Section 3.14 – Prior Authorization Requirements

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3.14.1 Introduction
It is important that persons receiving behavioral health/integrated care services have timely access to the most appropriate services. It is also important that limited behavioral health/integrated care resources are allocated in the most efficient and effective ways possible. Prior authorization processes are used to promote appropriate utilization of behavioral health/integrated care services while effectively managing associated costs. Except during an emergency situation, Mercy Maricopa requires prior authorization before accessing inpatient services in a licensed inpatient facility.

Securing Most Behavioral Health Services
Most behavioral health services do not require prior authorization. Based upon the recommendations and decisions of the clinical team (i.e., Child and Family Team or Adult Recovery Team), any and all covered services that address the needs of the person and family will be secured. During the treatment planning process, the clinical team may use established tools to guide clinical practice and to help determine the types of services and supports that will result in positive outcomes for the member. Clinical teams should make decisions based on a member’s identified needs and should not use these tools as criteria to deny or limit services.

Prior authorization is required for certain covered behavioral health/integrated care services. Behavioral health/integrated care services requiring prior authorization include:
- Services listed in Mercy Maricopa’s on-line tool, ProPat available on Mercy Maricopa’s Secure Web Portal;
- Planned/Non-emergency admissions to an inpatient facility, including residential facilities for persons under the age of 21;
- Continued stay in an inpatient facility; and
- All services provided by a non-participating provider in the Mercy Maricopa network.
When it is determined that a person is in need of behavioral health/integrated care services requiring prior authorization, the behavioral health/integrated care provider applies the designated authorization and continued stay criteria to approve the provision of covered service. When appropriate, Mercy Maricopa will provide a consultation with the requested provider to gather additional information to make a determination. A decision to deny a prior authorization request can only be made by a Mercy Maricopa Medical Director or physician designee.

3.14.2 Definitions
Definitions for terms are located online at http://www.azdhs.gov/bhs/definitions/index.php. The following terms are referenced in this section:
Adult Clinical Team
Behavioral Health Professional
Behavioral Health Inpatient Facility
Behavioral Health Residential Agency
Certification of Need (CON)
Child and Family Team
Clinical Teams
Denial
Emergency Behavioral Health Services
Inpatient Services
Medically Necessary Covered Services
Prior authorization
Prudent Layperson
Psychiatric Acute Hospital
Recertification of Need (RON)
Sub-Acute Facility

3.14.3 Procedures
3.14.3-A. Behavioral Health/Integrated Care services that do not require prior authorization
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 Referral for Behavioral Health Services form and refer the member to the appropriate Mercy Maricopa provider. Mercy Maricopa’s website includes a provider search function for your convenience. See Section 3.3 Referral and Intake Process for additional information.

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

As part of the service planning process, it is the clinical team’s responsibility to identify available resources and the most appropriate provider(s) for services. This is done in conjunction with the clinical team, the behavioral health recipient, family, and natural supports. If the service is available through a contracted provider the person can access the service directly. If the requested service is only available through a non-contracted provider or if the clinical team requests services from a non-contracted provider, the clinical team is responsible for coordinating with Mercy Maricopa to obtain the requested service as outlined below.

If Mercy Maricopa’s network does not have a Participating Healthcare Provider (PHP) to perform the requested service, 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 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.

For behavioral health, 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)
- Copy of the service plan indicating needed services have been documented
- Reason for going to a non-contracted provider (i.e., specialty not available otherwise)

The process for securing services through a non-contracted provider is as follows:

Mercy Maricopa and its Provider Network Organizations (PNOs) secure services through non-contracted providers with single case (ad hoc) agreements. Decisions regarding single case (ad hoc) services will be made within 14 calendar days.

For services for children, PNOs contract directly with providers for all levels of care except inpatient (including sub-acute), residential, and psychological testing. It is the assigned BHP/BHTs responsibility to secure all clinically necessary services in support of the treatment
plan, to include those from non-contracted providers. In the event the BHP/BHTs are unable to secure services through a contracted PNO provider, they will contact the Contact Manager from their respective PNO to initiate the single case agreement process.

For services for adults, Mercy Maricopa contracts directly with providers for all levels of care except inpatient (including sub-acute), residential, ECT and psychological testing. In the event the BHP/BHTs are unable to secure medically necessary services through the contract network, they will call Mercy Maricopa’s Member Services Department at 800-564-5465.

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 Section 5.1 Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons and Section 5.5, Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI), Section 5.1, Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons, and Section 5.5, Notice and Appeal Requirements (SMI and General).

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; and
- Facilitating the examination of clinicians and clinical teams that are effectively allocating services.

3.14.3-B. Prior authorization requirements for Integrated Care
Mercy Maricopa requires prior authorization for selected acute outpatient services and planned/nonemergent hospital admissions (including all levels of behavioral health admissions). Prior authorization guidelines are reviewed and updated regularly. In order to review electronic authorization requests, authorization requirements, or to check on the status of an authorization, you may visit Mercy Maricopa’s Secure Web Portal at mercymaricopa.com. You may also call our Prior Authorization department at 800-564-5465.

