
CHAPTER 200 – MERCY CARE COMPLETE CARE –
PLAN SPECIFIC TERMS

Mercy Care Provider Manual
Chapter 200 – Mercy Care Complete Care (MCCC) –
Plan Specific Terms

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MCCC Chapter 1 – Mercy Care Complete Care Overview

1.00 – Mercy Care Complete Care Overview

Mercy Care Complete Care (herein MCCC), as part of MC, is a not-for-profit partnership sponsored by Dignity Health and Ascension Care Management. MCCC is committed to promoting and facilitating quality health care services with special concern for the values upheld in Catholic social teaching, and preference for the poor and persons with special needs. Aetna Medicaid Administrators, LLC administers MCCC for Dignity Health and Ascension Care Management.

MCCC is a managed care organization that provides health care services to people in Arizona's Medicaid program. MCCC has held a pre-paid capitated contract with the AHCCCS Administration since 1985. MCCC provides services to the Arizona Medicaid populations including:

- **AHCCCS Complete Care:** Members select the managed care plan to administer their benefits. MCCC is contracted in Maricopa, Pinal and Gila Counties to provide covered services to enrolled members and integrates both their behavioral health and physical health needs.
- **Children's Rehabilitative Services (CRS):** Arizona's Children's Rehabilitative Services (CRS) program provides medical and behavioral health care, treatment, and related support services to Arizona Health Care Cost Containment System (AHCCCS) members who meet the eligibility criteria and completed the application to be enrolled in the CRS program and have been determined eligible.
- **Division of Developmental Disabilities Long Term Care program:** Members are enrolled through the Arizona Department of Economic Security/Division of Developmental Disabilities (DDD). DDD is a Medicaid program administered by AHCCCS through the Department of Economic Security (DES). MCCC is contracted with DDD to provide acute care services. DDD members are in the following counties:
 - Cochise
 - Gila
 - Graham
 - Greenlee
 - La Paz
 - Maricopa
 - Pima
 - Pinal
 - Santa Cruz
 - Yuma
- **General Mental Health and Substance Use (GMH/SU):** General Mental Health and Substance Use (GMH/SU) services are provided to adult members age 18 and older who

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have been determined to have an illness in this category. These individuals do not have a serious mental illness. General mental health disorders may include, but are not limited to, anxiety or depression. Substance use services are also provided for members using one or more substances or have a dependency on a substance that causes harm to themselves or others. Additionally, services are also available for members dealing with both a general mental health concerns and a substance use at the same time known as co-occurring disorders.

- **KidsCare:** AHCCCS offers health insurance through KidsCare for eligible children (under age 19) who are not eligible for other AHCCCS health insurance. For those who qualify, there are monthly premiums. Please review the KidsCare webpage on the AHCCCS website for additional information.

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MCCC Chapter 2 – Covered and Non-Covered Services

2.00 – Coverage Criteria

Except for emergency care, all covered services must be medically necessary and provided by a primary care provider or other qualified provider. Benefit limits apply.

Each line of business has specific covered and non-covered 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.

2.01 - Covered Services

Covered Services for all members include:

- Hospital care;
- Doctor office visits, including specialist visits;
- Health risk assessments and screenings for members age 21 years of age and over;
- Laboratory, radiology and medical imaging;
- Durable medical equipment and supplies'
- Medications on MCCC's list of covered medicines. Members with Medicare will receive their medications through Medicare Part D;
- Emergency care;
- Care to stabilize you after an emergency;
- Home health services (such as nursing and home health aide);
- Nursing home, when used instead of hospitalization, up to 90 days a year;
- Inpatient rehabilitation services, including occupational, speech and physical therapy;
- Respiratory therapy;
- Outpatient Rehabilitation services, including occupational, speech, physical and respiratory therapy (limitations apply) for patients older than age 21
- Routine immunizations;
- AHCCCS-approved organ and tissue transplants and related prescriptions (limitations apply);
- Dialysis;
- Foot and ankle services;
- Maternity care (prenatal, labor and delivery, postpartum);
- Family planning services;
- Behavioral health services;
- Medically necessary and emergency transportation. Providers may arrange medically necessary non-emergent transportation for MCCC members by calling Member Services at 602-263-3000 or 800-624-3879;
- Medical foods;

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- Emergency eye exam and lens post cataract surgery;
- Urgent care;
- Hospice;
- Wellness exams and preventative screenings; and
- Incontinence briefs to avoid or prevent skin breakdown, with limitations.

Additional covered services for children (under age 21):

- Identification, evaluation and rehabilitation of hearing loss;
- Medically necessary personal care. This may include help with bathing, toileting, dressing, walking and other activities that the member is unable to do for medical reasons;
- Routine preventive dental services, including oral health screenings, cleanings, fluoride treatments, dental sealant, oral hygiene education, X-rays, fillings, extractions and other therapeutic and medically necessary procedures;
- Vision services, including exams and prescriptive lenses (a limited selection of lenses and frames are covered);
- Outpatient speech, occupational and physical therapy;
- Chiropractic services;
- Conscious sedation;
- Adaptive aids (DD members only);
- Medically necessary practitioner visits to member’s home (DD members only);
- Incontinence briefs, with limitations; and
- Acute services for DDD Members enrolled in CR.

Additional services for Qualified Medicare Beneficiaries (QMB):

- Chiropractic services;
- Outpatient occupational therapy; and
- Any services covered by Medicare but not by AHCCCS.

Limited and Excluded Services

The following services are not covered for adults 21 years and older. (If a member is a Qualified Medicare Beneficiary, we will continue to pay their Medicare deductible and coinsurance for these services.)

BENEFIT/SERVICE	SERVICE DESCRIPTION	SERVICE EXCLUSIONS OR LIMITATIONS
Percussive vests	This vest is placed on a person’s chest and shakes to loosen mucous.	AHCCCS will not pay for percussive vests. Supplies, equipment maintenance (care of the vest) and repair of the vest will be paid for.

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Bone-anchored hearing aid	A hearing aid that is put on a person’s bone near the ear by surgery. This is to carry sound.	AHCCCS will not pay for Bone-Anchored Hearing AID (BAHA). Supplies, equipment maintenance (care if the hearing aid) and repair of any parts will be paid for.
Cochlear implant	A small device that is put in a person’s ear by surgery to help you hear better.	AHCCCS will not pay for cochlear implants. Supplies, equipment maintenance (care of the implant) and repair of any parts will be paid for.
Lower limb microprocessor controlled joint/prosthetic	A device that replaces a missing part of the body and uses a computer to help with the moving of the joint.	AHCCCS will not pay for a lower limb (leg, knee or foot) prosthetic that includes a microprocessor (computer chip) that controls the joint.
Emergency dental service	Emergency treatment for pain, infection, swelling and/or injury	Emergency dental services are covered for members under the age of 21. Covered emergency dental services for members 21 years of age and older are limited to problem focused exam, required X-rays, jaw fractures, biopsies and medically necessary anesthesia.
Transplants	A transplant is when an organ or blood cells are moved from one person to another.	Approval is based on the medical need and if the transplant is on the “covered” list. Only transplants listed by AHCCCS as covered will be paid for.
Occupational and Physical Therapy	Exercises taught or provided by a physical therapist to make you stronger or help improve movement	<p>Outpatient Occupational Therapy services are covered for members under the age of 21, when medically necessary.</p> <p>Outpatient Occupational Therapy services are covered for members, 21 years of age and older as follows:</p> <ul style="list-style-type: none"> • 15 OT visits per benefit year for restoring a skill or level of function and maintaining that skill or level of function once restored, and • 15 OT visits per benefit year for acquiring a new skill or a new level of function and maintaining that skill or level of function once acquired.

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Outpatient physical therapy visits are limited to 15 habilitate / 15 rehabilitative for a total of 30 visits for the continued care for one diagnosis per contract year (10/1– 9/30). For dual eligible members, the health plan is responsible for paying the Medicare cost of share limited to 15 habilitate/15 rehabilitative for a total of 30 visits for the continued care for one diagnosis per contract year (10/1-09/30).

Orthotic Devices

Orthotic devices for members under the age of 21 are provided when prescribed by the member’s primary care provider, attending physician or practitioner.

Orthotics devices for members who are 21 years of age and older:

MCCC covers orthotic devices for members who are 21 years of age and older when the orthotic is medically necessary as the preferred treatment based on Medicare Guidelines, along with the following criteria:

- The orthotic costs less than all other treatments and surgical procedures to treat the same condition; and
- The orthotic is ordered by a physician or primary care practitioner (nurse practitioner or physician assistant).

Repairs or Adjustments of Purchased Equipment:

Reasonable repairs or adjustments of purchased equipment are covered for all members over and under the age of 21 to make the equipment serviceable and/or when the repair cost is less than renting or purchasing another unit. The component will be replaced if at the time authorization is sought and documentation is provided to establish that the component is not operating effectively.

Member Handbook

MCCC is responsible for the **Member Handbook**, available on our [Member Handbook](#) web page.

The MCCC Member Handbook applies to ACC members, including GMHSU, non-CMDP and CRS. DDD members also receive the member handbook produced by the contractor who delivers their physical health benefits.

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GMHSU members will no longer receive the RBHA handbook, as the benefits for those members may be different. It is also important to note these members may be enrolled in one of seven health plans, so it is imperative providers ensure the corresponding handbook is offered to each member.

The member handbook is provided to all members in their welcome letter that contains their member ID card. MCCC also notifies members annually that they can request a printed copy of the member handbook by contacting Mercy Care Member Services.

For those members who do not have internet access, please direct them to contact:

- Mercy Care Member Services at 602-263-3000/800-624-3879 (ACC and DDD physical)

Per AHCCCS ACOM Chapter 400, Policy 406 – Member Handbook and Provider Directory, Member Handbooks must be distributed to members receiving services as follows:

- Provide the Member Handbook to each member/guardian/designated representative or household within 12 Business Days of receipt of notification of the enrollment date to members receiving physical health care services

Documentation of receipt of the member handbook should be filed in the member's record, if given to a member by a provider.

- Member Handbooks will be available and easily accessible on the Mercy Care Complete Care website ([Member Handbook](#)). The Member Handbook is available in English, Spanish, Arabic and Vietnamese.
- Members receiving healthcare services have the right to request and obtain a Member Handbook at least annually. MCCC notifies members of their right to request and obtain a Member Handbook at least annually by publishing this information using notices or newsletters accessible on MCCC's website.
- AHCCCS may require MCCC to revise the Member Handbook and distribute it to all current enrollees if there is a significant program change. AHCCCS determines if a change qualifies as significant.

Member Handbooks are reviewed annually, and updated by MCCC sooner, if needed.

2.02 – Non-Covered Services

Non-covered services include:

- Services from a provider who is NOT contracted with MCCC (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;

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- 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 MCCC;
- Prescriptions not on our list of covered medications, unless approved by MCCC;
- Physical exams for 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;
- Microprocessor controlled lower limbs and microprocessor-controlled joints for lower limbs;
- Percussive vests;
- Routine eye examinations for prescriptive lenses or glasses;
- 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);

Outpatient speech therapy (except for Medicare QMB members)

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Comprehensive mental health and substance abuse (behavioral health) services are available to MCCC members. A direct referral for a behavioral health evaluation can be made by any health care professional in coordination with the member's assigned PCP and care manager. MCCC members may also self-refer for a behavioral health evaluation. The level and type of behavioral health services will be provided based upon a member's strengths and needs and will respect a member's culture. Behavioral health services include:

- Behavior management (personal care, family support/home care training, peer support)
- Behavioral health care management services
- Behavioral health nursing services
- Emergency behavioral healthcare
- Emergency and non-emergency transportation
- Evaluation and assessment
- Individual, group and family therapy and counseling
- Inpatient hospital services
- Non-hospital inpatient psychiatric facilities services (Level I residential treatment centers and sub-Acute facilities)
- Lab and radiology services for psychotropic medication regulation and diagnosis
- Opioid Agonist treatment
- Partial care (supervised, therapeutic and medical day programs)
- Psychological rehabilitation (living skills training; health promotion; supportive employment services)
- Psychotropic medication
- Psychotropic medication adjustment and monitoring
- Respite care (with limitations)
- Rural substance abuse transitional agency services
- Screening
- Home Care Training to Home Care Client

3.01 - Behavioral Health Provider Types

Several main provider types typically provide behavioral health services for MCCC members. These may include, but are not limited to, the following licensed agencies or individuals:

- Outpatient behavioral health clinics
- Psychiatrists
- Psychologists
- Certified psychiatric nurse practitioners
- Licensed clinical social workers
- Licensed professional counselors

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- Licensed associate counselors
- Licensed marriage and family therapists
- Licensed substance abuse counselors
- Residential treatment facilities
- Behavioral health group homes, Levels II and III.
- Partial hospital programs
- Substance abuse programs

3.02 - Alternative Living Arrangements

MCCC also includes the following alternative living arrangements:

- **Behavioral Health Level II and III** – these settings provide behavioral health treatment with 24-hour supervision. Services may include on site medical services and intensive behavioral health treatment programs.
- **Traumatic Brain Injury Treatment Facility** – this setting provides treatment and services for people with traumatic brain injuries.
- **DDD Group Homes** – these settings provide behavioral health treatment with 24-hour supervision.

