facility must be initiated by the contracted rendering provider prior to the last day of the expiration of the current authorization.

Requests for continuing care within a Child and Adolescent Behavioral Health Inpatient facility must be initiated by the rendering provider by telephonic review by contacting Mercy Maricopa Member Services at 1-800-564-5465 at least one week prior to the expiration of the current authorization. Mercy Maricopa will make a determination within 24 hours or one business day of the completed request. An accurate and complete Recertification of Need (RON) from the Child and Adolescent Inpatient Residential Facility must be completed.

*Child and Adolescent Behavioral Health Residential Facilities*: The initial authorization is valid up to 60 days. A request for continued stay authorization must be made telephonically by the rendering provider to Mercy Maricopa Utilization Management at 800-564-5465 at least two weeks prior to the last day of the expiration of the current authorization; and

*Child and Adolescent HCTC*: The initial authorization is valid up to 90 days. A request for continued stay authorization must be made telephonically by the rendering provider to Mercy Maricopa Utilization Management at 800-564-5465 at least two weeks prior to the last day of the expiration of the current authorization.
**Adult Behavioral Health Residential Facilities:** The initial authorization for adult behavioral health residential facilities is valid up to 60 days. The initial authorization for adult HCTC is valid up to 90 days. A request for continued stay authorization by the rendering provider must include the Referral for Behavioral Health Residential Facility Services for Adults faxed to (855) 825-3165 two weeks prior to the last day of the expiration of the current authorization and a telephonic review to Mercy Maricopa Utilization Management at (800) 564-5465.

**Certification of Need (CON) and Recertification of Need (RON)**

A CON is a certification made by a physician that inpatient services are or were needed at the time of the person’s admission. 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 completed

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

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 include:

- If a person 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 persons under the age of 21 receiving inpatient psychiatric services: Federal rules set forth additional requirements for completing CONs when person 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.

- Compliance with federal requirements related to the Certification of Need (CON) and Recertification of Need (RON) for Mercy Maricopa 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.
- Mercy Maricopa will require monthly each Provider to Attest to accuracy of completion of CON and RON according to Federal guidelines utilizing the Monthly Showing Report Form including the signature by the Facilities’ Medical Director or Designee to validate that all CONs have been completed located in the Mercy Maricopa Provider Manual Forms. Mercy Maricopa will also require a random sample of CON and RON documents for audit each month. If it is determined that a facility is not maintaining compliance the facility will be required to submit the Certificate of Need for every admission. The Attestation Form and Copy of the CONs selected for audit need to be emailed CONandRON@mercymaricopa.org. The member names (ID#) will be sent to the facility by 3rd of each month and the Monthly Showing Report Form and CON/RON will need to be emailed into the Mercy Maricopa by the 10th of each month at CONandRON@mercymaricopa.org.

**Authorization Criteria**

For services in a psychiatric acute hospital or a sub-acute facility, ADHS/DBHS has developed the following criteria that are used by Mercy Maricopa and behavioral health providers:

- [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](#).

For services in a Behavioral Health Inpatient Facility for persons under the age of 21, the following criteria will be used by Mercy Maricopa and behavioral health providers:
Prior to denials for Behavioral Health Inpatient Facility or sub-acute facility placement, Mercy Maricopa Medical Directors or designees will 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 Mercy Maricopa’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 or sub-acute facility, Mercy Maricopa 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, 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.

- 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

Prior to denials for Behavioral Health Inpatient Facility placement, Mercy Maricopa Medical Directors or designees is 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 Mercy Maricopa Medical Director or designee to obtain the professional opinion of the behavioral health clinician.

In addition, if a denial is issued for admission to a Behavioral Health Inpatient Facility, Mercy Maricopa is expected to provide a clearly outlined alternative plan. 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.

- Admission to Behavioral Health Hospital Facility or Behavioral Health Inpatient Facility Authorization Criteria
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 Maricopa Member Services at 800-564-5465.

Alternative Placement not Available upon Discharge

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.

Prior Authorizations for Medications

Mercy Maricopa utilizes DBHS’ behavioral health drug list. This list denotes all drugs which require prior authorization. These prior authorization criteria have been developed by the state wide DBHS pharmacy and therapeutics committee, and must be used by Mercy Maricopa. Mercy Maricopa Medications or other prior authorization criteria may not be added to Mercy Maricopa’s medication list. For specific information on medications requiring prior authorization, see Chapter 15.0 – ADHS/DBHS Drug List. The approved prior authorization criteria are posted on the ADHS website under ADHS/DBHS Behavioral Health Drug List and Prior Authorization Guidance Documents. 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;
- 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 RBHA 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 the RBHA 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. Mercy Maricopa 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 RBHA justifies a need for additional information and the delay is 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. Mercy Maricopa 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

**Coverage and Payment of Emergency 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 Mercy Maricopa;
- Payment must not be denied when:
  - Mercy Maricopa 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;
- Mercy Maricopa may not refuse to cover emergency behavioral health services based on the failure of a provider to notify Mercy Maricopa of a person’s screening and treatment within 3 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 Mercy Maricopa.

The following conditions apply with respect to coverage and payment of post-stabilization care services for a person who was received emergency medical or psychiatric hospitalization who is Title XIX or Title XXI eligible. Mercy Maricopa 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 Maricopa for the following situations:
• Post-stabilization care services that were pre-authorized by Mercy Maricopa;
• Post-stabilization care services that were not pre-authorized by Mercy Maricopa
  or because Mercy Maricopa 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 Maricopa and the treating physician cannot reach agreement concerning
  the member’s care and Mercy Maricopa physician is not available for
  consultation. In this situation, Mercy Maricopa 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:
  o Mercy Maricopa physician with privileges at the treating hospital assumes
    responsibility for the person’s care;
  o Mercy Maricopa physician assumes responsibility for the person’s care
    through transfer;
  o Mercy Maricopa and the treating physician reach an agreement concerning
    the person’s care; or
  o The person is discharged.

PHYSICAL PROVIDERS UNDER INTEGRATED CARE
Mercy Maricopa 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 1-800-564-5465. Prior
authorization is not required for the following:
• Emergency services
• Non-par facility services for the following obstetrical services:
  o OB observation
  o 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

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 Maricopa’s Secure Web Portal at mercymaricopa.com. You
may also call our Prior Authorization Department at 800-564-5465.

Mercy Maricopa has staff available twenty-four 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/integrated care
needs have been met. If upon review of the circumstances, the service or admission did
not meet authorization criteria, payment for the service or admission 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.

**Newborn Notification Process**
Providers must fax a newborn notification to Mercy Maricopa’s dedicated Profax number: 1-844-525-2223. Mercy Maricopa 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 the newborn's AHCCCS health plan.

### 13.1 – Technology
ADHS/DBHS 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 T/RBHA coverage of new approved technologies including the usage of new applications for established technologies by submitting the proposal in writing to the T/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 Maricopa shall participate in the review of new approved technologies, including the usage of new applications for established technologies through the Mercy Maricopa Pharmacy and Therapeutics Committee and the Medical Management Committee.

Mercy Maricopa 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 recipient.

e. Discussion reflecting consideration of a new approved technology, including the usage of a new application for established technology and the T/RBHA's determination of coverage shall be documented in the Pharmacy and Therapeutics Committee meeting minutes and the Medical Management Committee meeting minutes.
Mercy Maricopa will notify ADHS/DBHS 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 ADHS/DBHS based on trends and the meta-analysis of peer reviewed literature.

13.2 – 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 person 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 person indeed has SMI and/or MR. If the person is determined to have SMI and/or MR, this stage of the evaluation process determines whether the person requires the level of services in a 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 MR prior to initial admission of persons to a nursing facility bed that is Medicaid certified or dually certified for Medicaid/Medicare.

**PASRR LEVEL 1 Screening**

See [AHCCCS Medical Policy Manual (AMPM) Exhibit 1220-1, PASRR Level I Screening Document and instructions](#).

PASRR Level I screenings can be performed by the following professionals:

- Arizona Long Term Care System (ALTCS) Pre-Admission Screening (PAS) assessors, or case managers;
- Hospital discharge planners;
- Nurses;
- Social workers; or
- Other NF staff that have been trained to conduct the Level I PASRR screening and make Level II PASRR referrals.

ALTCS PAS assessors or case 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 persons 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 person.

A PASRR Level I screening is required if a person 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 ADHS/DBHS Bureau of Quality Management Operations. If necessary, referrals for a PASRR Level II evaluation to determine if a person has a SMI diagnosis (See Serious Mental Illness (SMI) Qualifying Diagnoses) are forwarded to the ADHS/DBHS Office of the Medical Director. Alternatively, referrals for a PASRR Level II evaluation are forwarded to the Arizona Department of Economic Security/Division of Developmental Disabilities (ADES/DDD) PASRR Coordinator to determine if a person has Intellectual Disability (formerly known as mental retardation). For dually diagnosed persons (both SMI and MR), referrals for a PASRR Level II evaluation are forwarded to both ADES/DDD and ADHS/DBHS.

When a PASRR Level I screening is received by ADHS/DBHS, the PASRR Coordinator reviews it and, if needed, consults with the ADHS/DBHS 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 the RBHA; and
- Send a letter to the person/legal representative that contains notification of the requirement to undergo a Level II PASRR evaluation.

**PASRR LEVEL II Evaluations**

Mercy Maricopa must develop an administrative process for conducting PASRR Level II evaluations and must ensure that:

- If a person 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 person 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 Resident Review (PASRR) Invoice.

Review
The ADHS/DBHS Medical Director or designee reviews all evaluations and makes final Level II placement determinations prior to the proposed/current placement.

ADHS/DBHS 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
ADHS/DBHS 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
ADHS/DBHS shall report monthly to AHCCCS concerning the number and disposition of residents (1) not requiring nursing facility services, but requiring specialized services for SMI,
(2) residents not requiring nursing facility services or specialized services for SMI, and (3) any appeals activities and dispositions of appeal cases.

**DISCHARGE**
Per 42 C.F.R. 483.118(b) (1 and 2), ADHS/DBHS 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), ADHS/DBHS will work with the facility to provide an alternative disposition plan for any residents who require specialized services and who have continuously resided in a NF for at least 30 months prior to the determination as defined in 42 C.F.R. 483.120. ADHS/DBHS, in consultation with the resident’s family or legal representative and caregivers, offer the resident the choice of remaining in the facility or of receiving services in an alternative appropriate setting.

**RECOMMENDATIONS**
The ADHS/DBHS 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 ADHS/DBHS 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**
ADHS/DBHS 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.

Appeals shall be processed, consistent with the requirements in Chapter 20.0 – Title XIX/XXI Notice and Appeal Requirements and Chapter 20.3 – Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI).

Mercy Maricopa must provide ADHS/DBHS 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 Maricopa must retain case records for all Level II evaluations for a period of 6 years in accordance with A.R.S. § 12-2297.

Mercy Maricopa must permit authorized ADHS/DBHS 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.

### 13.3 – Concurrent Review

Policies and procedures for the concurrent review process must:

- Include relevant clinical information when making hospital length of stay decisions. Relevant clinical information may include but is not limited to symptoms, diagnostic test results, diagnoses, and required services.
- Specify timeframes and frequency for conducting concurrent review and decisions:
  - Authorization for institutional stays that will have a specified date by which the need for continued stay will be reviewed.
  - Admission reviews should be conducted within one business day after notification is provided to the T/RBHA by the hospital or institution (this does not apply to precertification) (42 C.F.R. 456.125).
- Provide a process for review that includes but is not limited to:
  - Necessity of admission and appropriateness of the service setting;
  - Quality of care;
  - Length of stay;
  - Whether services meet the member’s needs;
  - Discharge needs; and
  - Utilization pattern analysis.
- Establish a method for Mercy Maricopa’s participation in the discharge planning of all members in institutional settings.
- Mercy Maricopa must also:
  - Monitor timeframes and frequency for conducting concurrent review and decisions of acute levels of care including Skilled Nursing Facility (SNF)
  - Track the number of SNF days utilized by a member in a contract year and the process for intervening with AHCCCS Member Services on day 45 when an ALTCS application is pending

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

- Medical criteria must be approved by Mercy Maricopa’s Medical Management/Utilization Management (MM/UM) Committee. Criteria must be adopted from national standards. When providing concurrent review, Mercy Maricopa must compare the member’s medical information against medical necessity criteria that describes the condition or service.
Initial institutional stays are based on Mercy Maricopa’s adopted criteria, the member’s specific condition, and the projected discharge date.

Continued stay determinations are based on written medical care criteria that assess the need for the continued stay. The extension of a medical stay will be assigned a review date each time the review occurs. Mercy Maricopa ensures that each continued stay date is recorded in the member’s record.

13.4 – Discharge Planning

Mercy Maricopa developed and implemented a discharge planning process to address the post-discharge clinical and social needs of the member upon discharge. The process shall be initiated by a qualified health care professional as soon as possible before, upon or immediately after admission and updated periodically during the inpatient admission to ensure accurately determined continuing care needs. The discharge plan must be appropriately documented in the person’s medical record and must be completed before discharge occurs. Mercy Maricopa 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 person prior to discharge. This process shall include the involvement and participation of the eligible person and representative(s), as applicable. The person 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 person’s assessed and anticipated needs after discharge.

