320-V - BEHAVIORAL HEALTH RESIDENTIAL FACILITIES

EFFECTIVE DATES: 02/08/19, 10/01/19, 10/01/20, 10/01/21, 10/01/22, UPON PUBLISHING[1]

APPROVAL DATES: 10/18/18, 02/07/19, 07/02/19, 05/07/20, 04/13/21, 04/28/22, 05/02/24[2]

I. PURPOSE

This Policy applies to ACC, ACC-RBHA, ALTCS E/PD, DCS/CHP (CHP), DES/DDD (DDD) Contractors; and Fee-For-Service (FFS) programs including: American Indian Health Program (AIHP), DES/DDD Tribal Health Program (DDD THP), Tribal ALTCS, TRBHA; and all FFS populations, excluding Federal Emergency Services (FES). For FES, refer to AMPM Chapter 1100. This Policy establishes requirements for the provision of care and services required in a Behavioral Health Residential Facility (BHRF) level of care.

Throughout this Policy, all references to outpatient treatment team shall include Adult Recovery Team (ART), Child and Family Team (CFT), DDD, TRBHA, American Indian Medical Home (AIMH), Indian Health Services, tribally operated 638 Facility, Urban Indian Health (I/T/U), and/or Tribal ALTCS. A CFT/ART is not required for FFS members to receive services.

II. DEFINITIONS

Refer to the AHCCCS Contract and Policy Dictionary for common terms found in this Policy:

ADULT RECOVERY TEAM (ART)	**BEHAVIORAL HEALTH CONDITION**	**BEHAVIORAL HEALTH INPATIENT FACILITY (BHIF)**
BEHAVIORAL HEALTH PARAPROFESSIONAL (BHPP)	**BEHAVIORAL HEALTH PROFESSIONAL (BHP)**	**BEHAVIORAL HEALTH RESIDENTIAL FACILITY (BHRF)**
BEHAVIORAL HEALTH TECHNICIAN (BHT)	**CHILD AND FAMILY TEAM (CFT)**	**CLINICAL OVERSIGHT**
DESIGNATED REPRESENTATIVE (DR)	**HEALTH CARE DECISION MAKER (HCDM)**	**INTENSIVE OUTPATIENT PROGRAM (IOP)**
MEDICATIONS FOR OPIOID USE DISORDER (MOUD)	**MEMBER**	**NOTICE OF ADVERSE BENEFIT DETERMINATION (NOA)**
PRIMARY CARE PROVIDER (PCP)	**PRIOR AUTHORIZATION (PA)**	**SERVICE PLAN**
SUBSTANCE USE DISORDER (SUD)	**TREATMENT PLAN**	

[1] Date policy is effective
[2] Date Policy is approved

For purposes of this Policy, the following terms are defined as:

BEHAVIORAL HEALTH RESIDENTIAL FACILITY STAFF (BHRF STAFF)	Any employee of the agency providing the BHRF services including but not limited to administrators, Behavioral Health Paraprofessionals (BHPP), Behavioral Health Professionals (BHPs), and Behavioral Health Technicians (BHTs).
CLINICAL SUPERVISION	Direction or oversight provided either face to face or by videoconference or telephone by an individual qualified to evaluate, guide, and direct all behavioral health services provided by a licensee to assist the licensee to develop and improve the necessary knowledge, skills, techniques, and abilities to allow the licensee to engage in the practice of behavioral health ethically, safely, and competently, as defined in A.A.C. R4-6-101.
CO-OCCURRING CONDITION	The coexistence of both behavioral health and a Substance Use Disorder (SUD).
DIRECT OBSERVATION	Directly overseeing and inspecting the act of accomplishing a function or activity as specified in A.R.S. § 36-401(A)(49).

III. POLICY

The care and services provided in a Behavioral Health Residential Facility (BHRF) are based on a per diem rate (24-hour day), require prior and continued authorization, and do not include room and board. A BHRF level of care is inclusive of all treatment services in accordance with the treatment plan created by the treatment team. Clinical supervision of Behavioral Health Technicians (BHT) and Behavioral Health Paraprofessionals (BHPP), and direct observation of services provided by a BHPP, shall be in accordance with AMPM Exhibit 300-3. IHS/638 facilities are subject to Centers for Medicare and Medicaid Services (CMS) certification requirements, as specified in the IHS/638 Provider Billing Manual. The requirements outlined in this policy are specific to BHRFs providing treatment services to members who have been or will be admitted for behavioral health services provided 24 hours per day, 7 days per week. BHRF providers who have an approved supplemental application and scope of work to provide respite services as specified in A.A.C. R9-10-702 A. (5) shall refer to AMPM Policy 1250-D and AMPM Policy 310-B for limitations and requirements. For all other supplemental or partial day services approved under A.A.C. R9-10-702, providers shall refer to the Medical Coding Resources page of the AHCCCS website for additional information.

A. PRIOR AUTHORIZATION

All Prior Authorization (PA) requests submitted to the Contractor for BHRF services shall be treated as expedited requests. The Contractor shall refer to ACOM Policy 414 for request timeframes and requirements regarding authorization requests or changes to services previously authorized.