3.03 - Emergency Services

MCCC covers behavioral health emergency services for MCCC members. If a member is experiencing a behavioral health crisis, please contact the MCCC Behavioral Health Hotline at 800-876-5835.

During a member's behavioral health emergency, the MCCC Behavioral Health Hotline clinician may dispatch a behavioral health mobile crisis team to the site of the member to de-escalate the situation and evaluate the member for behavioral health services. All medically necessary services are covered by MCCC.

3.04 - Behavioral Health Consults

Behavioral Health consults are required by AHCCCS on all MCCC members who receive behavioral health services. Behavioral Health Consults are done between an MCCC care manager and a behavioral health care manager reviewing the behavioral health provider's progress notes and treatment plan to determine continued medical necessity of the services. Per AHCCCS guidelines, the following items are required for the Behavioral Health Consultations Process:

- Consults must take place quarterly for long term care members that are receiving behavioral health services and 30 days after a referral for behavioral health services is made.
- Behavioral health consultations must be reviewed face-to-face with, and the outcome signed by a master's Level Behavioral Health Clinician.

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MCCC behavioral health prescriber will send a letter to the member's PCP regarding the member's treatment and psychotropic medication regime.

3.05 - Behavioral Health Screening

- Members should be screened by their PCP for behavioral health needs during routine or preventive visits.
- Behavioral health screening by PCPs is required at each EPSDT visit for members under age 21

3.06 - Behavioral Health Appointment Standards

MCCC routinely monitors providers for compliance with appointment standards. The minimum standard requirements are:

- Urgent - Within 24 hours of referral.
- Routine - within 30 days of referral.

3.07 - Behavioral Health Provider Coordination of Care Responsibilities

It is critical that a strong communication link be maintained with behavioral health providers including:

- PCPs and other interested parties such as CPS (if the guardian and MCCC have the paper work)
- Public Fiduciary Department (if documentation is provided identifying the Public Fiduciary Department as the member's guardian)
- Veterans Office (when guardian)
- Children's schools (participation in the ISP with parental or guardian consent)
- The court system (when completing paper work for all court ordered treatments or evaluations)
- Other providers not described above

Information can be shared with the other party that is necessary for the member's treatment. This process begins once a member is identified as meeting medical necessity for seeing a behavioral health provider by the behavioral health coordinator. Information can be shared with other parties with written permission from the member or the member's guardian.

3.08 - PCP Coordination of Care

The PCP will be informed of the member's behavioral health provider so that communication may be established. It is very important that PCPs develop a strong communication link with the behavioral health provider. PCPs are expected to exchange any relevant information such as medical history, current medications, diagnosis and treatment within 10 business days of receiving the request from the behavioral health provider.

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Where there has been a change in a member’s health status identified by a medical provider, there should be coordination of care with the behavioral health provider within a timely manner. The update should include but is not limited to; diagnosis of chronic conditions, support for the petitioning process, and all medication prescribed.

The PCP should also document, and initial signifying review receipt of information received from a behavioral health provider who is treating the member. All efforts to coordinate on care on behalf of the member should be documented in the member’s medical record.

3.09 – General and Informed Consent

Each member has the right to participate in decisions regarding his or her behavioral health care, including the right to refuse treatment. It is important for members seeking behavioral health services to agree to those services and be made aware of the service options and alternatives available to them as well as specific risks and benefits associated with these services.

General Consent is a one-time agreement to receive certain services, including but not limited to behavioral health services that is usually obtained from a member during the intake process at the initial appointment, and is always obtained prior to the provision of any behavioral health services. General consent must be obtained from a member’s behavioral health recipient’s or legal guardian’s signature.

Informed Consent is an agreement to receive behavioral health services before the provision of a specific treatment that has associated risks and benefits. Informed consent is required to be obtained from a member or legal guardian prior to the provision of the following services and procedures:

- Complementary and Alternative Medicine (CAM),
- Psychotropic medications,
- Electro-Convulsive Therapy (ECT),
- Use of telemedicine,
- Application for a voluntary evaluation,
- Research,
- Admission for medical detoxification, an inpatient facility or a residential program (for members determined to have a Serious Mental Illness), and
- Procedures or services with known substantial risks or side effects

MCCC recognizes two primary types of consent for behavioral health services: general consent and informed consent.

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Prior to obtaining informed consent, an appropriate behavioral health representative, as identified in R9-21-206.01(c), must present the facts necessary for a member to make an informed decision regarding whether to agree to the specific treatment and/or procedures. Documentation that the required information was given, and that the member agrees or does not agree to the specific treatment, must be included in the comprehensive clinical record, as well as the member/ guardian's signature when required.

In addition to general and informed consent for treatment, state statute (A.R.S. §15-104) requires written consent from a child's parent or legal guardian for any behavioral health survey, analysis, or evaluation conducted about a school-based prevention program.

The intent of this section is to describe the requirements for reviewing and obtaining general, and informed consent, for members receiving services within the behavioral health system, as well as consent for any behavioral health survey or evaluation in connection with an AHCCCS school-based prevention program.

General Requirements

- Any member aged 18 years and older, in need of behavioral health services must give voluntary general consent to treatment, demonstrated by the member's or legal guardian's signature on a general consent form, before receiving behavioral health services.
- For members under the age of 18, the parent, legal guardian, or a lawfully authorized custodial agency (including foster care givers A.R.S. 8.514.05(C)) 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 member aged 18 years and older or the member's legal guardian, or in the case of members 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 member aged 18 years and older or the member's legal guardian, or in the case of members 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.
- Providers treating members in an emergency are not required to obtain general consent prior to the provision of emergency services. Providers treating members 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 the **AHCCCS AMPM Policy 940**.
- Contractors and TRBHAs must develop and make available to providers policies and procedures that include any additional information or forms.

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- A foster parent, group home staff, foster home staff, relative, or other person or agency in whose care a child is currently placed may give consent for:
 - 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 (EPSDT) services, and services by health care providers to relieve pain or treat symptoms of common childhood illnesses or conditions (A.R.S. §8-514.05(C)).
- To ensure timely delivery of services, consent for intake and routine behavioral health services may be obtained from either the foster caregiver or the Department of Child Safety Specialist (DCSS) whomever is available to do so immediately upon request (A.R.S. § 8-514.05(C)).
- Foster or kinship caregivers can consent to evaluation and treatment for routine medical and dental treatment and procedures, including behavioral health services. Examples of behavioral health services in which foster, or kinship can consent to include:
 - Assessment and service planning,
 - Counseling and therapy,
 - Rehabilitation services,
 - Medical Services,
 - Psychiatric evaluation,
 - Psychotropic medication,
 - Laboratory services,
 - Support Services,
 - Care Management,
 - Personal Care Services,
 - Family Support,
 - Peer Support,
 - Respite,
 - Sign Language or Oral Interpretive Services,
 - Transportation,
 - Crisis Intervention Services,
 - Behavioral Health Day Programs.
- A foster parent, group home staff, foster home staff, relative, or other person or agency in whose care a child is currently placed shall not consent to:
 - General Anesthesia,
 - Surgery,
 - Testing for the presence of the human immunodeficiency virus,
 - Blood transfusions,
 - Abortions.
- Foster or kinship caregivers may not consent to terminate behavioral health treatment. The termination of behavioral health treatment requires Department of Child Safety (DCS) consultation and agreement.

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- If the foster or kinship caregiver disagrees on the behavioral health treatment being recommended through the Child and Family Team (CFT), the CFT including the foster or kinship caregiver and DCS case worker should reconvene and discuss the recommended treatment plan. Only DCS can refuse consent to medically recommended behavioral health treatment.

General Consent

Administrative functions associated with a member's enrollment do not require consent, but before any services are provided, general consent must be obtained.

MCCC will make available to providers any form used to obtain general consent to treatment.

Informed Consent

- In all cases where informed consent is required by this policy, informed consent must include at a minimum:
 - The 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 member'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 member'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:
 - Members, or if applicable the member'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 for 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 member, must be established. If the informed consent is for psychotropic medication or telemedicine and the member, or if applicable, the member's guardian refuses to sign an acknowledgment and gives verbal informed consent, the medical practitioner shall document in the member's record that

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- the information was given, the member refused to sign an acknowledgment and that the member gives informed consent to use psychotropic medication or telemedicine.
- 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 member, parent, legal guardian or an appropriate court; and
 - Presented by a credentialed behavioral health medical 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 it 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.
 - 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 member, 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). The use of [AMPM Exhibit 310-V, Attachment A](#), Informed Consent/Assent for Psychotropic Medication Treatment Form 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 or services with known substantial risks or side effects.
 - Written informed consent must be obtained from the member, 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 member in research activities,
 - Prior to the provision of a voluntary evaluation for a member. The use of AMPM Exhibit 320-Q-1, Application for Voluntary Evaluation is required for members 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.

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- Written informed consent must be obtained from the member, legal guardian or an appropriate court prior to the member’s admission to any medical detoxification, inpatient facility or residential program operated by a behavioral health provider.
- 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 member. In such cases, treatment may be phased out to avoid any harmful effects.
- Informed Consent for Telemedicine:
 - Before a health care provider delivers health care via telemedicine, verbal or written informed consent from the member or their health care decision maker must be obtained. Refer to the AHCCCS AMPM Policy 320-I for additional detail.
 - Informed consent may 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 member and/or legal guardian can understand and comprehend.
 - Exceptions to this consent requirement include:
 - If the telemedicine interaction does not take place in the physical presence of the member;
 - In an emergency in which the member or the member’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.

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 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 section 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,

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- Foster parent, group home staff or another person with whom the 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:

INDIVIDUAL/ENTITY	DOCUMENTATION
Legal guardian	Copy of court order assigning custody
Relatives	Copy of power of attorney document
Another person/agency	Copy of court order assigning custody
DCS Placements (for children removed from the home by DCS), such as: <ul style="list-style-type: none"> • Foster parents • Group home staff • Foster home staff • Relatives • Other person/agency in whose care DCS has placed the child 	None required (see note)

NOTE: If behavioral health providers doubt whether the individual bringing the child in for services is a person/agency representative in whose care DCS has placed the child, the provider may ask to review verification, such as documentation given to the individual by DCS indicating that the individual is an authorized DCS placement. If the individual does not have this documentation, then the provider may also contact the child’s DCS case worker 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

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- 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 that marriage has been dissolved subsequently, any 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 emergencies 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 and can receive behavioral health care as needed for the treatment of the condition without general and, when applicable, informed consent to treatment.

At times, involuntary treatment can be necessary to protect safety and meet needs when a member, 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 a member may be willing and able to give informed consent for aspects of treatment even when not able to give general consent. Members should be assessed for capacity to give informed consent for specific treatment and such consent obtained if the member is willing and able, even though the member 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 about a school-based prevention program administered by AHCCCS.
- AMPM Exhibit 320-Q-2, Substance Abuse Prevention Program and Evaluation Consent 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 AHCCCS. The consent must satisfy all 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.
- 3. Completion of AMPM Exhibit 320-Q-2, Substance Abuse Prevention Program and Evaluation Consent applies solely to consent for a survey, analysis, or evaluation only, and does not constitute consent for participation in the program itself.

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3.10 - Family Involvement

Family involvement in a member's treatment is an important aspect in recovery. Studies have shown members who have family involved in their treatment tend to recover quicker, have less dependence on outside agencies, and tend to rely less on emergency resources. Family is defined as any person related to the member biologically or appointed (step-parent, guardian, and/or power of attorney). Treatment includes treatment planning, participation in counseling or psychiatric sessions, providing transportation or social support to the member. Information can be shared with other parties with written permission from the member or the member's guardian.

