Steward Health Choice of AZ Behavioral Health Residential Facility Prior Authorization and Continued Stay Form

Steward Health Care Network
HEALTH CHOICE ARIZONA

INSTRUCTIONS: Forms must be typed. Fax completed forms and required documents to SHCA Utilization Department: HCH.HCICauthorization@steward.org or via fax 480-760-4732.

Date of Request:_____ Type of Request: ☐ Expedited ☐ Standard ☐ Discharge

Requested Service Level:
☐ Adult Behavioral Health Residential Facility
☐ Child Behavioral Health Residential Facility

BHRF Name:_____ AHCCCS Provider ID:_____

NPI:_____ Tax ID:_____

Requester:_____ Telephone:_____

FAX:_____ Email:_____

Behavioral Health Home / Outpatient Provider:_____

Treating Physician Name:_____ Phone Number:_____

E-mail:_____

Member Name:_____ Age:_____ Gender:_____

AHCCCS ID:_____ SHCA ID:_____

DOB:_____ Population: ☐ T19 ☐ NT19 ☐ SMI ☐ Under 18

ICD 10 Diagnosis code and narrative (Complete for initial and continued stay request):

1. Code:_____ Narrative:_____

2. Code:_____ Narrative:_____

3. Code:_____ Narrative:_____

I. INITIAL REQUEST FOR AUTHORIZATION - ONLY FOR INITIAL PA

Current location of member?_____

What is the reason for the request for BHRF prior authorization?

Describe member's current symptoms and behaviors requiring this level of care:

What treatment and interventions have been attempted to keep the member in their natural living environment or treatment setting?

1. Behaviors and Functions over the last three months requiring requested level of care (Must meet one):

☐ Suicidal/ aggressive/ self-harm/ homicidal thoughts or behaviors; **or (Please describe and provide dates):**

☐ Significant impulsivity with poor judgment/insight; **or (Please describe and provide dates):**

☐ Maladaptive physical or sexual behavior, **or (Please describe and provide dates):**

☐ Inability to remain safe within his or her environment, despite environmental supports (i.e. Natural Supports); **or (Please describe and provide dates):**

☐ Medication side effects due to toxicity or contraindication. **(Please describe and provide dates):**

AND At least one area of serious functional impairment as evidence by:

☐ Inability to complete developmentally appropriate self-care or self-regulation due to Member's Behavioral Health Condition(s), **or (Please describe and provide dates):**

☐ Neglect or disruption of ability to attend majority of basic needs, such as personal safety, hygiene, nutrition or medical care, **or (Please describe and provide dates):**

☐ Frequent inpatient psychiatric admissions or legal involvement due to lack of insight or judgment associated with psychotic or affective/mood symptoms or major psychiatric disorders, **or (Please describe and provide dates):**

☐ Inability to independently self-administer medically necessary psychotropic medications despite interventions such as education, regimen simplification, daily outpatient dispensing, and long-acting injectable medications, **(Please describe and provide dates):**

EXCLUSIONARY CRITERIA

Admission to a BHRF shall not be used as a substitute for the following:

- An alternative to preventative detention or incarceration,
- As a means to ensure community safety in circumstances where a member is exhibiting primarily conduct disordered behavior without the presence of risk or functional impairment,
- A means of providing safe housing, shelter, supervision, or permanency placement,
- A behavioral health intervention when other less restrictive alternatives are available and meet the member's treatment needs; including situations when the member/guardian/designated representative are unwilling to participate, or
- An intervention for runaway behaviors unrelated to a Behavioral Health Condition.

Discharge:

What is the expected improvement in reduction in symptoms, behaviors, and functioning at this level of care? Please provide specific goals.

What is the aftercare plan and placement after discharge?

Required Documentation that must be submitted with prior authorization request.

- CFT/ART Note or Progress Note indicating need for this level of care. *If applicable
- Current Psychiatric Evaluation and progress notes
- Current Medication Sheets
- Treatment plan (Signed by member or guardian)
- ASAM for Co-occurring and CDR
- Psychological or psycho-educational evaluations;
- Any other relevant clinical information.

Standard request: For standard requests for prior authorization services, a decision must be made as expeditiously as the member's health condition requires, but not later than fourteen (14) calendar days following the receipt of the authorization request, with a possible extension of up to fourteen (14) calendar days if the member or provider requests an extension, or if Health Choice Integrated Care justifies a need for additional information and the delay is in the member's best interest. Expedited request: An expedited authorization decision for prior authorization services can be requested if Health Choice Integrated Care or provider determines that using the standard time frame could seriously jeopardize the member's life and/or health or the ability to attain, maintain or regain maximum function. The Health Choice Integrated Care must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires but no later than 72 HRS following the receipt of the authorization request, with a possible extension of up to fourteen (14) calendar days if the member or provider requests an extension, or if Health Choice Integrated Care justifies a need for additional information and the delay is in the member's best interest.

II. CONTINUED STAY REQUEST - ONLY FOR CONTINUED STAY

Must meet one:

☐ The member continues to demonstrate significant risk of harm and/or functional impairment as a result of a Behavioral Health Condition.

☐ Providers and supports are not available to meet current behavioral and physical health needs at a less restrictive lower level of care.

Describe member's specific current symptoms and/or behaviors and/or functioning that continue to need current level of care?

What are the specific barriers to transitioning member to a less restrictive level of care?

How are these barriers being addressed? Please provide specific details for each barrier?

What is the specific discharge plan including environment member will be discharged to?

Required Documentation that must be submitted with prior authorization request.

- CFT/ACT Note or Progress Note indicating continued need for this level of care. (CFT/ART required monthly)
- Rendering service providers documentation (I.e., monthly progress reports, progress notes, facility treatment plan, etc.)
- Current medication sheets
- Updated treatment plan
- ASAM (If applicable)

Authorization does not guarantee payment.