



Banner
University Health Plans

2021 Provider Manual

Banner – University Family Care/ACC

Banner – University Care Advantage



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Section 1 – Introduction

Banner – University Health Plans (B – UHP) would like to thank you for providing quality medical and behavioral health care to our members. We remain committed to developing a positive working relationship with all of our providers and welcome any comments or suggestions on how we can improve our operations and interactions with you, our customer.

For the purposes of this provider manual, we will refer to the parent organization as:

- Banner – University Health Plans (B – UHP) OR
- B – UHP; OR
- The Health Plans.

B – UHP operate as one component of an integrated health care system that includes Banner – University Medical Center Tucson Campus and South Campus as well as a comprehensive network of Banner Health primary care and specialty care providers.

We also have a robust and diversified community provider network across all counties of operation. Our goal is to ensure that our members have access to care nearby and that primary care providers have a good selection of local providers with which to work and refer our members.

Our Health Plans:

Banner – University Family Care / AHCCCS Complete Care (B – UFC/ACC)

Banner – University Family Care/ACC (B – UFC/ACC) is offered to Arizona Health Care Cost Containment System (AHCCCS) eligible Complete Care members. Eligibility is determined by the Arizona Department of Economic Security (ADES) and the AHCCCS Administration.

Banner – University Care Advantage (B – UCA)

Banner – University Care Advantage (B – UCA) is a Dual Eligible Special Needs Plan (D-SNP) members with both Medicare and Medicaid. Members must be entitled to Medicare Part A, enrolled in Medicare B and AHCCCS and reside in a contracted service area in order to be eligible.

Our Provider Manual is an extension of your Provider Agreement with B – UHP. We have designed the manual in an effort to supply you and your staff with pertinent operational protocols, policies, procedures, and regulatory expectations that will be critical to your success in working with B – UHP and administering the member benefit for each of the B – UHP product lines. We value your partnership and understand the fundamental role that you play in serving B – UHP members. Should you have any questions regarding the information conveyed in this manual, do not hesitate to contact your assigned Provider Relations Representative.

Section 2 – Definitions

1931 (ALSO REFERRED TO AS TANF RELATED) – Eligible individuals and families under the 1931 provision of the Social Security Act, with household income levels at or below 100% of the Federal Poverty Level (FPL).

ABUSE OF THE PROGRAM (BY PROVIDER) – Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes member practices that result in unnecessary costs to the Medicaid Program. 42 CFR 455.2

ABUSE OF A MEMBER – Abuse of a member means any intentional, knowing or reckless infliction of physical harm, injury caused by negligent acts or omissions, unreasonable confinement, emotional or sexual abuse, or sexual assault.

AGENT – Any person who has been delegated the authority to obligate or act on behalf of a provider.

AMBULATORY CARE – Preventive, diagnostic and treatment services provided on an outpatient basis by physicians, nurse practitioners, physician assistants and other health care providers.

ANNIVERSARY DATE – The anniversary date is 12 months from the date the member enrolled with the Contractor and annually thereafter. In some cases, the anniversary date will change based on the last date the member changed Contractors or the last date the member was given an opportunity to change.

ANNUAL ENROLLMENT CHOICE (AHCCCS ONLY) – The opportunity for each member to change Contractors every 12 months effective their anniversary date.

ARIZONA ADMINISTRATION CODE (A.A.C.) – State regulations established pursuant to relevant statutes. Referred to in Contract as “Rules.” AHCCCS Rules are State regulations which have been promulgated by the AHCCCS Administration and published by the Arizona Secretary of State.

ARIZONA DEPARTMENT OF HEALTH SERVICES (ADHS) BEHAVIORAL HEALTH RECIPIENT – A Title XIX or Title XXI acute care member who is eligible for, and is receiving, behavioral health services through Arizona Department of Health Services (ADHS) and its subcontractors.

ARIZONA DEPARTMENT OF HEALTH SERVICES, DIVISION OF BEHAVIORAL HEALTH (ADHS/DBHS) – The state agency mandated to provide behavioral health services to Title XIX and Title XXI Acute care members who are eligible for behavioral health services. Services are provided through the ADHS Division of Behavioral Health and its Contractors.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) – Arizona’s Medicaid

Program, approved by the Center for Medicare and Medicaid Services as Section 1115 Waiver Demonstration Program and described in A.R.S. Title 36, Chapter 29.

ARIZONA LONG TERM CARE SYSTEM (ALTCS) – An AHCCCS program which delivers long- term, acute, behavioral health and case management services as authorized by A.R.S. §36-2931 et seq., to eligible members who are either elderly and/or have physical disabilities, and to members with developmental disabilities, through contractual agreements and other arrangements.

ARIZONA REVISED STATUTES (A.R.S.) – Laws of the State of Arizona.

ARIZONA STATE IMMUNIZATION INFORMATION SYSTEM (ASIIS) – Arizona State Immunization Information System (ASIIS) is the central database maintained by the Arizona Department of Health Services to record all immunizations administered to children younger than age 19. Arizona law requires physicians to report all immunizations given to children in this age group at least monthly. PC immunize is free software which assists physicians in capturing and collecting this data for reporting to the State central registry.

AUDIT – A formal review of compliance with a particular set of standards (e.g., policies and procedures, laws and

regulations) used as a base measure.

BEHAVIORAL HEALTH PARAPROFESSIONAL – As specified in A.A.C. R9-10-101, an individual who is not a behavioral health professional who provides behavioral health services at or for a health care institution according to the health care institution's policies and procedures that:

- a. If the behavioral health services were provided in a setting other than a licensed health care institution, the individual would be required to be licensed as a behavioral professional under
- b. A.R.S. Title 32, Chapter 33; and
- c. Are provided under supervision by a behavioral health professional.

BEHAVIORAL HEALTH PROFESSIONAL – As specified in A.A.C. R9-10-101, an individual licensed under A.R.S. Title 32, Chapter 33, whose scope of practice allows the individual to:

- a. Independently engage in the practice of behavioral health as defined in A.R.S. §32-3251; or
- b. Except for a licensed substance abuse technician, engage in the practice of behavioral health as defined in A.R.S. §32-3251 under direct supervision as defined in A.A.C. R4-6-101;
- c. A psychiatrist as defined in A.R.S. §36-501; psychologist as defined in A.R.S. §32-2061;
- d. A physician;
- e. A registered nurse practitioner licensed as an adult psychiatric and mental health nurse; or
- f. A behavior analyst as defined in A.R.S. §32-2091; or
- g. A registered nurse.

BEHAVIORAL HEALTH RECIPIENT – A Title XIX or Title XXI acute care member who is receiving behavioral health services through ADHS and the subcontractors.

BEHAVIORAL HEALTH SERVICES – Physician or practitioner services, nursing services, health-related services, or ancillary services provided to an individual to address the individual's behavioral health issue. See also "COVERED SERVICES."

BEHAVIORAL HEALTH TECHNICIAN – As specified in A.A.C. R9-10-101, an individual who is not a behavioral health professional who provides behavioral health services at or for a health care institution according to the health care institution's policies and procedures that:

- a. If the behavioral health services were provided in a setting other than a licensed health care institution, the individual would be required to be licensed as a behavioral professional under
- b. A.R.S. Title 32, Chapter 33; and
- c. Are provided with clinical oversight by a behavioral health professional.

BOARD CERTIFIED – An individual who has successfully completed all prerequisites of the respective specialty board and successfully passed the required examination for certification and when applicable, requirements for maintenance of certification.

BREACH – Breach means the acquisition, access, use, or disclosure of Protected Health Information in a manner not permitted under the Privacy Rule, which compromises the security or privacy of Protected Health Information and is subject to the same exclusions as found in the definition of Breach in 45 C.F.R. § 164.402.

BREAST AND CERVICAL CENTER TREATMENT PROGRAM (BCCTP) – Eligible individuals under the Title XIX expansion program for women with income up to 250% of the FPL, who are diagnosed with and need treatment for breast and/or cervical cancer or cervical lesions and are not eligible for other Title XIX programs providing full Title XIX services. Qualifying individuals cannot have other creditable health insurance coverage, including Medicare.

BUSINESS PARTNERS – The collective grouping of all B – UHP first tier, downstream and related entities, subcontractors and agents.

CAPITATION – Payment to a provider by B – UHP of a fixed monthly payment per person in advance, for which the Contractor provides a full range of covered services as authorized under A.R.S. §36-2904 and §36-2907.

CATEGORICALLY LINKED TITLE XIX MEMBER – A member who is eligible for Medicaid under Title XIX of the Social Security Act including those eligible under 1931 provisions of the Social Security Act (previously AFDC), Sixth Omnibus Budget Reconciliation Act (SOBRA), Supplemental Security Income (SSI), SSI-related groups. To be categorically linked, the member must be aged 65 or over, blind, disabled, a child under age 19, parent of a dependent child, or pregnant.

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) – Federal Agency which administers Medicare and Medicaid programs.

CHILDREN'S REHABILITATIVE SERVICES (CRS) – A program that provides medical treatment, rehabilitation, and related support services to Title XIX and Title XXI members who have completed the CRS application and have met the eligibility criteria to receive CRS-related services as specified in 9 A.A.C. 22.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN) – Children under age 19 who are: Blind/Disabled Children and Related Populations (eligible for SSI under Title XVI). Children eligible under section 1902 (e)(3) of the Social Security Act; in foster care or other out-of-home placement; Receiving foster care or adoption assistance or receiving services through a family-centered community-based coordinated care system that receives grant funds of Title V (CRS).

CLAIM DISPUTE – A dispute, filed by a provider or Contractor, whichever is applicable, involving a payment of a claim, denial of a claim, and imposition of a sanction or reinsurance.

CLAIM FORMS UB-04 form is used to bill for: hospital inpatient, outpatient, emergency room, and hospital-based clinic charges, home health (dependent on the product line), and pharmacy charges for services provided as an integral part of a hospital service, dialysis clinic, nursing home, free standing birthing center, residential treatment center, and hospice services.

CLAIMS DATA – Claims Data means those standard transactions between two parties to carry out financial or administrative activities related to health care, including bills sent by Health Care Providers to B – UHP to request payment for medical services and payment of such bills by B – UHP. Claims Data consists of a clinical component (e.g., encounters, diagnosis code) and a financial/cost component (e.g., amount billed, amount paid).

CLEAN CLAIM – MEDICAID – A claim that may be processed without obtaining additional information for the provider of service or from a third party; but does not include claims under investigation for fraud or abuse or claims under review for medical necessity, as defined by A.R.S. §36-2904.

CLEAN CLAIM – MEDICARE – 42 CFR 422.520: - (1) A claim that has no defect, impropriety, lack of any required substantiating documentation (consistent with § 422.310(d)) or particular circumstance requiring special treatment that prevents timely payment; and (2) A claim that otherwise conforms to the clean claim requirements for equivalent claims under original Medicare.