3.11 - Members with Diabetes and the Arizona State Hospital

- Members with diabetes who are admitted to the Arizona State Hospital (herein AzSH) for behavioral health services will receive training to use a glucometer and testing supplies during their stay at AzSH.
- Upon discharge from AzSH, PCPs must ensure these members are issued the same brand and model of glucometer and supplies that they were trained to use during their AzSH admission.
- MCCC's behavioral health coordinator will notify the PCP of the member's discharge from AzSH and provide information on the brand and model of equipment and supplies that should be continued to be prescribed.
- The MCCC behavioral health coordinator will work with AzSH to ensure the member has enough testing supplies to last until an office visit can be scheduled with the provider.
- In the event the member's mental status renders them incapable or unwilling to manage their medical condition and that condition requires skilled medical care, the MCCC behavioral health coordinator will work with AzSH and the PCP to obtain an appropriate placement for additional outpatient services.
- For re-authorization for continued behavioral health services, contact the member's care manager and fax the Behavioral Health Treatment Plan and progress notes requesting continued authorization. Be sure to include the services to be delivered, frequency of services to be delivered and duration of services provided.
- ALWAYS verify member eligibility prior to the provision of services.

3.12 – 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 member's mental disorder when that member is unable or unwilling to participate in treatment. In Arizona, state law permits any responsible person to apply for pre-petition screening when another member may be, because of a mental disorder:

- **A danger to self (DTS);**

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

If the person who is the subject of a court ordered commitment proceeding is subject to the jurisdiction of an Indian tribe rather than the state, the laws of that tribe, rather than state law, will govern the commitment process.

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 because 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 member 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 member. A hearing, with the member and his/her legal representative and the physician(s) treating the member, will be conducted to determine whether the member 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, because of the evaluation, to be DTS, DTO, PAD, or GD. Court Ordered Treatment (COT) may include a combination of inpatient and outpatient treatment. Inpatient treatment days are limited contingent on the member's designation as DTS, DTO, PAD, or GD. Members 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 will be identified by the court to supervise the person's outpatient treatment. 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

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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 MCCC 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 the following forms AHCCCS Forms found under the [AHCCCS Medical Policy Manual, Section 320-U](#), for all other populations:

- **Application for Involuntary Evaluation**
- **Application for Voluntary Evaluation**
- **Application for Emergency Admission for Evaluation**
- **Petition for Court Ordered Evaluation**
- **Petition for Court Ordered Treatment Gravely Disabled Person**
- **Affidavit**
- **Special Treatment Plan for Forced Administration of Medications**

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 Public Health Licensing Services as a court ordered evaluation or court ordered treatment agency must adhere to ADHS licensing requirements.

Pre-Petition Screening

PINAL COUNTY

Pinal County contracts with Horizon Health and Wellness and CPR to complete Pre-Petition Screening within Pinal County. These services can be accessed by calling Nursewise at 1-866-495-6735.

GILA COUNTY

In Gila County, Community Bridges Inc. is the designated screening agency; however other behavioral health agencies may be granted permission upon request to the Gila County Attorney's Office. Community Bridges, Inc. can be contacted at 1-877-931-9142.

MARICOPA COUNTY

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There is an intergovernmental agreement between Maricopa County and AHCCCS for the management, provision of, and payment for Pre-Petition Screening and Court Ordered Evaluation. AHCCCS in turn contracts with MCCC for these pre-petition screening and court ordered evaluation functions. MCCC is required to coordinate provision of behavioral health services with the member's contractor responsible for the provision of behavioral health services.

The pre-petition screening includes an examination of the member'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 help, 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 Care Manager and Pre-Petition Team relative to AAC and ARC requirements, not intended to be instructive to provider/community members.

Non-emergent Process

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

- For all other residents of Maricopa County (not enrolled with a MCCC Clinic), the pre-petition team will complete these steps for petitions for COE. Any responsible individual may apply for a COE of a member who is alleged to be, because 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 MCCC Clinic, an applicant contacts the MCCC Customer Service Line at 800-564-5465 or the Crisis Response Network Crisis Line 800-631-1314 and requests a PAD or GD petition application be completed on an identified member in the community. An applicant can also go in person to UPC, RRC, or CPEC to begin the non-emergent process. 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 MCCC Clinic enrolled behavioral health members.
- For MCCC Clinic enrolled behavioral health members, the Clinical Team shall assist the

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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 member is determined to be in imminent danger of harming self or others, UPC, RRC, or CPEC will be contacted for assistance in evaluation and possible application for an emergency admission.

- For all MCCC Clinic enrolled or non-enrolled members, 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 member does consent to a voluntary evaluation the **Application for Voluntary Evaluation** shall be used.
- During the pre-petition screening, at least three attempts to contact the behavioral health member should be completed. If attempts at contacting the behavioral health member are unsuccessful and screening is not possible, screening staff will review 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 member does not consent to a voluntary outpatient evaluation or voluntary inpatient evaluation or when a voluntary evaluation is not appropriate as determined by the evaluating psychiatrist, the involuntary process shall continue.
- The Clinical Team or Pre-Petition Team will staff the application for involuntary evaluation (**Application for Involuntary Evaluation** and **Pre-Petition Screening Report**) with a psychiatrist. The psychiatrist need never have met the person to decide regarding whether to move forward with a Petition for COE. The psychiatrist will:
 - Review the application, pre-petition screening report, and any other collateral information made available as part of the pre-petition screening 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 member, due to a mental disorder, which may include 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 member, without immediate hospitalization, is likely to harm him/her or others, the psychiatrist must coordinate with the UPC, RRC-W or CPEC and ensure completion of the **Application for Emergency Admission for Evaluation** and take all reasonable steps to procure hospitalization on an emergency basis.

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- Pre-petition screens, application, and petition for Inpatient or Outpatient 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 member's Care Manager or the 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 member brought to the UPC, RRC or CPEC for evaluation. NOTE: The **Petition for Court Ordered Evaluation** 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 member's Case Manager or the pre-petition team in a secure place (such as a locked file cabinet) to ensure the behavioral health member'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.

Emergent Filing

In cases where it is determined that there is reasonable cause to believe that the member is in such a condition that without immediate hospitalization he/she is likely to harm himself/herself or others, an application for emergency admission can be filed. Only applications 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), 1201 S 7th Ave; Suite #150, Phoenix, AZ 85007; 602-416-7600; Response Recovery Center- (RRC, 11361 N. 99th Ave Suite 402, Peoria AZ 85345, 602-636-4605; or Community Psychiatric Emergency Center (CPEC), 358 E. Javelina, Mesa, AZ 85210, 480-507-3180. MCCC contracts with the UPC, RCC, and CPEC to assist the applicant in preparing the **Application for Emergency Admission for Evaluation** when an emergent evaluation is requested and can also assist when an Application for Court Ordered Evaluation on a non-emergent basis is needed due to the person not meeting criteria for an emergency admission.

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Emergent process

The applicant is a person who has, based on personal observation, knowledge of the behavioral health member'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/CPEC 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 or CPEC 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 member does not require medical care beyond the capacity of UPC, RRC or CPEC, then the UPC, RRC or CPEC staff will immediately coordinate with local law enforcement for the detention of the member and transportation to UPC, RRC or CPEC.
- If the Application for Emergency Admission for Evaluation is accepted by the UPC, RRC or CPEC admitting officer and the member requires a level of medical support not available at the UPC, RRC or CPEC, then within 24 hours the UPC, RRC or CPEC 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 or CPEC admitting officer, then the Mercy RBHA Medical Director must be notified.
- An **Application for Emergency Admission for Evaluation** may be discussed by telephone with a UPC, RRC or CPEC admitting officer, the referring physician, and a police officer to facilitate transport of the member to be evaluated at a UPC, RRC or CPEC.
- A member proposed for emergency admission for evaluation may be apprehended and transported to the UPC, RRC or CPEC by police officials through a written **Application for Emergency Admission for Evaluation** faxed by the UPC, RRC or CPEC admitting officer to the police.
- A 23-Hour Emergency Admission for Evaluation begins at the time the behavioral health member is detained involuntarily by the Admitting Officer at UPC, RRC or CPEC who determines there is reasonable cause to believe that the member, as a result of a mental disorder, is a DTS or DTO and that during the time necessary to complete prescreening procedures the member 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

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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/CPEC may contact the County Attorney prior to filing a petition if it alleges that a member is DTO.
- If the behavioral health member is determined to require a court ordered evaluation, then the petition for COE will be filed with the court within 24 hours of admission (not including weekends or court holidays). If the behavioral health member does not meet the criteria for an application for emergency admission but is determined to meet criteria for PAD and/or GD, UPC, RRC-W or CPEC will notify and offer to assist the applicant of the non-emergent process.

Court Ordered Evaluation

If the pre-petition screening indicates that the member 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:

MCCC and its subcontracted behavioral health provider must follow these procedures:

- A member being evaluated on an inpatient basis must be released within seventy-two hours (not including weekends or court holidays) if further evaluation is not appropriate, unless the member makes application for further care and treatment on a voluntary basis;
- A member who is determined to be DTO, DTS, PAD, or GD because of a mental disorder must have a petition for court ordered treatment prepared, signed and filed by Mercy RBHA's medical director or designee; and
- Title XIX/XXI funds must not be used to reimburse court ordered evaluation services.

MCCC encourages the utilization of outpatient evaluation on a voluntary or involuntary basis. MCCC 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 members 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 member is refusing a voluntary evaluation and the psychiatrist determines the member is safe to go through an Outpatient Court Ordered Evaluation, then the Case Manager or 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

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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 to have the member 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 member’s Care Manager or PAD team in a secure place (such as a locked file cabinet) to ensure the behavioral health member’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.
- The MIHS Legal Department will arrange for an outpatient Court Ordered Evaluation and notify the Case Manager or 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 member to and from the Outpatient COE and will provide any documents requested by the psychiatrists conducting the evaluation. If the member is not enrolled at an SMI Clinic, the MCCC Court Liaison will assist the member in arranging transportation.
- If the two evaluating psychiatrists do not believe that the member needs COT, then the MIHS Legal Department will forward the physicians’ affidavits to the Care Manager or Pre-Petition Team with an explanation that the member has been determined not to need COT.
- If the two evaluating psychiatrists completing the Outpatient Court Ordered Evaluation determine the member needs 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 MCCC Court Liaison will then file a Petition for Court Ordered Treatment with the Maricopa County Superior Court within 2 business days.

Voluntary Evaluation

Any MCCC contracted behavioral health provider that receives an application for voluntary evaluation must immediately refer the member 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** 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 Care Manager or PAD Team is to arrange for a voluntary admission to UPC, RRC, or CPEC, for the evaluation to take place, assist the member in signing in and deliver the original

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notarized **Application for Voluntary Evaluation** to the UPC, RRC, or CPEC Coordinator.

- If the psychiatrist determines an outpatient voluntary evaluation is acceptable, then the Case Manager or PAD Team will deliver the original, notarized **Application for Voluntary Evaluation** to the MIHS Legal Department. An outpatient evaluation will then be scheduled at Desert Vista Hospital and the Case Manager or PAD Team will be responsible for notifying the member 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, because 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 member needs COT, then the MIHS Legal Department will forward the physicians' affidavits to the Care Manager or PAD Team with an explanation that the member has been determined not to need COT.
- If the psychiatrists completing the voluntary inpatient evaluation or voluntary outpatient evaluation determine the member needs 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 MCCC 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** and provide evaluation at a scheduled time and place within five days of the notice that the member 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 member 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 must include:
 - A copy of the **Application for Voluntary Evaluation**;
 - A completed informed consent form; and
 - A written statement of the member's present medical condition.

MCCC contracts with Maricopa Integrated Health Systems for inpatient Court Ordered Evaluations and Outpatient Court Ordered Evaluations when the county does not contract with MCCC for court ordered evaluations.

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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 member'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 member nominated as guardian or conservator; and
- A copy of all petitions must be mailed to the superintendent of the Arizona State Hospital.

Responsibility of the Outpatient Agency Appointed to Supervise and Administer the Court Order for Treatment

For ACC members on COT, the Outpatient Agency appointed by the court to supervise and administer COT is responsible to file status reports as ordered by the court. These are typically ordered at 45 days, 180 days, and 305 days after COT start date. Status review hearings where a team member must appear may also be ordered by the court.