Mercy Maricopa will have staff available 24 hours a day, seven days a week to receive requests for any service that requires prior authorization.

Prior authorization must never be applied in an emergency situation. A retrospective review may be conducted after the person’s immediate behavioral health/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.
3.14.3-C. Behavioral Health Certification of Need (CON) and Recertification of Need (RON)

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

In the event of an emergency, the CON must be submitted:
- For persons age 21 or older, within 72 hours of admission; and
- For persons under the age of 21, within 14 days of admission.

For a sample CON form, see PM Form 3.14.1.

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. For a sample RON form, see PM Form 3.14.2.

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 submitted to Mercy Maricopa prior to the authorization of payment.
- For persons under the age of 21 receiving inpatient psychiatric services federal rules set forth additional requirements for completing CONs when 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.

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

For services in a Behavioral Health Inpatient Facility for persons under the age of 21, 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.
Prior to denials for Residential Treatment Center (RTC) or sub-acute facility placement, The Mercy Maricopa Medical Director 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 a behavioral health clinician.

In addition, if a denial is issued for admission to a RTC or sub-acute facility, Mercy Maricopa is expected to provide a clearly outlined alternative plan. This may require development of a 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.
community or other state agencies as applicable. All such instances shall be logged and provided to ADHS/DBHS upon request.

3.14.3-D. Prior authorization procedures for behavioral health providers contracted by Mercy Maricopa

Mercy Maricopa conducts concurrent utilization review on each member admitted to an inpatient facility or freestanding specialty hospital. Concurrent review activities include both admission certification and continued stay review. The review of the member's medical record assesses medical necessity for the admission, and appropriateness of the level of care, using ADHS/DBHS criteria.

Services requiring prior authorization are:
- Non-emergency admission to and continued stay in an inpatient facility;
- Admission to and continued stay in a Residential Treatment Center (level I)
- Admission to and continued stay in a Behavioral Health Residential Facility (BHRF)
- Admission to and continued stay in treatment for Home Care Training to Home Care Client (HCTC) services;
- Non-emergency services outside the geographic service area of the RBHA
- Non-emergency services outside the RBHA contracted Provider Network
- Psychological and Neuropsychological Testing;
- Specific Pharmacy Practices;
- Electroconvulsive Therapy (ECT) and;
- Non-emergency out of network single case agreement

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

As stated earlier, prior authorization must never be applied in an emergency situation.

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

For Title XIX/XXI covered services requested by persons who are Title XIX/XXI eligible or who have been determined to have a serious mental illness, the Provider must provide the person(s) requesting services with a Notice of Action (see PM Form 5.1.1) following:
- The denial or limited authorization of a requested service, including the type or level of service;
- The reduction, suspension, or termination of a previously authorized service; and
- The denial in whole or in part, of payment for a service (this is the RBHA’s responsibility).
Notice must be provided in accordance with Section 5.1 Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons. Before a final decision to deny is made, the person’s attending 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:

- Requests for authorization to a non-emergent Inpatient Psychiatric Acute Hospital or Sub-Acute facility admission must be made telephonically by the provider to Mercy Maricopa’s Member Services line (800) 564-5465, 24 hours a day, 365 days a year. A determination will be made within 1 hour.
- Prior to a non-emergent admission to an Inpatient Psychiatric Acute Hospital or Sub-Acute Facility, a Certification of Need (CON) (PM Form 3.14.1) CON – Adult Psychiatric Acute Hospital; CON – Adult sub-Acute Facility; CON – Medically Monitored Inpatient Detoxification (ASAM Level III.7D); CON – Child and Adolescent Inpatient Psychiatric Admission must be submitted to Mercy Maricopa via fax for at: 855-825-3165.
- Request for authorization to a non-emergent Child/Adolescent Inpatient Residential Treatment Center must submit Form 3.14.3 via fax to: 1-855-825-3165. A decision will be made within 24 hours or the next business day of the request for an Inpatient residential treatment center for persons under the age of 21. **Authorization cannot be provided without all the requested documentation.**
- Approval for Child/Adolescent Inpatient Residential Treatment Center is valid up to 45 days and must submit Form 3.14.10 Child/Adolescent 45 Day Update.
- Prior to an admission to a Child/Adolescent Residential facility, a CON (PM Form 3.14.1) must be submitted via fax: 1-855-825-3165.
- 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 CON (PM Form 3.14.1) and 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 HCTC the Mercy Maricopa Prior Authorization Request: Level I, RTC, BH Residential Facility or HCTC Services (Form 3.14.3) 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 up to 45 days and must submit Form 3.14.10 Child/Adolescent 45 Day Update. Approval for Child/Adolescent HCTC is valid up to 60 days and must submit Form 3.14.11 Child/Adolescent 60 Day Update.
Electroconvulsive Therapy (ECT) requires prior authorization. Complete the Request for Electroconvulsive Therapy (ECT) (Form 3.14.16, Attachment Electroconvulsive Therapy criteria) and fax to 844-424-3976; or for urgent requests call 800-564-5465 to review with Mercy Maricopa’s Utilization Management Department.