The Contractor shall ensure that their policy and procedures allow for the level of care recommendation of the Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System (CALOCUS), Early Childhood Level of Care Utilization System (ECSII), or the American Society of Addiction Medicine (ASAM) CONTINUUM™, to demonstrate sufficient medical necessity for admission to the indicated level of care.

Continued stay criteria and concurrent review may require additional documentation as determined by the Contractor, and in alignment with this Policy.
The Contractor shall allow for member engagement with family, community, and/or other natural supports while admitted to a BHRF. The Contractor shall allow for member preferences in care, including but not limited to dietary preferences/restrictions that are not solely based on medical or religious need(s), and/or other preferences related to lifestyle or care that are included in the treatment plan. Brief leave requests shall be reviewed on an individual basis and decisions rendered based on the individual's needs, circumstance, and in accordance with the treatment and/or discharge plan, however, a BHRF is unable to bill for any day member is not physically present at the BHRF at 11:59PM.

For information on PA requirements for BHRF level of care relating to FFS members, refer to AMPM Policies 810, 820, and the FFS webpage for more information. Members of the TRBHA, Tribal ALTCS, and/or outpatient treatment team shall be included in the BHRF treatment planning meetings. Providers not in compliance with this requirement will be denied authorization.

B. CRITERIA FOR ADMISSION

The Contractor shall develop admission criteria for medical necessity, submit admission criteria to AHCCCS for approval, as specified in Contract; and publish the approved criteria to the Contractor's website as specified in ACOM Policy 404.

The Contractors shall ensure all BHRF providers adhere to the minimum admission criteria elements listed below.

BHRF providers, including those providing services to FFS members, are required to adhere, at a minimum, to the admission criteria elements listed below.

1. Member is diagnosed with a behavioral health condition, documented in a current diagnostic assessment or evaluation completed by an individual within their scope of practice as specified in AMPM Exhibit 300-3 and AMPM Policy 320-O.

   The BHRF shall maintain this documentation which reflects the symptoms and behaviors necessary for a residential treatment level of care. As specified in AMPM Policy 940, this documentation shall be included in the member's medical record at the BHRF.

The behavioral health condition causing the significant functional and/or psychosocial impairment shall be evidenced in the assessment or evaluation and shall include the following:

a. At least one area of significant risk of harm within the past three months as a result of:
   i. Thoughts or behaviors of suicide, homicide, or harm to self or others; members expressing current plan and/or intent shall be assessed to determine if a higher level of care is needed, and referred appropriately,
   ii. Impulsivity with poor judgment/insight,
   iii. Maladaptive behavior, or
   iv. Inability to remain safe within alternative more independent environments, despite informal and/or formal supports.

AND

b. At least one area of serious functional impairment as evidenced by:
   i. An inability to attend to basic needs and/or complete developmentally appropriate self-care or self-regulation due to behavioral health condition(s),
   ii. 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,
   iii. Frequent withdrawal management services, which can include but are not limited to, detox facilities, ambulatory detox, and unsuccessful attempts utilizing Medication for Opioid Use Disorder (MOUD),
   iv. An inability to independently self-administer medically necessary psychotropic medications despite interventions such as education, regimen simplification, daily outpatient dispensing, and long-acting injectable medications, or
   v. Impairments persist in the absence of situational stressors that delay recovery from the presenting problem.
c. A behavioral health need for 24-hour supervision to develop adequate and effective coping skills that will allow the member to live safely in the community,
d. Anticipated stabilization cannot be achieved in a less restrictive setting, or
e. Documented outcomes associated with attempted interventions in a less restrictive level of care (e.g., Intensive Outpatient Program [IOP], or Partial Hospitalization Program [PHP]) which have not or are not anticipated to be effective or are not available, therefore warranting a higher level of care.

C. EXCLUSIONARY CRITERIA

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

1. Detention or incarceration.

2. To ensure community safety in circumstances where a member is exhibiting primarily conduct disorder or antisocial personality disorder behavior without the presence of a diagnosed behavioral health condition that causes risk or functional impairment.

3. A means of providing safe housing, shelter, supervision, or permanency placement unrelated to a behavioral health condition needing care.

4. A behavioral health intervention when other less restrictive alternatives are available and meet the member's treatment needs, including situations when the member/Health Care Decision Maker (HCDM) is unwilling to participate in the less restrictive alternative.

5. An intervention for elopement or wandering behaviors unrelated to the individual's behavioral health condition.

D. CRITERIA FOR CONTINUED STAY

The Contractor shall develop continued stay criteria for medical necessity, submit continued stay criteria to AHCCCS for approval, as specified in Contract; and publish the approved criteria to the Contractor's website as specified in ACOM Policy 404. The Contractor's medical necessity criteria for continued stay shall include at a minimum the criteria specified below.

Need for continued stay shall be assessed by the BHRF staff in coordination with the applicable outpatient treatment team, during each treatment plan review and update. Each treatment plan review shall assess the member's progress towards treatment goals, display of risk, functional impairment, and discharge readiness. Treatment interventions, frequency, crisis/safety planning, and targeted discharge shall be adjusted accordingly.