The Outpatient Agency will schedule members on COT to see a Behavioral Health Medical Professional (BMHP) at least once every 30 days. If a member does not attend a scheduled appointment, the clinical team will attempt to locate the member and re-schedule the appointment within one (1) business day. If the member cannot be engaged, then clinical team will discuss options for engagement and options for amending the COT to bring the member to inpatient or sub-acute facility for assessment.

Members placed on COT after finding of Not Competent/Not Restorable in a Criminal Matter (Rule 11 COT)

Members placed on COT after having been found not competent and not restorable (Rule 11) require special treatment and tracking by the Outpatient Agency. ARS §36-544 requires the Outpatient Agency to file a notice with the court and prosecuting attorney within five (5) days

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of a members unauthorized absence from treatment and request the court toll (suspend) the treatment order for the period the patient is absent. “Unauthorized absence” means:

- The member is absent from an inpatient treatment facility without authorization; or
- The member is no longer living in a placement or residence specified by the treatment plan and has left without authorization; or
- The member left or failed to return **to the county or state without authorization.**

Additionally, the statute requires the Outpatient Agency to:

- Use information and other resources available to the agency to facilitate efforts to locate and return the patient to treatment.
- File a status report every sixty (60) days specifying the information and resources used to facilitate the member’s return to treatment; and
- Notify the court of the patient’s return to treatment.

After 180 days, the Outpatient Agency may petition the court to terminate the order for treatment. The court may either terminate the treatment order or require additional outreach.

If a Notice of Noncompliance appears in the Court Order for Treatment or Minute Entry, the Outpatient Agency must report any noncompliance with the treatment order.

If the medical director intends to release a patient from a Rule 11 COT prior to the expiration of the COT, he/she must provide at least a ten (10) day notice to the court, prosecuting attorney, and any relative or victim of the patient who filed a demand for notice.

If the medical director decides not to renew a Rule 11 COT or the Application for Renewal was not filed on time, at least a ten (10) day notice of the pending expiration date of COT shall be provided to the court and prosecuting agency.

Judicial Review and COT Renewal Timelines/Forms

Judicial Review

Pursuant to ARS§36-546 each member Court Ordered Treatment must be provided with a Notice of the Right to Judicial Review 60 days after the start of COT and every 60 days thereafter. Any member of the clinical team can provide this notice and must document in a progress note the date and time notice was provided. The notice of right to judicial review can be completed verbally and/or with a form developed by the provider for this purpose. If the member does request Judicial Review, below is the timeline and paperwork that will need to be submitted:

- Member signs request for Judicial Review which is then signed by a member of the clinical team and notarized. The member does not need to make this request in person. Request for Judicial Review can be made on the phone and staff person receiving the

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phone call will complete the Request for Judicial Review form on behalf of the member and note that the request was made by phone on the form and in a progress note in the medical record.

- The Psychiatric Report for Judicial Review must be completed by a psychiatrist signed and notarized and filed with the court within 72 hours (not including weekends or court holidays) of the request for judicial review (please also note that the date of the MD signature MUST match the date of the notarization or it will be rejected).
- The original Request for Judicial Review and Psychiatric Report for Judicial Review must be filed with the court within 72 hours of the Request for Judicial Review.
- If the court orders a full hearing for the Judicial Review the medical director of the treating agency shall provide the member's attorney with a copy of the member's medical records at least 24hr prior to the hearing.

Application for COT Renewal

All renewal paperwork must be submitted to the provider agency court coordinator **NO LATER** than 45 days prior to the expiration of COT. If the Final Status Report states that renewal is requested, the following paperwork will need to be submitted:

- A Final Status Report stating that renewal is requested and can be signed by a psychiatrist or Nurse Practitioner.
- Psychiatric Report for Annual Review of COT must be completed by a psychiatrist, signed and notarized (please note that the date of the psychiatrist's signature MUST match the date of the notarization or it will be rejected).
- **ORIGINAL** Psychiatric Report for Annual Review of COT must be delivered to the provider agency court coordinator as copies cannot be filed with the court.
- Two witness statements for those who will be attending a hearing if one should be set. (The witness statements aren't notarized so these can be scanned and emailed, preferably at the same time.)

**Please note that both psych reports must be completed by a MD. A NP or PA CANNOT complete these, nor is co-signing permitted.*

Members who are Title XIX/XXI Eligible and/or Determined to have Serious Mental Illness (SMI)

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

- Conduct an evaluation to determine if the member has a Serious Mental Illness in accordance with **MCCC Chapter 3 – Behavioral Health, Section 3.14 – SMI Eligibility Determination**, and conduct a behavioral health assessment to identify the member's service needs in conjunction with the member's clinical team, as described in **MC Chapter 10 – Behavioral Health Assessments and Treatment/Service Planning**.
- Provide necessary court ordered treatment and other covered behavioral health

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services in accordance with the member

- Member’s needs, as determined by the member’s clinical team, the behavioral health member, family members, and other involved parties 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 member ordered by the court to undergo treatment can be transferred from one behavioral health provider to another behavioral health provider if:

- The member 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.
- In order to coordinate a transfer of a member under court ordered treatment to ALTCS or another RBHA, the behavioral health member’s clinical team will coordinate with the MCCC Court Advocacy Department at contractingdepartment@MercyCareAZ.org.
- To coordinate a transfer of a member under COT from one SMI Clinic to another, the behavioral health member’s current psychiatrist will discuss the transfer with the receiving psychiatrists. If both SMI Clinics agree that the transfer is appropriate, the receiving psychiatrist will then provide a Letter of Intent to Treat to the SMI Clinic Court Coordinator of the sending SMI Clinic. The SMI Clinic Court Coordinator will then prepare a motion to transfer treatment provider, review with SMI Clinic attorney, and file with the court. The member’s care will not be transitioned to the receiving SMI Clinic until the new treatment provider is reflected on the COT.

Court Ordered Treatment for Members Charged with or Convicted of a Crime

MCCC 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 RBHA will cover DV services with Title XIX/XXI funds when the member 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-

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TXIX/XXI eligible member's 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 MCCC 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 member 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, MCCC liaison(s), and tribal court representatives can be found on the AHCCCS 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.

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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.

MCCC providers must comply with state recognized tribal court orders for Title XIX/XXI and Non-Title XIX SMI members. When tribal providers are also involved in the care and treatment of court ordered tribal members, Mercy 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 to communicate and ensure clinical coordination with the MCCC. This clinical communication and coordination with MCCC 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." MCCC 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 [AHCCCS Tribal Court Procedures for Involuntary Commitment](#) web page for a diagram of these different payment structures).

3.13 - Behavioral Health Treatment Plans and Daily Documentation

Behavioral Health Treatment Plan

A Behavioral Health Treatment Plan must be developed and reviewed/updated annually on each MCCC member, and as needed should a change in the member's condition require a modification to the treatment plan. The treatment plan should include strengths, measurable goals and presenting behavioral issues. For the behavioral issues, list recommended behavioral interventions to be utilized. Amended/renewed plans should indicate goals achieved or barriers interfering with success and recommendations to address this.

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Daily Documentation

Daily documentation is required to reflect MCCC member's behaviors and issues that occur. This should include frequency of behaviors, frequency and type of staff interventions required throughout the day, and the member's level of responsiveness to interventions/redirections.

3.14 – SMI Eligibility Determination

General Requirements

This chapter applies to:

- Members who are referred for, request or have been determined to need an eligibility determination for Serious Mental Illness (SMI);
- Members who are enrolled as a member determined to have a SMI for whom a review of the determination is indicated; and
- MCCC, subcontracted providers and the MCCC 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 members must be evaluated for SMI eligibility by a qualified assessor, and have an SMI eligibility determination made by the Crisis Response Network, if the member:

- Requests an SMI determination;
- A guardian/legal representative who is authorized to consent to inpatient treatment makes a request on behalf of the member;
- An Arizona Superior Court issues an order instructing that a member is to undergo a SMI evaluation/determination; or
- Has both a qualifying SMI diagnosis and functional impairment because of the qualifying diagnosis.

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. MCCC 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.

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- The final determination is required three (3) business days from day 0, not 3 business days from the date of submission to MCCC or designee. Providers that contract with MCCC 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. **MCCC or 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 member will schedule an appointment for an initial meeting with the member and a qualified assessor. This shall occur no later than 7 days after receiving the request or referral.

During the initial meeting with the member by a qualified assessor, the assessor must:

- Make a clinical assessment whether the member is competent enough to participate in an assessment;
- Obtain general consent from the member or, if applicable, the member's guardian to conduct an assessment; and
- Provide to the member and, if applicable, the member'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 member the assessor is unable to obtain sufficient information to determine whether the applicant is SMI, the assessor must:

- Request the additional information to make a determination of whether the member is SMI and obtain an authorization for the release of information, if applicable
- Initiate an assessment including completion of the [AHCCCS Medical Policy Manual 320-P Serious Mental Illness Eligibility 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.

Functional Criteria for SMI Determination

To meet the functional criteria for SMI, a member 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,

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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 member’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 member’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
- Lack of a face-to-face psychiatric or psychological evaluation

Member with Co-occurring Substance Abuse

For members 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 (i.e., 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 (i.e., 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

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

SMI Eligibility Determination for Children Transitioning into the Adult System

When the adolescent reaches the **age of 17.5** and the Child and Family Team (CFT) believes that the youth may meet eligibility criteria as an adult with a Serious Mental Illness (SMI), the T/RBHA and their subcontracted providers must ensure the young adult receives an eligibility determination as outlined in the [AHCCCS Medical Policy Manual 320-P Serious Mental Illness Eligibility Determination](#).

If the youth is determined eligible, or likely to be determined eligible for services as a member with a Serious Mental Illness, the adult behavioral health services care manager is then contacted to join the CFT and participate in the transition planning process. **After obtaining permission from the parent/guardian, it is the responsibility of the children’s behavioral health service provider to contact and invite the adult behavioral health services care manager to upcoming planning meetings.** Additionally, the children’s provider must track and report the following information to MCCC, CFT transition date (date the adult and children’s provider attended a CFT) and adult intake date. When more than one T/RBHA and/or behavioral health service provider agency is involved, the responsibility for collaboration lies with the agency that is directly responsible for service planning and delivery.

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If the young adult is not eligible for services as a member with a Serious Mental Illness, it is the responsibility of the children’s behavioral health provider, through the CFT, to coordinate transition planning with the adult GMH/SU provider. The importance of securing representation from the adult service provider in this process cannot be overstated, regardless of the member’s identified behavioral health category assignment (SMI, General Mental Health, Substance Abuse). The children’s behavioral health provider should be persistent in its efforts to make this occur.

For additional guidance regarding the Transition to Adulthood Process for youth determined SMI prior to turning 18, [see AHCCCS Clinical Guidance Tool Transition to Adulthood Practice Protocol](#).

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 member 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
- 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 member 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 member’s comprehensive clinical record.
- **Disagreement regarding functional impairment:** Determination that the member 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 member’s comprehensive clinical record.

If there is sufficient information to determine SMI eligibility, the member shall be provided written notice of the SMI eligibility determination within three (3) business days of the initial meeting with the qualified assessor.

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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 member agrees to the extension and:

- There is substantial difficulty in scheduling a meeting at which all necessary participants can attend
- The member fails to keep an appointment for assessment, evaluation or any other necessary meeting
- The member is capable of, but temporarily refuses to cooperate in the preparation of the completion of an assessment or evaluation
- The member or the member’s guardian and/or designated representative requests an extension of time
- Additional documentation has been requested, but has not yet been received
- There is insufficient functional or diagnostic information^{1F1} to determine SMI eligibility within the required time periods.

Crisis Response Network

Crisis Response Network must:

- Document the reasons for the delay in the member’s eligibility determination record when there is an administrative or other emergency that will delay the determination of SMI status
- Not use the delay as a waiting period before determining SMI status or as a reason for determining that the member 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 member’s current treating clinician, if any, prior to the determination of SMI, if there is insufficient information to determine the member’s level of functioning
- SMI eligibility must be determined within three days of obtaining sufficient information, but no later than the end date of the extension

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).

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If the member refuses to grant an extension, SMI eligibility must be determined based on the available information. If SMI eligibility is denied, the member 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, the member shall be notified that the determination may, with the agreement of the member, be extended for up to 90 (calendar) days.