- The coordination and management of the care that the eligible person receives following discharge from an acute setting. This may include:
  - Providing appropriate post discharge community referrals and resources or scheduling follow up appointments with the person’s primary care provider and/or other outpatient healthcare providers within 7 days or sooner of discharge;
  - Coordination of care involving effective communication of the eligible person’s treatment plan and medical history across the various outpatient providers to ensure that the member receives medically-necessary services that is 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 case management, disease management, placement options, and community support services.
  - Access to prescribed discharge medications;
  - Coordination of care with the acute care plan when applicable; and
  - 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.
ACCESS TO DURABLE MEDICAL EQUIPMENT (DME)
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.

REPORTING
Mercy Maricopa has developed a process to audit discharge plans that includes determining and applying a minimum performance score for compliance with this chapter. Mercy Maricopa is expected to report as a standing agenda item within the appropriate committee, the outcomes of such audits with plans for corrections when discharge planning standards as set forth by Mercy Maricopa are not met. Mercy Maricopa discharge plan audits will be subject to monitoring and oversight by the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS).

13.5 – Retrospective Review
Mercy Maricopa 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 Maricopa utilizing the following processes (if they have not filed a claims appeal or an appeal for the member with Grievance & Appeal):
- **STFP**: Mercy Maricopa Integrated Care 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 Liaison (PRL) OR
- **Mailing** to: Mercy Maricopa Integrated Care Utilization Management Department
  4350 E. Cotton Center Blvd, Bldg D
  Phoenix, AZ 85040

Mailing addresses for Mercy Maricopa Integrated Care Claims Appeals or Grievance & Appeals is provided below:

Mailing for Claims Appeals: Mercy Maricopa Integrated Care Claims Disputes
4500 E. Cotton Center Blvd
Phoenix, AZ 85040

Mailing for Grievance & Appeals: Mercy Maricopa Integrated Care Grievance & Appeals
Retrospective reviews are conducted by qualified staff: nurses, nurse practitioners, physicians, physician assistants and behavioral health professionals. The reviewer must monitor the appropriateness of care that was provided, the progress a recipient made, and the progress that was made toward the recipient's discharge planning using standardized criteria. Retrospective review findings must be reported to Mercy Maricopa's Medical Management/Utilization Management (MM/UM) Committee and ADHS on a quarterly basis.

**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 (OPPC), 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, the Contractor must conduct a quality of care investigation and report the occurrence and results of the investigation to the AHCCCS Clinical Quality Management Unit.

**13.6 – Inter-Rater Reliability**

Inter-rater reliability testing must be completed by all staff making medical necessity determinations, including medical directors, nurses, physicians, behavioral health professionals, nurse practitioners, and/ or physician assistants (see R9-20-204). Medical necessity determinations include, but are not limited to: conducting prior authorization, concurrent review, retrospective review, and serious mental illness (SMI) eligibility determinations. Mercy Maricopa documents the reviewer’s testing outcomes as documented in the **ADHS/DBHS Bureau of Quality and Integration Specifications Manual**.

**TESTING**

Mercy Maricopa has a policy and an accompanying process in place to conduct Inter-Rater Reliability testing for all staff involved in clinical decision making, including the Medical Director. Mercy Maricopa has established the minimum percentage criteria required for staff to demonstrate IRR consistently over time, including when the criteria are revised. The IRR process must meet requirements in accordance with the Arizona Health Care Cost Containment System (AHCCCS) Medical Policy Manual (AMPM) Chapter 1000 (see **AHCCCS/ADHS Contract** and **AMPM, Chapter 1000**) and must minimally consist of the following IRR testing methodology:

- Clinicians review examples that are representative of typical determination decisions they might encounter;
Clinicians apply standardized criteria to determine that Medical Necessity Criteria has been met or not;
Clinicians document their authorization decision, and rationale for that decision;
Clinician’s scores are calculated based on the percentage of agreement among reviewers.

Mercy Maricopa conducts IRR testing for all individuals involved in making medical necessity determinations to ensure that they participate in IRR testing within three (3) months of hire, or within three (3) months of being in a position to make medical necessity decisions, and annually thereafter to ensure consistent application of review criteria and decision making.

**PERFORMANCE**
Mercy Maricopa reviews IRR testing results for any variations in decisions and interpretation of MNC among staff, and provides training regarding the correct responses. Mercy Maricopa staff receives an IRR test score per their internal policy. At a minimum, Mercy Maricopa takes the following actions when staff does not demonstrate this level of consistency in the authorization or approval/denial of services:
- Corrective action plans (CAPs) must be initiated for those individuals who do not achieve the minimum expected IRR test score.
- Re-test and train staff based on CAP.
- If, upon re-test, the staff does not achieve the expected minimum IRR test score, that staff will be held from making initial and continuous medical necessity determinations until a passing score and the desired outcomes are achieved as stated in the CAP.

**REPORTING**
Internal Mercy Maricopa Reporting: Mercy Maricopa IRR testing and training results (individual and unit variances in scores) will be reported internally to Mercy Maricopa Medical Management/Utilization Management Committee on a quarterly basis.

External Reporting to ADHS/DBHS: As a contract deliverable (see AHCCCS/ADHS Contract), Mercy Maricopa is required to report IRR test results through the submission of the IRR Testing report template per the ADHS/DBHS Specifications Manual, and attach any IRR trainings and current IRR CAPs. As requested per the AHCCCS/ADHS Contract requirements, Mercy Maricopa submits all IRR policies and procedures for testing, training materials, and a list of all qualified staff involved in medical necessity determinations. ADHS/DBHS will monitor the Mercy Maricopa’s compliance with these requirements and report findings to the ADHS/DBHS Medical Management/Utilization Management Committee for actions and recommendations.
CHAPTER 14 – CARE COORDINATION

14.0 – Case Management and Disease Management

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

The Disease Management team administers disease management programs intended to enhance the health outcomes of members. Disease management identifies, educates and monitors members with the following conditions:

- Asthma
- Chronic Obstructive Pulmonary Disease
- Congestive Heart Failure
- Diabetes

CASE MANAGEMENT

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

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

Please refer to the Clinical Guidelines available on Mercy Maricopa’s website for treatment protocol related to:

- Diabetes
- Asthma
- Congestive Heart Failure (CHF)
- Chronic Obstructive Pulmonary Disease (COPD)
- Community Acquired Pneumonia (CAP)
- HIV

Referrals

The Mercy Maricopa central intake coordinator accepts referrals from any source. Please call the central intake coordinator at 800-564-5465 to make a referral. For the most part, the central intake coordinator can respond to questions and resolve the issue during the initial call. However, a case management referral is initiated for members that require more than a single intervention. Case managers will contact the member either by telephone or by letter. The Case Management staff communicates with members, family and the PCP on an ongoing
basis while the member’s case is open.

**Case Management and DD**

Mercy Maricopa provides case management services to medically complex members. The members are assigned to an RN, LPN or social work case manager who works closely with the PCP and member to coordinate care and services. The case 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 case management also will be considered for case 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 case management. A care plan will be developed and the member's compliance with the plan will be monitored. The case manager interacts routinely with the PCP, the member and the member’s care giver/family.

**HIV/AIDS**

Early identification and intervention of members with HIV allows the case manager to assist in developing basic services and information to support the member during the disease process. The case 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.

The Mercy Maricopa case manager works closely with the PCP, the Mercy Maricopa corporate director of pharmacy, and a Mercy Maricopa 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 Maricopa 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 OB**

Members that have been identified as high-risk obstetrical patients, either for medical or social reasons, are assigned to an OB case manager to try to ensure a good newborn/mother outcome. Refer to **Chapter 4.1 – Maternity and Medically Necessary Pregnancy**
Termination for additional information. The case manager may refer the expectant mother to a variety of community resources, including WIC, food banks, childbirth classes, smoking cessation, teen pregnancy case management, shelters and counseling to address substance abuse issues. A case manager monitors the pregnant woman throughout the pregnancy, and provides support and assistance to help reduce risks to the mother and baby.

Case 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 case manager so that all of the member’s medical and perinatal care issues are addressed appropriately.

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:
- 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 Mercy Maricopa’s Disease Management programs and have associated Clinical Guidelines that are reviewed annually.

Asthma
The Asthma Disease Management program offers coordination of care for identified members with primary care physicians, 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.

**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.
- 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 Maricopa, 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.

**Diabetes**

The Diabetes Disease Management program is designed to develop a partnership between Mercy Maricopa, 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 Maricopa 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 Maricopa’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.
**Active Health**

Mercy Maricopa has contracted with Active Health Management to administer a patient health-tracking program with providers. Members will be receiving letters concerning their “Care Considerations” as well.

Active Health will expand Mercy Maricopa’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 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. Mercy Maricopa’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.

14.1 – Care Management

Mercy Maricopa’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 mercymaricopa.org website under Care Management. Referrals for care management can be done by calling the Care Management Referral Line at (602) 798-2627 or emailing the Care Management Department at MMICCareManagementReferrals@aetna.com

RESPONSIBILITIES

Mercy Maricopa’s Chief Medical Officer (CMO) is responsible for directing and overseeing Mercy Maricopa’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 Maricopa 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 members’ 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.
  - Upon discharge from the Arizona State Hospital (AzSH) the Integrated RBHA must provide all insulin dependent diabetic members with the same brand and model glucose monitoring device as used in the hospital;
  - Inform members of particular health care conditions that require follow up;
  - Inform members of their responsibility to comply with prescribed treatment regimens.

GENERAL REQUIREMENTS

For all members determined to have a SMI diagnosis who are receiving physical health care services through the Integrated RBHA, Mercy Maricopa must:

- Establish and maintain a Care Management Program (CMP).
- Allow the member to select (or Mercy Maricopa) 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:
  - 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.
- 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 Integrated RBHA’s organizational units with emphasis on regular channels of communication with the Integrated RBHA’s Medical Management, Quality Management and Provider Network departments.

Establish communication to exchange information within 7 days 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 the Integrated RBHA’s Care Management Program 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.

ELIGIBILITY
Mercy Maricopa’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. 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;
- Have inappropriately managed their health care, and require more complex or frequent healthcare and services.

MEMBER IDENTIFICATION FOR CASE MANAGEMENT
Mercy Maricopa 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 comorbid 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 monthly basis, HRAs are incorporated into predictive modeling reports to further identify members that may need care management. These reports 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 Maricopa and through external sources. 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 Maricopa 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
- Division of Behavioral Health Services (DBHS)
- AHCCCS
- Department of Economic Security (DES)/Division of Developmental Disabilities

To make a referral to the Care Management program, contact 800-564-5465, Option 2 for Provider Calls then Option 6 for a Behavioral Health Representative. Upon receipt of referral, Mercy Maricopa’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 align with the member’s Individual Recovery Plan/Individual Service Plan, but will be neither a part of nor a substitute for that plan.

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 prescheduled and designed to evaluate progress toward care plan goals and meeting member needs. The care plan can be revised/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 bi-weekly, twice a month.
CHAPTER 15 – SERVICE/DRUG UTILIZATION

15.0 – ADHS/DBHS Drug List

ACCESS TO MEDICATION USING THE BEHAVIORAL HEALTH DRUG LIST

To ensure coverage of medications through Mercy Maricopa, providers must utilize the ADHS/DBHS Behavioral Health Drug List.

The Mercy Maricopa Medication Preferred Drug List (PDL) can be found on our website at: www.MercyMaricopa.org.

Title XIX/XXI eligible persons receiving medication(s) have the right to notice and appeal when a decision affects coverage for medication(s), in accordance with Chapter 20.0 – Title XIX/XXI Notice and Appeal Requirements. Non-Title XXI/XXI persons determined SMI have the right to notice and appeal when a decision affects medication coverage, in accordance with Chapter 20.3 – Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI).

Members can appeal by contacting Mercy Maricopa at 800-564-5465 or by submitting a letter or completed ADHS/DBHS Appeal or SMI Grievance Form (English /Spanish), no later than 60 calendar days after the date of Notice to:

Mercy Maricopa Integrated Care
Attn: Grievances and Appeals
4350 E. Cotton Center Blvd.
Phoenix, AZ 85040

Behavioral health recipients 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 recipient in submitting an appeal with the health plan. Mercy Maricopa will cover medications for persons 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 ADHS/DBHS Behavioral Health Drug List.

Applicable co-payments must only be collected in accordance with Chapter 8.0 – Copayments and Other Member Fees. For persons with coverage from third party payers, co-payments are collected in accordance with Chapter 9.0 - Third Party Liability and Coordination of Benefits.

Mercy Maricopa does not require prior authorization processes for medications, which have been approved for payment under Medicare plans.
PRIOR AUTHORIZATION
ADHS/DBHS requires that Mercy Maricopa prior authorize coverage of those medications indicated in the ADHS/DBHS Behavioral Health Drug List as requiring prior authorization and those that have age limits. (See ADHS/DBHS Drug List and Prior Authorization Guidance Documents webpage.)

When these prior authorization criteria are utilized, the requirements outlined in Chapter 13.0 – Securing Services and Prior Authorization, Chapter 20.0 – Title XIX/XXI Notice and Appeal Requirements and Chapter 20.3 – Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI) must be met.