1. BHRF providers, including those providing services to FFS members, are required to adhere, at a minimum, to the criteria for continued stay elements listed below:
   a. The member continues to demonstrate significant risk of harm and/or functional impairment because of a behavioral health condition,
   b. The member's condition is expected to improve through the continuation of treatment in the BHRF, and
   c. Providers and supports are not available to meet the member's current behavioral and physical health needs at a less restrictive lower level of care.

2. If it is determined that the member no longer meets the criteria for continued stay, the following requirements shall be met:
   a. If the stay was discontinued by the Contractor prior to the authorization end date, and all parties are not in agreement, issue a Notice of Adverse (NOA) Benefit Determination meeting all requirements in accordance with ACOM Policy 414, and
   b. Transition planning and documentation of the coordination of care for the member's discharge and transition is completed.

BHRF providers providing services to FFS members are required to submit to AHCCCS/Division of Fee-For-Service Management (DFSM) documentation of all participants in the treatment planning during the continued stay review process.

E. CRITERIA FOR DISCHARGE

The Contractor shall develop medical necessity criteria for discharge which aligns with this policy and at a minimum includes the elements listed below. The Contractor shall submit discharge criteria to AHCCCS for approval as specified in Contract Section D, Behavioral Health Residential Facility Services, within 30 days prior to implementation of a change and publish the approved criteria to the Contractor's website as specified in ACOM Policy 404.

BHRF providers providing services to any member, including FFS members, are required to adhere to the minimum discharge elements below.

Discharge planning shall begin at the time of admission. Measurable, documented discharge readiness shall be assessed by the BHRF BHP in coordination with the applicable outpatient treatment team during each treatment plan review and updated a minimum of once a month.

The following criteria shall be considered when determining discharge readiness:

1. Symptom or behavior relief is reduced as evidenced by completion of treatment plan goals.

2. Functional capacity is improved, and/or treatment can be provided at a lower level of care, the member can participate in needed monitoring, or a caregiver is available to provide monitoring in a less restrictive level of care.

3. Providers and supports are available to meet current behavioral and physical health needs at a less restrictive level of care.

F. SERVICE PROVISION AND DOCUMENTATION REQUIREMENTS

The Contractor shall establish policies to ensure all services, including admission, assessment, treatment, and discharge planning processes are completed consistently among all providers in accordance with A.A.C. R9-10-707, 708, and 709, Contract requirements, and this Policy.

BHRF providers shall maintain a readily accessible daily census list of all individuals receiving treatment at the BHRF. At a minimum, the census list shall include the member's full name, date of birth, emergency contact, and AHCCCS ID, if applicable.

1. Clinical practices, as applicable to services offered and population served in the BHRF, shall demonstrate adherence to best practices for treating specialized service needs, including but not limited to the following:
   a. Cognitive/intellectual disability,
   b. Cognitive disability with co-occurring conditions,
   c. Older adults,
   d. Co-occurring conditions, and/or
   e. Comorbid physical and behavioral health condition(s).

2. The following services shall be made available and provided by BHRF staff working within their scope of practice, license requirements, and as specified in this Policy and cannot be billed separately:
   a. Counseling and Therapy (group or individual), and
   b. Skills Training and Development:
      i. Independent living skills (e.g., self-care, household management, budgeting, avoidance of exploitation/safety education and awareness),
      ii. Community reintegration skill building (e.g., use of public transportation system, understanding community resources and how to use them), and
      iii. Social communication skills (e.g., conflict and anger management, same/opposite-sex friendships, development of social support networks, recreation).

   c. Behavioral Health Prevention/Promotion Education and Medication Training and support services including but not limited to:
      i. Symptom management (e.g., including identification of early warning signs and crisis planning/use of crisis plan),
      ii. Health and wellness education (e.g., benefits of routine medical check-ups, preventive care, communication with the Primary Care Provider (PCP) and other health practitioners),
      iii. Medication education and self-administration skills,
      iv. Relapse prevention,
      v. Prevocational services and ongoing support to maintain employment, work and vocational skills, educational needs assessments, and skill building,
      vi. Treatment for Substance Use Disorder (SUD) (e.g., substance use counseling, groups), and
      vii. Personal care services, if the BHRF is licensed to provide these services, (refer to A.A.C. R9-10-702, R9-10-715, R9-10-814 for additional licensing requirements).

3. In addition to treatment received at BHRF, members may receive additional specialized services under the following conditions:
   a. Specialized services shall be included in the comprehensive service plan coordinated by the outpatient treatment team and/or case manager including the provider of the service, type of treatment, frequency, duration, present level, and target goal with criteria for discontinuation, and
   b. Specialized services shall be rendered by a BHP, as defined by A.A.C. R9-22-101, utilizing CPT codes.

4. The Contractor and BHRF providers shall ensure BHRF behavioral health services adhere to the following:
   a. Services are provided under the direction and oversight of a BHP,
   b. In a private area in compliance with A.A.C. R9-10-722,
   c. Are provided by an individual within their scope of practice,
   d. Are provided under the appropriate, clinical supervision, clinical oversight, and/or direct observation as specified in AMPM Exhibit 300-3, and
   e. Shall be conducted by BHRF staff and included in the BHRF daily rate, and in accordance with the requirements as specified in AMPM Policy 310-B and the Covered Behavioral Health Services Guide (CBHSG).