CMS 1500 form is used to bill for: services other than those described above, including professional services, transportation, and durable medical equipment.

CONCURRENT REVIEW – Concurrent review is a utilization management function performed by registered nurses for each inpatient admission to acute care hospitals or extended care facilities. The concurrent review process determines the appropriateness of the hospital stay and level of care and is based on standardized review criteria (MCG and InterQual criteria are used for inpatient/hospital stays). Services that extend over a long period of time, such as home health services, may be subject to the concurrent review process.

CONTINUATION AREA – An area outside of the contracted service area within which the Health Plan arranges to furnish services to our continuation of enrollment members. Members must reside in a continuation area on a permanent basis. A continuation area does not expand the service area of the Health Plan.

CONTINUING EDUCATION AND ONGOING LEARNING – Activities of professional development intended to enhance relevant knowledge and build skills within a given practice. These activities may involve, but are not limited to, acquiring traditional Continuing Education Units.

CONVICTED – A judgment of conviction has been entered by a Federal, State or local court, regardless of whether an appeal from that judgment is pending.

COPAYMENT – A monetary amount that the member pays directly to a provider at the time covered services are rendered, as defined in 9 A.A.C. 22, Article 7.

CO-INSURANCE – The portion of a covered service expense for which the member is responsible.

CORRECTIVE ACTION PLAN (CAP) – A written work plan that identifies the root cause(s) of deficiency, includes goals and objectives, actions/tasks to be taken to facilitate an expedient return to compliance, methodologies to be used to accomplish CAP goals and objectives, and staff responsible to carry out the CAP within established timelines. CAPs are generally used to improve performance of the Contractor and/or its providers, to enhance Quality Management/Process Improvement activities and the outcomes of the activities, or to resolve a deficiency.

COVERED SERVICES – Covered services are medically necessary health services (which may vary by benefit package) that are delivered to the Health Plan members at the direction of the member's primary care provider (PCP).

CREDENTIALLED PARENT/FAMILY SUPPORT PROVIDER (CPFSP) – An individual who meets the lived experience as specified in AHCCCS Medical Policy 964 and has passed an AHCCCS/OIFA approved credentialed training exam.

DEDUCTIBLE – The amount a member must pay each calendar year for certain benefits before a health plan will pay for covered services.

DEEMED PROVIDER, SUPPLIER OR BUSINESS PARTNER – A provider or supplier that has been accredited by a national accreditation program (approved by CMS) as demonstrating compliance with certain conditions.

DENTAL ADA form is used to bill for charges for dental services identified with "D" codes.

DISENROLLMENT – The discontinuance of a member's ability to receive covered services through any Health Plan product line.

DOWNSTREAM ENTITY – An organization or individual that enters into an acceptable written arrangement below the level of the arrangement between B – UHP and a first-tier entity. This continues down to the level of the ultimate provider of a service or product. Example: A health care services group.

DUAL ELIGIBLE – A member who is eligible for both Medicare and Medicaid.

DURABLE MEDICAL EQUIPMENT (DME) – An item or appliance that is not an orthotic or prosthetic and that is: designed for a medical purpose, is generally not useful to a person in the absence of an illness or injury, can withstand repeated use and is generally reusable by others.

EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT (EPSDT) – A comprehensive child health program of prevention, treatment, correction, and improvement (amelioration) of physical and mental health problems for AHCCCS members under the age of 21. The purpose of EPSDT is to ensure the availability and accessibility of health care resources as well as to assist Medicaid recipients in effectively utilizing these resources. EPSDT services provide comprehensive health care through primary prevention, early intervention, diagnosis, medically necessary treatment, and follow-up care of physical and behavioral health problems for AHCCCS members less than 21 years of age. EPSDT services include screening services, vision services, dental services, hearing services and all other medically necessary mandatory and optional services listed in Federal Law 42 U.S.C. 1396d(a) to correct or ameliorate defects and physical and mental illnesses and conditions identified in an EPSDT screening whether or not the services are covered under the AHCCCS State Plan. Limitations and exclusions, other than the requirement for medical necessity and cost effectiveness, do not apply to EPSDT

services.

ELIGIBILITY DETERMINATION – A process of determining, through a written application, and including required documentation, whether an applicant meets the requirements for Title XIX or Title XXI.

CHANGE HEALTH CARE (FORMERLY EMDEON & MediFax) – A company that makes available electronic claims processing software and electronic eligibility verification information. Providers may contract directly with Change Health Care for these services. Change Health & Echo is the clearinghouse and payment vendor of the Health Plan.

EMERGENCY MEDICAL CONDITION – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: a) placing the patient's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, b) serious impairment to bodily functions, or c) serious dysfunction of any bodily organ or part [42 CFR 438.114(a)].

EMERGENCY MEDICAL SERVICE – Covered inpatient and outpatient services provided after the sudden onset of an emergency medical condition. These services must be furnished by a qualified provider and must be necessary to evaluate or stabilize the emergency medical condition [42 CFR 438.114(a)].

ENCOUNTER – A record of a health care-related service rendered by a provider or providers registered with AHCCCS to a member who is enrolled with a Contractor on the date of service. Providers are required to report all services to the Health Plan, including services under capitated arrangements. The Health Plan, in turn, electronically reports these encounters.

ENROLLEE – A Medicaid recipient who is currently enrolled with a Contractor [42 CFR 438.10(a)].

ENROLLMENT (AHCCCS/SNP) – The process by which a person who has been determined eligible to receive AHCCCS and/or SNP benefits will become a member of a health plan.

FAMILY MEMBER (CHILDREN'S SYSTEM) – A parent or primary caregiver with lived experience who has raised or is currently raising a child with emotional, behavioral health and/or substance use disorders.

FAMILY MEMBER (ADULT SYSTEM) – An individual who has lived experience as a primary natural support for an adult with emotional, behavioral health and/or substance use disorders.

FAMILY-RUN ORGANIZATIONS (FRO) – Family-run organizations employ parents who have real life experience in the behavioral, medical and/or Department of Child Safety (DCS) systems. They specialize in providing family support services and can provide one-on-one support to children, youth and families.

FEDERALLY QUALIFIED HEALTH CENTER (FQHC) – A public or private non-profit health care organization which meets the requirements and receives a grant and funding pursuant to Section 330 of the Public Health Service Act. An FQHC includes an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (PL93 –638) or an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act.

FEDERALLY QUALIFIED HEALTH CENTER LOOK-ALIKE – A public or private non-profit health care organization that has been identified by the HRSA and certified by CMS as meeting the definition of "health center" under Section 330 of the Public Health Service Act but does not receive grant funding under Section 330.

FEE-FOR-SERVICE (FFS) – A method of payment to an AHCCCS registered provider on an amount- per-service basis for services reimbursed directly by AHCCCS for members not enrolled with a managed care Contractor.

FEDERAL EMERGENCY SERVICES (FES) – Federal emergency services program covered under R9-22-217 to treat an emergency medical condition for an AHCCCS member who is determined eligible.

FEDERAL FINANCIAL PARTICIPATION (FFP) – Federal financial participation (FFP) refers to the contribution that the Federal government makes to the Title XIX and Title XXI program portions of AHCCCS.

FIRST TIER ENTITY – An organization or individual that enters into an acceptable written arrangement with B –

UHP to provide administrative or health care services. Example: A call center contracted directly with Banner Health Network is a first-tier entity.

FISCAL AGENT – Any person (individual or corporation) serving as the Health Plan’s financial agent (e.g., paying claims on behalf of the Health Plan).

FORMULARY – means the entire list of Part D drugs covered by a Part D plan and all associated requirements outlined in Medicare Prescription Drug Benefit Manual, Chapter 6.

FRAUD – An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable State or Federal law, as defined in 42 CFR 455.2. Fraud is knowingly and willingly executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. 18U.S.C. § 1347.

FREEDOM OF CHOICE (FC) – The opportunity given to each member who does not specify a Contractor preference at the time of enrollment to choose between the Contractors available within the Geographic Service Area (GSA) in which the member is enrolled.

GATEKEEPER – Primary care provider who is primarily responsible for all medical treatment rendered, who makes referrals as necessary, and who coordinates and monitors the member’s treatment. Except for annual well woman exams, behavioral health and children’s dental services and consistent with the terms of the demonstration, covered services must be provided by or coordinated with a primary care provider.

GENERAL MENTAL HEALTH (GMH) AND SUBSTANCE ABUSE (SA) DUAL ELIGIBLE – A classification of adult persons age 18 and older who either have general behavioral health issues or have been diagnosed with a substance use disorder and have not been determined to have a serious mental illness but are eligible to receive covered behavioral health services. Dual Eligible means they are also eligible for both Medicare and Medicaid.

GEOGRAPHIC SERVICE AREA (GSA) – The locations (counties, cities, etc.) covered by the Health Plans.

HEALTH CARE PROFESSIONAL – A physician, podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist and certified nurse midwife), licensed social worker, registered respiratory therapist, licensed marriage and family therapist and licensed professional counselor.

HEALTH CARE PROVIDER – A provider of services (as defined in section 1861(u) of the Social Security Act, 42 U.S.C. § 1395x(u)), a provider of medical or health services (as defined in section 1861(s) of the Social Security Act, 42 U.S.C. § 1395x(s)), and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business. Refer to 45 C.F.R. § 160.103. Examples of Health Care Providers include but are not limited to Health Care Professionals, Medical Practitioners, Primary Care Providers, Specialty Physicians, Behavioral Health Paraprofessionals, Behavioral Health Professionals and Behavioral Health Technicians.

HIGH RISK PREGNANCY – A pregnancy in which the mother, fetus, or newborn is, or will be, at increased risk for morbidity or mortality before or after delivery. High risk is determined through the use of standardized medical risk assessment tools such as the AMERICAN COLLEGE OF GYNECOLOGY tool, as well as a physical assessment.

HIPAA REGULATIONS – The Health Insurance Portability and Accountability Act of 1996 (**HIPAA**) and related regulations, including the Privacy of Individually Identifiable Health Information, 45 C.F.R. Parts 160 and 164, Subpart E (**Privacy Rule**), the Security Standards for the Protection of Electronic Protected Health Information, 45 C.F.R. Parts 160 and 164, Subpart C (**Security Rule**), the standards for Notification in the Case of Breach of Unsecured Protected Health Information, 45 C.F.R. Parts 160 and 164, Subpart D (**Breach Notification Rule**), and the Health Information Technology for Economic and Clinical Health (**HITECH**) Act, all of which may be amended from time to time.

HIPAA RESTRICTED SELF PAY DATA – HIPAA Restricted Self Pay Data means Protected Health Information pertaining to a health care item or service for which a Member has fully paid for out-of-pocket and which the

Member requested not to be disclosed to B – UHP.

