1620-G BEHAVIORAL HEALTH STANDARDS

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REVIEW DATE: 03/01/13

INITIAL EFFECTIVE DATE: 02/14/1996

In addition to all other Arizona Long Term Care System (ALTCS) case management standards, the following standards also apply to members who need or receive behavioral health services:

~~1. Direct referral for a behavioral health evaluation may be made by the member or by any health care professional in coordination with the case manager and Primary Care Provider (PCP).~~

1. When the case manager receives a ~~R~~requests for behavioral health services ~~made by~~from the member or member representative or when the case manager identifies the need for behavioral health services, the case manager must ~~be assessed for appropriateness within three business days of the request. If it is determined that services are needed, the~~ send a referral to a behavioral health provider for an initial assessment on the same day that the request was received or a need is identified. ~~evaluation must be made within one business day.~~

2. The case manager shall send referrals for SMI Determinations to a qualified clinician, as defined in A.A.C. R9-21-101(B) for assessment and evaluation.

~~1.~~ 3. The case managers shall ensure members receive services in accordance with ~~Behavioral health services which have been determined to be medically necessary by a qualified behavioral health professional (as defined in Arizona Administrative Code 9 A.A.C.10) may be provided.~~

~~The case manager must ensure there is communication with the PCP and behavioral health providers involved in the member's care and that care is coordinated with other agencies and involved parties.~~

~~The case manager must ensure the timely involvement of a behavioral health professional to assess, develop a care plan and preserve the current placement if possible when a member in a non-behavioral health setting presents with difficult to manage behaviors (new or existing). Refer to the "Policy for Management of Acute Behavioral Health~~

~~Situations" found in Appendix H of this manual for more detailed information on that process.~~

~~Information from the Pre-Admission Screening and Resident Review (PASRR) Level II Evaluation for determination of mental illness (completed by the Arizona Department of Health Services when indicated by PASRR Level I screening) regarding a member's need for specialized services must be incorporated into the member's service plan. AHCCCS registered Nursing Facilities (NFs) must complete Level I PASRR screening, or verify that a screening has been conducted, in order to identify mental illness and/or an intellectual disability prior to initial admission of individuals to a NF bed that is Medicaid certified or dually certified for Medicaid/Medicare. (See additional information related to PASRR in Chapter 1200, Policy 1220 of this Manual)~~

behavioral health appointment standards:

a. ~~1.~~ Immediate Need appointments within 24 hours from identification of need

b. ~~2.~~ Routine care appointments:
   i. Initial assessment within seven days of referral

   ii. The first behavioral health service following the initial assessment within the timeframe indicated by the behavioral health condition, but no later than 23 days after the initial assessment

   iii. All subsequent behavioral health services within the timeframe indicated by the behavioral health condition, but no later than 45 days from identification of need

4. The case manager must ensure there is communication with the PCP and behavioral health providers involved in the member's care and that care is coordinated with other agencies and involved parties.

5.
The case manager must ensure the timely involvement of a behavioral health professional to assess, develop a care plan and preserve the current placement if possible when a member in a non-behavioral health setting presents with difficult to manage behaviors (new or existing). Refer to the "Policy for Management of Acute Behavioral Health Situations" found in AMPM Appendix H for more detailed information on that process.

6.
~~Within 24 hours of referral for emergency appointments, or~~

~~Within 30 days of referral for routine appointments.~~

Case management for a member receiving behavioral health services must be provided in ~~consultation/~~collaboration with a qualified Bb~~b~~ehavioral Hh~~h~~ealth Pp~~p~~rofessional in those cases where the case manager does not meet the qualifications of a Bb~~b~~ehavioral Hh~~h~~ealth Pp~~p~~rofessional (as defined in 9 A.A.C. 10). The consultation does not have to be with the provider of behavioral health services. It may be with the Contractor's behavioral health coordinator or other qualified designee.

7. The ~~ALTCS~~ case manager must make contact with the behavioral health professional prior to the initial behavioral health consultation for all members receiving/needing behavioral health services. Quarterly discussions between the ALTCS case manager and the behavioral health professional are required thereafter as long as the member continues to receive/need behavioral health services.

8. Initial and quarterly discussions are not required for members who are stable on psychotropic medications and/or are not receiving any behavioral health services other than medication management.

9. The case manager must document the content and results of the initial and quarterly discussions with the behavioral health professional. The discussion must be a communication between the case manager and a behavioral health professional about the member's status and plan of treatment. It must not simply be a report from the provider that has been received by the case manager and put in the case file.

10. As part of the service plan monitoring, the case manager must review the psychotropic medications being taken by the member. Only those medications used to modify behavioral health symptoms need to be included in this special monitoring. Examples of medication uses that do not require this monitoring are sedative hypnotics when used to treat insomnia or on an as needed basis prior to a procedure, anti-anxiety medications used for muscle spasms and anticonvulsants used to treat a seizure disorder.

11. Documentation of the medication review must be clearly evident in the member case file. The review must take place at each reassessment and include the purpose of the medication, the effectiveness of the medication and any adverse side effects that may have occurred. Any concerns noted (for example, medication appears to be ineffective, adverse side effects are present, multiple medications apparently prescribed for the same diagnosis) must be discussed with the behavioral health consultant and/or prescribing practitioner. Case notes must reflect this discussion and a plan of action to address these issues.

12. Case managers are responsible for identifying, assisting with and monitoring the special needs and requirements related to members who are unable or unwilling to consent to treatment (i.e. petitioning, court ordered treatment and judicial review). Case file documentation must reflect this activity.

13. The behavioral health code that reflects the member's current behavioral health status must be updated at the time of each review visit on the CA161/Placement Maintenance screen in Client Assessment Tracking System (CATS). Refer to the AHCCCS Contractors Operations Manual ~~(ACOM), Chapter 400,~~ ACOM Policy 411, for a list and description of these codes.