5. The Contractor and BHRF providers shall ensure services are documented in compliance with AMPM Policy 940, A.A.C. Title 9, Chapter 10, Article 7, and reflect the following:
   a. Each activity shall be documented in a separate, individualized medical record, including the date, time, and valid signature, including credentials of the professional conducting the treatment activity, and the professional's printed full name,
   b. Identify treatment goals being achieved,
   c. Progress towards desired treatment goal, and
   d. Frequency, length and type of each treatment service or session.

6. The Contractor and BHRF providers shall ensure members are provided written notice of all policies and procedures regarding the member's responsibility for covering the cost of room and board. Documentation of consent shall be maintained as a part of the member's medical record. Notice and consent documentation shall include, at minimum:
   a. The total cost and/or percentage of income charged to cover rent,
   b. Policies regarding member's share of cost for groceries and/or household items, including the use of Supplemental Nutrition Assistance Program (SNAP) benefits, and
   c. Any other costs that are charged to the member or the member's HCDM.

Services cannot be billed under another level of care while a member is receiving services in a BHRF. Additional guidance on FFS billing and restrictions can be found in the FFS Provider Billing Manual and the CBHSG.

G. COORDINATION AND MEMBER PARTICIPATION

The Contractor and FFS providers shall ensure BHRF providers coordinate care with the outpatient treatment team throughout the admission, assessment, treatment, and discharge process. All coordination efforts, services, and participation shall be documented and signed in accordance with this Policy, AMPM Policy 940, AMPM Policy 830, and AMPM Policy 320-O.

The member must agree to participate in admission, treatment planning, treatment, and discharge planning. In the case of those who have a HCDM, including minors, the HCDM must consent to the member's participation in treatment, and participate as part of the treatment team.

For FFS providers, written notification shall be sent to Tribal ALTCS, TRBHA, or DDD support coordinator, PCP, behavioral health provider and/or outpatient treatment team, agency, or clinic, upon intake to and discharge from the BHRF. Evidence of the notification must be present in the member's medical record at the BHRF.

H. ADMISSION

A member's outpatient treatment team, including the TRBHA for members assigned to a TRBHA for their behavioral health enrollment and the Tribal ALTCS case manager, shall be included in the pre-admission assessment and treatment plan formulation, including when the documentation is created by another qualified provider. Exception to this requirement exists when the member is evaluated by a crisis provider, emergency department, or Behavioral Health Inpatient Facility (BHIF).

The BHRF shall notify the member's outpatient treatment team, including the TRBHA for members assigned to a TRBHA for their behavioral health enrollment, of admission prior to creation of the BHRF treatment plan.

Medical history and physical examination are required for admission to a BHRF and shall meet the following requirements in accordance with A.A.C. R9-10-707.

1. Except as provided in subsection A.A.C. R9-10-707(E)(1)(a), a medical practitioner shall perform a medical history and physical examination, or a registered nurse shall perform a nursing assessment on a member within 30 calendar days before admission or within 72 hours after admission and shall document the medical history and physical examination or nursing assessment, and, if present, the need for personal care assistance in the member's medical record.

2. If a medical practitioner performs a medical history and physical examination or a nurse performs a nursing assessment on a member before admission, the BHRF medical practitioner or nurse shall enter a note in the members medical record indicating the examination/assessment was completed and shall include a copy of the medical history, physical examination, or nursing assessment in the member's chart within seven calendar days after admission.

I. ASSESSMENT AND TREATMENT PLANNING

A behavioral health assessment for a member shall be completed before treatment is initiated, and within 48 hours of admission. The behavioral health assessment may be completed by a staff at the BHRF or received from a behavioral health provider other than the BHRF if it meets the assessment requirements of AMPM Policy 310-B, AMPM Policy 320-O and AMPM Policy 940, and adhere to the following:

1. The member's assessment information shall be reviewed before treatment is initiated, and updated if additional information that affects the resident's assessment is identified. The review and update of the resident's assessment information is documented in the resident's medical record within 48 hours after the review is completed.

2. The applicable outpatient treatment team shall be included and involved in the development of the treatment plan within 48 hours of admission. The BHRF staff, including the BHRF BHP, the outpatient treatment team, the member, and, as applicable, the HCDM, shall meet to review and modify the treatment plan at least once a month.

3. The BHRF treatment plan shall connect back to the member's service plan, and the treatment goals shall be developed in accordance with the following:
   a. Specific to the member's behavioral health condition(s),
   b. Measurable and achievable,
   c. Cannot be met in a less restrictive environment or lower level of care,
   d. Based on the member's unique needs and tailored to the member, HCDM, Designated Representative (DR), and/or family member(s) choices where possible, and
   e. Support the member's improved or sustained functioning and integration into the community.

The Contractor shall ensure all BHRF providers implement and utilize the following:

1. A system to document and report on timeliness of BHP oversight and review of services as indicated by BHP signature when the assessment and/or treatment plan is completed by a master's level BHT.

2. A process to actively engage family/HCDM and DR in the treatment planning process as applicable.

J. MEDICATION MANAGEMENT AND COORDINATION

The Contractor and BHRF providers shall ensure proactive care coordination occurs to ensure members are able to receive all prescribed medications while receiving services in a BHRF, including coordination surrounding pick up or delivery of medication, assistance with self-administration and management of medications for co-occurring conditions.