INTEGRATED REGIONAL BEHAVIORAL HEALTH AUTHORITY (INTEGRATED RBHA) – An organization that provides behavioral health services to AHCCCS members determined to have a Serious Mental Illness, with the exception of American Indians who choose AIHP.

INTERDISCIPLINARY CARE – A meeting of the interdisciplinary team members or coordination of care among interdisciplinary treatment team members to address the totality of the treatment and service plans for the member based on the most current information available.

KIDSCARE – Federal and State Children’s Health Insurance Program (Title XXI – SCHIP) administered by AHCCCS. The KidsCare I program offers comprehensive medical, preventive and treatment services and a full array of behavioral health care services Statewide to eligible children under the age of 19, in households with income at or below 200% Federal Poverty Level (FPL). The KidsCare II program has the same benefits and premium requirements as KidsCare I, however household income limits cannot be greater than 175% FPL. The KidsCare II program is available May 1, 2012 through January 31, 2014. All members, except American Indian members, are required to pay a premium amount based on the number of children in the family and the gross family income.

MEDICAL PRACTITIONER – A physician, physician assistant or registered nurse practitioner.

MEDICARE ADVANTAGE (MA) – Statutes and regulations pertaining to benefits and beneficiary protections.

MEDICAID – A Federal/State program authorized by Title XIX of the Social Security Act, as amended, which provides Federal matching funds for a medical assistance program for recipients of Federally aided public assistance, Supplemental Security Income (SSI) benefits and other specified groups. Certain minimal populations and services must be included to receive Federal financial participation (FFP); however, States may optionally include additional populations and services at State expense and also receive FFP.

MEDICALLY NECESSARY – As defined in 9 A.A.C. 22 Article 101. Medically Necessary means a covered service provided by a physician or other licensed practitioner of the health arts within the scope of practice under State law to prevent disease, disability or other adverse conditions or their progression, or prolong life

MEDICALLY NECESSARY SERVICES – Those covered 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.

MEDICARE – A Federal program authorized by Title XVIII of the Social Security Act, as amended that generally serves members 65 or older and selected others.

MEDICARE MANAGED CARE PLAN – A managed care entity that has a Medicare contract with CMS to provide services to Medicare beneficiaries, including Medicare Advantage Plan (MAP), Medicare Advantage Prescription Drug Plan (MAPDP), MAPDP Special Needs Plan, or Medicare Prescription Drug Plan.

MEDICARE HMO – A Health Maintenance Organization or Comprehensive Medical Plan, which provides Medicare services to Medicare beneficiaries pursuant to a Medicare risk contract with Centers for Medicare and Medicaid Services (CMS).

MEMBER – An eligible person who is enrolled in AHCCCS, as defined in A.R.S. §36-2931, §36-2901, §36-2901.01 and A.R.S. §36-2981.

MISCONDUCT – Any action or behavior that does not conform to the organization’s stated or intended standards, guidelines or procedures; or is a violation of any federal/state law or regulation.

MONITORING ACTIVITIES – Regular reviews performed as part of B – UHP’s normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.

NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) – An independent, non-profit organization that reviews and “accredits” managed care organizations.

NON-COMPLIANCE – Failure or refusal to act in accordance with the organization’s Compliance Program; or other standards or procedures; or with federal or state laws or regulations.

NON-COMPLIANT – A non-compliant member is one whose behaviors conflict with a prescribed plan of care, or the service provider’s recommendations or instructions. These behaviors put the member at a higher risk for an adverse outcome.

NON-CONTRACTED PROVIDER – A person and/or facility that provides services as prescribed in A.R.S. §36-2901 who does not have a contract with Banner – University Health Plans.

OFFSHORE SUBCONTRACTING – Provide services that are performed by workers located in offshore countries, regardless of whether the workers are employees of American or foreign companies.

PARENT/FAMILY SUPPORT SERVICES – Home care training (family support) with family member(s) directed toward restoration, enhancement, or maintenance of the family functions in order to increase the family’s ability to effectively interact and care for the individual in the home and community.

PART 2 – Part 2 collectively refers to Title 42, United States Code, section 290dd-2, and its implementing regulations located at 42 C.F.R. Part 2, which may be amended from time to time.

PART 2 CONSENT – A Member’s signed release of information that complies with the Part 2 consent requirements. Refer to 42 C.F.R. § 2.31.

PART 2 PROGRAM – A Part 2 Program is a “federally assisted” individual or entity (or an identifiable unit within a general medical facility), which holds itself out as providing, and provides, Substance Use Disorder Services. Medical personnel or other staff in a general medical facility are considered a Part 2 Program if their primary function is the provision of Substance Use Disorder Services and they are identified as Substance Use Disorder providers. Refer to 42 C.F.R. §§ 2.11, 2.12. All Providers are “federally assisted” because of their contract with B – UHP.

PART 2 PROTECTED SUBSTANCE USE DISORDER (SUD) INFORMATION – Patient identifying information of a Part 2 Program that identifies a Member as having (or having had) a Substance Use Disorder either directly, by reference to publicly available information, or through verification of such identification by another person.

PEER AND RECOVERY SUPPORT – Intention partnerships based on shared experiences of living with a behavioral health and/or substance use disorder to provide social and personal support. This support is coupled with specific, skill-based training, coaching or assistance to bring about social or personal change, at an individual, family or community level. These services can include a variety of individualized and personal goals, including living preferences, employment or educational goals and development of social networks or interest.

PEER AND RECOVERY SUPPORT SPECIALIST – An individual trained, credentialed, and qualified to provide peer/recovery support services within the AHCCCS Programs.

PEER-RUN ORGANIZATIONS (PRO) – Peer-run organizations are service providers owned, operated and administrated by persons with lived experiences of mental health and/or substance use disorders. These organizations are based in the community and provide support services.

PERFORMANCE STANDARDS – A set of standardized measures designed to assist AHCCCS in evaluation, comparing and improving the performance of its contractors.

POST STABILIZATION SERVICES – Medically necessary services, related to an emergency medical condition, provided after the member’s condition is sufficiently stabilized so that the member could alternatively be safely discharged or transferred to another location. The services must be provided at the site where the member was treated for the emergency condition.

PRIMARY CARE PROVIDER (PCP) – An individual who meets the requirements of A.R.S. §36- 2901, and who is responsible for the management of the member’s health care. A PCP may be a physician defined as a person licensed as an allopathic or osteopathic physician according to A.R.S. Title 32, Chapter 13 or Chapter 17, or a practitioner defined as a physician assistant licensed under A.R.S Title 32, Chapter 25, or a certified nurse practitioner licensed under A.R.S. Title 32, Chapter 15. The PCP must be an individual, not a group or association of persons, such as a clinic.

PRIOR AUTHORIZATION (PA) – A process whereby services are reviewed prospectively to determine if they are medically necessary and appropriate. This review also includes verification of member enrollment, verification that the request is a covered benefit, and determination of the provider's eligibility to perform the service.

PRIOR PERIOD COVERAGE – The period of time prior to the member's enrollment, during which a member is eligible for covered services. The timeframe is from the effective date of eligibility (usually the first day of the month of application) until the date the member is enrolled with the Contractor. Refer to 9 A.A.C. 22 Article 1. If a member made eligible via the Hospital Presumptive Eligibility (HPE) program is subsequently determined eligible for AHCCCS via the full application process, prior period coverage for the member will be covered by AHCCCS Fee-For-Service and the member will be enrolled with the Contractor only on a prospective basis.

PRIOR QUARTER COVERAGE – The period of time prior to an individual's month of application for AHCCCS coverage, during which a member may be eligible for covered services. Prior Quarter Coverage is limited to the three-month time period prior to the month of application. An applicant may be eligible during any of the three months prior to application if the applicant:

1. Received one or more covered services described in 9 A.A.C. 22, Article 2 and Article 12, and 9
2. A.A.C. 28, Article 2 during the month; and
3. Would have qualified for Medicaid at the time services were received if the person had applied regardless of whether the person is alive when the application is made. Refer to A.A.C. R9-22- 303.
4. AHCCCS Contractors are not responsible for payment for covered services received during the prior quarter.

PROSPECTIVE REVIEW – A utilization management process that requires review and approval of services in advance of service provision.

PROTECTED HEALTH INFORMATION (PHI) – Any information about health status, provision of health care, or payment for health care that can be linked to a specific individual. Refer to 45 C.F.R. § 160.103.

PROVIDER – Any person or entity that contracts with AHCCCS or the Health Plan for the provision of covered services to members according to the provisions A.R.S. §36-2901 or any subcontractor of a provider delivering services pursuant to A.R.S. §36-2901.

PSYCHOTHERAPY NOTES – Notes recorded (in any medium) by a Health Care Provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. Refer to 45 C.F.R. § 164.501.

QUALIFIED SERVICE ORGANIZATION AGREEMENT (QSOA) – A written agreement between a Part 2 Program and a person or entity that is providing services to, or on behalf of, the Part 2 Program, which allows for the sharing of Substance Use Disorder Information between the two for certain purposes without a Member's Part 2 Consent.

QUALITY MANAGEMENT – Activities that focus on measuring, monitoring, and improving the quality of care outcomes for members and internal and external processes.

QUALITY IMPROVEMENT SYSTEM FOR MANAGED CARE (QISMIC) – Developed by the Centers for Medicare/Medicaid (CMS), formerly (HCFA), for use in evaluation and management of the quality of care provided by Medicare and Medicaid managed care Contractors.

QUALIFIED MEDICARE BENEFICIARY DUAL ELIGIBLE (QMB) DUAL – A person determined eligible under Title 9 Chapter 29 Article 2 of A.A.C. for Qualified Medicare Beneficiary (QMB) and eligible for acute care services provided for in 9 A.A.C. 22 or ALTCS services provided for in 9 A.A.C. 28. A QMB dual person receiving both Medicare and Medicaid services and cost sharing assistance.

RATE CODE – A rate code identifies the AHCCCS member's eligibility category status, age and sex. It is used to determine the capitation payment amount to health plans and to providers for prepaid services.

RISK GROUP – Grouping of rate codes that are paid at the same capitation rate.

RURAL HEALTH CLINIC (RHC) – A managed care entity that has a Medicare contract with CMS to provide services to Medicare beneficiaries, including Medicare Advantage Plan (MAP), Medicare Advantage Prescription Drug Plan (MAPDP), MAPDP Special Needs Plan, or Medicare Prescription Drug Plan.

SECURITY EVENT – A Breach of Unsecured Protected Health Information or a successful Security Incident.

SECURITY INCIDENT – The attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system. Refer to 45 C.F.R. § 164.304. An attempted Security Incident includes, but is not limited to, unsuccessful attempts to penetrate computer networks or servers, and immaterial incidents that occur on a routine basis, such as general pings and other broadcast attacks on a firewall, port scans, unsuccessful log-on attempts, denials of service attacks, so long as such incident does not result in unauthorized access, use or disclosure of Protected Health Information.

