

**Arizona Department of Health Services**  
**Division of Behavioral Health Services**  
**PROVIDER MANUAL**  
*Magellan Health Services of Arizona Edition*

**Section 3.13**      **Covered Behavioral Health Services**

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**3.13.1      Introduction**

The ADHS/DBHS system of care offers an assortment of covered behavioral health services to meet the individual needs of persons seeking behavioral health services. The continuum of available services includes supervised and semi-supervised facility-based care, an array of treatment services and support services. Covered behavioral health services assist and encourage each person to achieve and maintain the highest possible level of health and self-sufficiency. The provision of covered behavioral health services is contingent on each person's current eligibility status and, for some persons, may be based on available funding.

**3.13.2      References**

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

- [42 CFR Part 400](#)
- [42 CFR Part 403](#)
- [42 CFR Part 411](#)
- [42 CFR Part 417](#)
- [42 CFR Part 422](#)
- [42 CFR Part 423](#)
- [R9-22-1205](#)
- [R9-31-1205](#)
- [AHCCCS/ADHS Contract](#)
- [ADHS/RBHA Contracts](#)
- [ADHS/TRBHA IGAs](#)
- [Section 3.1, Eligibility for AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage, and the Limited Income Subsidy Program](#)
- [Section 3.4, Co-payments](#)
- [Section 3.21, Service Prioritization for Non-Title XIX/XXI Funding](#)
- [ADHS/DBHS Covered Behavioral Health Services Guide](#)

**3.13.3      Scope**

**To whom does this apply?**

- All Title XIX/XXI (Medicaid/SCHIP) and Title XVIII (Medicare) eligible persons;
- All persons determined to have a Serious Mental Illness; and

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- All other persons, based on available funding according to [Section 3.21, Service Prioritization for Non-Title XIX/XXI Funding](#).

#### 3.13.4 Did you know...?

The [ADHS/DBHS Covered Behavioral Health Services Guide](#) contains information regarding each of the covered behavioral health services that are available through the publicly funded behavioral health system including:

- A definition of each service;
- The requirements of individuals or agencies providing the service; and
- Any limitations to using or billing for the service.

Medicare eligible behavioral health recipients, including persons who are dually eligible for Medicare (Title XVIII) and Medicaid (Title XIX/XXI), receive Medicare Part D prescription drug benefits through Medicare Prescription Drug Plans (PDPs) or Medicare Advantage Prescription Drug Plans (MA-PDs). Prescription drug coverage for Medicare eligible behavioral health recipients enrolled in Part D is based on Part D plans' formularies.

#### 3.13.5 Definitions

[Flex funds](#)-Funds utilized to purchase any of a variety of one-time or occasional goods and/or services needed for enrolled persons (children or adults) and their families, when the goods and/or services cannot be purchased by any other funding source, and the service or good is directly related to the enrolled person's service plan.

[Medically necessary covered services](#)-Covered behavioral health services provided by qualified service providers within the scope of their practice to prevent disease, disability, and other adverse health conditions or their progression or to prolong life. Medically necessary services are aimed at achieving the following:

- The prevention, diagnosis, and treatment of behavioral health impairments;
- The ability to achieve age-appropriate growth and development; and
- The ability to attain, maintain, or regain functional capacity.

#### 3.13.6 Objectives

The intent of this section is as follows:

Behavioral health providers must provide medically necessary covered behavioral health services, within their scope of practice, based upon the needs of the person.

Services must be provided in collaboration with other agencies to coordinate the culturally appropriate delivery of covered behavioral health services with other services and supports provided to the person and the person's family.

Covered behavioral health services must be available to family members of persons enrolled with a T/RBHA to the extent that services are provided in support of the treatment goals of the identified eligible or enrolled person.

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#### 3.13.7 Procedures

##### 3.13.7-A: Covered services matrix

[PM Attachment 3.13.1, Covered Services Matrix](#), lists the available covered behavioral health services for each population of T/RBHA enrolled persons. These services must be provided by AHCCCS registered providers, ADHS-only providers or Medicare registered providers.