Mercy Maricopa shall not require prior authorization processes for medications, which have been approved for payment under Medicare plans.

Behavioral health providers may request prior authorization by completing the appropriate Prior Authorization Requests for Medications. 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.

BEHAVIORAL HEALTH PROVIDER INPUT TO DRUG LIST
Behavioral health providers can offer suggestions for adding or deleting medications to the ADHS/DBHS Behavioral Health Drug List or Mercy Maricopa’s Medication Preferred Drug List.

Changes to the ADHS/DBHS Behavioral Health Drug List
To propose additions or deletions to the ADHS/DBHS Behavioral Health Drug List, a behavioral health professional should submit a written request to the address below:

Chief Medical Officer
Mercy Maricopa Integrated Care
Attn: Chief Medical Officer
4350 E. Cotton Center Blvd.
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 Maricopa Chief Medical Officer or designee will present requests, as determined appropriate, to the ADHS/DBHS Pharmacy and Therapeutics Committee.

15.1 – Utilization Data Analysis and Data Management

ADHS/DBHS RESPONSIBILITY
The ADHS/DBHS MM/UM committee conducts the following Utilization Data Management Activities specific to data that is reported to ADHS/DBHS:

- Establish utilization Variance Criteria;
- Review and analyze T/RBHA data to identify trends;
- Interpret variances;
- Review Outcomes;
- Determine, based on the review of data, if action (new or changes to current intervention) is required to improve the efficient utilization of services;
- Develop and/or approve corrective action and interventions based on findings;
- Review and evaluate the effectiveness/outcomes of the intervention; and,
- Ensure follow-up with T/RBHAs on identified actions and interventions.

RESPONSIBILITIES OF MERCY MARICOPA MM/UM COMMITTEES
Mercy Maricopa must convene Medical Management/Utilization Management (MM/UM) Committee meetings on a regularly scheduled and ongoing basis. RBHAs must discuss data submitted to ADHS/DBHS as part of the MM/UM Committee. Mercy Maricopa MM/UM Committee is expected to conduct the following Utilization Data Management Activities specific to data that is reported to ADHS/DBHS:

- Review and analyze data to identify trends;
- Interpret variances;
- Review Outcomes;
- Determine, based on the review of data, if action (new or changes to current intervention) is required to improve the efficient utilization of services;
- Develop and/or approve corrective action and interventions based on findings; and
- Review and evaluate the effectiveness/outcomes of the intervention.

Both ADHS/DBHS and the Mercy Maricopa’s evaluation of findings and interventions must include a review of the impact to service utilization, quality, and outcome.

Both ADHS/DBHS and the Mercy Maricopa’s intervention strategies are to address both over and under-utilization of services and must be integrated throughout the organization. All strategies must have measurable outcomes and must be reported in MM/UM minutes. RBHAs must also incorporate their evaluation of over and under-utilization into their annual Medical Management Plan and summarize action taken to correct areas of concern.

Minimum Required Utilization Data Elements include, but are not limited to:
- Over- and Under-utilization of services and costs;
- Avoidable hospital admissions and readmissions, and average length of stay for all psychiatric inpatient stays;
- Follow-up after discharge;
- Court-ordered treatment;
- Emergency Department utilization and crisis services;
- Prior Authorization, denials and notices of action;
- Pharmacy Utilization
- Lab and diagnostic utilization
- Serious Mental Illness Eligibility Determination; and
- Bed days per 1000 admissions.
CHAPTER 16 – CONTRACT COMPLIANCE

16.0 – Confidentiality (REVISED May 15, 2015)
Information and records obtained in the course of providing or paying for covered health services to a person 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 persons. 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 Maricopa 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 T/RBHAs and health care providers are required to use and disclose protected health information. In addition T/RBHAs and health care providers are now required to notify each individual 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 person’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 person related to the provision of healthcare services to the person is confidential whether the information is in oral, written, or electronic format.

All records generated as a part of the ADHS/DBHS or Mercy Maricopa grievance and appeal processes are legal records, not medical records, although they may contain copies of portions of a person’s medical record. To the extent these legal records contain personal medical information, ADHS/DBHS or Mercy Maricopa will redact or de-identify the information to the extent allowed or required by law.

**List of Persons Accessing Records**
Providers are required to maintain a list of every person or organization that inspects a currently or previously enrolled person’s records other than the person’s clinical team, the uses to be made of that information and the staff person authorizing access. The access list must be placed in the enrolled person’s record and must be made available to the enrolled person, their guardian or other designated representative. Providers must retain consent and authorization medical records as prescribed in A.R.S. § 12-2297 and in conformance with Chapter 10.1 – Medical Record Standards.

**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 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.
Rule requires the authorization of the person or the person’s legal guardian or parent as prescribed in this chapter.

**Disclosure to Persons in Court Proceedings**
Disclosure of information to persons 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 person 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 persons 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;
  - For law enforcement purposes;
  - About deceased persons;
  - 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 Persons 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 person or entity as otherwise required by state or federal law;
- To a person or entity permitted by the federal regulations on alcohol and drug abuse treatment (42 C.F.R. Part 2);
- To a person 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 person 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 person (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 person(s), or class of persons, authorized to make the requested use or disclosure;
- The name or other specific identification of the person(s), or class of persons, 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 person for treatment, payment or healthcare operations as defined in the HIPAA Rule. These disclosures are typically made to 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 person that it is not in the individual’s best interest to be notified (45 C.F.R. § 164.512(c)).

**Disclosure to Other Persons**
A covered entity may disclose protected health information without authorization to other persons 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 person's designee must have a verbal discussion with the person to determine whether the person objects to the disclosure. If the person objects, the information cannot be disclosed. If the person does not object, or the person lacks capacity to object, the treating professional must perform an evaluation to determine whether disclosure is in that person's best interests. A decision to disclose or withhold information is subject to review pursuant to A.R.S. § 36-517.01.

An agency or non-agency treating professional may only release information relating to the person'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 persons including family members. A covered entity may disclose to a family member or other relative the protected health information directly relevant to the person’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 person’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 person 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 person 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 can be disclosed to a parent, guardian or other person 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 person 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 person 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 persons 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 persons: If under applicable law, an executor, administrator or other person has authority to act on behalf of a deceased individual or of the individual’s estate, a covered entity must treat such persons 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 persons with authority to act on behalf of a deceased person.

**Disclosure for Court Ordered Evaluation or Treatment**

An agency in which a person is receiving court ordered evaluation or treatment is required to immediately notify the person’s guardian or agent or, if none, a member of the person’s family that the person 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 person’s designee interviews the person undergoing treatment or evaluation to determine whether the person objects to the disclosure and whether the disclosure is in the person’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.

**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 Persons Doing Research**
A covered entity may disclose protected health information to persons 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 person, 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 person or the public and is to a person or persons 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).

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 ADHS/DBHS 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)). For additional information see ADHS/DBHS Policy, Section 7, Chapter 1800, Policy 1806.

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 person (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 person or the public (45 C.F.R. § 164.512(j)).

Disclosure to Sexually Violent Persons (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 person who may be a psychologist or psychiatrist, is approved by the Superior Court and is familiar with the state's sexually violent persons' 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 person involved in the sexually violent persons program and must be given reasonable access to the
person in 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 persons 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 persons program, the covered entity may have the authority to disclose if the protected health information is for treatment, payment or healthcare 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 person 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;
- ADHS 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;
- Persons 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;
  - Reports to the Department; and
  - Applicability to insurance entities.

- An authorization for the release of communicable disease related the protected
person must sign information or, if the protected person lacks capacity to consent, the person’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 person 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.

**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 person is mentally or physically unable to consent to a release of confidential information, and the person 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 person has been abused or neglected.
Disclosure to Third Party Payors
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 Maricopa 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 Maricopa and subcontracted providers must notify persons seeking and/or receiving alcohol or drug abuse services of the existence of the federal confidentiality law and regulations and provide each person 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 person responsible for clinical oversight of the person.

Mercy Maricopa and subcontracted providers may require enrolled persons to carry identification cards while the person is on the premises of an agency. A subcontracted provider may not require enrolled persons to carry cards or any other form of identification when off the subcontractor’s premises that will identify the person as a recipient of drug or alcohol services.

Mercy Maricopa and subcontracted providers may not acknowledge that a currently or previously enrolled person is receiving or has received alcohol or drug abuse services without the enrolled person’s authorization.

Mercy Maricopa and subcontracted providers must respond to any request for a disclosure of the records of a currently or previously enrolled person 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 person 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 Maricopa or subcontracted provider must advise the person 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 for 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 person 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 person 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 person or guardian; and
- The date on which the authorization is signed.

RE-DISCLOSURE

Any disclosure, whether written or oral made with the person'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 person 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 person is a minor, authorization must be given by both the minor and his or her parent or legal guardian.

If the person 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 person’s spouse; or
- If there is no spouse, by any responsible member of the person’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 person, and which requires immediate medical intervention. The disclosure must be documented in the person’s medical record and must include the name of the medical person to whom disclosure is made and his or her affiliation with any healthcare facility, name of the person 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 person.

- **Internal Agency Communications**: The staff of an agency providing alcohol and drug abuse services may disclose information regarding an enrolled person 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 person. 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 person that does not include any information about the enrolled person’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 person’s receipt of medication for a psychiatric condition, unrelated to the person’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 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 Person on an Agency’s Premises or Against Program Personnel**: Agencies may disclose information to a law enforcement agency when a person 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 person’s name, address, last known whereabouts and status as a person 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 Maricopa and their subcontracted providers, in the event of an impermissible use/disclosure of unsecured PHI, must provide notification to any and all persons 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.

16.1 – 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:

- Persons determined to be eligible for AHCCCS.
- Persons not eligible for AHCCCS but determined to have a Serious Mental Illness (SMI) AND can provide documentation of citizenship/lawful presence see Requirement to Verify Citizenship For Non-AHCCCS Eligible Individuals (Department of Economic Security).

ELIGIBILITY FOR BEHAVIORAL HEALTH SERVICES WITHOUT VERIFICATION
Persons 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 in accordance with Chapter 2.9 – Special Populations. However, persons receiving services funded by SABG or PATH must still be screened for AHCCCS eligibility in accordance with Chapter 2.0 – Eligibility Screening for AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage and Limited Subsidy Program.

Persons 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 person is currently enrolled with AHCCCS and has been assigned to Mercy Maricopa, 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 persons who are exempt from citizenship verification, see Persons Who Are Exempt from Verification of Citizenship during the Prescreening and Application Process.
Providers must complete an eligibility determination screening for all persons who are not identified as being currently enrolled with AHCCCS using the subscriber version of the Health-e-Arizona PLUS online application. 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 person’s financial status.

**Completing Eligibility Screening using Health-e-Arizona PLUS**

The behavioral health provider meets with the person and completes the Health-e-Arizona PLUS online application. Once the online application screening has been completed, the Health-e-Arizona PLUS online application tool will indicate:

- If the person is potentially AHCCCS eligible the behavioral health provider must obtain, from the applicant:
  - Documentation of identification and U.S. Citizenship needed if the person 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).
  - 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 person may not be eligible for AHCCCS, the person may:

- Choose to continue with the AHCCCS eligibility application, in which case the provider must assist the person 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 person is eligible for behavioral health services as described in Chapter 2.9 – Special Populations. The provider must continue to work with the person 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).

Persons 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 person 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 person may be provided services in accordance with **Chapter 2.9 – Special Populations**.

**DOCUMENT REQUIREMENTS**

Documentation of screening a person 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 person has refused to participate in the screening process, the documented refusal to participate in the screening and/or application process must be maintained in accordance with **Chapter 2.0 – Eligibility Screening for AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage and Limited Subsidy Program**.

**16.2 – Reporting Discovered Violations of Immigration Status**

**IDENTIFICATION OF VIOLATIONS**

Mercy Maricopa employees and providers must refrain from conduct or actions that could be considered discriminatory behavior. It is unlawful and discriminatory to deny a person healthcare services, exclude persons from participation in those services, or otherwise discriminate against any person based on grounds of race, color or national origin.

Mercy Maricopa employees and providers must not use any information obtained about a person’s citizenship or lawful presence for any purpose other than to provide a person with healthcare contracted services.

Factors that must **NOT** be considered when identifying a potential violation:
- The person’s primary language is a language other than English;
- The person was not born in the United States;
- The person does not have a Social Security number;
- The person has a “foreign sounding” name;
- The person cannot provide documentation of citizenship or lawful presence;
- The person is identified by others as a non-citizen; and
• The person has been denied AHCCCS eligibility for lack of proof of citizenship or lawful presence.

If a person applying for healthcare services, in the course of completing the application process or while conducting business with Mercy Maricopa 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 Maricopa employee or healthcare provider consider it to be a reportable violation.

Mercy Maricopa employees and providers must not require documentation of citizenship or lawful presence from persons 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).

It is not the responsibility of Mercy Maricopa 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 (see Chapter 16.2 – Verification of U.S. Citizenship or Lawful Presence for Public Behavioral Health Benefits).

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 (see Chapter 16.2 – Verification of U.S. Citizenship or Lawful Presence for Public Behavioral Health Benefits).

Mercy Maricopa employees and healthcare providers must follow the expectations outlined in this policy when identifying and reporting violations. Questions regarding reporting requirements may be submitted via email to the ADHS/DBHS Corporate Compliance Officer at reportfraud@azdhs.gov.