SELF-HELP/PEER SERVICES (PEER SUPPORT) – Supports intended for enrolled members and/or their families who require greater structure and intensity of services than those available through community-based recovery fellowship groups and who are not yet ready for independent access to community-based recovery groups.

SENSITIVE DATA – The categories of health information that are afforded a higher degree of protection under Applicable Law than the protections provided by the HIPAA Regulations.

SERIOUSLY MENTALLY ILL (SMI) – A person 18 years of age or older who has been determined to have a serious mental illness as defined in A.R.S. §36-550.

SIXTH OMNIBUS BUDGET AND RECONCILIATION ACT (SOBRA) – Eligible pregnant women under Section 9401 of the Sixth Omnibus Budget and Reconciliation Act of 1986, amended by the Medicare Catastrophic Coverage Act of 1988, 42 U.S.C. 1396(a)(10)(A)(ii)(IX), November 5, 1990, with individually budgeted incomes at or below 150% of the FPL, and children in families with individually budgeted incomes ranging from below 100% to 140% of the FPL, depending on the age of the child.

SPECIFIED LOW INCOME MEDICARE BENEFICIARY (SLMB) – A State program similar to medical assistance for people who need help paying for Medicare services. Members must be eligible for Medicare Part A, have limited income but not be financially eligible for medical assistance.

SPECIAL HEALTH CARE NEEDS – Serious or chronic physical, developmental and/or behavioral health conditions. Members with special health care needs require medically necessary services of a type or amount beyond that generally required by members.

SPECIAL NEEDS PLAN (SNP) – Special Needs Plans (SNP) is available to people with Medicare benefits that are also enrolled in Medicaid. Members enrolled in AHCCCS for their Medicaid benefits may choose to receive their Medicare benefits, as well as their prescription drug coverage, through a SNP like Banner – University Care Advantage.

SPECIALTY PHYSICIAN – A physician who is specially trained in a certain branch of medicine related to specific services or procedures, certain age categories of patients, certain body systems, or certain types of diseases.

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP) – State Children's Health Insurance Program under Title XXI of the Social Security Act). The Arizona version of CHIP is referred to as "KidsCare."

SUBCONTRACTOR –

1. A provider of health care who agrees to furnish covered services to members.
2. A person, agency or organization with which the Contractor has contracted or delegated some of its management/administrative functions or responsibilities.

3. A person, agency or organization with which a fiscal agent has entered into a contract, agreement, purchase order or lease (or leases of real property) to obtain space, supplies equipment or services provided under the AHCCCS agreement.

SUPPLEMENTAL SECURITY INCOME (SSI) AND SSI RELATED GROUPS – Eligible individuals receiving income through Federal cash assistance programs under Title XVI of the Social Security Act who are aged, blind or have a disability and have household income levels at or below 100% of the FPL.

SUBSTANCE ABUSE – As specified in R9-10-01, an individual's misuse of alcohol or other drug or chemical that:

- a. Alters the individual's behavior or mental functioning
- b. Has the potential to cause the individual to be psychologically or physiologically dependent on alcohol or the drug or chemical and
- c. Impairs, reduces or destroys the individual's social or economic functioning.

SUBSTANCE USE DISORDER (SUD) – A cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems such as impaired control, social impairment, risky use, and pharmacological tolerance and withdrawal. For purposes of Part 2, a Substance Use Disorder does not include tobacco or caffeine use. Refer to 42 C.F.R. § 2.11.

SUBSTANCE USE DISORDER SERVICES (SUD SERVICES) – Substance Use Disorder Services include treating a Substance Use Disorder, making a diagnosis for Substance Use Disorder treatment (even if the diagnosis is not ultimately used for treatment or referral for treatment), or making a referral for that treatment.

TEMPORARY ASSISTANCE TO NEEDY FAMILIES PROGRAM (TANF) – A Federal cash assistance program under Title IV of the Social Security Act established by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104 –193). It replaced Aid to Families with Dependent Children (AFDC).

TITLE XIX – Known as Medicaid, Title XIX of the Social Security Act provides for Federal grants to the states for medical assistance programs. Title XIX enables states to furnish medical assistance to those who have insufficient income and resources to meet the costs of necessary medical services, rehabilitation and other services, to help those families and individuals become or remain independent and able to care for themselves. Title XIX members include but are not limited to those eligible under Section 1931 of the Social Security Act, Supplemental Security Income (SSI), SSI-related groups, Medicare cost sharing groups, Breast and Cervical Cancer Treatment Program and Freedom to Work Program. Which include those populations 42 U.S.C. 1396 a(a)(10)(A).

TITLE XIX MEMBER – Member eligible for Federally funded Medicaid programs under Title XIX of the Social Security Act including those eligible under 1931 provisions of the Social Security Act (previously AFDC), Sixth Omnibus Budget Reconciliation Act (SOBRA), Supplemental Security Income (SSI), SSI-related groups, Title XIX Waiver Groups, Medicare Cost Sharing groups and Breast and Cervical Cancer Treatment Program, Title IV-E Foster Care and Adoption Subsidy, Young Adult Transitional Insurance, and Freedom to Work.

TITLE XIX WAIVER GROUP MEMBER – Eligible individuals and couples whose income is at or below 100% of the Federal Poverty Level who are not categorically linked to another Title XIX program. Formerly known as Non-MED members.

TITLE XXI – Title XXI of the Social Security Act provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low income children in an effective and efficient manner that is coordinated with other sources of child health benefits coverage.

TITLE XXI MEMBER – Member eligible for acute care services under Title XXI of the Social Security Act, referred to in Federal legislation as the "Children's Health Insurance Program" (CHIP). The Arizona version of CHIP is referred to as "KidsCare."

TREATMENT PLAN – A written plan of services and therapeutic interventions based on a complete assessment of a member's developmental and health status, strengths and needs that are designed and periodically updated by the multi-specialty, interdisciplinary team.

UNSECURED PROTECTED HEALTH INFORMATION (UNSECURED PHI) – Protected Health Information that is

not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology specified by regulatory guidance issued under section 13402(h)(2) of Public Law 111-5. Refer to 45 C.F.R. § 164.402.

URGENT – An acute, but not necessarily life –threatening disorder, which, if not attended to, could endanger the member.

VACCINES FOR CHILDREN (VFC) PROGRAM (AHCCCS) – The program is an entitlement program (a right granted by law) for eligible children, The Centers for Disease Control and Prevention (CDC) recommends immunizing children for 12 preventable diseases. VFC helps families of children who may not otherwise have access to vaccines by providing free vaccines to doctors that serve them. Providers serving children must be enrolled in the Vaccines for Children (VFC) program.

WASTE – Over-utilization or inappropriate utilization of services, misuse of resources, or practices that directly or indirectly result in unnecessary costs to the Medicaid or Medicare Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

WELL WOMAN HEALTHCHECK PROGRAM (WWHP) – Well Woman Health Check Program is administered by the Arizona Department of Health Services and funded by the Centers for Disease Control and Prevention.

Section 3 – Contacts Reference Guide

Please use the following contact information when reaching one of the departments. Direct Lines, Fax Numbers and Emails are noted below by department when applicable.

Customer Care Center

Banner – University Family Care/ACC

Phone: (800) 582-8686 / TTY: 711

Banner – University Care Advantage

Phone: (877) 874-3930 / TTY: 711

Call the Customer Care Center for inquiries or services such as:

Interpreter & Translation Services, Transportation, Member Eligibility, and Claims.

Behavioral Health Care Management

Fax: (520) 874-3411 Tucson / (602) 344-8372 Phoenix

Email: BUHPCareMgmtBHMailbox@bannerhealth.com

Care Management - Adults, aged 21 and greater

Fax: (520) 874-5750 Tucson / (602) 344-8372 Phoenix

Email: BUHPCaseMgmtAHMB@bannerhealth.com

Care Management – Pediatrics (aged less than 21) and CRS

Fax: (520) 874-5750 Tucson / (602) 344-8372 Phoenix

Email: BUHPMaternalChildHealth@bannerhealth.com

Care Management - Pregnant Members

Fax: (520) 874-5750 Tucson / (602) 344-8372 Phoenix

Email: BUHPMaternalChildHealth@bannerhealth.com

Claims Customer Care Center

Email: BUHPClaims@bannerhealth.com

Contracting

Fax: (520) 694-0201

Email: UAHNContractingMailbox@bannerhealth.com

Compliance

Phone: (888) 747-7989 Confidential & Anonymous Hotline

Fax: (520) 874-7072

Email: BUHPCompliance@bannerhealth.com

Credentialing

Phone: (520) 874-2483

Fax: (520) 874-7142

Email: hpcredentials@bannerhealth.com

EPSDT Coordinator

Phone: (520) 874-7248

Grievance & Appeals

Fax: (866) 465-8340 or (520) 874-3462

Email: BUHPGrievances&Appeals@bannerhealth.com

Healthy Together Partnership

Phone: (520) 626-5813

Email: UAHNHealthyTogetherMailbox@bannerhealth.com

Hospital Admission Notification

Fax: (520) 874-3420

Member Eligibility

Fax: (520) 874-3434

Office of Individual and Family Affairs (OIFA)

Administrator: Colleen McGregor, (480) 827-5988, colleen.mcgregor@bannerhealth.com

General Email: OIFATeam@bannerhealth.com

OIFA offers support through connecting with a Member Advocate to provide support in navigating the health care system. Member Advocates help to break down barriers. If you need help email us at: OIFATeam@bannerhealth.com and someone from the OIFA team will reach back out to in 24 hours or less.

Pharmacy

Fax: (866) 349-0338

Email: BUHPParmacy@bannerhealth.com

Prior Authorization

Fax: (866) 210-0512 or (520) 874-3418

Provider Relations

Fax: (520) 874-7144

Email: BUHPProviderNotifications@Bannerhealth.com

Quality Management

Phone: (623) 385-0863 Phoenix / (520) 874-2760 Tucson

Section 4 – Network Development

Overview

The Network Development Department is responsible for helping to develop and maintain our network of Primary Care Providers (PCP), specialists, hospitals and ancillary providers. The Network Development Department coordinates with other departments and agencies to provide valuable information on services and programs. Within the department of Network Development, Contracting and Provider Relations play a pivotal role.

Contracting

B – UHP Contractors routinely review information for each plan about the provider network. They work with many other B – UHP personnel to identify potential areas for network expansion or modification. Contractors monitor the services that the network is providing for each plan and assists the Network Development Director and Network Development Managers in securing new contracts and services.

New provider associates are considered to be joining a group if they are sharing the same tax identification number of the currently contracted provider(s). Associates will be added to the network after they have been credentialed. Providers who share office space will be considered for participation solely on the basis of network need under his/her own contract. Satellite offices of contracted groups are not automatically added to the network unless a network need exists.