For prior authorization requests of psychological and neuropsychological testing, complete the Request for Testing form (See Request for Psychological Testing Preauthorization form) fax it to Mercy Maricopa’s Utilization Management Department at 855-825-3165.

For requests for prior authorizations for medications, Mercy Maricopa contracted prescribing clinicians shall refer to Section 3.16.7-B Medication Formulary. Formulary medications do not require prior authorization. Prior Authorization criteria and the PA request form can be found on www.mercymaricopa.org with other provider 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.

- Within one hour of the request for psychiatric acute hospital or sub-acute facility;
- Within 24 hours of the request for a residential treatment center for persons under the age of 21; and
- Within 3 business days of the request for Children’s Behavioral Health Residential Facility;
Within 3 business days of the request for Children’s HCTC and Adult Behavioral Health Residential Facility;

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 to make the request for ongoing care within the following timeframes:
- Requests for continuing care within an inpatient or sub-acute facility must be initiated by the contracted rendering provider prior to the last day of the expiration of the current authorization.
- For inpatient or sub-acute facility requests for continued stay, Mercy Maricopa will make a determination within three hours of the request.
- An appropriate service matching completed Recertification of Need (RON PM 3.14.2 form) must be faxed to Mercy Maricopa at faxed to 855-825-3165 at time of review and prior to receiving payment.

Requests for continuing care within a Child and Adolescent Inpatient Residential 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 RON (see RON PM Form 3.14.2) from the Child and Adolescent Inpatient Residential Facility must be received prior to payment. Fax RON to 855-825-3165.

**Child and Adolescent 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; and

Adult Behavioral Health Residential Facilities: The initial authorization is valid up to 60 days. A request for continued stay authorization by the rendering provider must include both the:

- **Adult Behavioral Health Residential Facility or HCTC Continued Stay Review** form 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 1-800-564-5465; and
- **Adult HCTC**: The initial authorization is valid up to 90 days. The Adult Behavioral Health Residential Facility or HCTC Continued Stay Review form must be 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.

3.14.3-E. Prior authorizing 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 Section 3.16 ADHS/DBHS Behavioral Health Drug List. The approved prior authorization criteria are posted on the [ADHS/DBHS Behavioral Health Drug List and Prior Authorization Guidance Documents website](#). For implementation of this process for prior authorization the following requirements must be met:

- Adherence to all prior authorization requirements outlined in this section, including:
  - Prior authorization availability 24 hours a day, seven days a week;
  - **Standard requests**: For standard requests for prior authorization services, a decision must be made as expeditiously as the member’s health condition requires, but not later than fourteen (14) calendar days following the receipt of the authorization request, with a possible extension of up to fourteen (14) calendar days if the member or provider requests an extension, or if the RBHA justifies a need for additional information and the delay is in the member’s best interest.
  - **Expeditied 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.

3.14.3-F. Coverage and payment of emergency behavioral health services

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

- Emergency behavioral health services must be covered and reimbursement made to providers who furnish the services regardless of whether the provider has a contract with 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 10 calendar days of presentation for emergency services.
- A person who has an emergency behavioral health condition must not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the person; and
- The attending emergency physician, or the provider actually treating the person, is responsible for determining when the person is sufficiently stabilized for transfer or discharge, and such determination is binding Mercy Maricopa.

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

- Mercy Maricopa is responsible for ensuring adherence to the following requirements, even in situations when the function has been delegated to a subcontracted provider;
Post-stabilization care services must be covered without authorization and reimbursement made to providers that furnish the services regardless of whether the provider has a contract with 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:
  - Mercy Maricopa physician with privileges at the treating hospital assumes responsibility for the person’s care;
  - Mercy Maricopa physician assumes responsibility for the person’s care through transfer;
  - Mercy Maricopa and the treating physician reach an agreement concerning the person’s care; or
  - The person is discharged.

3.14.4 References

The following citations serve as additional resources for this content area:

- 42 CFR 438.10 (a)
- 42 CFR 438.114
- 42 CFR 441
- 42 CFR 456
- 9 A.A.C.10
- 9 A.A.C. 34
- R9-22-210
- R9-22-1204
- R9-22-1205
- R9-31-210
- R9-31-1205
- AHCCCS/ADHS Contract
- ADHS/RBHA Contract
- ADHS/T/RBHA IGAs
- Section 3.9 Assessment and Service Planning
- Section 3.16 ADHS/DBHS Behavioral Health Drug List
- Section 5.1 Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons
- Section 5.2 Member Complaints
- Section 5.3 Grievance and Request for Investigation for Persons Determined to have a Serious
Mental Illness (SMI)
Section 5.5 Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI)
ADHS/DBHS website, Behavioral Health Drug List and Prior Authorization Guidance Documents
Practice Improvement Protocol 8, The Adult Clinical Team
DBHS Practice Protocol, The Child and Family Team
Technical Assistance Document 3, The Child and Family Team Process
The Arizona Vision and Twelve Principles