Notification of SMI Eligibility Determination

If the eligibility determination results in approval of SMI status, the SMI status must be reported to the member in writing, including notice of his/her right to appeal the decision.

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
- The statement that Title XIX/XXI eligible members will continue to receive needed Title XIX/XXI covered services. In such cases, the member's behavioral health category assignment must be assigned based on criteria.

Re-enrollment or Transfer

If the member's status is SMI at disenrollment, or upon transfer from another T/RBHA, the member'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 member with a SMI may be initiated by MCCC or behavioral health provider:

- As part of an instituted, periodic review of all members determined to have a SMI
- When there has been a clinical assessment that supports that the member no longer meets the functional and/or diagnostic criteria
- An individual currently enrolled as a member with a SMI, or their legally authorized representative, upon their request

A review of the determination may not be requested by MCCC 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 member is determined to no longer meet the diagnosis and functional requirements for SMI status, MCCC must ensure that:

- Services are continued depending on Title XIX/XXI eligibility, or other MCCC service

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priorities.

- Written notice of the determination made on review with the right to appeal is provided to the affected member 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 MCCC 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 MCCC for approval. MCCC is responsible for monitoring and validating the forms. MCCC must keep copies of the validated Serious Mental Illness Determination Verification form in the member's record.

SMI Decertification

There are two established methods for removing a SMI designation, one clinical and the other an administrative option, as follows:

1. SMI Clinical Decertification

- A member who has a SMI designation or a member working with an individual from the member's clinical team may request a SMI Clinical Decertification. A SMI Clinical Decertification is a determination that a member who has a SMI designation no longer meets SMI criteria. If, because of a review, the member is determined to no longer meet the diagnostic and/or functional requirements for SMI status:
 - The Determining Entity shall ensure that written notice of the determination and the right to appeal is provided to the affected member with an effective date of 30 days after the date the written notice is issued.
 - MCCC must ensure that services are continued in the event an appeal is filed timely, and that services are appropriately transitioned as part of the discharge planning process.

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2. SMI Administrative Decertification

- A member who has a SMI designation may request a SMI Administrative Decertification if the member has not received behavioral health services for a period of two or more years.
 - Upon receipt of a request for Administrative Decertification, MCCC shall direct the member to contact AHCCCS DHCM Customer Service.
 - AHCCCS will evaluate the member's request and review data sources to determine the last date the member received a behavioral health service. AHCCCS will inform the member of changes that may result with the removal of the member's SMI designation. Based upon review, the following will occur:
 - In the event the member has not received a behavioral health service within the previous two years, the member will be provided with AMPM Exhibit 320-P-3. This form must be completed by the member and returned to AHCCCS.
 - In the event the review finds that the member has received behavioral health services within the prior two-year period, the member will be notified that they may seek decertification of their SMI status through the Clinical Decertification process.

SMI Clinic Transfer Protocol

- Once CRN determines the SMI decertification, CRN sends an email to the SMI clinic indicating the specific member status of decertification.
- As soon as the SMI clinic receives notification that a member has completed and been approved for SMI decertification, the SMI clinic will immediately begin working with the member to determine where the member wants to transfer their services.
- The SMI clinic must complete appropriate coordination between a GMH/SU provider(s) or BHMP/PCP of the member's choice to eliminate any gaps in care for the member.
- The transferring of services from the SMI clinic to the GMH/SU provider(s) or alternative BHMP/PCP must be completed in less than thirty (30) days from the time the SMI clinic is notified the member is determined to no longer meet SMI criteria.
- All coordination must be appropriately documented in the member's medical record.
- It is the sending provider's responsibility to gather a release of information from the member and transfer all applicable records to the receiving provider.
- If a member is not currently receiving services from an SMI clinic but is T19, the SMI clinic that the member was paneled to under the Navigator level of care is responsible for completing the transfer of the member.
- If a member does not want to transfer to a GMH/SU provider or BHMP/PCP or refuses to sign a release of information for a receiving provider, the SMI clinic will complete appropriate outreach and engagement which requires two outreach attempts.

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- The SMI clinic will offer the member the opportunity to obtain their medical records (see **MC Chapter 4 – Provider Requirements, Section 4.17 – Member’s Medical Records**) if the member declines further assistance with the transfer process.
- If the member is unable to be contacted or declines obtaining their records, the SMI clinic must retain the original or copies of the member’s medical records for at least six (6) years after the last date the member receives medical or health care services from the provider.

MCCC Transfer Protocol

MCCC member transition process, in coordination with Arizona Health Care Cost Containment System (AHCCCS), helps to ensure that members’ healthcare continues without interruption or delay when there is a change of health plans. When an individual has been approved for SMI decertification, MCCC, as the relinquishing Contractor, will complete and transmit the Enrollment Transition Information (ETI) form to the appropriate parties no later than 10 business days from receipt of AHCCCS notification. MCCC’s transition coordinator will also notify the receiving health plan’s transition coordinator to ensure that the member’s services are appropriately transferred.

Paneling of Members with GMH/SU

All members enrolled in MCCC and Non-Title XIX SMI eligibility plans are paneled to an Assigned Behavioral Health Clinic (ABHC) once behavioral health services are initiated within identified paneling organizations. Members will be re-paneled, as appropriate, to paneling organizations that are the primary catalyst of behavior health services. Members entering behavioral health services via emergency and/or crisis services will paneled according to member preference and geographical location. If member preference is unavailable, the member is paneled to an ABHC based on geographic proximity. Paneling to an ABHC is aligned to member eligibility. Members are not paneled to an ABHC during gaps in enrollment or while eligible in a plan other than Integrated or Non-Title XIX SMI.

Paneling of Members with SMI

All members enrolled in MCCC and Non-Title XIX SMI eligibility plans are paneled to an Assigned Behavioral Health Clinic (ABHC). MCCC panels newly enrolled members to an ABHC based on member preference. If member preference is unavailable, the member is paneled to an ABHC based on geographic proximity. Paneling to an ABHC is aligned to member eligibility. Members are not paneled to an ABHC during gaps in enrollment or while eligible in a plan other than Integrated or Non-Title XIX SMI.

There are numerous scenarios where members determined with SMI may be enrolled in a plan other than Integrated or Non-Title XIX SMI.

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- **Native American** – Native American members have choice and may opt-out of enrollment in an integrated plan.
- **Opt-Out Request** – A member determined SMI, who is currently enrolled in a RBHA, may opt out of receiving physical health services from the RBHA and be transferred to an Acute Care Contractor for his/her physical health services if one or more of the applicable opt out criteria are satisfied. Members who meet the opt-out criteria will continue to receive behavioral health services through Mercy Maricopa.
- **Recent Determination** – There is a 14-day transitional period for a change in health plan for Medicaid members determined with SMI.

In addition to being paneled to an ABHC, members receiving services through Assertive Community Treatment (ACT) teams must be paneled to an ACT Team. MCCC does not panel newly enrolled members to ACT teams.

SMI clinics and ACT teams are required to manage their panels through the Member Paneling tool available in Provider Intake on the Medicaid Web Portal. Panel changes submitted through the Member Paneling tool are processed nightly and loaded directly into the Mercy Maricopa provider information systems. Specific instructions on utilization of the **Provider Intake Member Paneling Tool** are available under the [Reference Material and Guides](#) of our website.

IHH Health Homes, SMI clinics and ACT teams that fail to manage their panels are subject to corrective action, loss or reduction of incentives and sanctions.

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[MCCC Chapter 4 – General Mental Health/Substance Use \(GMH/SU\)](#)

[4.00 – About General Mental Health/Substance Use \(GMH/SU\)](#)

MCCC's integrated system joins both physical and behavioral health services together to treat all aspects of our members' health care needs under one plan. MCCC encourages more coordination between providers within the same network which can mean better health outcomes for our members.

[4.01 – Funding](#)

Special Populations

MCCC receives some funding for behavioral health services through the Federal Substance Abuse Block Grant (SABG). SABG funds are used to provide substance use services for Non-Title XIX/XXI eligible members. 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 network contracted providers receive SABG Block Grant funding. Providers who do receive these 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:** Teenagers who use substances;
- Then:** Other injection drug users;
- Then:** Substance-using females with dependent children, including those attempting to regain custody of their children; and
- Finally:** All other members in need of substance use 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 member within another provider agency facility, including those in other geographic service areas. If capacity still does not exist, the member shall be placed on an actively managed wait list and interim services must be provided until the individual is admitted. Interim services include

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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 use treatment (includes pregnant injection drug users and pregnant substance users) and Substance-using females with dependent children, including those attempting to regain custody of their children.
- **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 member.
- **WHAT:** Includes any needed covered behavioral health services. Admit to a clinically appropriate substance use treatment program (can be residential or outpatient based on the member's clinical needs); if unavailable, interim services must be offered to the member. Interim services shall minimally include education/interventions about 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.

4.02 – Referral and Intake Process

Behavioral Health Referral and Intake Process

To facilitate a member's access to behavioral health services in a timely manner, MCCC 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 MCCC, 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;
- 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;
- 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

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disability or who require language services are afforded appropriate accommodations to assist them in fully expressing their needs.

Responding to Referrals

Follow-Up

When a request for behavioral health services is initiated but the member does not appear for the initial appointment, the provider must attempt to contact the member and implement engagement activities consistent with **MCCC Chapter 4 – General Mental Health/Substance Use, Section 4.03 – Outreach, Engagement, Reengagement and Closure**.

MCCC or provider will also attempt to notify the entity that made the referral.

Documenting and Tracking Referrals

MCCC 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);
- 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; and
- Final disposition of the referral.

Intake

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

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

- The collection of contact information, insurance information, the reason why the member is seeking services and information on any accommodations the member may

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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 member's primary/preferred language;
- The completion of any applicable authorizations for the release of information to other parties;
- The dissemination of a Member Handbook to the member;
- The review and completion of a general 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;
- Advising Non-Title XIX/XXI members determined to have a Serious Mental Illness (SMI) that they may be assessed a co-.
- The review and dissemination of MCCC's Notice of Privacy Practices (NPP) and the AHCCCS HIPAA Notice of Privacy Practices (NPP) located at; and
- The review of the member's rights and responsibilities as a member of behavioral health services, including an explanation of the appeal process.

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

Behavioral health providers conducting intakes must be appropriately trained, approach the member 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 MCCC 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** available on our [Forms Library](#) web page and refer the member to the appropriate MCCC Participating Health Provider (PHP). MCCC's website includes a provider search function for your convenience.

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 use treatment.

Referrals must meet the following conditions:

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- 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 MCCC on the date of service (s) and eligible to receive the service.
- If MCCC’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 MCCC’s network.
 - MCCC 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 MCCC’s policies. Both referring and receiving providers must comply with MCCC 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 MCCC 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 MCCC if the communication between providers is documented and maintained in the member’s 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 MCCC.
- Obtain prior authorization for services that require prior authorization or are performed by a non-PHP.
- Complete a Specialist Referral Form available on our [Forms Library](#) web page 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 MCCC’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 MCCC on the date of service, MCCC will not render payment regardless of referral or prior authorization status.

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- 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 MCCC 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, if the member is enrolled and eligible with MCCC on the date of service.

Maternity Referrals

Referrals to Maternity Care Health Practitioners may occur in two ways:

- A pregnant MCCC member may self-refer to any MCCC contracted Maternity Care Practitioner.
- The PCP may refer pregnant members to a MCCC 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 MCCC 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 MCCC contracted ancillary providers.

Member Self-Referrals

MCCC members can self-refer to participating providers for the following covered services:

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- Family Planning Services
- OB/GYN Services
- Dental Services for Members Ages 18 through 20 years old.
- Vision services for Members Ages 18 through 20 years old.
- Behavioral Health Services for Members 18 years of age and older.

4.03 – Outreach, Engagement, Reengagement 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. MCCC 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 members.