B – UHP contracts with providers on a geographic and plan-specific basis. Network need is determined by a variety of factors including the membership, utilization and existing coverage in an area.

You must notify your Provider Rep with prior notification of any changes to address, tax identification numbers, telephone numbers, or professional staffing in order to comply with contractual requirements and ensure correct payment and continuity of care. Lack of timely notification to B – UHP may result in payment denials or delays in patient referrals. Changes in the location of your office may result in contract termination if the new location is not in an area where additional practitioners are needed.

Credentialing

Physicians, mid-level professionals, and dentists are credentialed prior to participation. Practitioner performance is reviewed at least every three years. This process requires the practitioner to complete a reappointment application and provide proof of license renewal and current liability coverage. Failure to respond timely to these requests from B – UHP for information may be interpreted as voluntary withdrawal from the network. Facility licensure and accreditation are also regularly reviewed and must be updated to maintain contracted status with the plan.

The CMS Preclusion List and Office of Inspector General (OIG) of the U.S. Department of Health & Human Services (HHS) and Government Services Administration (GSA) exclusion lists are also checked with respect to all employees, governing body members, and FDRs monthly and coordinating any resulting personnel issues with the sponsor's Human Resources, Security, Legal or other departments, as appropriate.

Provider Relations

Each contracted provider is assigned a Provider Relations Representative, or Provider Rep. Provider Reps serve as a provider's vital link to health plans services. The Provider Rep staffing is maintained to enable providers to receive prompt resolution to problems or inquiries and appropriate education about participation in the Arizona Health Care Cost Containment System (AHCCCS) program.

Provider Relations Representatives also conduct provider training activities and keep you informed of your responsibilities as a provider. They can help in resolving many administrative issues or concerns you may have.

Ways Network Development assists provider offices:

- Acts as the primary liaison between internal departments and the provider network.
- Provides in-services and Provider Manuals to all newly contracted providers.
- Educates provider on how to locate a copy of the provider manual in the "Provider Resource" section of the B – UHP website, along with other vital resources. There is also a PDF copy of the provider manual that can be downloaded, which allows providers to obtain a hard copy.
- Additional education on where to obtain a copy of the most recent version of provider manual during provider site visits, using the "Provider Site Visit" tool. Education is also provided on where to locate the provider manual during "Provider Education Forum" sessions.
- Sends time-sensitive bulletins and communications regarding AHCCCS specific initiatives, health plan changes and updates.
- Visits provider offices and provides ongoing communication and education.
- Helps resolve benefit, enrollment, contracting, claims and reimbursement issues. Assist with claims billing and education.
- Publishes an online provider quarterly notification that provides education, news and updates.
- Conducts provider satisfaction surveys.
- Assists in negotiations of new or renewing contracts.
- Assists in monitoring activities regarding compliance and network accessibility.
- Instruct providers on the need to contact the Provider Representative when the provider changes address, contact information, or other demographic information or email at BUHPPProviderNotifications@bannerhealth.com. Providers must update changes with AHCCCS by calling 602-417-7670 (Local Maricopa), or 800-794-6862 (Outside Maricopa County)

Role of Provider Relations Representatives

Provider Relations Representatives serve a variety of roles. They serve as both provider educator and advocate. They also participate in network development and monitoring activities. Provider Relations Representatives often serve as the "intermediary" between the provider and internal departments.

Provider Relations Representatives are available to provide initial and follow-up training for office staff. They will visit your office to review changes and update the Health Plan policies and procedures and review specific provider profile information. Visits include discussions about problems or issues that have occurred since the last visit, information about B – UHP changes and offer an opportunity for the provider to express any concerns.

Please consult with your Provider Relations Representative as questions arise. Provider Relations Reps can answer many of your questions, research your problem or issue, or help direct you to proper information resources.

Provider Relations Goals

Provider Relations Representative have set goals for responding to provider inquiries. They also monitor adherence to provider appointment availability, to ensure access to care for members

- Response Timeframe to Provider Inquires
 - Respond to escalated requests within 24 hours
 - Respond and initiate resolution to escalated request within 3 business days
 - Respond to non-escalated request with 48 hours

AHCCCS Minimum Subcontract Provisions

All subcontracts must reference the provisions of Attachment A, Minimum Subcontract Provisions located on the AHCCCS website at <http://www.azahcccs.gov/commercial/MinimumSubcontractProvisions.aspx>, subject to updates as received. Please remember as a part of your agreement with our organization you are required to adhere to the contractual obligations as outlined in the AHCCCS Subcontract Provisions.

Changes in Professional and Administrative Staff

Changes in the professional staff in your office, for example Physicians, Physicians Assistants, Nurse Practitioners, or Nurse Midwives, must be reported to your Provider Relations Representative. All professionals rendering care to University Family Care and Banner – University Care Advantage members must be registered by the AHCCCS Administration and Medicare and all office-based providers must be credentialed by the B – UHP prior to rendering services to our members. Lack of timely notification to the B – UHP may result in payment denials or delays in patient referrals. When reporting services for claims or encounter purposes for any product line, his or her provider number (i.e. AHCCCS, Medicare, NPI), must identify the individual rendering the care. Failure to identify the individual rendering care when reporting claims is considered to be fraud under Federal reporting regulations.

Administrative changes in your office staff may result in the need for additional training. Contact your Provider Relations Rep. to schedule any needed staff training. Regular visits from your Provider Relations Rep. are intended to provide updates, education, review of compliance issues and address concerns of the Plan and provider. The Provider Relations Rep. will meet with the office manager and/or providers, when available. Visits are usually completed in less than one hour.

Provider Feedback and Communication

B – UHP is very interested in your opinions, both compliments and suggestions for improvement. Provider and member satisfaction surveys are conducted to help improve service to our providers and members. You will receive feedback from the member survey if the responding members make specific mention of you or your office. Your comments need not be reserved for these surveys. The B – UHP welcomes your opinions/feedback at any time.

Subcontractor Feedback and Communication

B – UHP is responsible for ensuring that changes in policy, procedure, and AHCCCS regulation are communicated, and providers are educated on where to locate the information on the Health Plan website. The Health Plan will ensure that any member communications created by the administrative services subcontractor contains the appropriate Health Plan branding.

All communications regarding modification or updates to any AHCCCS guidelines, policies and manuals will be sent to all approved AHCCCS Administrative Services Subcontractors via email.

The subcontractor account managers will review and implement as applicable.

Subcontractor will return a signed cover sheet to acknowledge they have received the information on the modification to the guideline, policy or manual.

Section 5 – Provider Standards & Responsibilities

Introduction

B – UHP is pleased you have chosen to provide health care to our members and partner with our plan. B – UHP has established the highest standards for the delivery of health care for all members. To that end, we require the following commitments from our health care providers:

1. Ensure members are treated without discrimination.
2. Meet standards for member care.
3. Meet Quality and Utilization Management standards.
4. Comply with reporting requirements.
5. Meet credentialing standards.
6. If providing services for AHCCCS members, providers must obtain an AHCCCS provider identification number and register with Arizona Department of Health Services Program Vaccines for Children if providing EPSDT services. This requirement is for our B – UFC/ACC and B – UCA product lines.
7. Register locations of service with AHCCCS. Link Provider AHCCCS number to Tax Identification Number. This requirement is for our B – UFC/ACC and B – UCA product lines.
8. Notify plan with changes to providers, locations, key contacts, telephone numbers, Tax Identification Numbers or corporate structure, etc. This notification should occur within 30 days of the above noted changes.
9. Provide care for members via in-network facilities to ensure the most cost effective and quality care.
10. Provide transition plan and 30-day notice when terminating a member from medical practice.

Workforce Development and Training

B – UFC’s Workforce Development (WFD) department implements, monitors, and regulates Provider WFD activities and requirements. In addition, B – UFC evaluates the impact of the WFD requirements and activities to support Providers in developing a qualified, knowledgeable and competent workforce.

In collaboration with the Workforce Development Alliance, which consists of the Arizona Association of Health Plans, AHCCCS, and all seven ACC health plans, we ensure that all course content is culturally appropriate, has a trauma informed approach and is developed using adult-learning principles and guidelines. Additionally, it is aligned with company guidelines and WFD industry standards, the Substance Abuse and Mental Health Services Administration (SAMHSA) core competencies for WFD, federal and state requirements and the requirements of the following agencies, entities and legal agreements:

- Centers for Medicare and Medicaid Services (CMS)
- Culturally and Linguistic Appropriate Services (CLAS) Standards
- Arizona Health Care Cost Containment System (AHCCCS)

Behavioral Health ACC Providers:

Workforce Development Plan (WFDP) - The Workforce Development Alliance requires that all Behavioral Health AHCCCS Complete Care (ACC) contracted provider agencies complete a biannual Workforce Development Plan (WFDP). A WFDP Template is provided for this deliverable by the Workforce Development Alliance to providers. Due dates for these plans will be determined by the Workforce Development Alliance and communicated to Providers.

Exceptions to the above include: Individual practitioners, hospitals, transportation, housing, and prevention agencies.

Relias Learning - All AHCCCS Complete Care (ACC) Behavioral Health (BH) providers must have access to Relias Learning. This is the Learning Management System used by the ACC/RBHA Plans and their contracted BH providers through the Arizona Association of Health Plans (AzAHP). Agencies must manage and maintain their Relias Learning portal. This includes activating and deactivating users as well as enrollment and disenrollment of courses/events.

To request access to Relias, please contact your B – UFC Provider Relations Representative who will forward the request to the B – UFC Workforce Development Administrator for further assistance. The request should include the following information:

- Provider Agency Name
- Contract Start Date
- Address
- Key WFD Contact
 - Name
 - Phone Number
 - Email Address
- Contract Type (ACC)
- Provider Type (GMH/SU, Children's, Integrated Health Home, etc.)
- Number of Users (# employees at the agency who need Relias access)
- List of Health Plans provider is contracted with (if known)

BH provider agencies with 20 or more users will be required to purchase access to Relias Learning for a one-time fee of \$1500 for full-site privileges. A full-site is defined as a site in which the agency may have full control of course customizations and competency development.

Provider agencies with 19 or fewer users will be added to AzAHP Relias Small Provider Portal at no cost with limited-site privileges. A limited-site is defined as one in which the courses and competencies are set-up according to the standard of the plan with no customization or course development provided. This can be done by contacting workforce@azahp.org.

Provider agencies that expand to 20 or more users will be required to purchase full site privileges to Relias Learning immediately upon expansion.

*Fee is subject to change if a Provider requires additional work beyond a standard sub-portal implementation.

Member Rights

B – UHP is committed to treating members with dignity and respect at all times. Member rights and responsibilities are shared with staff, providers and members and are included in our Member Handbook. A list of member's rights under 42 CFR 438.100 is include below:

- A member's right to be treated with dignity and respect,
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand,
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or

retaliation,

- Request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR part 164 and applicable State law, and
- Exercise his or her rights and that the exercise of those rights shall not adversely affect service delivery to the member.