REPORTING PROCESS
The Mercy Maricopa employee or provider who identifies a violation must submit a report to ADHS/DBHS via secure email to ADHS/DBHS Corporate Compliance at reportfraud@azdhs.gov. The report must contain the following information:

• First and last name of identified individual;
• Residential address/street Address of identified individual, including city, state, and zip code; and
• Reason for referral.

DOCUMENTATION EXPECTATIONS
The Mercy Maricopa employee/provider must document in the person’s medical record (if the provider) or in the Corporate Compliance Office (if Mercy Maricopa) 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 ADHS/DBHS;
• Any actions taken as a result of the report; and
A copy of the email to ADHS/DBHS that contains the report.

16.3 – Duty to Report Abuse, Neglect or Exploitation

DUTY TO REPORT ABUSE, NEGLECT AND EXPLOITATION OF INCAPACITATED/VULNERABLE ADULTS

Mercy Maricopa 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 person 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 persons 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 person 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 person 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 (see [Chapter 16.0 – Confidentiality](#)). 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.
DUTY TO REPORT ABUSE, PHYSICAL INJURY, NEGLECT AND DENIAL/DEPRIVATION OF MEDICAL OR SURGICAL CARE OR NOURISHMENT OF MINORS

Any Mercy Maricopa 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.

In the event that a report concerns a person 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 person 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 person(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 person 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 person 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 person 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 (see Chapter 16.0 – Confidentiality). 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.
- 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.

16.4 – Duty to Warn

DUTY TO PROTECT POTENTIAL VICTIMS OF PHYSICAL HARM
All Mercy Maricopa healthcare providers have a duty to protect others against the violent conduct of a patient. When a Mercy Maricopa 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 Maricopa 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 Maricopa 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, and in accordance with Chapter 2.8 – Pre-Petition Screening, Court-Ordered Evaluation, and Court-Ordered Treatment; or
- Taking any other precautions that a reasonable and prudent mental health provider would take under the circumstances.
CHAPTER 17 – CORPORATE COMPLIANCE

17.0 – Corporate Compliance (formerly Fraud and Program Abuse Reporting)

Mercy Maricopa is responsible for ensuring that mechanisms are in place for the prevention, detection and reporting of fraud and/or program abuse. All employees of providers must be familiar with the types of fraud and/or program abuse that could occur during their normal daily activities. Mercy Maricopa is responsible for adhering to the policies, procedures, and initiatives found in the ADHS/DBHS BCC Operations and Procedures Manual.

ADHS/DBHS’ Bureau of Corporate Compliance (BCC) Program and Mercy Maricopa incorporates the required elements listed in 42 CFR §438.608 including: a Corporate Compliance Plan; Corporate Compliance Officer; a Corporate Compliance Committee; effective training and education, communication, monitoring/auditing; and effective written policies and procedures. Any person(s) found to be guilty for knowingly obtaining any benefit by means of false or fraudulent pretenses, representations, promises or material omissions could be charged with a Class 2 Felony.

REPORTING FRAUD AND PROGRAM ABUSE INVOLVING TITLE XIX/XXI FUNDS

Within ten (10) business days of discovery of a suspected incident of fraud and/or program abuse involving any Title XIX/XXI funds, including a suspected incident committed by Mercy Maricopa and/or the provider will notify the AHCCCS Office of the Inspector General (OIG). Listed below are the methods for reporting:

Online form:  http://www.azahcccs.gov/fraud/reporting/reporting.aspx
Email:  AHCCCSFraud@azahcccs.gov
Phone: 602-417-4193 or 602-417-4045
Fax:  602-417-4102

A copy of the referral, along with any and all supporting documentation, shall also be provided to ADHS/DBHS Bureau of Corporate Compliance using one of the above methods.

REPORTING FRAUD AND PROGRAM ABUSE INVOLVING NON-TITLE XIX/XXI OR GRANT FUNDS

Mercy Maricopa is required to report all other instances of suspected fraud, waste and program abuse involving all funding sources other than Title XIX/XXI to ADHS/DBHS/BCC directly within ten (10) business days of discovery.

Reports to ADHS/DBHS/BCC shall be completed in written format using the approved designated ADHS/DBHS/BCC reporting form: Suspected Fraud and Program Abuse Report (English/Spanish).
When reporting fraud, waste or program abuse of Non-Title XIX/XXI funds or grant funds, the report shall be submitted in a format which identifies and separates the amount(s) by each appropriate fiscal year.

The reporting format should also identify the different funding streams for each dollar amount and whether it was a claim or an encounter. The form may be submitted directly via any of the following methods:

**Mail:** Arizona Department of Health Services
Division of Behavioral Health Services
Bureau of Corporate Compliance
15 North 18th Avenue, Suite 250
Phoenix, AZ 85007

**Email:** ReportFraud@azdhs.gov

**Phone:** (602) 364-3758 or 1-866-569-4927

**Fax:** (602) 364-3940

**AHCCCS-OIG COMMUNICATIONS**
Mercy Maricopa shall report to ADHS/DBHS BCC, within ten (10) days of notification, any and all contact made by AHCCCS-OIG in reference to any open/closed fraud, waste and program abuse case, a voluntary self-disclosure settlement and/or any other type of fraud, waste and program abuse activity involving official communications by AHCCCS-OIG.

ADHS/DBHS BCC shall be advised of the final disposition of any case and/or settlement agreement made between the contractor and/or provider and AHCCCS-OIG.

**REPORTING FRAUD AND PROGRAM ABUSE TO MERCY MARICOPA**
In addition to notifying ADHS or AHCCCS, providers must immediately notify Mercy Maricopa of all suspected incidents of fraud or program abuse through one of the following methods:

**Mail:** Mercy Maricopa Integrated Care
Attn: Corporate Compliance Officer
4350 E Cotton Center Blvd., Bldg. D
Phoenix, Arizona 85030

**Email:** MercyMaricopaCompliance_fraud-abuse@Aetna.com

**Phone:** 602-586-1880 or 866-602-1979

**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 similar to the FCA but with state-specific requirements, including administrative remedies and related 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 Mercy Maricopa’s Compliance Office.
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 Assessment
CHAPTER 18 – DEMOGRAPHIC AND OTHER MEMBER DATA

18.0 - 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 Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) behavioral health service delivery system. It is necessary for behavioral health providers to submit specific data on each person 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 ADHS/DBHS to:

- Monitor and report on outcomes of individuals in active care (e.g., changes in diagnosis or Global Assessment of Functioning (GAF), 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 TRANSACTIONS REQUIREMENTS

General Requirements

- Arizona Health Care Cost Containment System (AHCCCS) enrolled individuals are considered enrolled with the Mercy Maricopa at the onset of their eligibility. They are provided an AHCCCS identification card listing their assigned T/RBHA. This assignment is sent daily from ADHS/DBHS to Mercy Maricopa.
- For a Non-Title XIX/XXI eligible person to be enrolled, providers must submit an 834 enrollment transaction to Mercy Maricopa. All AHCCCS enrolled individuals with a mental health benefit are considered enrolled with Mercy Maricopa at the time of their AHCCCS eligibility.
- For a Non-Title XIX/XXI eligible person who receives a covered behavioral health service, he/she must be enrolled effective the date of first contact by a behavioral health provider.
- All persons who are served through the ADHS/DBHS behavioral health system must have an active episode of care, even if the person 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.
**Collection of Enrollment Information**

For Non-Title XIX/XXI eligible individuals, information necessary to complete an 834 transaction is usually collected during the intake and assessment process (see **Chapter 2.4 – Assessment and Service Planning**). **834 Transaction Data Requirements** contains a list of the data elements necessary to create an 834 enrollment transaction.

For AHCCCS enrolled individuals, the 834 information will be provided to Mercy Maricopa by ADHS/DBHS daily for the providers to access.

ADHS/DBHS has developed a flow chart that includes the timeframes for all data submissions (see **Timeframes for Data Collection and Submission**).

**Data Included in an 834 Transmittal**

The data fields that are included in the 834 transmittals are dictated by HIPAA and consist of:

- Key client identifiers used for file matching (e.g., person’s name, address, date of birth);
- Basic demographic information (e.g., gender, marital status); and
- Information on third party insurance coverage.

For a specific list of data elements necessary to create an 834 enrollment and disenrollment, for Non-Title XIX/XXI eligible individuals, see **834 Transaction Data Requirements**.

Providers must actively secure any needed information to complete the enrollment (834 transactions) for a Non-Title XIX/XXI eligible individual. An 834 transaction will not be accepted by Mercy Maricopa if required data elements are missing. For Title XIX/XXI eligible individuals, the 834 information will be provided to Mercy Maricopa by ADHS/DBHS.

**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 834-enrollment transaction must be submitted to Mercy Maricopa within 14 days of the first contact with a behavioral health recipient;

The 834 disenrollment transaction must be submitted to Mercy Maricopa within 14 days of the person being disenrolled from the system; and any changes to the enrollment/disenrollment transaction data fields (e.g., change in address, insurance coverage) must be submitted 14 days from the date of identifying the need for the change.

**Required Events for Submittal of an 834 Transaction for Non-Title XIX/XXI Eligible Individual**

In addition to submitting an 834 transaction at enrollment and disenrollment, an 834 transaction must also be submitted when any of the following elements of the 834 transaction 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 ADHS/DBHS of changes to the above
information. That information will be provided from ADHS/DBHS to Mercy Maricopa on a
daily file.

When a person 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 Chapter
11.0 – Inter-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 an 834 disenrollment transaction effective on the
date of transfer and end the episode of care, and
• The receiving T/RBHA must submit an 834 enrollment transaction on the date of
accepting the person for services and start an episode of care.
• AHCCCS will notify ADHS/DBHS when a Mercy Maricopa enrolled person is
determined eligible for the Arizona Long Term Care System (ALTCS) Elderly and
Physically Disabled (EPD) Program. This information will be passed to Mercy
Maricopa 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 Maricopa 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 Non-
Title XIX/XXI eligible individuals, an 834 must be completed. 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 ADHS/DBHS within 55 days. Additional clinical data may
be collected at subsequent assessment and service planning meetings with the person (e.g.,
education, vocation) as well as during periodic and annual updates. Demographic and clinical
data recorded in the person’s behavioral health medical record must match the demographic
file on record with ADHS/DBHS.

Specific Data Elements
The ADHS/DBHS Demographic Data Set User Guide describes the data elements that
comprise the demographic data set and the timeframe requirements for submitting the
demographic data set. Mercy Maricopa must ensure that providers collect required
demographic data set elements in accordance with the ADHS/DBHS Demographic Data Set User Guide. Demographics can be submitted to Mercy Maricopa on the mercymaricopa.org secured web portal or through batch transactions.

**Timeframes for Submitting Demographic and Clinical Data**
The following timeframes apply to demographic and clinical data submissions (see the ADHS/DBHS Demographic Data Set User Guide):

- All required demographic data submitted to Mercy Maricopa within 45 days of the initial intake for all enrolled persons.
- Outcome measures, for children birth through age 17, submitted to Mercy Maricopa within 7 days of the 6 month anniversary date of the last demographic submission (see Chapter 2.4 – Assessment and Service Planning). For outcome measures submission dates that do not coincide with the annual update, the reason for submission will be indicated as a “change” (see specific instructions in the ADHS/DBHS Demographic Data Set User Guide).
- All required demographic data submitted to Mercy Maricopa within 7 days of the annual update (see Chapter 2.4 – Assessment and Service Planning).
- All required demographic data submitted to Mercy Maricopa within 7 days of a recorded change in the person’s demographic data record. Providers must ensure that the person’s medical record matches the demographic data set on file with ADHS/DBHS.
- All required data elements submitted to Mercy Maricopa within 7 days of the end of the episode of care. The required data elements include the reason for the person’s disenrollment. See the ADHS/DBHS Demographic Data Set User Guide to determine the specific data elements that must accompany a demographic disenrollment transaction.

**Determining a Recipient's Behavioral Health Category Assignment**
Behavioral health providers must designate a person’s behavioral health category assignment during the assessment process as well as at any other times that necessitate changes to the person’s assignment (e.g., transition to adulthood). Behavioral health categories include:

- Child,
- Seriously Emotionally Disturbed (SED) Child (see SMI and SED Qualifying Diagnoses Table),
- Adult with Serious Mental Illness (SMI),
- Adult, non-SMI with general mental health need, and
- Adult, non-SMI with substance abuse (see Substance Abuse Disorders Qualifying Diagnoses Table).

Behavioral health providers must initially assign and update, as necessary, behavioral health category assignments as follows (see the ADHS/DBHS Demographic Data Set User Guide for more detailed instructions on assignment of behavioral health categories):

- For a child who is non-SED, enter “C”;
- For a child who is SED, enter “Z”;

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- For a person determined to have a Serious Mental Illness in accordance with [Chapter 2.5 – SMI Eligibility Determination](#), enter “S”, then enter “a” or “b”;
- For an adult non-SMI person with a general mental health need (who does not have a substance abuse problem) enter “M”; and
- For an adult non-SMI person with a reported substance abuse problem enter “G”.