The Contractor and BHRF providers shall establish policies and procedures to ensure members prescribed MOUD are not excluded from admission and are able to receive the specific type of MOUD and dosage prescribed by the member's Opioid Treatment Provider (OTP) or Office Based Opioid Treatment Provider (OBOT) to ensure compliance with Arizona Opioid Epidemic Act SB 1001, Laws 2018, First Special Session. Members shall not be excluded from admission based on amount or type of medication prescribed and shall not be required to change medications or providers to be admitted to a BHRF. BHRFs shall coordinate care with the member's OTP or OBOT to ensure the member is able to receive prescribed MOUD medications while receiving services in a BHRF, including coordination surrounding pick up or delivery of medication and assistance with self-administration of prescribed MOUD medications.

BHRFs shall ensure compliance with A.A.C. R9-10-120 pertaining to provider qualifications and requirements for dispensing controlled substances.

K. EXPECTED TREATMENT OUTCOMES

Treatment outcomes shall align with:

1. The Arizona Vision-12 Principles for Children's Behavioral Health Service Delivery as directed in AMPM Policy 100.

2. The Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems as outlined in Contract.

3. The members' individualized basic physical, behavioral, and developmentally appropriate needs.

L. DISCHARGE PLANNING, COORDINATION, AND READINESS

The BHRF administrator and BHP shall ensure the following:

1. The member and HCDM/DR, as applicable:
   a. Are involved and participate in the discharge planning process,
   b. Understand the written discharge plan, instructions, and recommendations provided by the facility, and
   c. Are provided resources, referrals, including housing, and possible interventions to meet the member's assessed and anticipated needs after discharge.

2. Discharge planning shall occur upon completion of initial intake and shall be reviewed and updated at each treatment team meeting thereafter.

3. Ongoing support and service providers the member will be engaged with upon discharge shall be included in discharge planning meetings, where initial step-down goals and follow up treatment plan will be created.

4. The final discharge plan shall be documented in the medical record and include:
   a. Progress toward treatment goals,
   b. Follow up treatment plan and safety plan compliant with AMPM Policy 320-0,
   c. Follow up appointment with the PCP and/or specialist for service, within seven days of discharge, is scheduled,
   d. Plan for medication pick up and coordination of outgoing medication management, and
   e. BHRF coordination and/or referral is complete, acceptance confirmed, and discharge date has been communicated to ensure safe and clinically appropriate discharge, with the following:
      i. Confirmation of discharge location or step-down level of care,
      ii. Outpatient providers,
      iii. Community support services,
      iv. Transportation services, and
      v. All other support and services identified in the discharge plan.

5. For FFS members, BHRFs shall notify AHCCCS/DFSM, the assigned TRBHA, and Tribal ALTCS case manager, upon member discharge and include the discharge plan with member's disposition including follow up appointments with outpatient behavioral health services. For FFS members, this notification shall take place via the PA process. The discharge plan for TRBHA enrolled members shall be submitted securely to the assigned TRBHA case manager or TRBHA designee.

M. BHRF WITH PERSONAL CARE SERVICE LICENSE

BHRFs that provide personal care services shall be licensed to provide personal care services. Services shall be in accordance with A.A.C R9-10-702, A.A.C R9-10-715 and adhere to the following:

1. Personnel members who provide personal care services shall have documentation of completion of a caregiver training program that complies with A.A.C. R4-33-702(A)(5).

2. Residents shall receive personal care services according to the requirements in A.A.C R9-10-814 (A), (D), (E), and (F).

3. A resident who has a stage 3 or stage 4 pressure sore is not admitted to the BHRF.

4. Examples of services that may be provided include, but are not limited to:
   a. Administration of oxygen,
   b. Application and care of orthotic devices,
   c. Application and care of prosthetic devices,
   d. Application of bandages and medical supports, including high elastic stockings,
   e. ACE wraps, arm, and leg braces, etc.,
   f. Application of topical medications,
   g. Assistance with ambulation,
   h. Assistance with correct use of cane/crutches,
   i. Bed baths,
   j. Blood sugar monitoring, accu-check diabetic care,
   k. Care of hearing aids,
   l. Catheter care,
   m. Denture care and brushing teeth,
   n. Dressing member,
   o. G-tube care,
   p. Hair care, including shampooing,
   q. Incontinence support, including assistance with bed pans/bedside commodes/bathroom supports,
   r. Measuring and giving insulin, glucagon injection,
   s. Measuring and recording blood pressure,
   t. Non-sterile dressing change and wound care,
   u. Ostomy and surrounding skin care,
   v. Passive range of motion exercise,
   w. Radial pulse monitoring,
   x. Respiration monitoring,

y. Use of pad lifts,
z. Shaving,
aa. Shower assistance using shower chair,
bb. Skin and foot care,
cc. Supervising self-feeding of members with swallowing deficiencies, and
dd. Use of chair lifts.