Primary Care

Primary Care Providers (PCP's) perform a critical function for B – UHP. Each PCP is responsible and accountable for the coordination, supervision, delivery and documentation of health care services to any B – UHP member (except for children's dental services when provided without a PCP referral). PCP's are responsible for maintaining a complete medical record of all services delivered by all providers involved in the members care, including vision, behavioral health, rehabilitative therapy and medical specialty services, as applicable. The use of the PCP in this model provides for less fragmentation and ensures continuity of care for our members. This model helps to attain effective control over utilization of medical services while maintaining the highest level of care.

The appropriate education of members regarding disease management is not only expected and encouraged, it is required. Providers may discuss medically necessary or appropriate treatment options with members – even if the options are not covered services. Health maintenance education is not only expected and encouraged; it is required for all providers participating with AHCCCS and Special Needs Plans (SNP). B – UHP develops and implements procedures to ensure that our providers have information required for effective and continuous care and quality review. This includes the provider's good faith effort to conduct an initial health assessment of all new SNP members within 90 days of the effective date of enrollment and follow up on unsuccessful attempts to contact a SNP member. Members should receive counseling regarding disease management, prevention and the importance of regular health maintenance visits. B – UHP has no policies preventing our providers from advocating on behalf of a member and encourages this dual approach to care and disease management. PCP's are expected to advise the members of their ability to treat behavioral health conditions within the scope of their practice.

Members must be included in the planning and implementation of their care. Providers must recognize that it is the patient's right to choose their final course of action among clinically acceptable choices. Services must be provided in a culturally competent manner to all members, including those with limited English proficiency or limited reading skills. Providers should always consider the ethnic and religious beliefs of their members and their impact on members' participation in care. Providers must maintain compliance with the Cultural Competency Plan (CCP) and Limited English Proficiency (LEP requirements).

PCP's are expected to educate members on the differences between urgent and emergent conditions and instruct members to contact their PCP before visiting an emergency room or calling an ambulance unless a life-threatening emergency exists.

At a minimum, PCPs are responsible for the following activities:

- Supervision, coordination and provision of care to each assigned member.
- Initiation of referrals for medically necessary specialty care.
- Maintaining continuity of care for each assigned member.
- Maintaining the member's medical record, including documentation of all services provided to the member by the PCP, as well as any specialty or referral services.

Provider Panel

A PCP who contracts with the B – UHP is required to have a panel and accept a minimum of 100 members. If a PCP wishes to close a panel to new members after reaching this minimum, the PCP must send the Network Development Department written notification at least 60 days in advance. The Network Development Department will review the request and may agree to close the panel 60 days from the date the written notice is received. The PCP is obligated to accept assignment of any member assigned until the approved date of the panel

closure. Members already assigned to a panel at the time of panel closure are considered to be established patients whether or not they have been seen in the office at the time of panel closure.

If a PCP participates in an AHCCCS product line, their AHCCCS member panel should not exceed a ratio of 1:1800. This regulation is to ensure AHCCCS members do not comprise the majority of the PCP's panel of patients.

A PCP's total panel size (all AHCCCS and non-AHCCCS patients) is considered when assessing the PCP's ability to meet appointments and other standards.

Provider Assignment

The Customer Care Center will ensure every member is assigned to an appropriate PCP. This assignment is based on the geographical location of the member's residence, needs of the member, and provider's appointment availability standards. Members may call and change their PCP at any time although it is recommended that they change no more than 5 times per year and not within 30 days of their last change.

Members receive written notice of their assigned PCP via their "New Member Packet". Members are given the option of selecting another available PCP, as well as information on how to complete this change.

AHCCCS, Medicare and State regulations require a PCP to be licensed in Arizona as an allopathic or osteopathic physician who generally specializes in family practice, internal medicine, pediatrics or are a certified nurse practitioner, or physician's assistant.

Selecting and Changing Primary Care Providers

Members have the right to select their own PCP using the print and/or online directory of participating and available providers. Members also have the right to change a PCP at any time.

- Changes become effective the first of the month following the day of their request. Please refer members to our Customer Care Center for further assistance.
- When a member changes PCPs, his or her original or copied medical records MUST be forwarded to the new PCP within 10 business days from receipt of the request for the transfer of medical records.

Primary Care Provider Initiated Changes

A PCP may request member reassignment for a variety of reasons. The PCP must send a written request to their Provider Relations Representative. The request should include the reason and a copy of the medical record/office notes or other supporting documentation. All requests to reassign members must be reviewed and approved by the B – UHP Medical Director.

PCPs must allow 30 days for a member reassignment and are obligated to continue to treat the member as necessary during this change. Members are offered freedom of choice within our PCP Network.

However, we may restrict this choice when a member has shown an inability to form a relationship with a PCP, as evidenced by frequent changes, or when there is a medically necessary reason. We hope all of our patients and providers have satisfactory, productive relationships. If provider staff are having difficulties with a member (not keeping appointments or not complying with their care regime, etc.), please notify our Case Management Department.

PLEASE NOTE: Primary Care Providers rendering services for the B – UHP should not advise a member that they have been discharged until the request has been approved and communicated by the B – UHP Chief Medical Officer. Upon final decision by the B – UHP Chief Medical Officer the Administrative Assistant will notify the member of the outcome in writing.

AHCCCS Member Plan Changes

There may be times outside of the AHCCCS Annual Enrollment Choice period that AHCCCS allows members to change plans.

PCP offices should direct members inquiring about plan changes to the Health Plan Customer Care Department. The assigned Provider Representative, in coordination with B – UHP Medical Director(s), will determine whether the request meets AHCCCS criteria and if the change is in accordance with AHCCCS guidelines. B – UHP Medical Director(s) may contact the PCP for additional information.

Covering Providers

Emergency and After-Hours Coverage

Health Plan members who are a patient of record in a provider office should receive the same service in an emergency that would be extended to any other patient of record in that office.

Providers will maintain coverage for their practice 24 hours a day, seven days a week.

Acceptable Emergency Coverage includes the following:

- An answering service that answers the provider's telephone after hours. The operator must be able to contact the provider or a covering provider.
- An answering machine that either directs the caller to the office of the covering provider or directs the caller to call the provider at another number.
- Call forwarding services that automatically sends the call to another number that will reach the provider or covering provider.
- An answering machine that directs the caller to leave a message that will automatically page the provider to retrieve the message and respond as appropriate.

Unacceptable Emergency Coverage includes the following:

- An answering machine that directs the caller to go to the emergency room.
- An answering machine that directs the caller to a cellular phone, which bills the caller for the call. Members should not receive a telephone bill for contacting a provider.
- An answering machine that does not direct / educate the caller at all regarding after-hours procedures.
- No answering machine or service.

Vacation / Meeting Coverage

It is the responsibility of the Provider to arrange for coverage for members 24 hours a day, 7 days a week. B – UHP must be notified of any coverage dates and provider covering, in advance. B – UHP must credential ALL covering providers.

Specialty Care Providers

If a member requires services outside the scope of the PCP practice, the PCP will refer the member to a contracted specialty care physician. PCPs are responsible and accountable for the coordination, supervision, delivery and documentation of health care services for members (except for children's dental services when provided without a PCP referral). Female members have direct access to OB/GYN providers including physicians, physician assistants and nurse practitioners within the scope of their practice, without a referral for preventative and routine services.

Some services do require Prior Authorization or notification. Please refer to the B – UHP Prior Authorization grid for additional information which can be found on the B – UHP websites as well as from your Provider Relations Representative. The PCP is responsible for the referral of the member as well as initiating authorization for some specialties.

Specialty care physicians will provide members' PCP all medical information in writing, within 30 days of initial date of service, describing all covered services provided to the member.

Appointment Availability Standards

B – UHP has made a commitment to meet appointment availability standards as set forth by AHCCCS, Medicare and community standards. All members must be offered the same appointment availability standards as other patients receiving care in their office. Should the Provider segregate any B – UHP members, the Provider may receive a Corrective Action Plan (CAP) or have their provider agreement terminated.

In accordance with AHCCCS and Medicare standards, appointment standards/wait time audits are conducted regularly to ensure members timely access to care. Should providers be non-compliant with appointment or wait time standards, a CAP is required.

Note: All Providers are to become familiar with and adhere to the following appointment availability standards.

Appointment Availability Standards

PCP
Within 2 calendar days for urgent care
Within 7 calendar days for non-urgent but in need of attention (SNP only)
Within 21 calendar days for routine physicals or health maintenance visits
Specialty Care
Within 2 calendar days of a referral for urgent care
Within 45 calendar days of a referral for routine care
Maternity Care
Within 14 calendar days for first trimester
Within 7 calendar days for second trimester
Within 3 calendar days for third trimester
Within 3 calendar days of identification of high risk, or immediately if an emergency
Within 45 calendar days for routine care (SNP only)
Uncomplicated pregnancy – every 4 weeks for the first 28 weeks and every two to three weeks until 36 weeks of pregnancy, and weekly thereafter
One postpartum visit at approximately 6 weeks after delivery
Behavioral Health Providers
Urgent appointment the same day or within 24 hours of the referral or request
Appointment for initial assessment within 7 calendar days of referral
Appointment for ongoing services within 23 calendar days of initial assessment for members 18 years or older
Appointment for ongoing services with 21 days of initial assessment for members under the age of 18 years old
Subsequent behavioral health services no later than 45 calendar days from the identification of needs
Psychotropic Medications
Appointment within a timeframe that ensures member does not run out of needed medication or decline in behavioral health condition, but no later than 30 days from the identification of need
Dental Care
Within 3 calendar days for urgent care
Within 45 calendar days for routine care

Wait Times

Appointments

Members with an appointment shall not wait more than 45 minutes for treatment, except when the provider is unavailable due to an emergency. If an emergency or delay arises, members should be given the option to reschedule his/her appointment within a reasonable period of time. B – UHP will actively monitor appointment wait times and ensure provider compliance.

Transportation

Medically necessary transportation shall be scheduled so that the member arrives on time for the appointment, but no sooner than one hour before the appointment; nor have to wait more than one hour after the conclusion of the treatment for transportation home; nor be picked up prior to the completion of treatment. We encourage members to make their transportation requests 72 hours before their appointment date and cancel them as soon as they are aware that they cannot make their appointment.

Missed or Canceled Appointments

Please notify the assigned Provider Representative if a member consistently misses appointments or cancels without rescheduling. Complete the “No Show Log” or furnish a copy of your own “No Show Log” and email or fax it to the Network Department at 520-874-7144. The Network Department will forward it to the Customer Care Department.

The Customer Care Department will contact the member to provide education on the importance of keeping appointments and provide assistance in scheduling future appointments. B – UHP also encourages providers to talk to their patients regarding the importance of keeping all scheduled appointments.