**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 persons who receive behavioral health services. Providers may consider:

- Utilizing and integrating collected demographic data into the person’s assessments,
- Monitoring the nature of the provider’s behavioral health recipient population, and
- Evaluating the effectiveness of the provider’s services towards improving the clinical outcomes of persons enrolled in the ADHS/DBHS 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 receiving T/RBHA. If a provider requires assistance for technical related problems or issues, please contact Customer Service at 800-564-5465.
CHAPTER 19 – REPORTING REQUIREMENTS

19.0 – Medical Institution Reporting of Medicare Part D

Medicare eligible members, including persons 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 persons. However, Medicare Part D co-payments are waived when a dual eligible person enters a Medicaid funded medical institution for at least a full calendar month. Medical institutions must notify the Arizona Health Care Cost Containment System (AHCCCS) when a dual eligible person 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 person continues to reside in a medical institution. Given the limited resources of many dual eligible persons 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 persons’ Medicare Part D co-payments are waived when it is expected that dual eligible persons 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 person has been discharged from the medical institution to submit the form. Reporting must be done on behalf of the following:

- Persons who have Medicare Part “B” only;
- Persons who have used their Medicare Part “A” lifetime inpatient benefit; and
- Persons 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)

19.1 – Reporting of Seclusion, Restraint and Emergency Safety Response (Updated as of 02/28/16)

REPORTING TO MERCY MARICOPA

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 Maricopa’s Quality Management Department within five (5) days of the occurrence. The individual reports must be submitted on the Seclusion and Restraint Reporting or submitting the necessary required fields as specified in Attachment Seclusion, Restraint and Emergency Safety Response Reporting Requirements.

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 Maricopa along with the Seclusion and Restraint Reporting (see Face-to-Face Monitoring Requirements).

Each subcontracted ADHS licensed Behavioral Health Inpatient Facility reports the total number of occurrences of the use of seclusion, restraint, and emergency safety response that occurred in the prior month to the Mercy Maricopa by the 5th calendar day of the month. If there were no occurrences of seclusion, restraint, and/or emergency safety response during the reporting period, the report should so indicate.

REPORTING TO OFFICE OF HUMAN RIGHTS
Mercy Maricopa will submit individual reports concerning the use of seclusion and restraint with member’s designated as individuals determined to have a Serious Mental Illness and children to the ADHS/DBHS Office of Human Rights (OHR) on a weekly or monthly basis, as arranged with the OHR. Mercy Maricopa should redact any information on substance abuse or HIV/AIDS/communicable disease from the reports. Individual reports must be submitted, via a secure and encrypted e-mail system or portal, to the following address: OHRts@azdhs.gov.

Submit monthly reports of seclusion and restraint information involving member’s designated as SMI to the OHR using the Seclusion and Restraint Monthly Report for DBHS/OHR. Reports are to be forwarded by the 15th day of each month.

Submit summary seclusion and restraint reports to the ADHS/DBHS Bureau of Quality and Integration (BQ&I) as required by ADHS/RBHA contracts and ADHS/TRBHA Intergovernmental Agreements (IGAs).

DISTRIBUTION OF REPORTS
The RBHA and the AzSH shall distribute individual and summary reports of the use of seclusion, restraint, or emergency safety response as follows:

- Forward individual reports of the use of seclusion, restraint, or emergency safety response for all enrolled persons to the appropriate Human Rights Committee (HRC) for the region on a weekly or monthly basis, as arranged with the individual HRC. The Arizona State Hospital or RBHA must ensure that the disclosure of protected health information is in accordance with Chapter 16.0 – Confidentiality.
- Submit monthly summary reports of seclusion, restraint, and emergency safety response information for all enrolled persons to the appropriate Human Rights Committee for the region using the Seclusion and Restraint Monthly Report for the Human Rights Committees included in the ADHS/DBHS Performance Improvement Specifications Manual. The reports must be submitted by the 15th day of each month.
Monthly summary reports must be redacted.

Non-licensed facilities shall distribute individual and summary reports of the use of seclusion or restraint as follows:

- Submit monthly summary seclusion, restraint, and emergency safety response reports to the ADHS/DBHS BQ&I. Each organization shall report the total number of occurrences of the use of seclusion, restraint, and emergency safety response that occurred in the prior month to ADHS/DBHS BQ&I by the 10th calendar day of the month. If there were no occurrences of seclusion, restraint, and/or emergency safety response during the reporting period, the report should so indicate. Individual reports must be submitted, via a secure and encrypted e-mail delivery system or portal, to the following address: BHSQMO@azdhs.gov.

19.2 – Reporting of Incidents, Accidents and Deaths

REPORTING OF INCIDENTS, ACCIDENTS AND DEATHS TO MERCY MARICOPA

Healthcare providers must report any incident, accident or death as defined by this chapter, of a healthcare recipient to Mercy Maricopa within 48 hours.

Mercy Maricopa must ensure the timely and accurate reporting of incidents, accidents, and deaths involving behavioral health members to the ADHS/DBHS Bureau of Quality and Integration (BQ&I) Office of Quality of Care (QOC). Mercy Maricopa must submit to ADHS/DBHS/BQ&I all Incident Accident and Death reports that pertain to the following for all behavioral health members with an open Episode of Care (EOC):

- Deaths;
- Medication error(s);
- Abuse or neglect allegation made about staff member(s);
- Suicide attempt;
- Self-inflicted injury;
- Injury requiring emergency treatment;
- Physical injury that occurs as the result of personal, chemical or mechanical restraint;
- Unauthorized absence from a licensed behavioral health facility, group home or HCTC of children or recipients under court order for treatment;
- Suspected or alleged criminal activity;
- Discovery that a client, staff member, or employee has a communicable disease as listed in R9-6-202 (A) or (B);
- Incidents or allegations of violations of the rights as described in A.A.C. R9-20-203 or 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 or seclusion as retaliation; and/or
- Health Care-Acquired and Provider Preventable Conditions as described in the AHCCCS AMPM Chapter 900

Mercy Maricopa will submit Incidents, Accidents and Death (IAD) reports regarding “sentinel events” to ADHS/DBHS Bureau of Quality and Integration (BQ&I) Office of Quality of Care (QOC) weekly. A sentinel event is defined as any of the following:
- Suicide or significant suicide attempt by a member;
- Homicide committed by a member;
- Unauthorized absence of a member from a locked behavioral health inpatient facility;
- Sexual assault while a member is a resident of a locked behavioral health inpatient facility;
- Death of a member.

**Incident, Accident, Death Report** must be used for reporting incidents, accidents and deaths of enrolled healthcare members. (See BQ&I Specifications Manual for additional information). The email address to send to Mercy Maricopa is on the form.

Upon receipt of an IAD Report from providers, Mercy Maricopa must:
- Take action necessary to ensure the safety of the persons involved in the incident.
- Ensure that the information required on the IAD form is fully and accurately completed as required. If the IAD form is returned to the subcontracted provider for additions or corrections, the subcontracted provider must return the corrected version of the report to Mercy Maricopa within 24 hours of receipt.

**19.3 – Encounter Validation Studies**

**CRITERIA USED IN ENCOUNTER VALIDATION STUDIES**
The criteria include timeliness, correctness, and omission of encounters, in addition to encountering for services not 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 person. Correctness errors frequently identified include, but are not limited to, invalid procedure or revenue codes and ICD-10 diagnoses not reported to the correct level of specificity; and
- **Omission** - Provider documentation shows a service was provided, however, an encounter was not submitted.
- **Lack of Documentation** - A description of adequate documentation is referenced in Chapter 10.1 – Medical Record Standards.

In addition, assessment compliance will be monitored by Mercy Maricopa in accordance with
Chapter 2.4 – Assessment and Service Planning.

Mercy Maricopa conducts data validation studies with all contracted providers/ACO. The data validation 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 Maricopa will establish a review schedule with ACOs and providers and provide advance notice of the data validation review. Reviews may be conducted on site or applicable documentation may be requested for submission to Mercy Maricopa. Mercy Maricopa will attempt to utilize documentation that has previously been submitted (e.g., claims/encounter data) before requesting that providers submit additional information to support the review. The purpose of the data validation review is to confirm that covered services are encountered correctly and completely and on a timely basis. ACOs and 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 ADHS/DBHS Covered Behavioral Health Services Guide. Healthcare providers must document adequate information in the clinical record and submit encounters in accordance with Chapter 7.0 – Submitting Claims and Encounters to Mercy Maricopa to Mercy Maricopa. Any data validation findings that indicate suspected fraud and/or program abuse must be reported to the DBHS Bureau of Corporate Compliance and the AHCCCS Office of Inspector General as required. A determination of overpayment as the result of a data validation study will result in a recovery of the related funds/voiding of related encounters as required, pursuant to the Affordable Care Act.

ENCOUNTER VALIDATION STUDY FINDINGS
Mercy Maricopa will report the data validation findings to the provider.

AHCCCS ENCOUNTER DATA VALIDATION
AHCCCS performs periodic data validation studies. All AHCCCS contractors and subcontractors are contractually required to participate in this process. In addition, the data validation studies enable AHCCCS to monitor and improve the quality of encounter data. Information regarding AHCCCS Encounter Data Validation Study procedures can be found in the Office of Program Support Operations and Procedures Manual.
CHAPTER 20 – GRIEVANCE SYSTEMS AND MEMBER RIGHTS

20.0 – 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, with the exception of 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
Entities responsible for sending notice to Title XIX/XXI eligible persons must ensure that:

- Notice and written documents related to the appeals process must be available in each prevalent, non-English language spoken within Mercy Maricopa’s Geographic Service Area;
- As applicable, providers 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 person; 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 personally delivered or mailed by certified mail to the required party at their last known residence or place of business. In the event that it may be unsafe to contact the person at his or her home address, or the person 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.

Prohibition of Punitive Action
Providers must not take punitive action against a Title XIX/XXI eligible person who decides to exercise their right to appeal. Mercy Maricopa does not take punitive action against a provider who requests an expedited resolution to an appeal or who supports a Title XIX/XXI eligible person’s appeal.

NOTICE OF ACTION
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 person’s request to obtain services outside the network.

Responsibility for Sending the Notice
Following an action requiring notice to a Title XIX/XXI eligible person at the provider level, the subcontracted provider must ensure the communication of a notice to the person. For prior authorized services, Mercy Maricopa ensures the communication of a notice to the person.

ADHS/DBHS sends notices to Title XIX/XXI eligible persons enrolled with a Tribal RBHA (TRBHA) following:

- The denial or limited authorization of a requested service, including the type or level of service (see Chapter 13.0 – Securing Services and Prior Authorization); and
- The reduction, suspension or termination of a previously authorized service

ADHS/DBHS sends notices to Title XIX/XXI eligible persons who have been adversely affected by a PASRR determination in the context of either a preadmission screening or a resident review.

Communication of Notice to Title XIX/XXI Eligible Persons
The use of Notice of Action is required when providing notice regarding an action concerning a Title XIX/XXI person. (Please see the AHCCCS Contractors Operations Manual (ACOM) 414 for guidance in preparation of this form). Notice of Action 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 the Arizona Health Care Cost Containment System (AHCCCS) (See AHCCCS Contractors Operations
Manual (ACOM) 414, Attachment C).

**Delivery of Notices**
The Notice of Action must be delivered to the Title XIX/XXI eligible person and, when applicable, their legal representative or designated representative (e.g., Department of Economic Security/Division of Children, Youth and Families/Child Protective Services Specialist and/or advocate for SMI persons requiring special assistance). For Title XIX/XXI eligible persons under the age of 18, the Notice of Action must be delivered to their legal or custodial parent or a government agency with legal custody of the Title XIX/XXI eligible person.

All notices must be personally delivered or mailed by certified mail to all parties at their last known residence or place of business. In the event that it may be unsafe to contact a person at his or her home address, or the person does not want to receive mail at home, alternate methods identified by the person for communicating notice must be used.

**NOTICE OF ACTION TIMEFRAMES**

**Notice of Action for Service Authorization Requests**
For service authorization requests, the following timeframes for sending notice of action are in effect (See Chapter 13.0 – 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 person, the responsible entity must send a notice of action within 14 days following the receipt of the person’s request;
- For an authorization request in which the provider indicates, or the responsible entity determines, that the 14 calendar day timeframe could seriously jeopardize the person’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 Action as expeditiously as the person’s health condition requires, but no later than three working days after receipt of the request for service;
- If the Title XIX/XXI eligible person requests an extension of either timeframe above, the responsible entity must extend the timeframe up to an additional 14 days;
- If the responsible entity needs additional information and the extension is in the best interest of the person, the responsible entity shall extend the 14-calendar day or the three working day timeframe up to an additional 14 days. If the responsible entity extends the timeframe, the responsible entity must:
  - Give the Title XIX/XXI eligible person 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 (English/Spanish), and inform the person of the right to file a complaint if the person disagrees with the decision; and
  - Issue and carry out the determination as expeditiously as the person’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.

- ADHS/DBHS, Mercy Maricopa, or subcontracted providers shall provide the requesting provider written notification of a decision to deny a service authorization.