~~320-V - BEHAVIORAL HEALTH RESIDENTIAL FACILITIES~~[3]

~~EFFECTIVE DATES: 02/08/19, 10/01/19, 10/01/20, 10/01/21, 10/01/22~~

~~APPROVAL DATES:10/18/18, 02/07/19, 07/02/19, 05/07/20, 04/13/21, 04/28/22~~

~~I. PURPOSE~~

~~This Policy applies to ACC, ACC-RBHA, ALTCS E/PD, DCS/CHP (CHP), DES/DDD (DDD) Contractors, and Behavioral Health Residential Facility (BHRF) Providers serving Fee-For-Service (FFS) Programs including: American Indian Health Program (AIHP), Tribal ALTCS, and TRBHA; and all FFS populations, excluding Federal Emergency Services (FES). (For FES, refer to AMPM Chapter 1100). This Policy establishes requirements for the provision of care and services in a BHRF.~~

~~Throughout this Policy, all references to outpatient treatment team can indicate Child and Family Team (CFT), Adult Recovery Team (ART),TRBHA, American Indian Medical Home (AIMH), Indian Health Services, Tribally operated 638 Facility, Urban Indian Health (I/T/U), Tribal ALTCS, and/or DDD. A CFT/ART is not required in order for FFS members to receive services.~~

~~II. DEFINITIONS~~

~~Definitions are located on the AHCCCS website at: AHCCCS Contract and Policy Dictionary.~~

~~III. POLICY~~

~~Care and services provided in a BHRF are based on a per diem rate (24-hour day), require prior and continued authorization and do not include room and board. BHRF is considered a level of care that is inclusive of all treatment services provided by the BHRF, in accordance with the treatment plan created by the treatment team. BHRF providers shall be ADHS licensed facilities in accordance with A.A.C. Title 9, Chapter 10, Article 7. IHS/638 facilities are subject to CMS certification requirements.~~

~~The Contractor shall refer to ACOM Policy 414 for request timeframes and requirements regarding prior authorization. All authorization requests for BHRF services shall be treated as expedited requests.~~

~~Prior and continued authorization are not applicable to a Secured Behavioral Health Residential Facility (Secured BHRF) as placement of a member into a Secured BHRF is accomplished pursuant to an order of the Superior Court as specified in A.R.S § 36-550.09.~~

~~For information on prior authorization requirements for FFS members, refer to the FFS web page.~~

[3] The previous AMPM Policy 320-V has been re-written with pertinent information incorporated in the updated AMPM Policy 320-V above.

~~The Contractor and BHRF Providers shall ensure appropriate notification is sent to the Primary Care Physician and Behavioral Health Provider/Agency/TRBHA/Tribal ALTCS program upon intake to and discharge from the BHRF.~~

~~Sections applicable to Secured BHRF will not be effective until such time that these facilities are developed.~~

~~B. CRITERIA FOR ADMISSION~~

~~The Contractor shall develop admission criteria for medical necessity which at a minimum includes the below elements. The Contractor shall submit admission criteria to AHCCCS for approval, as specified in Contract, and publish the approved criteria to the Contractor's website as specified in ACOM Policy 404.~~

~~BHRF providers providing services to FFS members are required to adhere to the below elements.~~

~~2. Member has a diagnosed behavioral health condition which reflects the symptoms and behaviors necessary for a request for residential treatment level of care. The behavioral health condition causing the significant functional and/or psychosocial impairment shall be evidenced in the assessment by the following:~~
~~a. At least one area of significant risk of harm within the past three months as a result of:~~
~~i. Suicidal/aggressive/self-harm/homicidal thoughts or behaviors without current plan or intent,~~
~~ii. Impulsivity with poor judgment/insight,~~
~~iii. Maladaptive physical or sexual behavior,~~
~~iv. Inability to remain safe within environment, despite environmental supports (i.e., informal supports), or~~
~~v. Medication side effects due to toxicity or contraindications.~~

~~AND~~

~~b. At least one area of serious functional impairment as evidenced by:~~
~~vi. Inability to complete developmentally appropriate self-care or self-regulation due to behavioral health condition(s),~~
~~vii. Neglect or disruption of ability to attend to majority of basic needs, such as personal safety, hygiene, nutrition, or medical care,~~
~~viii. 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,~~
~~ix. Frequent withdrawal management services, which can include but are not limited to, detox facilities, Medicated Assisted Treatment (MAT), and ambulatory detox,~~
~~x. Inability to independently self-administer medically necessary psychotropic medications despite interventions such as education, regimen simplification, daily outpatient dispensing, and long-acting injectable medications, or~~
~~xi. Impairments persisting in the absence of situational stressors that delay recovery from the presenting problem.~~

c. A behavioral health need for 24 hour supervision to develop adequate and effective coping skills that will allow the member to live safely in the community,
d. Anticipated stabilization cannot be achieved in a less restrictive setting,
e. Evidence that behavioral health treatment in a less restrictive level of care (e.g., Intensive Outpatient Program (IOP), Partial Hospitalization Program, etc.) has not been successful or is not available, therefore warranting a higher level of care,
f. Member or Guardian agrees to participate in treatment. In the case of those who have a Health Care Decision Maker (HCDM), including minors, the HCDM also agrees to, and participates as part of, the treatment team,
g. Agreement to participate in treatment is not a requirement for individuals who are court ordered to a secured BHRF,
h. Member's outpatient treatment team, shall be part of the pre-admission assessment and treatment plan formulation, including when the documentation is created by another qualified provider. Exception to this requirement exists when the member is evaluated by the Crisis provider, Emergency Department, or Behavioral Health Inpatient Facility, and
i. The BHRF shall notify the member's outpatient treatment team of admission prior to creation of the BHRF treatment plan.