Confirmation Calls

A confirmation telephone call to the member is encouraged to minimize the number of missed appointments. B – UHP encourages providers to remind members during the confirmation call that medically necessary transportation is available to our AHCCCS and SNP members. If B – UHP can assist you with managing your membership, including those members who frequently miss scheduled appointments, please let us know. We are committed to ensuring our members receive quality care in accordance with the expectations of their providers.

Release and Confidentiality of Medical Information

It is the policy of B – UHP to ensure the appropriate and confidential exchange of member information among providers to ensure continuity of care. All contracted providers who house medical records shall appoint a “custodian of medical records”. Such person shall be responsible for the safe storage and handling of the medical record as well as procedures to maintain confidentiality and integrity of each record.

Note: Subject to change per State and Federal requirements. Please contact B – UHP to verify the most current policy.

HIPAA (Health Insurance Portability and Accountability Act) requires covered entities, including, but not limited to, health plans and providers, to safeguard protected health information (PHI) and use or disclose it only as permitted under Federal and State law. The confidentiality of member PHI must be protected by policy and/or procedure as required by Federal and State law, (Health Plan Policy #CP 6007). Documentation must also exist that both the B – UHP and provider office staff are informed of, understand and agree to required confidentiality standards.

Certain PHI may be disclosed without member authorization as outlined in HIPAA 45 CFR 164.512, including but not limited to the following reasons:

- Requirement by law
- Regarding victims of abuse, neglect or domestic violence
- Health oversight

- Judicial and Administrative proceedings

When a member chooses a new Primary Care Provider, medical records must be transferred to the new provider within 10 days of the request in order to assure and promote continuity of care. Any provider sending member records, upon member written request to a new or referring provider must ensure the medical records are forwarded in such a way that unauthorized individuals are not able to access or alter PHI.

HIPAA also provides the member the right to obtain a copy of their records. Any B – UHP member is entitled to receive one copy of his/her medical records from the provider office at no cost, annually as specified in Title 45 of the Code of Federal Regulations CFR 164.524. The records maintained in the designated record set must be provided within 30 days unless the provider requests a 30-day extension from the member and the member agrees. The records must be provided in the form and format requested by the member if it is readily producible in such form and format, or if not in a readable hard copy form or a form agreed upon by both parties. If a member requests an amendment of their medical record, you must review the request including the reason that supports the request and inform the member of the decision regarding their request. You may require members to make this request in writing. You must act on the member's request no later than 60 days of the receipt of such request. You may deny the request for an amendment if the information was not created by you, is not part of the record used to make decisions about the member, is not part of the information that the member is permitted to inspect or copy or if the information is accurate and complete. If the request is denied, you must provide a written denial with the basis for the denial and information on the member's right to submit a written statement disagreeing with denial and how to file the statement. You must, as appropriate, identify the record or protected health information in the designated record set that is the subject of the request for amendment and either amend or attach the statement of disagreement to the designated record set. Additional information on the amendment of protected health information can be located at Title 45 of the Code of Federal Regulations CFR 164.526.

Additional HIPAA requirements and information is available via the government website:

www.hhs.gov/ocr/privacy/hipaa/understanding/summary.

Availability and Retention of Medical Records

It is the policy of the Health Plan to make available at all reasonable times during the term of the contract, all Health Plan member records for inspection, audit or reproduction for quality review purpose by an authorized representative of the Health Plan, State or Federal regulatory agencies. The Designated Record Set (DRS)

The following applies to the member's DRS:

The DRS is the property of the provider who generates the DRS. The DRS is a group of records maintained by the provider. The DRS may include the following:

- Medical and billing records maintained by the provider. According to Arizona Revised Statute 12-2291, "Medical records" means all communications related to a patient's physical or mental health or condition that are recorded in any form or medium and that are maintained for purposes of patient diagnosis or treatment, including medical records that are prepared by a health care provider or by other providers."
- Case/medical management records, or
- Any other records used by the provider to make medical decisions about the member

For retention of patient medical records, the Health Plan shall ensure compliance with A.R.S. §12-2297 which provides, in part, that a health care provider shall retain patient medical records according to the following:

If the patient is an adult, the provider shall retain the patient medical records for at least six years after the last date the adult patient received medical or health care services from that provider.

If the patient is under 18 years of age, the provider shall retain the patient medical records either for at least three years after the child's eighteenth birthday or for at least six years after the last date the child received medical or health care services from that provider, whichever date occurs later.

The Health Plan will retain member records from as required by specific State and Federal agencies.

The Health Plan may obtain a copy of the member's medical records, without written approval of the member, if the reason for such request is directly related to the administration of the health plan.

AHCCCS, CMS and DOI may obtain a copy of the member's medical records from the PCP or any other agency, without written approval of the member. They shall be afforded access to said records within 20 working days of receipt of request.

Health Information Network of Arizona (HINaz)

The state of Arizona is moving toward further integration of technology base solutions and the meaningful use of electronic health records within the system of care. Health Information Exchange (HIE) provides a network and universal format that connects hospital, doctors and other providers. HIE allows electronic health records containing personal health information (PHI) to be securely shared among health organizations.

Health Information Network of Arizona (HINaz) is a non-for-profit organization tasked with improving access, quality and safety of health care in Arizona while reducing and stabilizing cost of care.

Implementation of a HIE may reduce total spending on health care by diminishing the number of inappropriate tests and procedures, reducing paperwork and administrative overhead, and decreasing the number of adverse events resulting from medical errors. HINaz will provide a secure system that allows complete patient health records to be access electronically by authorized health care providers and health care facilities. HINaz aligns health plans, hospitals, provider offices, business leaders and local administrators throughout the state with the collective intention of protecting the personal health information and privacy of all patients.

AHCCCS requires all health plans to contract with HINaz as a data user. B – UHP will actively participate in the HINaz initiative by offering information and providing provider support and education to further expand provider adoption and use of health information technology. B – UHP encourages eligible hospitals and eligible professionals to participate in the statewide HIE initiative.

For additional information and resources about health information technology:

- Health Information Network of Arizona (HINaz) - <http://healthnetworkarizona.org/index.php>
- HINaz Health Care Provider FAQs - <http://healthnetworkarizona.org/provider-faq>
- Arizona Health-e Connection - http://www.azhec.org/?page=About_Us
- AHCCCS Electronic Health Record Initiative Program - <http://www.azahcccs.gov/EHR/default.aspx>
- The Arizona Regional Extension Center (REC) - http://www.azhec.org/?page=The_REC
- Medicare and Medicaid Electronic Health Record Incentive Programs - <https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/ehrincentiveprograms>

Advanced Directives

Health Plan members have the right to make decisions about their health care, including the right to accept or refuse medical care and the right to execute an advanced directive. Members can exercise his or her rights, and the exercising those rights shall not have an adverse effect on service delivery to the member.

PCP's are required to:

- Provide written information to adult members regarding their rights under state law to make decisions regarding their medical care and the provider's policies concerning advanced directives, including conscientious objections, if applicable.
- Document in the member's medical record whether or not the adult member has been provided with the above information and whether or not an advanced directive has been executed.
- Not discriminate against a member because of his or her decision to execute or not execute an advanced directive and not make it a condition of or the provision of health care.

- Provide education to staff on issues concerning advanced directives, including notification of direct care providers of services, such as home health care and personal care providers, of any advanced directives executed by the member to whom they are assigned to provide services.

PCP's are encouraged to obtain a copy of the member's executed advanced directive from a hospital, nursing facility, home health agency, hospice or any organization responsible for providing personal care for inclusion in their medical record.

Information concerning advanced directives may be obtained from your Provider Relations Representative or at <https://www.azag.gov/seniors/life-care-planning>.

Medical Record Transfer During Member Transition

Member Transitioning Out of the Health Plan

If a member is under active treatment for an acute or chronic condition and transitioning out of the Health Plan the Primary Care Physician is responsible for providing a copy of the medical record upon request from the receiving health plan or program contractor.

- Medical records must include records related to diagnostic tests and determinations, current treatment services, immunizations, hospitalizations with concurrent review data and discharge summaries, medications, current specialist services, behavioral health quarterly summaries and emergency care.
- The cost of copying and transmitting the medical record information will be the responsibility of the relinquishing provider for AHCCCS and SNP members. These members may not be billed.
- The records must be available to the new provider within ten 10 days of receipt of request or upon request for an urgent visit.
- Confidentiality must be maintained by all staff, provider and/or vendors according to medical record policy and procedure.

Member Transitioning to the Health Plan

When a case managed member is transitioned into the Health Plan, the new provider will receive notification from our Care Management Department. Pertinent information will be relayed via telephone or fax request. Records will be requested of current provider and forwarded to you within 10 days.

Member Care Requirements

EPSDT Services

AHCCCS providers are required to offer comprehensive health care and preventative services to eligible members. The EPSDT (early and periodic screening, diagnosis and treatment) program is federally mandated and includes all AHCCCS eligible members from birth through the age of 20 years (until the 21st birthday). EPSDT includes well-child visits and referrals for dental, vision and behavioral health. Medically necessary services to treat conditions noted in EPSDT screens are covered services. The program requires documentation of visits at specific intervals and the completion of AHCCCS- approved EPSDT Tracking Forms that prompt appropriate health maintenance activities at each age.

Immunizations

Age appropriate immunizations are to be provided following the standards adopted by the Advisory Committee on Immunization Practices (ACIP), which includes the American Academy of Pediatrics and the Center for Disease Control (CDC). Those members who are unable to document prior immunizations should be immunized until current with their appropriate age group. Arizona State law requires that providers report all immunizations administered to children under age 19 to the Arizona Department of Health Services. Adult immunizations should be provided according to CDC standards. Additional immunizations for influenza and pneumonia should be given when medically indicated.

AHCCCS providers must register and provide immunizations from the Vaccines for Children (VFC) Program. The program guarantees vaccine purchase and supply to all States for use by participating providers. Through VFC, the Federal and State governments purchase, and make available to providers at no cost, vaccines for AHCCCS children under age 19. Any provider, licensed by the State to administer immunizations, may register with ADHS as a VFC provider and receive free vaccines.

The provider shall comply with all VFC requirements. Arizona State law requires reporting of all immunizations given to children under the age of 19. Immunizations must be reported at least monthly to ADHS. Reported immunizations are held in a central database known as ASIIS (Arizona State Immunization Information System), which can be accessed by providers to obtain complete, accurate immunization records. Software is available from ADHS to assist in meeting the reporting requirements.

The vaccine portion of childhood immunizations shall be reimbursed through the State of Arizona's VFC Program. It is the responsibility of the provider to submit billing to the VFC Program for reimbursement. Plan will reimburse provider for the administration of VFC vaccines in accordance with AHCCCS fee schedule. The Plan will not reimburse provider for the administration of the vaccines in excess of the maximum allowable set by CMS, found in the AHCCCS fee schedule.