**Notice of Action for Service Termination, Suspension or Reduction**

For service terminations, suspensions or reductions, the following timeframes are in effect:

- The responsible entity must send the Notice of Action at least 10 days before the date of the action with the following exceptions. The responsible entity may send the Notice of Action no later than the date of the action if:
  - The responsible entity has factual information confirming the death of a Title XIX/XXI person;
  - The responsible entity receives a clear written statement signed by the Title XIX/XXI person or their legal representative that the person no longer wants services or gives information to the responsible entity that requires termination or reduction of services and indicates that the person understands that this will be the result of supplying that information;
  - The Title XIX/XXI person is an inmate of a public institution that does not receive federal financial participation and the person becomes ineligible for Title XIX/XXI;
  - The Title XIX/XXI person’s whereabouts are unknown and the post office returns mail to the responsible entity indicating no forwarding address;
  - The Title XIX/XXI eligible person’s whereabouts are unknown and the post office returns mail, directed to the Title XIX/XXI eligible person, to ADHS/DBHS, the T/RBHA or T/RBHA provider, indicating no forwarding address;
  - The responsible entity establishes the fact that the Title XIX/XXI person has been accepted for Medicaid by another state. The responsible entity may shorten the period of advance notice to five days before the date of action if the responsible entity has verified facts indicating probable fraud; or
  - ADHS/DBHS, the T/RBHA or T/RBHA provider 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 person.

**Notice of Action for Denial of Claim for Payment**

ADHS/DBHS, the T/RBHA or T/RBHA provider designated to authorize services shall send a Notice of Action to the Title XIX/XXI eligible person 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 person 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 Title XIX/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
- The denial of a TXIX/XXI enrollee’s request to obtain services outside the T/RBHA’s provider network.

A Title XIX/XXI eligible person 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 Maricopa is responsible for processing appeals and does not delegate this function to a provider. ADHS/DBHS processes appeals related to actions initiated by a Tribal RBHA or one of their subcontracted providers. Any responsibilities attributed to a RBHA are the responsibility of ADHS/DBHS 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 person’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 persons or authorized representative(s) may file an appeal or request a State Fair Hearing regarding an action:
- A Title XIX/XXI eligible person;
- A legal or authorized representative, (e.g., Department of Economic Security/Division of Children, Youth and Families/Child Protective Services Specialist and/or advocate for SMI persons requiring special assistance), including a provider, acting on behalf of the person, with the person’s or legal representative’s written consent. A Title XIX/XXI eligible person 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 Maricopa refuses to accept a late appeal or determines that the decision being appealed does not constitute an action subject to these appeal requirements, Mercy Maricopa must inform the appellant in writing by sending a Notice of Appeal Resolution.

**Timeframe for Filing Standard Appeal**
A Title XIX/XXI eligible person has up to 60 days after the date of the Notice of Action to file a
standard appeal. The appeal may be filed orally or in writing.

**Timeframes for Mercy Maricopa to Resolve a Standard Appeal**
Mercy Maricopa resolves standard appeals and mail a 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 person requests an extension of the 30-day timeframe, Mercy Maricopa will extend the timeframe up to an additional 14 days. If Mercy Maricopa needs additional information and the extension is in the best interest of the person, Mercy Maricopa may extend the 30-day timeframe up to an additional 14 days.

**Expedited Appeal**
Mercy Maricopa conducts an expedited appeal if:

- Mercy Maricopa receives a request for an appeal from a Title XIX/XXI eligible person and determines that taking the time for a standard appeal resolution could seriously jeopardize the person’s life or health, or ability to attain, maintain, or regain maximum function;
- Mercy Maricopa receives a request for an expedited appeal from a Title XIX/XXI eligible person supported with documentation from the provider that taking the time for a standard resolution could seriously jeopardize the person’s life or health, or ability to attain, maintain or regain maximum function; or
- Mercy Maricopa receives a request for an expedited appeal directly from a provider, with the Title XIX/XXI eligible person’s written consent, and the provider indicates that taking the time for a standard resolution could seriously jeopardize the person’s life or health, or ability to attain, maintain or regain maximum function.

**Denial of Expedited Appeal**
If Mercy Maricopa denies a request for expedited resolution of an appeal from a Title XIX/XXI eligible person, Mercy Maricopa will resolve the appeal within the standard resolution timeframe and make reasonable efforts to give the person prompt oral notice of the denial. Within two calendar days, Mercy Maricopa follows up with written notice of the denial.

**Timeframes for Mercy Maricopa to Resolve an Expedited Appeal**
Mercy Maricopa must resolve expedited appeals and mail a written Notice of Appeal Resolution within three working days after the day Mercy Maricopa receives the appeal, unless an extension is in effect.

**Extension of Expedited Appeal Resolution Timeframe**
If a Title XIX/XXI eligible person requests an extension of the three working day timeframe, Mercy Maricopa will extend the timeframe up to an additional 14 days. If Mercy Maricopa needs additional information and the extension is in the best interest of the person, Mercy Maricopa 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 Maricopa Integrated Care  
Attn: Grievance and Appeals  
4350 E. Cotton Center Blvd, Building D  
Phoenix, AZ 85040  
Fax: 602-431-7443

A member can also file an appeal orally by contacting:  
Mercy Maricopa Integrated Care  
Grievance and Appeals  
Phone: 602-586-1719  
866-386-5794

**Requesting a State Fair Hearing**

A Title XIX/XXI eligible person, legal or authorized representative may request a State Fair Hearing following Mercy Maricopa’s resolution of an appeal. The request must be in writing and submitted to:

Mercy Maricopa Integrated Care  
Attn: Grievance and Appeals  
4350 E Cotton Center Blvd; Building D  
Phoenix, AZ 85040  
Phone: 602-586-1719  
866-386-5794  
Fax: 602-431-7443

The request must be received by Mercy Maricopa no later than 30 days after the date that the person received the Notice of the Appeal Resolution.

**Assistance to Title XIX/XXI Eligible Persons in Filing an Appeal and/or Requesting a State Fair Hearing**

Mercy Maricopa provides reasonable assistance to Title XIX/XXI eligible persons 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 Maricopa 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](https://legiscalmi.gov/legislative/cf/app/Review_public/2015/3815/HB3815.html) 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 person 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 the RBHA, not including the number of days the Title XIX/XXI eligible person took to file for a State Fair Hearing, and days for continuances granted at the Title XIX/XXI eligible person’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 the RBHA concerning an expedited appeal resolution, AHCCCS will send the Title XIX/XXI eligible person 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 person’s services can continue during the appeal and State Fair Hearing process, unless continuation of services would jeopardize the health or safety of the person or another person, if:

- The person 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 person requests continuation of services.

*Timely filing means filing on or before the later of the following:
- Within 10 days after the date that Mercy Maricopa or the subcontracted provider mails or delivers the Notice of Action; or
- The effective date of the action as indicated in the Notice of Action.

If a person 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 Maricopa is required to continue services until one of the following occurs:
- The Title XIX/XXI eligible person withdraws the appeal;
- The Title XIX/XXI eligible person makes no request for continued benefits within 10 days of the delivery of the Notice of Appeal Resolution or
- The AHCCCS Administration or ADHS Director issues a State Fair Hearing decision adverse to the Title XIX/XXI eligible person.

Upheld Appeal
If the AHCCCS Director’s decision upholds Mercy Maricopa’s action, Mercy Maricopa may recover the cost of the services furnished to a Title XIX/XXI eligible person while the appeal is pending if the services were furnished solely because of the requirements above.

**Overturned Appeal**

If Mercy Maricopa 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 Maricopa will process a claim for payment from the provider in a manner consistent with the Mercy Maricopa or Director’s Decision and applicable statutes, rules, policies, and contract terms. (See ARS § 36-2904).

The provider will have 90 days from the date of the reversed decision to submit a clean claim to Mercy Maricopa for payment. For all claims submitted as a result of a reversed decision, Mercy Maricopa is prohibited from denying claims as untimely if they are submitted within the 90-day timeframe.

Mercy Maricopa is also prohibited from denying claims submitted by providers as a result of a reversed decision because the member chooses not to request continuation of services during the 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.

**20.1 – Complaint Resolution**

**GENERAL REQUIREMENTS**

Mercy Maricopa develops and provides training to staff responsible for taking complaints. The training plan is submitted to DBHS and updated annually and 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 Chapter 6.3, 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 Chapter 20.0 – Title XIX/XXI Notice and Appeal Requirements in order to establish the earliest possible filing date for the appeal.
- For persons determined to have SMI who are appealing a decision regarding SMI eligibility, or Non-TXIX/XXI recipients appealing the need for a covered service, see Chapter 20.3, Notice and Appeal Requirements (SMI and Non-Title XIX/XXI).
- For allegations of rights violations concerning persons determined to have SMI see Chapter 20.2 – Conduct of Investigations Concerning Persons 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 Maricopa shall not route or otherwise encourage the direct filing of complaints with Arizona Health Care Cost Containment System (AHCCCS) unless the person 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 MARICOPA REQUIREMENTS FOR HANDLING COMPLAINTS**

Responsibilities for resolving complaints pursuant to requirements of this policy shall not be delegated by Mercy Maricopa to provider agencies.

Regardless of who within the organization receives a complaint or whether it is filed orally or in writing, ADHS/DBHS and Mercy Maricopa shall have a centralized complaint resolution process and designated individuals to whom all complaints shall be referred.

Complaints may be made to the Mercy Maricopa orally or in writing by persons or those seeking covered services, their families or legal guardian(s), authorized representatives, other agencies, or the public.

- For oral complaints: Call Mercy Maricopa at 602-586-1841
- To submit a written complaint: Mail the complaint to:
  
  Mercy Maricopa Integrated Care  
  Attn: Complaints  
  4350 Cotton Center Blvd. Bldg. D  
  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 Maricopa 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 Maricopa must follow requirements outlined in [Chapter 6.5 – Cultural Competence](#), 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 Maricopa shall provide a written translation in accordance with the requirements of [Chapter 6.5 – Cultural Competence](#).
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 Maricopa shall provide oral interpretation of written materials or make alternative communication formats available as indicated.

Mercy Maricopa must follow up on each complaint as expeditiously as the person’s condition requires.

Mercy Maricopa must address the identified issues as expeditiously as the person’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 Maricopa 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 Maricopa 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 recipient’s condition.

If the complainant is dissatisfied with Mercy Maricopa’s resolution of their complaint, Mercy Maricopa will advise the complainant that they may contact the ADHS/DBHS for additional review. ADHS/DBHS will review the complaint and Mercy Maricopa’s efforts to resolve the complaint and intervene as indicated by the review.

In the event Mercy Maricopa receives a complaint referred from ADHS/DBHS, Mercy Maricopa will provide ADHS/DBHS 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 ADHS/DBHS. Mercy Maricopa will acknowledge receipt of ADHS/DBHS referred complaints expeditiously and according to the urgency and response timeframe identified by ADHS/DBHS.

Mercy Maricopa shall ensure that any specific corrective action or other action directed by ADHS/DBHS is implemented.
Mercy Maricopa 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;
  - 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 Maricopa’s quality improvement strategy and network sufficiency review.

**ADHS/DBHS REQUIREMENTS FOR HANDLING COMPLAINTS**

Complaints made to ADHS/DBHS Issue Resolution staff will be referred, as appropriate, to Mercy Maricopa staff designated to respond to complaints according to the protocol established with Mercy Maricopa and consistent with the process described in this chapter.

ADHS/DBHS staff shall enter information regarding complaints into the automated ADHS/DBHS complaint database.

ADHS/DBHS shall routinely review the data collected through the complaint process as part of its quality improvement strategy.
Instances of abuse, neglect, exploitation, and unexpected deaths are reported as described in *Chapter 19.2, Reporting of Incidents, Accidents and Deaths*.  

**20.2 – Conduct of Investigations Concerning Persons with Serious Mental Illness**  
(formerly Grievance and Requests for Investigation for Persons Determined to have a Serious Mental Illness)  

**GENERAL REQUIREMENTS**  
Persons requesting or receiving services shall be notified of their right to file grievances or request investigations according to the requirements set forth in *Chapter 20.3 - Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI)*. ADHS/DBHS, Mercy Maricopa, 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 of time 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 extended until the end of the next day that is not a weekend or a legal holiday. If the period of time 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.  

The ADHS/DBHS, Mercy Maricopa or the AzSH shall use the unique ADHS/DBHS Docket Number auto-generated by the Office of Grievance and Appeals (OGA) database for each appeal filed. The file and all correspondence generated shall reference the ADHS/DBHS 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 Maricopa or 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 Maricopa 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 Maricopa or one of its subcontracted providers or as a result of an action of a person employed by Mercy Maricopa or one of its subcontracted providers shall be addressed to the ADHS/DBHS and investigated by the ADHS/DBHS.  

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 the AzSH, Mercy Maricopa or their subcontracted providers, shall be addressed to the appropriate regulatory division or agency.
The ADHS/DBHS' Deputy Director, or designee, the Mercy Maricopa 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 ADHS/DBHS, the AzSH, or Mercy Maricopa, 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 ADHS/DBHS’ Deputy Director, or designee, Mercy Maricopa Director, or CEO of the 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 Maricopa Integrated Care
Attn: Grievances and Appeals
4350 E. Cotton Center Blvd. Bldg. D
Phoenix, AZ 85040
Fax Number: 602-431-7443
Phone: 602-586-1719 or 866-386-5794

Within five days of receipt of a grievance or request for investigation, the ADHS/DBHS, the AzSH, or Mercy Maricopa, must inform the person filing the grievance or request for investigation, in writing, that the grievance or request has been received.