C. EXPECTED TREATMENT OUTCOMES

1. Treatment outcomes shall align with:
   a. The Arizona Vision 12 Principles for Children's Behavioral Health Service Delivery as directed in AMPM Policy 430,
   b. The Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems as outlined in Contract, and
   c. The member's individualized basic physical, behavioral, and developmentally appropriate needs.

2. Treatment goals shall be developed in accordance with the following:
   a. Specific to the member's behavioral health condition(s),
   b. Measurable and achievable,
   c. Cannot be met in a less restrictive environment or lower level of care,
   d. Based on the member's unique needs and tailored to the member and the family's/HCDM and designated representative's choices where possible, and
   e. Support the member's improved or sustained functioning and integration into the community.

D. EXCLUSIONARY CRITERIA

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

1. An alternative to detention or incarceration.

2. As a means to ensure community safety in circumstances where a member is exhibiting primarily conduct disorder behavior without the presence of risk or functional impairment.

3. A means of providing safe housing, shelter, supervision, or permanency placement.

4. A behavioral health intervention when other less restrictive alternatives are available and meet the member's treatment needs, including situations when the member/HCDM are unwilling to participate in the less restrictive alternative, or

5. As an intervention for runaway behaviors unrelated to a behavioral health condition.

E. CRITERIA FOR CONTINUED STAY

1. The Contractor shall develop medical necessity criteria for continued stay which at a minimum includes the below elements. The Contractor shall submit continued stay criteria to AHCCCS for approval, as specified in Contract, and publish the approved criteria within 10 days of the changes being approved.

   BHRF providers providing services to FFS members are required to submit to AHCCCS/Division of Fee-For-Service Management (DFSM) documentation of all participants in the treatment planning during the continued stay review process and to adhere to the below elements:

   a. Continued stay shall be assessed by the BHRF staff in coordination with the applicable outpatient treatment team during treatment plan review and updates. Progress towards the treatment goals and continued display of risk and functional impairment shall also be assessed. Treatment interventions, frequency, crisis/safety planning, and targeted discharge shall be adjusted accordingly to support the need for continued stay. The following criteria shall be considered when determining continued stay:
      i. The member continues to demonstrate significant risk of harm and/or functional impairment as a result of a behavioral health condition, and
      ii. Providers and supports are not available to meet current behavioral and physical health needs at a less restrictive lower level of care.

F. DISCHARGE READINESS

1. The Contractor shall develop medical necessity criteria for discharge which at a minimum includes the below elements. The Contractor shall submit discharge criteria to AHCCCS for approval, as specified in Contract, and publish the approved criteria within 10 days of the changes being approved.

   BHRF providers providing services to FFS members are required to adhere to the minimum discharge elements below.

   a. Discharge planning shall begin at the time of admission. Discharge readiness shall be assessed by the BHRF staff in coordination with the applicable treatment team during each treatment plan review and update. The following criteria shall be considered when determining discharge readiness:
      i. Symptom or behavior relief is reduced as evidenced by completion of treatment plan goals,
      ii. Functional capacity is improved, essential functions such as eating or hydrating necessary to sustain life has significantly improved or is able to be cared for in a less restrictive level of care,

iii. Member can participate in needed monitoring, or a caregiver is available to provide monitoring in a less restrictive level of care, and
iv. Providers and supports are available to meet current behavioral and physical health needs at a less restrictive level of care.

G. ADMISSION, ASSESSMENT, TREATMENT AND DISCHARGE PLANNING

The Contractor shall establish a policy to ensure the admission, assessment, and treatment planning process is completed consistently among all providers in accordance with A.A.C. R9-10-707 and 708, Contract requirements, and as stated below.

BHRF Providers rendering services to FFS members shall follow the below outlined admission, assessment, treatment, and discharge planning requirements.

3. Except as provided in subsection A.A.C. R9-10-707(A)(9), a behavioral health assessment for a member shall be completed before treatment is initiated and within 48 hours of admission.

4. The applicable outpatient treatment team shall be included in the development of the treatment plan within 48 hours of admission.

5. BHRF documentation shall reflect:
   e. All treatment services provided to the member,
   f. Each activity shall be documented in a separate, individualized medical record, including the date, time, and professional conducting treatment activity,
   g. Which treatment plan goals are being achieved,
   h. Progress towards desired treatment goal, and
   i. Frequency, length and type of each treatment service or session.

6. All BHRFs shall coordinate care with the outpatient treatment team throughout the admission, assessment, treatment, and discharge process.

7. The BHRF treatment plan shall connect back to the member's comprehensive service plan.

8. For secured BHRF the treatment plan also aligns with the court order.
   a. A comprehensive discharge plan shall be created during the development of the initial treatment plan and shall be reviewed and/or updated at each review thereafter. The discharge plan shall document the following:
      i. Clinical status for discharge,
      ii. Member/health care decision maker and designated representative and, outpatient treatment team understands follow-up treatment, crisis, and safety plan, and
      iii. Coordination of care and transition planning are in process (e.g., reconciliation of medications, applications for lower level of care submitted, follow-up appointments made, identification of wrap around supports and potential providers).