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

Engagement

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

- The member and/or member's legal guardian

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- The member’s family/significant others, if applicable and amenable to the member
- Other agencies/providers as applicable

Behavioral health providers must provide services in a culturally competent manner in accordance with MCCC’s Cultural Competency Plan. Additionally, behavioral health providers must:

- Provide a courteous, welcoming environment that provides members with the opportunity to explore, identify and achieve their personal goals
- Engage members 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 member’s unique family, culture, traditions, strengths, age and gender
- Provide an environment that in which members 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 **MC Chapter 4 – Provider Requirements, Section 4.25 – Cultural Competency, Health Literacy and Linguistic Services**)
- Be aware of and seek to gain an understanding of members with varying disabilities and characteristics
- Display sensitivity to, and respect for, various cultural influences and backgrounds (e.g., ethnic, racial, gender, sexual orientation, socio-economic class, and veteran status)
- Establish an empathic service relationship in which the member 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 member, and/or the member’s legal guardian, the member’s family members, others involved in the member’s treatment and other service providers as collaborators in the treatment planning and implementation process
- Demonstrate the desire and ability to include the member’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 member’s motivation for recovery
- Provide information on available services and assist the member and/or the member’s legal guardian, the member’s family, and the entire clinical team in identifying services that help meet the member’s goals
- Provide the member with choice when selecting a provider and the services they participate in

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Reengagement

For GMH/SU members, the reengagement policy is as follows:

Behavioral health providers must attempt to re-engage members 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 reengage members 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 reengage the member with a minimum of three (3) separate outreach attempts by:

- Communicating in the member’s preferred language
- Contacting the member or the member’s legal guardian by telephone, at times when the member may reasonably be expected to be available (e.g., after work or school)
- Whenever possible, contacting the member or the member’s legal guardian (if applicable) face-to-face, if telephone contact is insufficient to locate the member or determine acuity and risk
- Sending a letter to the current or most recent address requesting contact once three (3) separate outreach 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 GMH/SU members, if the member had a hospitalization during the review period, the discharge policy is as follows:

- BHMP appointment must be scheduled within 5 business days following discharge. Please Note: If the child is receiving care management services only from a High Needs Care Management provider, there must be evidence of the High Needs Care Manager (HNCM) coordinating with the Qualified Service Provider (QSP) providing medication monitoring services to set up a BHMP appointment within the required timeframe.
- Behavioral Health providers must have telephonic or face to face contact with the member within 24 business hours of crisis episode or discharge.
- A face to face visit must be completed within 5 business days following discharge.
- Telephonic contact must be made each week for 4 weeks following discharge (weekly contact is monitored by 7-day intervals).

MCCC behavioral health providers are expected to:

- Involve the member, their parent/guardian, their families, or significant others in transition or aftercare planning;
- For extenuating circumstances involving crisis calls, follow up within 24 hours and if the

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member is unreachable, initiate a welfare check that could include utilizing law enforcement services, family members and significant others as designated by the member;

- 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 MCCC Care Coordinator to provide an initial discharge plan;
 - Involve the member, parent/guardian, 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 members have enough 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 MCCC;
 - 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 member'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 members 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 enough, 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.

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- ** The children’s provider may not employ a RN, if that is the case, it is enough if there is evidence in the BHMP note ensuring the member/guardian understands medications; dosages, side effects and any medication changes post discharge.

For Children members, the reengagement policy is as follows:

Children’s Behavioral Health Providers shall ensure re-engagement attempts are made with members who 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 based on a clinical assessment of need. All attempts to reengage members shall be documented in the comprehensive clinical record.

The Children’s Behavioral Health Provider shall attempt to re-engage the member by:

- a. Communicating in the member’s preferred language,
- b. Contacting the member/guardian/designated representative by telephone at times when the member may reasonably be expected to be available (e.g. after work or school),
- c. When possible, contacting the member/guardian/designated representative face-to-face if telephone contact is insufficient to locate the member or determine acuity and risk, and,
- d. 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.

2. If the above activities are unsuccessful, Children’s behavioral health providers shall ensure further attempts are made to re-engage children, pregnant teenagers with substance use disorder, and any member determined to be at risk of relapse, decompensation, deterioration or a potential harm to self or others based on the member’s clinical needs. Further attempts shall include at a minimum: contacting the member/guardian/designated representative face-to-face and contacting natural supports for whom the member has given permission to the provider to contact. All attempts to re-engage these members shall be clearly documented in the comprehensive clinical record.

Children’s Behavioral Health Providers shall ensure activities are documented in the clinical record and follow-up activities are conducted to maintain Engagement within the following timeframes:

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- a. Discharged from inpatient services, in accordance with the discharge plan and within seven days of the member’s release to ensure member stabilization, medication adherence, and to avoid re-hospitalization;
- b. Involved in a behavioral health crisis within timeframes based upon the member’s clinical needs, but no later than seven days;
- c. Refusing prescribed psychotropic medications within timeframes based upon the member’s clinical needs and history; and
- d. Changes in the level of care

For members receiving General Mental Health/Substance Use services, behavioral health providers must also document activities in the clinical record related to coordination of care upon admission and with discharge planning, and conduct follow-up activities to maintain engagement including:

- Discharge from inpatient services in accordance with the discharge plan within 7 days of discharge upon notification;
- Involved in a behavioral health crisis within timeframes based upon the member’s clinical needs, but no later than 7 days upon notification;
- Ensure members have enough medications or a prescription to last until the follow-up BHMP appointment, as applicable and upon notification. This includes coordination with the inpatient treating physician;
- Refusing prescribed psychotropic medications within timeframes based upon the member’s clinical needs and individual history;
- Involve the member, their parent/guardian, their families, or significant others in transition or aftercare planning; and
- Released from local and county jails and detention facilities within 7 days upon notification.

Additionally, for members to be released from these settings, behavioral health providers must help establish priority prescribing clinician appointments, as applicable, to ensure client stabilization, medication adherence, and to avoid re-hospitalization.

Should members receiving GMH/SU services with recurrent hospitalizations meet specific criteria as being at ‘high risk’, additional navigator assistance services may be available through specifically funded providers through the Comprehensive Community Health Program. Navigators assist members with engagement and coordination of care.

Ending an Episode of Care for Member in Behavioral Health System

Under certain circumstances, it may be appropriate or necessary to dis-enroll a member or end an episode of care from services after reengagement efforts described in **Reengagement** have been expended except for members designated as SMI, TXIX or Non-Title XIX. Ending the episode of care can occur due to clinical or administrative factors involving the enrolled

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member. 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 member is dis-enrolled or has an episode of care ended, notice and appeal requirements may apply.

For children in the custody of DCS who have been enrolled with a Qualified Service Provider (QSP) for less than 12 months, the QSP must elevate closure reasons of ‘Treatment Completed’, ‘Lack of Contact’, or ‘Declined Further Services’ to the MCCC Child Welfare Single Point of Contact at DCS@MercyCareAZ.org prior to ending the Episode of Care.

Clinical Factors

Treatment Completed:

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

Further Treatment Declined:

A member’s episode of care must be ended if the member or the member’s legal guardian decides to refuse ongoing behavioral health services. A Non-Title XIX member would also be dis-enrolled from services except for members designated as SMI, TXIX or nontitle XIX. Prior to ending the episode of care or dis-enrolling a member for declining further treatment or moving a member to a Patient Navigator, the behavioral health provider must ensure the following:

- All applicable and required reengagement activities described in *Reengagement* have been conducted and clearly documented in the member’s comprehensive clinical record; and
- The member does not meet clinical standards for initiating the pre-petition screening or petition or petition for treatment process.
- Upon receiving a request from a DCS Specialist or representative for a child in the custody of DCS to discontinue services and/or dis-enroll a foster child, the behavioral health provider will conduct a Child Family Team (CFT) meeting to determine if this is clinically sound. If the child has been enrolled with the QSP for less than 12 months, the QSP must elevate the request to decline further treatment to MCCC Child Welfare Single Point of Contact at DCS@MercyCareAZ.org.

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Lack of Contact:

A member's episode of care may be ended if MCCC or behavioral health provider is unable to locate or contact the member after ensuring that all applicable and required re- engagement activities described in **Reengagement** have been conducted.

A Non-Title XIX individual would also be dis-enrolled 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
- Members who become or are enrolled as elderly or physically disabled (EPD) under the Arizona Long Term Care System (ALTCS) must be dis-enrolled 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 dis-enroll Non-Title XIX/XXI eligible members for non-payment of assessed co-payments per **MC Chapter 4 – Provider Requirements, Section 4.309 -**

Copayments under the following conditions:

- The member is not eligible as a member determined to have a Serious Mental Illness (SMI); 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 member's comprehensive clinical record, in accordance with **MC Chapter 4 – Provider Requirements, Section 4.30 – Copayments.**

Out-of-State Relocations:

A member's episode of care must be ended for a member who relocates out-of-state after appropriate transition of care. A Non-Title XIX individual would also be dis-enrolled. This does not apply to members placed out-of-state for purposes of providing behavioral health treatment.

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Inter-T/RBHA Transfers:

A member 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.

Children in the Custody of DCS:

Inter-RBHA transfers are not to be initiated if an AHCCCS-eligible child is in the custody of DCS, remains with the same court of jurisdiction and moves to a different county due to the location of an out-of-home placement (e.g., foster home, kinship or group home).

Arizona Department of Corrections Confinements:

A member age 18 or older must be dis-enrolled upon acknowledgement that the member 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 MCCC prior to detainment in a county detention facility will remain in an active episode of care if the child remains Title XIX/XXI eligible. MCCC 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, MCCC is obligated to cover the services regardless of the perception of the member's legal status.

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 member's 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.**

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Please note that providers ***do not*** need to report members incarcerated with the Arizona Department of Corrections.

Deceased Members:

A member's episode of care must be ended following acknowledgement that the member is deceased, effective on the date of the death. The Non-Title XIX individual would be dis-enrolled from the system.

Crisis Episodes:

For members who are enrolled because of a crisis episode, the member's episode of care would end if the following conditions have been met:

- The behavioral health provider conducts all applicable and required reengagement activities and such attempts are unsuccessful; or
- The behavioral health provider and the member or the member's legal guardian mutually agrees that ongoing behavioral health services are not needed; a Non-Title XIX individual would be dis-enrolled from the system.

One-Time Consultations:

For members who are in the system for a one-time consultation, the member's episode of care may be ended if the behavioral health provider and the member or the member's legal guardian mutually agrees that ongoing behavioral health services are not needed. The Non-Title XIX individual would also be dis-enrolled.

Serving Members Previously Enrolled in Behavioral Health System

Some members who have ended their episode of care or were dis-enrolled may need to re-enter the behavioral health system. The process used is based on the length of time that a member has been out of the behavioral health system.

For members not receiving services for less than one year:

- If the member has not received a behavioral health assessment in the last year, conduct a new behavioral health assessment and revise the member's service plan as needed. If the member has received a behavioral health assessment in the last year and there has not been a significant change in the member's behavioral health condition, behavioral health providers may utilize the most current assessment. Review the most recent service plan (developed within the last year) with the member, and if needed, coordinate the development of a revised service plan with the member's clinical team.
- If the member presents at a different T/RBHA or provider, obtain new general and informed consent to.
- If the member presents at a different T/RBHA or provider, obtain new authorizations to

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disclose confidential information, as applicable.

For members not receiving services for one year or longer:

- Conduct a new intake, behavioral health assessment and service plan.
- Continue the member’s SMI status if the member was previously determined to have a Serious Mental Illness (SMI)
- Obtain new general and informed consent to treatment.
- Obtain new authorizations to disclose confidential information, as applicable.

4.04 – Serious Mental Illness Determination

General Requirements

This section applies to:

- Members who are referred for, request or have been determined to need an eligibility determination for Serious Mental Illness (SMI);
- Members who are enrolled as a member determined to have a SMI for whom a review of the determination is indicated; and
- MCCC, subcontracted providers and the MCCC 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 members must be evaluated for SMI eligibility by a qualified assessor, and have an SMI eligibility determination made by the Crisis Response Network, if the member:

- Requests an SMI determination;
- A guardian/legal representative who is authorized to consent to inpatient treatment makes a request on behalf of the member;
- An Arizona Superior Court issues an order instructing that a member is to undergo a SMI evaluation/determination; or
- Has both a qualifying SMI diagnosis and functional impairment because of the qualifying diagnosis.

The SMI eligibility determination record must include all 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. MCCC 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.

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- 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 MCCC or designee. Providers that contract with MCCC 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. MCCC or 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 member will schedule an appointment for an initial meeting with the member and a qualified assessor. This shall occur no later than 7 days after receiving the request or referral.

During the initial meeting with the member by a qualified assessor, the assessor must:

- Make a clinical assessment whether the member is competent enough to participate in an assessment;
- Obtain general consent from the member or, if applicable, the member's guardian to conduct an assessment; and
- Provide to the member and, if applicable, the member'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 member, the assessor is unable to obtain enough information to determine whether the applicant is SMI, the assessor must:

- Request the additional information to decide of whether the member is SMI and obtain an authorization for the release of information, if applicable; 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 because of the qualifying diagnosis.