Any employee or contracted staff of ADHS/DBHS, the AzSH, Mercy Maricopa or its subcontracted provider, shall, upon request, assist a person receiving services, or their legal guardian, in making an oral or written grievance or request for investigation or direct the person to an available supervisory or managerial staff who shall assist the person to file a grievance or request for investigation.

All oral grievances and requests for investigation must be accurately reduced to writing by the ADHS/DBHS, the AzSH, Mercy Maricopa or its subcontracted provider, that receives the grievance or request, on the ADHS/DBHS Appeal or SMI Grievance Form (English/Spanish).

Preliminary Disposition

Summary Disposition – ADHS/DBHS, the AzSH, or Mercy Maricopa 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, the ADHS/DBHS, the AzSH, or Mercy Maricopa 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 similar to 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.

Within seven days of the grievance or request for investigation, the ADHS/DBHS, the AzSH, or Mercy Maricopa’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 ADHS/DBHS Office of Human Rights (OHR) and the State Protection and Advocacy System. Copies of the decision shall be sent to the person filing the grievance or request for investigation and to the ADHS/DBHS OHR for persons who need special assistance.

Conducting Investigation of Grievances
ADHS/DBHS, the AzSH, and Mercy Maricopa 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 Maricopa investigator or any other official responsible for responding to grievances must address their extension request to Mercy Maricopa Director or designee.
- The ADHS/DBHS investigator or any other ADHS/DBHS official responsible for responding to grievances must address their extension request to the ADHS/DBHS Deputy Director or designee; and
- A Mercy Maricopa request for an extension to complete an investigation for grievances remanded pursuant to A.A.C. R9-21-407(B)(2) or any other time period established by ADHS/DBHS decisions relating to a grievance shall be addressed to the ADHS/DBHS Deputy Director or designee.

Grievance Investigations – Allegations of Rights Violations or Physical Abuse
The investigator shall:
- Interview the person who filed the grievance and the person receiving services who is identified as the subject of the violation or abuse (if different) prior to interviewing
the person alleged to be the perpetrator of the rights violation, or physical or sexual abuse.

- If the person who is the subject of the investigation needs special assistance, the investigator shall contact the person’s advocate; or if no advocate is assigned, the person shall contact ADHS/DBHS OHR, and request that an advocate be present to assist the person during the interview and any other part of the investigation process.
- Request assistance from the ADHS/DBHS OHR if the person 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;
  - A summary of any other activities conducted as a part of the investigation;
  - A description of any issues identified during the course of 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, ADHS/DBHS’s Deputy Director, or designee, Mercy Maricopa 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 Maricopa Director, and send copies of the decision, subject to confidentiality requirements provided for in [Chapter 16.0 – Confidentiality](#) to the investigator, AzSH, Mercy Maricopa Director, the person who filed the grievance, the person receiving services identified as the subject of the violation or abuse (if different), the ADHS/DBHS Office of Human Rights for persons deemed in need of Special Assistance. The decision sent to the grievant and the person 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 ADHS/DBHS’s Deputy Director, or designee, Mercy Maricopa Director, or the Chief Executive Officer of the AzSH within 10 days.

**Actions**
ADHS/DBHS’s Deputy Director, or designee, Mercy Maricopa Director, or the CEO of the AzSH may identify actions to be taken, as indicated in (c)(1) 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 the course of 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
- 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 Maricopa or AzSH, may file a request for an administrative appeal within 30 days from the date of their receipt of Mercy Maricopa 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 Mercy Maricopa or AzSH decision.

**Administrative Appeal**
In the event an administrative appeal is filed, Mercy Maricopa or AzSH, shall forward the full investigation case record, which includes all elements in A.A.C. R9-21-409(D)(1), to ADHS/DBHS’s Deputy Director, or designee through the ADHS/DBHS OGA. The failure of Mercy Maricopa or AzSH to forward a full investigation case record that supports Mercy Maricopa or AzSH decision may result in a summary determination in favor of the person filing the administrative appeal. Mercy Maricopa or AzSH shall prepare and send with the investigation case record, a memo in which Mercy Maricopa states:

- Any objections AzSH or Mercy Maricopa has to the timeliness of the administrative appeal,
- AzSH’s, or Mercy Maricopa’s response to any information provided in the administrative appeal that was not addressed in the investigation report, and
- The AzSH or Mercy Maricopa understands of the basis for the administrative appeal.

Within 15 days of the filing of the administrative appeal, ADHS/DBHS’s Deputy Director, or designee, will review the appeal and the investigation case record and may discuss the matter with any of the persons 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 Maricopa 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 Maricopa or AzSH for further investigation and decision, Mercy
Maricopa or AzSH shall conduct further investigation and complete a revised report and decision to ADHS/DBHS’s Deputy Director or designee within 10 days. Upon receipt of the report and decision, ADHS/DBHS shall render a final decision consistent with the procedures described in section g.(1) above; or;

- Reject Mercy Maricopa’s decision and remand the matter with instructions to Mercy Maricopa 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 ADHS/DBHS 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 person who is the subject of the grievance who is dissatisfied with the decision of ADHS/DBHS’s 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 Maricopa or AzSH Director, or the Deputy Director, or designee of the ADHS/DBHS, 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 ADHS/DBHS OHR for persons 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 persons receiving services shall be conducted as described in Chapter 19.2 – Reporting of Incidents, Accidents and Deaths.

**Grievance Investigation Records and Tracking System**

ADHS/DBHS AzSH, and Mercy Maricopa 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.
- ADHS/DBHS, AzSH, and Mercy Maricopa 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 ADHS/DBHS 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 persons interviewed, written documentation of the interviews, summary of all documents reviewed, the investigator’s findings, conclusions and recommendations;
- A copy of the acknowledgment letter, final decision letter and any information/documentation generated by an appeal of the grievance decision.
- ADHS/DBHS, AzSH, and Mercy Maricopa will maintain all grievance and investigation files in a secure designated area and retain for at least 5 years.
- The Public Log – ADHS/DBHS OGA, Mercy Maricopa and AzSH will maintain a public log of all grievances or requests for investigation in ADHS/DBHS’s OGA Database which shall be considered the public record. Entry must be made within three (3) working days of each reportable event. The Public Log will contain the following information:
  - A docket number;
  - A description of the grievance or request for investigation issue;
  - The date of the filing of grievance;
  - The date of the initial decision or appointment of the investigator;
  - The date of the filing of the investigator’s final report;
  - The dates of all subsequent decisions, appeals or other relevant events;
  - A description of the final decision and any actions taken by the ADHS/DBHS Deputy Director, or designee, Mercy Maricopa Director, or the CEO of AzSH.

OTHER MATTERS RELATED TO GRIEVANCE PROCESS
Pursuant to the applicable statutes and Chapter 16.0 – Confidentiality, AzSH, Mercy Maricopa 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 person, as required by law, that an incident involving death, abuse, neglect, or threat to a person receiving services has occurred, or that a dangerous condition or event exists (see Chapter 19.2 – Reporting of Incidents, Accidents and Deaths).

AzSH, or Mercy Maricopa shall notify the Deputy Director or designee of ADHS/DBHS when (see Chapter 19.2 – Reporting of Incidents, Accidents and Deaths):
- A person 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 person receiving services;
- An employee, contracted staff, or person receiving services is charged or convicted of a crime related to a rights violation, physical or sexual abuse, or death of a person receiving services.

20.3 – 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 the Mercy Maricopa and/or may be asked to provide assistance to persons 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 time period must be calculated using calendar days, which means that weekends and legal holidays are counted. If, however, the period of time is less than 11 days, the time 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.

**Language, Format and Comprehensive Clinical Record Requirements**
Notice and related forms must be available in each prevalent, non-English language spoken in Mercy Maricopa’s geographic service area (GSA). As designated by Mercy Maricopa, behavioral health providers must provide free oral interpretation services to all persons who speak non-English languages for purposes of explaining the appeal process and/or information contained in the notice. Mercy Maricopa is responsible for providing oral interpretation services at no cost to the person 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 person applying for or receiving behavioral health services Mercy Maricopa 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 person’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. In the event that it may be unsafe to contact the person at his or her home, or the person has indicated that he or she does not want to receive mail at home, the alternate methods identified by the person for communicating notices must be used.

**NOTICE REQUIREMENTS FOR PERSONS WITH SERIOUS MENTAL ILLNESS**

**Notice Requirements**
For actions (see definition) related to Title XIX/XXI covered services, see [Chapter 20.0 – Title XIX/XXI Notice and Appeal Requirements](#).

The following provisions apply to notice requirements for persons determined to have a SMI and for persons for which an SMI eligibility determination is being considered.

Persons who are evaluated for an SMI eligibility determination must receive [ADHS/DBHS Appeal or SMI Grievance Form](#) (English/Spanish) at the time of determination.
Notice of Decision and Right to Appeal (for Individuals with a Serious Mental Illness) (English/Spanish) must be provided to persons determined to have a Serious Mental Illness or to persons applying for SMI services when:

- Initial eligibility for SMI services is determined. The notice must be sent within 3 days of the eligibility determination;
- 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. In this case, notice must be provided at least 30 days prior to the effective date unless the person 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 person receiving services or others;
- A decision is made that the person 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 person.

Additional Notices
The following additional notices must be provided to persons determined to have a Serious Mental Illness or persons applying for SMI services:

- Notice of Legal Rights for Persons with Serious Mental Illness (English/Spanish) at the time of admission to a behavioral health provider agency for evaluation or treatment. The person receiving this notice must acknowledge in writing the receipt of the notice and the behavioral health provider must retain the acknowledgement in the person’s comprehensive clinical record. All behavioral health providers must post Notice of Legal Rights for Persons with Serious Mental Illness (English/Spanish) in both English and Spanish, so that it is readily visible to behavioral health recipients and visitors;
- Notice of Discrimination Prohibited, posted in English and Spanish so that it is readily visible to persons 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 recipient, Mercy Maricopa will ensure the communication of a notice to the person.

NOTICE REQUIREMENTS FOR NON-TITLE XIX/XXI/NON-SMI POPULATION

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6 Actions or decisions that deny, suspend, reduce, or terminate a person’s or persons’ services or benefits in order to avoid exceeding the state funding legislatively appropriated for those services or benefits do not require Notice.
Notice is not required to persons who are not eligible for Title XIX/XXI or SMI services under this policy.

**APPEAL REQUIREMENTS**

Appeals that are related to Mercy Maricopa or one of their contracted behavioral health providers’ decisions must be filed with Mercy Maricopa.

Title XIX/XXI eligible persons 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 Chapter 20.0 – Title XIX/XXI Notice and Appeal Requirements) or the appeal process for persons determined to have a SMI described in Chapter 20.3 – 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 persons applying for an eligibility determination or who have been determined to have a SMI; and
- Appeals for other covered service related issues.

**Filing Persons and Entities**

The following persons 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, the person meeting Special Assistance needs;
- A legal guardian or parent who is the legal custodian of a person under the age of 18 years;
- A court appointed guardian ad litem or an attorney of a person 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 ADHS, but which does not have legal custody or control of the person, to the extent specified in the ISA/IGA between the agency and the ADHS; and
- A provider, acting on the behavioral health recipient’s behalf and with the written authorization of the person.

**Timeframes for Appeals**

Appeals must be filed orally or in writing with Mercy Maricopa or ADHS/DBHS when required, within 60 days from the date of the decision being appealed. Late appeals must be accepted upon showing good cause.

**Where to Appeal**

- Mercy Maricopa
  - Oral Appeal: Call (800) 564-5465
  - Fax Appeal: Fax to (602) 351-2300
o Written appeal:
   Mercy Maricopa Integrated Care
   Attn: Appeals
   4350 E. Cotton Center Blvd. Bldg. D
   Phoenix, AZ 85040

   ADHS/DBHS:
   o Oral appeal: Call (800) 867-5808 or (602) 364-4575 (within Maricopa County)
   o Fax Appeal: Fax (302) 364-4591
   o Written appeal:
     ADHS/DBHS
     150 North 18th Avenue, Suite 230
     Phoenix, AZ 85007

APPEAL PROCESS FOR PERSONS WITH SERIOUS MENTAL ILLNESS

An appeal may be filed concerning one or more of the following:

- Decisions regarding the person’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 with regard to the person’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 case management services to a person who is refusing such services, or a decision not to provide such services to the person;
- Decisions regarding a person’s fee assessment or the denial of a request for a waiver of fees;
- Denial of payment of a claim;
- Failure of Mercy Maricopa or ADHS/DBHS 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 person.

Standard Appeal Process

Within 5 working days of receipt of an appeal, Mercy Maricopa must inform the appellant in writing that the appeal has been received and of the procedures that will be followed during the appeal.
In the event Mercy Maricopa refuses to accept a late appeal or determines that the issue may not be appealed Mercy Maricopa must inform the appellant in writing that they may, within 10 days of their receipt of Mercy Maricopa’s decision, request an Administrative Review of the decision with the ADHS/DBHS OGA.