9. The BHRF staff and the outpatient treatment team shall meet to review and modify the treatment plan at least once a month.

10. A treatment plan may be completed by a BHP, or by a BHT with oversight and signature by a BHP within 24 hours.

11. Implementation of a system to document and report on timeliness of BHP signature/review when the treatment plan is completed by a BHT.
12. Implementation of a process to actively engage family/health care decision maker and designated representative in the treatment planning process as appropriate.

13. Clinical practices, as applicable to services offered and population served, shall demonstrate adherence to best practices for treating specialized service needs, including but not limited to:
    f. Cognitive/intellectual disability,
    g. Cognitive disability with comorbid behavioral health condition(s),
    h. Older adults, and co-occurring disorders (substance use and behavioral health condition(s), or
    i. Comorbid physical and behavioral health condition(s).

14. BHRF is a level of care available to members. Members cannot receive services under another level of care while receiving services in a BHRF. For additional guidance on billing and restrictions, see the FFS Provider Billing Manual and the Behavioral Health Services Matrix.

    Services deemed medically necessary through the assessment and/or outpatient treatment team which are not offered at the BHRF, shall be documented in the member's comprehensive service plan and documentation shall include a description of the need, identified goals and identification of provider meeting the need. The following services shall be made available and provided by the BHRF and cannot be billed separately unless otherwise noted below:
    d. Counseling and Therapy (group or individual):
       Behavioral Health Counseling and Therapy may not be billed on the same day as BHRF services unless specialized behavioral health counseling and therapy have been identified in the service plan as a specific member need that cannot otherwise be met as required within the BHRF setting,
    e. Skills Training and Development:
       iv. Independent Living Skills (e.g., self-care, household management, budgeting, avoidance of exploitation/safety education and awareness),
       v. Community Reintegration Skill building (e.g., use of public transportation system, understanding community resources and how to use them), and
       vi. Social Communication Skills (e.g., conflict and anger management, same/opposite-sex friendships, development of social support networks, recreation).
    f. Behavioral Health Prevention/Promotion Education and Medication Training and Support Services including but not limited to:
       viii. Symptom management (e.g., including identification of early warning signs and crisis planning/use of crisis plan),
       ix. Health and wellness education (e.g., benefits of routine medical check-ups, preventive care, communication with the PCP and other health practitioners),
       x. Medication education and self-administration skills,

xi. Relapse prevention,
xii. Psychoeducation services and ongoing support to maintain employment work and vocational skills, educational needs assessment and skill building,
xiii. Treatment for substance use disorder (e.g., substance use counseling, groups), and
xiv. Personal care services (refer to A.A.C. R9-10-702, R9-10-715, R9-10-814 for additional licensing requirements).

H. BHRF AND MEDICATION ASSISTED TREATMENT

The Contractor and BHRF Providers shall establish policies and procedures to ensure members on MAT are not excluded from admission and are able to receive MAT to ensure compliance with Arizona Opioid Epidemic Act SB 1001, Laws 2018, First Special Session.

I. BHRF WITH PERSONAL CARE SERVICE LICENSE

BHRFs that provide personal care services shall be licensed to provide personal care services. Services offered shall be in accordance with A.A.C R9-10-702 and A.A.C R9-10-715. Contractors and BHRF providers shall ensure that all identified needs can be met in accordance with A.A.C. R9-10-814 (A)(C)(D) and (E).

1. Examples of services that may be provided include, but are not limited to:
   a. Administration of oxygen,
   b. Application and care of orthotic devices,
   c. Application and care of prosthetic devices,
   d. Application of bandages and medical supports, including high elastic stockings,
   e. ACE wraps, arm, and leg braces, etc.,
   f. Application of topical medications,
   g. Assistance with ambulation,
   h. Assistance with correct use of cane/crutches,
   i. Bed baths,
   j. Blood sugar monitoring, Accu-Check diabetic care,
   k. Care of hearing aids,
   l. Catheter care,
   m. Denture care and brushing teeth,
   n. Dressing member,
   o. G-tube care,
   p. Hair care, including shampooing,
   q. Incontinence support, including assistance with bed pans/bedside commodes/ bathroom supports,
   r. Measuring and giving insulin, glucagon injection,
   s. Measuring and recording blood pressure,
   t. Non-sterile dressing change and wound care,
   u. Ostomy and surrounding skin care,
   v. Passive range of motion exercise,
   w. Radial pulse monitoring,
   x. Respiration monitoring,
   y. Use of pad lifts,

~~z. Shaving,~~
~~aa. Shower assistance using shower chair,~~
~~bb. Skin and foot care,~~
~~cc. Skin maintenance to prevent and treat bruises, injuries, pressure sores. Members with a stage 3 or 4 pressure sore are not to be admitted to BHRF (A.A.C. R9-10-715(3)), and infections,~~
~~dd. Supervising self-feeding of members with swallowing deficiencies, and~~
~~ee. Use of chair lifts.~~