Functional Criteria for SMI Determination

To meet the functional criteria for SMI, a member must have, because 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

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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 most 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 member'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 member'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 enough 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.

Member with Co-Occurring Substance Use

For members who have a qualifying SMI diagnosis and co-occurring substance use, 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

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

SMI Eligibility Determination for Children Transitioning into the Adult System

When the adolescent reaches the **age of 17.5** and the Child and Family Team (CFT) believes that the youth may meet eligibility criteria as an adult with a Serious Mental Illness (SMI), the T/RBHA and their subcontracted providers must ensure the young adult receives an eligibility determination as outlined in the [AHCCCS Medical Policy Manual 320-P Serious Mental Illness Determination](#).

If the youth is determined eligible, or likely to be determined eligible for services as a member with a Serious Mental Illness, the adult behavioral health services care manager is then contacted to join the CFT and participate in the transition planning process. **After obtaining permission from the parent/guardian, it is the responsibility of the children’s behavioral health service provider to contact and invite the adult behavioral health services care manager to upcoming planning meetings.** Additionally, the children’s provider must track and report the following information to MCCC, CFT transition date (date the adult and children’s provider attended a CFT) and adult intake date. When more than one T/RBHA and/or

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behavioral health service provider agency is involved, the responsibility for collaboration lies with the agency that is directly responsible for service planning and delivery.

If the young adult is not eligible for services as a member with a Serious Mental Illness, it is the responsibility of the children's behavioral health provider, through the CFT, to coordinate transition planning with the adult GMH/SU provider. The importance of securing representation from the adult service provider in this process cannot be overstated, regardless of the member's identified behavioral health category assignment (SMI, General Mental Health, Substance Use). The children's behavioral health provider should be persistent in its efforts to make this occur.

For additional guidance regarding the Transition to Adulthood Process for youth determined SMI prior to turning 18, see [AHCCCS Clinical Guidance Tool Transition to Adulthood Practice Protocol](#).

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 member 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; 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 member 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 member's comprehensive clinical record.
- Disagreement regarding functional impairment: Determination that the member 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 member's comprehensive clinical record.

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If there is enough information to determine SMI eligibility, the member 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 member agrees to the extension and:

- There is substantial difficulty in scheduling a meeting at which all necessary participants can attend;
- The member fails to keep an appointment for assessment, evaluation or any other necessary meeting;
- The member is capable of, but temporarily refuses to cooperate in the preparation of the completion of an assessment or evaluation;
- The member or the member'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 information to determine SMI eligibility within the required time periods.

Crisis Response Network must:

- Document the reasons for the delay in the member'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 member 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 member's current treating clinician, if any, prior to the determination of SMI, if there is insufficient information to determine the member's level of functioning; and
- SMI eligibility must be determined within three days of obtaining enough information, but no later than the end date of the extension.

If the member refuses to grant an extension, SMI eligibility must be determined based on the available information. If SMI eligibility is denied, the member will be notified of his/her appeal rights and the option to reapply).

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If the evaluation or information cannot be obtained within the required time because of the need for a period of observation or abstinence from substance use to establish a qualifying mental health diagnosis the member shall be notified that the determination may, with the agreement of the member, be extended for up to 90 (calendar) days.

Notification of SMI Eligibility Determination

If the eligibility determination results in approval of SMI status, the SMI status must be reported to the member in writing, including notice of his/her right to appeal the decision.

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; and
- The statement that Title XIX/XXI eligible members will continue to receive needed Title XIX/XXI covered services.

Re-Enrollment or Transfer

If the member's status is SMI at disenrollment, or upon transfer from another T/RBHA, the member'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 member with a SMI may be initiated by MCCC or behavioral health provider:

- As part of an instituted, periodic review of all members determined to have a SMI; or
- When there has been a clinical assessment that supports that the member no longer meets the functional and/or diagnostic criteria.
- An individual currently enrolled as a member with a SMI, or their legally authorized representative, upon their request.

A review of the determination may not be requested by MCCC or behavioral health provider within six months from the date an individual has been determined SMI eligible.

If, because of such review, the member is determined to no longer meet the diagnosis and functional requirements for SMI status, MCCC must ensure that:

- Services are continued depending on Title XIX/XXI eligibility, MCCC service priorities and any other requirements.
- Written notice of the determination made on review with the right to appeal is provided to the affected member with an effective date of 30 days after the date the written notice is issued.

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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 MCCC 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 MCCC for approval. MCCC is responsible for monitoring and validating the forms. MCCC must keep copies of the validated Serious Mental Illness Determination Verification form in the member’s record.

4.05 - Special Populations

MCCC 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 AHCCCS. AHCCCS 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 member with substance use disorders. It is used to plan, implement and evaluate activities to prevent and treat substance use. Grant funds are also used to provide early intervention services for HIV and tuberculosis disease in high-risk substance users. This section is intended to present an overview of the major Federal grants that provide AHCCCS and the public behavioral health system with funding to deliver services to member 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 member 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 use disorder, regardless of gender or route of use, (as

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funding is available).

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

Choice of Substance Use Providers

Members receiving substance use 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 use services under the SABG must notify members of this right. Members must document that the member has received notice in the member's comprehensive clinical record.

If a member objects to the religious character of a behavioral health provider, the provider must refer the member 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 MCCC of the referral and ensure that the member contacts the alternative provider.

Upon making a referral, the provider will notify MCCC's General Mental Health/Substance Use Administrator by calling 800-564-5465.

Available Services

The following services must be made available to Substance Abuse Block Grant (SABG) special populations, as clinically identified and appropriate: 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 use treatment
- Therapeutic interventions for dependent children

MCCC is required to ensure the following issues do not pose barriers to access to obtaining substance use treatment:

- Child care
- Care management
- Transportation

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MCCC is required to publicize the availability of gender-based substance use 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 use treatment services at no cost.

Subcontracted providers must notify MCCC if, based on moral or religious grounds, the provider elects to not provide or reimburse for a covered service.

Providers may call MCCC 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 use, 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 MCCC 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 members who also meet a priority population type may not be placed on a wait list (see **MCCC Chapter 3 – Behavioral Health, Section 3.06 – Behavioral Health Appointment Standards**). 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 Children and Intravenous Drug Users) who are waiting for placement in a Residential Treatment Center, to the MCCC SABG Waitlist System, or in a different format upon written approval by MCCC.

- Title XIX/XXI members may not be added to the wait list.
- Priority Population Members must be added to the wait list if MCCC or its providers are not able to place the member in a Residential Treatment Center within the timeframes prescribed.
 - 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.

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- Non-Title XIX/XXI members may be added to the waitlist if there are no available services.

Other SABG Requirements

MCCC is required to designate:

- A lead substance use treatment coordinator who will be responsible for ensuring MCCC 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 members with substance use disorders are considered at high risk for contracting HIV-related illness, the SABG requires HIV intervention services to reduce the risk of transmission of this disease.

In Maricopa County, Terros, Inc., provides HIV early intervention services at substance use programs, care 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. Available for your review is a complete list of waived Rapid HIV tests listed on the CDC website under [Rapid HIV tests suitable for use in non-clinical settings \(CLIA Waived\)](#). 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.

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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 MCCC must be completed by MCCC 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.

MCCC 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 MCCC on an annual basis, or as indicated by AHCCCS. The Webinar will be recorded and made available by MCCC. 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 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

MCCC is required to collect monthly progress reports from subcontracted providers and submit quarterly progress reports to AHCCCS.

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Site visits to providers offering HIV Early Intervention Services must be conducted bi-annually. The AHCCCS HIV Coordinator, MCCC 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

MCCC 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 members. Specific requirements apply regarding preferential access to services and the timeliness of responding to a member's identified needs. Providers funded with SABG funding must coordinate non-emergency transportation to covered SABG services.

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, except for detox services;
- To make cash payments to intended members 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 use 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; 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 children, and intravenous drug users with a SUD).

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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, care 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 use services;
 - Health and behavioral health services; and
- To provide for training of providers of emergency health services regarding behavioral health.
- To provide for a system of integrated services to include:
 - Social services;
 - Educational services;
 - Juvenile justice services;
 - Substance use services;
 - Health and behavioral health services; and
 - To provide for training of providers of emergency health services regarding

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behavioral health.

Restrictions on Use of MHBG Funds

The State shall not expend MHBG funds on the following activities:

- To provide inpatient hospital services; except for detox services
- To make cash payments to intended members 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 use 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; 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.

4.06 – Crisis Intervention Services

Crisis intervention services are provided to a member for 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 member’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.

General Requirements

To meet the needs of individuals in communities throughout Arizona, MCCC will ensure that the following crisis services are available:

- Telephone Crisis Intervention Services:
 - Telephone crisis intervention and NurseLine services, including a toll-free

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- 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%) percent.
- Offer interpretation or language translation services to members 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) hour to a psychiatric crisis in the community.
 - If a two-member team responds, one member may be a Behavioral Health Technician, 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 use 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

Community Bridges- Community Psychiatric Emergency Center
358 E. Javelina Ave.
Mesa, AZ 85210
Phone: 877-931-9142

Connections AZ Urgent Psychiatric Care Center (UPC)
1201 S. 7th Ave., #150
Phoenix, AZ 85007
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

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Substance Use Emergencies for Adults

Community Bridges Central City Addiction Recovery Center (CCARC)
2770 E. Van Buren St.
Phoenix, AZ 85008
Phone: 877-931-9142

Community Bridges East Valley Addiction Recovery Center (EVARC)
506 S. Bellview
Mesa, AZ 85204
Phone: 877-931-9142

Up to 72 hours of additional crisis stabilization as funding is available for mental health and substance use related services at an inpatient psychiatric acute or sub-acute facility.

Management of Crisis Services

While MCCC must provide a standard set of crisis services to ensure the availability of these services throughout the state, MCCC will also be able to meet the specific needs of communities located within their service area. MCCC 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 MCCC-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, MCCC will use the generic medication formulary identified in the Non-Title XIX SMI benefit.

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

General Mental Health/Substance Use (GMH/SU) 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 daily.
- Behavioral health providers must actively participate in the client's discharge planning

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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 MCCC 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.

4.07 – Training Requirements

MCCC leadership’s expectation is that all contracted General Mental Health/Substance Use providers are knowledgeable about the Substance Abuse Block Grant (SABG). This includes providers having SABG posters and materials available in waiting areas, and to be able to speak to uninsured and underinsured individuals who may need treatment or providing a referral for treatment.

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MCCC Chapter 5 – Dental and Vision Services

5.00 - Dental Overview

DentaQuest

Effective January 1, 2015, DentaQuest will administer dental benefits for MCCC. DentaQuest has administrative oversight for the following responsibilities:

- Credentialing
- Patient Management
- Prior Authorization
- Claims
- Customer Service Calls from Providers
- Appeals

MCCC will administer the following for our members:

- Grievances
- Customer Service Calls from Members

Claims with dates of service on or after January 1, 2015 need to be sent to DentaQuest at the following claims address:

DentaQuest of Arizona, LLC – Attention: Claims
P.O. Box 2906
Milwaukee, WI 53201-2906

For electronic claims submissions, DentaQuest works directly with the following Clearinghouses:

Change Healthcare (888-255-7293)
Tesla (800-724-7420)
EDI Health Group (800- 576-6412)
Secure EDI (877-466-9656)
Mercury Data Exchange (866-633-1090)

You can contact your software vendor to make certain that they have DentaQuest listed as the payer and claim mailing address on your electronic claim. Your software vendor will be able to provide you with any information you may need to ensure that submitted claims are forwarded to DentaQuest. DentaQuest's Payer ID is CX014.

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If you have additional questions regarding your claims for DentaQuest, you may contact them directly at 844-234-9831. They will be happy to assist you.

You may also utilize their Interactive Voice Response (IVR) system 24 hours a day, 7 days a week that provides up-to-date information regarding member eligibility, claim status, and much more. Benefits associated with this program and more detailed information regarding DentaQuest can be found in their Office Reference Manual on-line at www.dentaquestgov.com.