If a timely request for Administrative Review is filed with ADHS/DBHS of Mercy Maricopa’s decision, ADHS/DBHS shall issue a final decision of within 15 days of the request (for persons requiring Special Assistance, see Chapter 2.12 – Special Assistance for Individuals with a Serious Mental Illness).

**Informal Conference with Mercy Maricopa**

Within 7 days of receipt of an appeal, Mercy Maricopa shall hold an informal conference with the person, guardian, any designated representative, case manager or other representative of the service provider, if appropriate.

Mercy Maricopa 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 Maricopa with authority to resolve the issues under appeal, who shall seek to mediate and resolve the issues in dispute.

Mercy Maricopa 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 person or guardian, if applicable, Mercy Maricopa 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 person or guardian and the issues in dispute do not relate to the person’s eligibility for behavioral health services, the person or guardian shall be informed that the matter will be forwarded for further appeal to ADHS/DBHS for informal conference, and of the procedure for requesting a waiver of the ADHS/DBHS informal conference.

If the issues in dispute are not resolved to the satisfaction of the person or guardian and the issues in dispute relate to the person’s eligibility for SMI services or the person or guardian has requested a waiver of the ADHS/DBHS informal conference in writing, Mercy Maricopa shall:

- Provide written notice to the person or guardian of the process to request an administrative hearing.
- Determine at the informal conference whether the person or guardian is requesting Mercy Maricopa to request an administrative hearing on behalf of the person or guardian and, if so, file the request with ADHS/DBHS within 3 days of the informal conference.
- For a person who is in need of 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 person appealing fails to attend the informal conference and fails to notify Mercy Maricopa of their inability to attend prior to the scheduled conference, Mercy Maricopa shall reschedule the conference. If the person appealing fails to attend the rescheduled conference and fails to notify Mercy Maricopa of their inability to attend prior to the rescheduled conference, Mercy Maricopa will close the appeal docket and send written notice of the closure to the person 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 Maricopa can re-open the appeal and proceed with the informal conference.
- For all appeals unresolved after an informal conference with Mercy Maricopa, Mercy Maricopa must forward the appeal case record to the ADHS/DBHS OGA within three days from the conclusion of the informal conference.

**ADHS/DBHS Informal Conference**

Unless the person or guardian waives an informal conference ADHS/DBHS or the issue on appeal relates to eligibility for SMI services, ADHS/DBHS shall hold a second informal conference within 15 days of the notification from Mercy Maricopa that the appeal was unresolved.

- At least 5 days prior to the date of the second informal conference, ADHS/DBHS 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 ADHS/DBHS with authority to resolve the issues under appeal who shall seek to mediate and resolve the issues in dispute.
- The ADHS/DBHS 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 person or guardian, ADHS/DBHS 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.
  - For a person in need of Special Assistance, ADHS/DBHS 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 person or guardian, ADHS/DBHS shall:
  - Provide written notice to the person or guardian of the process to request an administrative hearing.
o Determine at the informal conference whether the person or guardian is requesting ADHS/DBHS to request an administrative hearing on behalf of the person or guardian and, if so, file the request within 3 days of the informal conference.
o For a person who is in need of Special Assistance, send a copy of the notice to the OHR.
o In the event the person appealing fails to attend the informal conference and fails to notify ADHS/DBHS of their inability to attend prior to the scheduled conference, ADHS/DBHS 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.
o 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, the ADHS/DBHS can re-open the appeal and proceed with the informal conference.

Requests for Administrative Hearing
A written request for hearing filed with ADHS must contain the following information:
- Case name (name of the applicant or person receiving services, name of the appellant and the ADHS/DBHS 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 Maricopa, Mercy Maricopa shall ensure that the written request for hearing, appeal case record and all supporting documentation is received by the ADHS/DBHS 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 person, or a provider on the person’s behalf, may request an expedited appeal for the denial or termination of crisis or emergency services, the denial of admission to or the 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 Maricopa 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 ADHS/DBHS of this decision within 3 days of the decision. The appeal shall then proceed according to the standard process described in this chapter.

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Expedited Informal Conference
Within 2 days of receipt of a written request for an expedited appeal, Mercy Maricopa shall hold an informal conference to mediate and resolve the issues in dispute.

ADHS/DBHS Expedited Informal Conference
Within two days of notification from Mercy Maricopa, ADHS/DBHS 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 ADHS Director to schedule an administrative hearing.

Within one day of the informal conference with ADHS/DBHS, if the conference failed to resolve the appeal, the appeal shall be forwarded to the ADHS Director to schedule an administrative hearing.

Requests for Administrative Hearing
A written request for hearing filed with ADHS must contain the following information:

- Case name (name of the applicant or person receiving services, name of the appellant and the ADHS/DBHS 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 the Mercy Maricopa, Mercy Maricopa shall ensure that the written request for hearing, appeal case record and all supporting documentation is received by the ADHS/DBHS OGA within 3 days.

Administrative hearings shall be conducted and decided pursuant to A.R.S. §41-1092 et seq.

Continuation of Services during Appeal Process
For persons determined to have a SMI, the person’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 person or another individual; or
- The person or, if applicable, the person’s guardian, agrees in writing to the modification or termination.

APPEALS FOR NON-TITLE XIX/XXI/ NON SMI POPULATION
Based on available funding, a person who is Non-Title XXI/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 person).
these circumstances, there is no continuation of services available during the appeal process.

Mercy Maricopa 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 person 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 Maricopa shall advise the appellant in writing of their right to request an administrative hearing with ADHS no later than 30 days from the date of Mercy Maricopa’s decision, and how to do so.

Requests for Administrative Hearing
A written request for hearing filed with ADHS must contain the following information:

- Case name (name of the applicant or person receiving services, name of the appellant and the ADHS/DBHS 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 Maricopa, Mercy Maricopa shall ensure that the written request for hearing, appeal case record and all supporting documentation is received by ADHS/DBHS OGA within 3 days.

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 Maricopa, ADHS/DBHS 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 person in the filing of an appeal. For persons determined to have a SMI, the Office of Human Rights may be available to assist the person in filing as well as resolving the appeal.

Behavioral health providers must not retaliate against any person who files an appeal or interfere with a person’s right to file an appeal. Additionally, no punitive action may be taken against a behavioral health provider who supports a person’s appeal.

20.4 – Contractor and Provider Claims Disputes
The healthcare provider (hereinafter “provider”) claim disputes process affords providers the opportunity to challenge a decision by Mercy Maricopa or Arizona Department of Health
Services/Division of Behavioral Health Services (ADHS/DBHS) 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 file a claim dispute directly with either Mercy Maricopa or ADHS/DBHS, depending upon:

- Which entity is responsible for the decision; and/or
- If a claim payment issue, if the dispute involves services to a person enrolled with Mercy Maricopa Integrated Care (Mercy Maricopa).

Providers initially submit a claim dispute to Mercy Maricopa when:

- Challenging a decision of Mercy Maricopa; or
- Disputing a claim payment issue for services provided to persons enrolled with Mercy Maricopa.

Providers initially submit a claim dispute to ADHS/DBHS when:

- Challenging a decision of ADHS/DBHS; or
- Disputing a claim payment issue for services provided to persons enrolled with a TRBHA.

Once Mercy Maricopa or ADHS/DBHS 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 Maricopa or ADHS/DBHS 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.

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 Maricopa or ADHS/DBHS. The chapter is organized to delineate the process for filing a claim dispute:

- For providers disputing a decision of Mercy Maricopa;
- For providers disputing a decision of ADHS/DBHS; and
- The process for requesting an administrative hearing in the event a provider does not agree with the claim dispute decision of Mercy Maricopa or ADHS/DBHS.

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 Maricopa Integrated Care
4350 E Cotton Center Blvd.; Bldg. D
Phoenix, AZ 85040
Phone: 800-564-5465

GENERAL REQUIREMENTS

Computation of Time - A written claim dispute is considered filed when it is received by the ADHS/DBHS established by a date stamp or other record of receipt. Providers must use the following methodology in computing any period of time 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 Maricopa, the provider must file the claim dispute with Mercy Maricopa at:

Mercy Maricopa Integrated Care
Attn: Appeals Department
4350 E Cotton Center, Blvd.; Bldg. D
Phoenix, AZ 85040

For all claim disputes related to decisions of ADHS/DBHS, the provider must file the claim dispute with ADHS/DBHS at:

Office of Grievance and Appeals
ADHS/DBHS
150 North 18th Avenue, Suite 230
Phoenix, Arizona 85007

ADHS/DBHS and/or Mercy Maricopa must utilize a unique ADHS/DBHS Docket Number for each claim dispute filed. The Docket Number is established as follows:

- The ADHS/DBHS or Mercy Maricopa letter code (see T/RBHA Codes for Docket Numbers form);
- 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 ADHS/DBHS Office of Grievance and Appeals database shall maintain the log of all claim disputes initiated under this policy. Mercy Maricopa, and ADHS/DBHS on behalf of a Tribal RBHA, are 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 ADHS/DBHS 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**
ADHS/DBHS and Mercy Maricopa 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. ADHS/DBHS and Mercy Maricopa must notify an affected provider or Mercy Maricopa of the right to file a claim dispute and how to do so when a decision is made to impose a sanction.

**INITIATING 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 ADHS/DBHS DECISIONS
Within five days of receiving the claim dispute, ADHS/DBHS will notify the provider in writing that:

- The claim dispute has been received;
- The claim dispute will be reviewed; and
- A decision will be issued within 30 days of receipt of the claim dispute, absent extension of the timeline.

It is possible that ADHS/DBHS will determine that it is not the appropriate entity to process the claim dispute. This can happen when ADHS/DBHS determines that it is not responsible for the denial, non-payment or recoupment of the disputed claim or imposition of a sanction.

If ADHS/DBHS determines that it is not responsible for the claim dispute, the claim dispute and all documentation will be sent immediately to the appropriate entity as well as a copy of the transmittal and all documentation to the provider that initiated the claim dispute.

ADHS/DBHS Notice of Decision
A copy of the written Notice of Decision by ADHS/DBHS will be mailed by certified mail to all parties no later than 30 days after the provider files a claim dispute with ADHS/DBHS, unless the provider and ADHS/DBHS agreed to a longer period. The Decision must include and describe in detail, the following:

- The nature of the claim;
- The issues involved;
- The ADHS/DBHS decision and the reasons supporting ADHS/DBHS’ 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 ADHS/DBHS no later than 30 days after the date the provider receives the ADHS/DBHS decision; and
- If the claim dispute is overturned, the requirement that ADHS/DBHS shall reprocess and pay the claim(s) with interest, where applicable, in a manner consistent with the decision within 15 business days of the date of the Decision.
- A statement that the provider may request an administrative hearing by filing a request with the ADHS/DBHS Office of Grievance and Appeals, 150 North 18th Avenue, Suite 230, Phoenix, Arizona 85007, within 30 days of receipt of the decision.
- A statement advising the provider of the right to request an informal settlement conference must also be included.

CLAIM DISPUTES OF MERCY MARICOPA DECISIONS
Within 5 days of receipt of a claim dispute, Mercy Maricopa 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
If Mercy Maricopa determines that it was not responsible for the claim dispute, they must immediately forward the claim dispute to the responsible RBHA or to ADHS/DBHS with an explanation of why the claim dispute is being forwarded.

- A copy of the transmittal shall be sent by the RBHA to the party filing the claim dispute.
- The receiving RBHA or ADHS/DBHS must ensure that a decision is rendered within 30 days of the original RBHA’s receipt of the notice of claim dispute, unless an extension has been granted pursuant to 3.g.of this policy.

**Mercy Maricopa Notice of Decision**

Mercy Maricopa 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 Maricopa, unless the provider and Mercy Maricopa 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;
- Mercy Maricopa’s decision and the reasons supporting the RBHA’s 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 ADHS/DBHS no later than 30 days after the date the provider receives Mercy Maricopa’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 Maricopa 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 ADHS/DBHS, 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 ADHS/DBHS may also request an extension. In either case, the provider and ADHS/DBHS 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 ADHS/DBHS or Mercy Maricopa 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, a request with the ADHS/DBHS 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 ADHS/DBHS no later than 30 calendar days of the date of receipt of the ADHS/DBHS or Mercy Maricopa Notice of Decision, absent of an extension of time. A written request for hearing is considered filed when received by ADHS/DBHS 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 ADHS/DBHS must include:

- Provider name, AHCCCS identification Number, address, phone number and the ADHS/DBHS 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 Maricopa actions undertaken to resolve the claim dispute and basis of the determination.

**Scheduling of an Administrative Hearing**

Pursuant to A.R.S. § 41-1092.03, upon receipt of a request for hearing, the ADHS/DBHS Office of Grievance and Appeals must request that ADHS schedule an administrative hearing pursuant to A.R.S. § 41-1092.05.

If ADHS/DBHS or Mercy Maricopa decision regarding a claim dispute is reversed through the claim dispute or hearing process, ADHS/DBHS or Mercy Maricopa 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 ADHS/DBHS Director's decisions:

- For Title XIX and Title XXI covered services, an appellant aggrieved by the Director’s decision may appeal the decision to AHCCCSA 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 Maricopa tracks, trends and analyzes claim disputes for purposes of detecting fraud and program abuse. Mercy Maricopa 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 consistent with the requirements in Chapter 17.0, Corporate Compliance.