[PM Attachment 3.13.1, Covered Services Matrix](#) is a condensed summary of available behavioral health services and related funding sources. Behavioral health providers may reference the [ADHS/DBHS Covered Behavioral Health Services Guide](#) for more detailed information.

##### 3.13.7-B: Medicare Part D Prescription Drug Coverage

Persons eligible for Medicare Part D must access the Medicare Part D prescription drug coverage by enrolling with a Medicare Prescription Drug Plan (PDP) or Medicare Advantage Prescription Drug plan (MA-PD). Persons eligible for both Medicare Part D and Title XIX/XXI (AHCCCS) will continue to have coverage of the following excluded Part D drugs through Title XIX/XXI, if not included in the PDP or MA plans' formulary:

- Benzodiazepines;
- Barbiturates; and
- Certain over the counter drugs.

##### 3.13.7-C: Flex Funds

T/RBHAs and/or their subcontracted providers may provide flex funds based on available funding.

##### When can flex funds be used?

Flex funds may only be used for goods and/or services that are described in the person's service plan that cannot be purchased by any other funding source. The good and/or service to be provided using flex funds must be related to one or more of the following outcomes:

- Success in school, work or other occupation;
- Living at the person's own home or with family;
- Development and maintenance of personally satisfying relationships;
- Prevention or reduction in adverse outcomes, including arrests, delinquency, victimization and exploitation; and/or
- Becoming or remaining a stable and productive member of the community.

##### When can flex funds not be used?

Flex funds must not be used for:

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- Inpatient or other covered behavioral health services;
- The purchase or improvement of land;
- The purchase, construction or permanent improvement of any building or other facility (with the exception of minor remodeling consistent with this Section); and
- The purchase of major medical equipment.

T/RBHAs and/or their subcontracted providers must use flex funds for the direct purchase of goods and/or services and may not provide flex funds as direct cash payments to behavioral health recipients or their families. See the [ADHS/DBHS Covered Behavioral Health Services Guide](#) for additional information regarding flex funds and applicable billing limitations.

#### How are flex funds accessed?

Each T/RBHA may approve flex fund services of up to \$1,525 per individual/family per year. Clinical teams may access flex funds by assisting recipients in completing a flex funds request and submitting it to the PNO Regional Director for initial approval. The following items will be included in a completed request:

- The check request
- A copy of the vendor bill
- W-9
- Recipient's budget
- Progress Notes
- ISP and ISP signature page (the request must align with specific ISP requirements)
- Completed flex funds checklist
- Service Ticket

For assistance in preparing the requests or acquiring copies of forms or checklists, providers may contact the Magellan Adult Services Department at (602) 797-8293. The PNO Regional Director will ensure that all required information, documentation and justification are provided in the request, and then forward approved requests to the Magellan Adult Services Director for Quality of Care for final review and approval at either the following address or fax number:

Magellan Health Services of Arizona  
Attention: Adult Services Director of Quality of Care  
P.O. Box 68110  
Phoenix, AZ 85082-8110

or

1-888-656-5267

If multiple checks are required for more than one vendor (i.e. rent, utilities, etc.) a separate check request, vendor bill and W-9 must be submitted for each request.

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The Adult Services Director for Quality of Care or their designee, is responsible for approving all flex fund requests. For approved requests, Magellan will prepare a check made out to the vendor, and coordinate with the provider for the check to be picked up. Providers will subsequently, ensure payment is made directly to the appropriate vendor. For all denied requests, Magellan will provide the recipient with written notice of the denial. Should a recipient wish to appeal the denial, the case manager will provide assistance to the recipient in following the applicable appeal process. A copy of the written denial notice and applicable appeal documentation will be included in the medical record.

Magellan must forward requests for approval of flex fund expenditures of \$1,525 or more to the following office within ADHS/DBHS for approval: Director of Clinical Operations.