5.01 – Dental Covered Services

Dental Screening/Dental Treatment for children under 21

More information regarding Dental Screening/Dental Treatment for children under 21 is available under the **MC Chapter 100 – Mercy Care Provider Manual - Chapter 5 – Early and Periodic Screening, Diagnostic and Treatment (EPSDT), under Section 5.13 – Dental Screening and Referrals.**

The following dental services/dental treatments are covered for children under age 21:

- oral health screenings
- cleanings
- fluoride treatments
- dental sealant
- oral hygiene education
- x-rays
- fillings
- extractions
- other therapeutic and medically necessary procedures
- routine dental services

Two (2) routine preventive dental visits are covered per year. Visits to the dentist must take place within six months and one day after the previous visit. The first dental visit should take place by one year of age. Members under 21 years of age do not need a referral for dental care.

Benefits covered for children under age 21 are in accordance with AHCCCS' [Exhibit 431, Attachment A - AHCCCS Dental Periodicity Table](#). Benefits are also outlined in the DentaQuest Office Manual available at www.dentaquestgov.com.

Mercy Care assigns all members under 21 years of age to a dental home. A dental home is where the member and a dentist work together to best meet dental health needs. Having a dental home builds trust between the member and the dentist. It is a place where the member can get regular, ongoing care, not just a place to go when there is a dental problem. A “dental

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home” may be an office or facility where all dental services are provided in one place. Members can choose or change their assigned dental provider.

Emergency Dental Services for Members 21 Years of Age and Older

Members 21 years of age or older have a \$1,000 annual emergency dental benefit per health plan year. The annual benefit plan year runs from October 1 - September 30. A dental emergency is an acute disorder of oral health resulting in severe pain and/or infection because of pathology or trauma.

Emergency dental services* include:

- Emergency oral diagnostic examination (limited oral examination - problem focused);
- Radiographs and laboratory services limited to the symptomatic teeth;
- Composite resin due to recent tooth fracture for anterior teeth;
- Prefabricated crowns, to eliminate pain due to recent tooth fracture only;
- Recementation of clinically sound inlays, onlays, crowns, and fixed bridges;
- Pulp cap, direct or indirect plus filling;
- Root canals and vital pulpotomies when indicated for the treatment of acute infection or to eliminate pain;
- Apicoectomy performed as a separate procedure, for treatment of acute infection or to eliminate pain, with favorable prognosis;
- Immediate and palliative procedures, including extractions if medically necessary, for relief of pain associated with an oral or maxillofacial condition;
- Tooth reimplantation of accidentally avulsed or displaced anterior tooth, with favorable prognosis;
- Temporary restoration which provides palliative/sedative care (limited to the tooth receiving emergency treatment);
- Initial treatment for acute infection, including, but not limited to, periapical and periodontal infections and abscesses by appropriate methods;
- Preoperative procedures and anesthesia appropriate for optimal patient management; and
- Cast crowns limited to the restoration of root canal treated teeth only.

*Emergency dental services do not require prior authorization.

Dental services that are **not** covered:

- Diagnosis and treatment of TMJ - except to reduce trauma
- Maxillofacial dental services that are not needed to reduce trauma
- Routine restorative procedures and routine root canal therapy
- Bridgework to replace missing teeth
- Dentures

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Covered dental services not subject to the \$1,000 emergency dental limit include:

- Extraction of teeth in preparation for radiation treatment of cancer of the jaw, neck or head.
- Members who require medically necessary dental services before getting a covered organ or issue transplant**:
 - Treatment for oral infections
 - Treatment of oral disease, including dental cleanings, treatment of periodontal disease, medically necessary extractions and simple restorations.

**These services are covered only after a transplant evaluation determines that the member is a candidate for organ or tissue transplantation.

Anesthesia related to the emergency dental services also falls under the annual \$1,000 benefit.

Emergency dental codes are covered only if they meet the criteria of emergent treatment per AHCCCS policy. For additional detail regarding this benefit, we are including the following links to the AHCCCS Medical Policy Manual:

- [Dental Services for Members 21 Years of Age and Older](#)
- [Arizona Long Term Care System Adult Dental Services](#)

The list of codes that are included in the dental emergency benefit are below:

D0140	D2390	D2933	D3347	D7250	D7440	D7560
D0191	D2740	D2940	D3348	D7251	D7441	D7970
D0220	D2750	D2950	D3410	D7260	D7450	D7971
D0230	D2751	D2952	D3421	D7261	D7451	D7972
D0270	D2752	D2954	D3425	D7270	D7460	D7980
D0272	D2790	D3110	D3426	D7285	D7461	D7981
D0273	D2791	D3120	D3430	D7286	D7465	D7982
D0274	D2792	D3220	D7111	D7310	D7510	D7983
D0277	D2794	D3221	D7140	D7311	D7511	D7999
D0330	D2910	D3310	D7210	D7320	D7520	D9223
D2330	D2915	D3320	D7220	D7321	D7521	D9230
D2331	D2920	D3330	D7230	D7410	D7530	D9243
D2332	D2931	D3331	D7240	D7411	D7540	D9248

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D2335	D2932	D3346	D7241	D7415	D7550	
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5.02 – Vision Services

Vision Overview

MCCC 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 and for adults when medically necessary following cataract removal.
- Cataract removal is covered for all eligible members under certain conditions. For more information, please review the **AHCCCS Medical Policy Manual, Chapter 300**.

Coverage for Children (Under Age 21)

- 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 under age 21 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 MCCC’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 MCCC’s website. The member may call Nationwide directly to schedule an appointment.

Coverage for Adults (21 years and older)

- 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.

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- 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 MCCC's Member Services at 6

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MCCC Chapter 6 – Grievances, Appeals and Claims Disputes

6.00 - Grievances

MCCC's Grievance System includes a process for enrollee grievances, enrollee appeals, provider claim disputes and access to the State Fair Hearing system.

A Grievance is described as any written or verbal expression of dissatisfaction over anything that does not involve appealing a decision, such as a denial or discontinuance of services or benefits. Grievances may be filed by a member or provider authorized in writing to act on the member's behalf. A grievance may be submitted orally or in writing to any MCCC staff person. Grievances include, but are not limited to, issues regarding:

- Quality of care or services
- Accessibility or availability of services
- Interpersonal relationships (e.g. rudeness of a provider or employee, cultural barriers or insensitivity)
- Claims or billing
- Failure to respect a member's rights

To file a grievance, members and/or providers filing on behalf of a member, should contact Member Services by phone at 602-263-3000, Toll -Free at 800-634-3879, or in writing at:

Mercy Care
Member Services Department
4755 S. 44th Place
Phoenix, AZ 85040

MCCC will respond and resolve member grievances at the time of the initial call, if possible, or within 90 days if further investigation is needed. If resolution to the grievance is not favorable to the member or representative, MCCC will also provide written information to both members and providers, regarding the Grievance and Appeal System requirements. This includes:

- The right to a state fair hearing, the method for obtaining a state fair hearing
- The Rules that govern representation at the hearing
- The right to file grievances, appeals and claim disputes
- The requirements and timeframes for filing grievances, appeals and claims disputes
- The availability of assistance in the filing process, the toll-free numbers that the member can use to file a grievance or appeal by phone
- That benefits will continue when required by the member in an appeal or a state fair hearing request concerning certain actions which are timely filed
- That the member may be required to pay the cost of services furnished during the appeal/hearing process if the final decision is averse to the member, and

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- That a provider may file an appeal on behalf of a member with the member’s written consent

If the grievance involves a quality of care concern, it will be forwarded to MCCC’s Quality Management Department for further review. The concern will be investigated, and the member and/or the member’s representative will be notified in writing within 90 days of the results of the investigation.

6.01 - Provider Claim Disputes

A claim dispute is a dispute involving the payment of a claim, denial of a claim, imposition of a sanction or reinsurance. A provider may file a claim dispute based on:

- Claim Denial
- Recoupment
- Dissatisfaction with Claims Payment

Before a provider initiates a claims dispute, the following needs to occur:

- The claim dispute process should only be used after other attempts to resolve the matter have failed.
- The provider should contact MCCC Claims and/or Provider Relations to seek additional information prior to initiating a claim dispute.
- The provider must follow all applicable laws, policies and contractual requirements when filing.
- According to the Arizona Revised Statute, Arizona Administrative Code and AHCCCS guidelines, all claim disputes related to a claim for system covered services must be filed in writing and received by the administration or the prepaid capitated provider or program contractor:
 - Within 12 months after the date of service.
 - Within 12 months after the date that eligibility is posted.
 - Or within 60 days after the date of the denial of a timely claim submission, whichever is later.

You may submit your claim dispute in writing through the mail or send electronically to us through fax. Not only do we now have the ability to receive disputes by fax, but we can also respond back to our providers via fax, allowing you to receive faster decisions. If you choose to send via fax, please fax your disputes to 602 351-2300.

Written claim disputes must be submitted to the MCCC Appeals Department. Please include all supporting documentation with the initial claim dispute submission. The claim dispute must specifically state the factual and legal basis for the relief requested, along with copies of any supporting documentation, such as remittance advice(s), medical records or claims. Failure to specifically state the factual and legal basis may result in denial of the claim dispute.

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MCCC will acknowledge a claim dispute request within five (5) business days after receipt. If a provider does not receive an acknowledgement letter within five (5) business days, the provider must contact the Appeals Department. Once received, the claim dispute will be reviewed, and a decision will be rendered within 30 days after receipt. MCCC may request an extension of up to 45 days, if necessary. If you are submitting via mail, the claim dispute, including all supporting documentation, should be sent to:

Mercy Care
Appeals Department
4755 S. 44th Place
Phoenix, AZ 85040

If a provider disagrees with the MCCC Notice of Decision, the provider may request a State Fair Hearing. The request for State Fair Hearing must be filed in writing no later than 30 days after receipt of the Notice of Decision. Please clearly state “State Fair Hearing Request” on your correspondence. All State Fair Hearing Requests must be sent in writing to the follow address:

Mercy Care
Appeals Department
Attention: Hearing Coordinator
4755 S. 44th Place
Phoenix, AZ 85040

[6.02 - Appeals](#)

An appeal is a request for review of an action by an enrollee (member) or their authorized representative, such as a provider. An appeal can be filed for various reasons including the denial or limited authorization of a requested service, the type or level of service, or for the reduction, suspension or termination of a previously authorized service. An authorized representative acting on behalf of the member, with the member's written consent, may file an appeal or request a State Fair Hearing on behalf of a member.

Standard Appeals - An appeal must be filed either orally or in writing with MCCC within 60 days after the date of the Notice of Adverse Benefit Determination. A provider may assist a member in filing an appeal. MCCC does not restrict or prohibit a provider from advocating on behalf of a member.

Standard Appeal Resolution - MCCC will resolve the appeal and mail the written Notice of Appeal Resolution to the member within 30 days after the day MCCC receives the appeal.

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Expedited Appeals - If a provider believes that the time for a standard resolution appeal could seriously jeopardize the member’s life, health, or ability to attain, maintain, or regain maximum function, the provider can submit a request for an Expedited Appeal, with the member’s written consent, along with supporting documentation to MCCC. MCCC will acknowledge an expedited appeal within one working day of receipt.

Expedited Appeal Resolution - MCCC will resolve the appeal and mail a written Notice of Appeal Resolution to the member within 3 working days after MCCC receives the Expedited Appeal. MCCC will also make reasonable efforts to provide prompt oral notification to the member. This timeframe may be extended if MCCC needs additional information and the extension is in the best interest of the member. If the request for an Expedited Appeal is denied, MCCC will decide the appeal within the standard timeframe (30 days from the day MCCC receives the Expedited Appeal).

Each appeal should be filed separately. To file an appeal, please submit in writing, along with all substantiating documentation to:

Mercy Care
Appeals Department
4755 S. 44th Place
Phoenix, AZ 85040
602-351-2300 (FAX)

A member may also file an Appeal orally by contacting:

Mercy Care
Appeals Department
Phone: 602-453-6098
Toll Free: 800-624-3879

An authorized representative, including a provider, acting on behalf of the member, with the member’s written consent, may request a State Fair Hearing on behalf of the member. The request for State Fair Hearing must be in writing, submitted to and received by MCCC, no later than 30 days after the date the member receives the Notice of Appeal Resolution.

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All State Fair Hearing Requests must be sent in writing to the follow address:

Mercy Care
Appeals Department
Attention: Hearing Coordinator
4755 S. 44th Place
Phoenix, AZ 85040
602-351-2300 (fax)