ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Outpatient Behavioral Health Re-Certification of Need (RON) Form

(For Behavioral Health Residential Facilities and Intensive Outpatient Treatment Programs)

The RON must be completed and signed by the treating behavioral health professional (BHP), licensed under A.R.S. Title 32, Chapter 33, and submitted to DFSM upon expiration of the CON, or upon expiration of a previously submitted RON.

I. Treatment Type

Check the applicable treatment type (required)*:*

☐ **IOP SUD Treatment:** Treatment for alcohol or other substances at least three hours/day and at least three days/week (Nine hours or more per week, may be less with adolescents). Non-IHS/638 IOPs focused on the treatment of substance use and co-occurring disorders shall include a copy of the American Society of Addiction Medicine (ASAM, 3rd edition) with the RON. RON for IOP SUD treatment is due at a minimum every 12 weeks.

☐ **IOP Psychiatric Mental and Behavioral Health:** All-inclusive behavioral health service. All IOP related services and programming are included in the rate. Treatment is at least three hours per day for two or more days per week (9-19 hours per week). Non-IHS/638 IOPs focused on the treatment of substance use and co-occurring disorders shall include a copy of the American Society of Addiction Medicine (ASAM, 3rd edition) with the RON. RON for IOP psychiatric treatment is due at a minimum every 30 days.

☐ **BHRF Treatment:** BH treatment for an individual experiencing issues that limit the individual's ability to be independent or causes the individual to require treatment to maintain or enhance independence, as specified in the member's treatment plan.

BHRF treatment is expected to be inclusive of all services specified in the member's BH treatment plan developed by the member's outpatient treatment team. Members in a BHRF shall not receive consecutive IOP treatment or other treatment from outside providers that is duplicative of the services the BHRF is expected to provide. RON for BHRF services is due at a minimum every 60 days.

II. Member and BHP Demographic Information

Member

Member Last Name: Member First Name:

Member DOB: Member AHCCCS ID Number:

Member Behavioral Health ICD-10 Diagnosis- Primary: Other ICD-10 Diagnoses:

Member's Phone: Member's Email:

Certifying BHP

BHP Printed Name and Credentials:

BHP AHCCCS Provider ID Number (six digits) BHP Phone Number:

BHP Business Email:

BHP Signature: Date:

III. BHP Certification (Required)

The BHP signature on the RON certifies that he/she is the treating BHP, and that:

☐ He/She has current knowledge of the client's behavioral health condition and treatment needs,

He/She certifies his/her accountability for and oversight of all services that are expected to be delivered in accordance with the member's current treatment plan.

☐ He/She has sufficient information to determine that continued treatment at the specified care level is most appropriate to safely meet the behavioral health needs of the member.

☐ The member has agreed to participate in treatment in the level of care specified above, or in the case of a member who has a health care decision maker (HCDM), including minors, the HCDM has agreed to the member's participation in treatment at the level of care specified above.

☐ Please specify the date of the current treatment plan:

BHP Signature: Date:

BHP AHCCCS Provider ID Number (six digits): BHP Phone Number:

For IOP see Sections IV. and VI., or For BHRF see Sections V. and VI (Required)

IV. IOP Service Continuation

Specify the signs and symptoms that are the result of the member's diagnosed behavioral health condition, and which necessitate continued treatment in a Behavioral Health Residential Facility, including the specific criteria the member has met, in accordance with AMPM 320-V. Please also indicate what evidence-based practices and programs (EBPPs) were used to determine medical necessity.

V. BHRF Service Continuation

Specify the signs and symptoms that are the result of the member's diagnosed behavioral health condition and which necessitate continued treatment in a Behavioral Health Residential Facility, and which criteria the member meets in accordance with AMPM 320-V:

VI. Accompanying Documentation (Required)

**The following documents shall accompany submission of the RON:*

- ☐ Most current treatment plan, which must include documentation of **all** of the following:
  - Targeted discharge date,
  - Member/HCDM signature,
  - Evidence of treatment planning/coordination with the member's outpatient treatment team.
- ☐ Progress Notes (most recent 7 days preceding RON submission).

* Prior Authorization is not a guarantee of payment. Additional documentation may be requested as needed by AHCCCS/DFSM for the purpose of determining the medical necessity and quality of services delivered.