All routine childhood vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) are available through this program. For more information about this program, contact the Maternal Child Health Department.

If vaccines are not available through the VFC Program, please contact your Provider Relations Representative immediately.

Family Planning Services

Family planning services are covered for both male and female members, who voluntarily choose to delay or prevent pregnancy. Covered services also include the provision of accurate information and counseling to allow members to make informed decisions about specific family planning methods available. Please note that coverage benefits, and limitations are dictated by the plan in which member is enrolled. Members may receive family planning services from any contracted provider. PCP's are responsible for ensuring that members have information and access to these services.

Arizona State statutes requires AHCCCS members of reproductive age be reminded that family planning services are available to them.

Formulary

The plan specific Drug Formularies can be found on the MedImpact website at www.medimpact.com and Health Plan websites) or from your Provider Relations Representative. The formularies are updated quarterly, and a hard copy can be obtained by going to the MedImpact website. If available, providers must prescribe generic medications and medications listed in the Plan's formulary and in accordance with Pharmacy guidelines. If a medication is not listed in the formulary or the provider is requesting a name brand, provider shall obtain approval before prescribing medication in accordance with Prior Authorization policies. Provider signatures on prescriptions must be legible in order for the prescription to be dispensed.

Hospital Admissions

PCPs are expected to admit members to Health Plan contracted facilities and follow his/her own patients in the hospital. If the PCP is unable to admit and or follow the patient, it remains his/her responsibility to arrange for an admitting/attending provider. The selected provider must be contracted and must have privileges at the admitting facility.

Referrals/Prior Authorizations

The PCP is responsible for initiating and coordinating referrals to specialists within the contracted network when necessary and obtaining prior authorization for services listed on the Prior Authorization Grid. Please refer to the Prior Authorization Grid and Referral Guidelines at www.bannerUHP.com.

The Health Plan encourages contracted specialists to secure needed authorizations, but it is the responsibility of the PCP to ensure the authorization is requested. It is critical that the PCP maintains a strong communication link with specialists who are treating their members.

Caring for Members with Special Needs

B – UHP considers our contracted providers partners in caring for our members. As health care reform becomes a reality, it is a critical time for health plans and providers to align their efforts in providing care for members and patients with special needs.

The methods in which plans, and providers will be reimbursed are rapidly moving toward payment for quality and improved health outcomes. B – UHP would like to share some of the specific areas where you can impact the outcomes of your patients and assist the plan in achieving high quality ratings.

Health Outcomes Survey

The Health Outcomes Survey (HOS) is used to gather valid, reliable, and clinically meaningful health status data from patients for use in quality improvement activities, pay for performance, program oversight, public reporting, and improving health. HOS measures include questions on the following topics:

1. Improving or Maintaining Physical Health
2. Improving or Maintaining Mental Health
3. Monitoring Physical Activity
4. Reducing the Risk of Falling
5. Management of Urinary Incontinence

Consumer Assessment of Healthcare Providers and Systems

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey asks patients to report on and evaluate their experiences with health care and their provider. The survey covers topics that are important to consumers and focuses on aspects of quality that consumers are best qualified to assess.

CAHPS survey questions incorporate the following topics:

- Communicating with your physician
- Getting appointments and care quickly
- Overall health care quality
- Getting needed prescription drugs
- Ease of getting needed care

Healthcare Effectiveness Data and Information Set

The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by health plans to measure performance on important dimensions of care and service. The following are a representative sample of the measures:

Prevention and Screening

- Adult BMI Assessment
- Breast Cancer Screening
- Colorectal Cancer Screening
- Glaucoma Testing Managing Chronic Conditions
- Diabetes Care – Blood Sugar Controlled, Cholesterol Controlled, Kidney Disease Monitoring, and Dilated

Retinopathy Exam

- Cardiovascular Care – Cholesterol Management and Controlling High Blood Pressure
- Care for Older Adults – Medication Review, Functional Status Assessment and Pain Screening

Another important consideration is medication safety for members with chronic conditions like diabetes, heart disease and hypertension. Quality focus areas include medication adherence, review and reconciliation.

Using **SOURCE** as a reminder will help to maximize the provider-patient experience. After all, your patient is the best **SOURCE** of information about their healthcare needs.

Screenings and Immunizations: Encourage members to have preventive screenings including breast cancer screening, colorectal cancer screening, bone density testing, etc. according to age and gender guidelines. Don't forget annual flu shots and pneumococcal vaccinations.

Organize Medications: Review the patient's current medications. If possible, replace medications with a high risk of serious side effects with safer drug choices. Also, encourage adherence with maintenance medications for hypertension, diabetes and cholesterol.

Urinary Incontinence: This can be a difficult topic for patients to bring up with their physician. Find out if the patient has experienced problems with the leakage of urine. If yes, consider recommending bladder training, exercises, medication, and/or surgery.

Risk of Falling: Determine if the patient had a fall or problems with balance or walking in the past 12 months. The patient may benefit from having their blood pressure taken in a lying or standing position, an exercise or physical therapy program, a vision or hearing test, or even prescribing a cane or walker.

Chronic Conditions: Members with hypertension, heart disease, diabetes, rheumatoid arthritis, chronic obstructive pulmonary disease, etc. require extra care. Be sure to allow sufficient time for monitoring disease specific criteria in addition to routine preventative care.

Exercise: Discuss level of physical activity; encouraging patients to initiate, increase or maintain an exercise program. Don't forget to calculate the patient's Body Mass Index (BMI) as part of the overall assessment.

Banner – University Care Advantage has many resources available to assist you including medical directors, case managers and pharmacists. The best place to start is to contact your Provider Relations Representative.

Children with Special Health Care Needs

The Health Plan is committed to providing children with special health care needs referral and access to experienced providers. Children with Special Health Care needs frequently need referral to Children's Rehabilitative Services (CRS), specialized health care for specific conditions, behavioral health or coordination with the Arizona Department of Child Safety (DCS). A Case Manager can provide assistance in accessing these services working with the physician and the family to ensure the child is receiving the appropriate services. Please contact the Maternal Child Health Department for assistance.

AHCCCS Children's Rehabilitation Services (CRS) <https://www.azahcccs.gov/Commercial/CRS.aspx>

Healthy Together Care Partnership

Collaborating with Providers to Care for Patients and Families

The Healthy Together Care Partnership (HTCP) is a Banner – University Medical Group (BUMG) program aimed at meeting the needs of our Network's most complex patients. This program is specifically for adult patients of BUMG's primary care clinics who have Banner – University Family Care as their AHCCCS plan. HTCP is a joint effort between the BUMG and Banner – University Health Plans.

HTCP is an interdisciplinary team care model that is home and community-based, utilizing evidence-based, high touch, coordinated care to achieve the Institute of Healthcare Improvement's Triple Aim— Better Health, Better Healthcare and Lower Costs. The needs of complex patients often cannot be fully addressed within the clinic setting alone. Patients, families and healthcare providers all benefit from an extended team approach serving to

augment the care of the primary care provider and facilitate engagement with the patient's medical home.

Who are the team members?

The team consists of a BUMG nurse practitioner, clinical nurse case manager, social work/health behavior partner, clinical pharmacist, and community health partner who collaborate with the primary care team to coordinate, assess and follow up on recommended treatment through a patient-centered approach.

Who is a candidate?

- University Family Care enrolled adults who are established with a BUMG primary care provider
- People with multiple morbidities or co-morbid medical and behavioral health diagnoses
- Are high need, high utilizing patients who are at risk for a preventable hospital admission
- Are able to engage with a health care team and participate in a home-based needs assessment

What do we do?

- Assist with hospital to home transition and post-discharge home visits
- Conduct in-home safety and health needs assessments
- Perform medication reconciliation, education, and adherence strategies
- Coordinate follow-up health care appointments and pre-visit preparation
- Provide chronic disease education and self-management support
- Coordinate care among providers, health plans, and regional behavioral health services
- Enhance communication among health care partners via the electronic health record (Epic)
- Develop a 30-90 day collaborative care plan. May extend and/or monitor beyond 90 days.

What do we expect to achieve?

1. Improve patient satisfaction, empowerment, and access to care
2. Enhance provider satisfaction by supporting care beyond the clinic visit
3. Prevent complications post-discharge and preventable readmissions
4. Reduce avoidable ED visits
5. Reduce avoidable hospitalizations and length of stay

To learn more about the program or discuss a potential referral, contact the program at (520) 626-5813 or UAHNHealthyTogetherMailbox@bannerhealth.com.

Provider as Member's Advocate

The Health Plan does not prohibit, or otherwise restrict a provider, acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient, for the following:

- The member's health care, medical needs or treatment options, including alternative treatment that may be self-administered, even if needed services are not covered by the Health Plan.
- Any information the member needs in order to decide among all relevant treatment options.
- The risks, benefits and consequences of treatment or non-treatment.
- The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment and to express preferences about future treatment decisions. (42 CFR 438.102)

Providers must provide information regarding treatment options in a culturally-competent manner, including the option of refusing treatment, and must ensure that members with disabilities have effective communication in making decisions regarding treatment options.

Adult Health Care

Adult Preventive Care

The following information is based on the periodicity schedule for adult preventive care and is available to all members over the age of 21 for discussion with their PCPs.

19 - 39 Years

- First mammogram between ages 35-40 or at any age if medically necessary.
- HIV and other STD tests if unprotected sexual relations or IV drug use. STD screenings at least once during pregnancy.
- Cholesterol screening.
- Tuberculosis screening.
- Tetanus shot once every 10 years.

40 - 64 Years

- Routine mammography annually after age 50 or at any age if considered medically necessary.
- HIV and other STD tests if unprotected sexual relations or IV drug use. STD screening at least once during pregnancy.
- Cholesterol blood screening.
- Colon cancer screenings digital rectal exam and stool blood test, annually after age 50.
- Tuberculosis screening.
- Tetanus shot once every 10 years.

65 Years and Over

- Cholesterol blood test every 5 years, more may be approved if medically necessary.
- Yearly mammograms.
- HIV and other STD tests if unprotected sexual relations or IV drug use.
- Pneumonia vaccine every 10 years.
- Tetanus vaccine every 10 years.
- Flu vaccine every year.

Immunizations

Covered medically necessary immunizations for adults include, but are not limited to:

- Diphtheria-tetanus
- Influenza
- Pneumococcus
- Rubella
- Measles

- Hepatitis-B

Please note coverage is dictated by the plan member is enrolled; please call our Customer Care Center for more detailed information or refer to our websites for plan specific benefit structures.

Women's Preventative Care Services

An annual well-woman preventative care visit is a covered benefit for women to obtain the recommended preventative services, including preconception counseling. An annual well-woman preventative care visit is intended for the identification of risk factors for disease, identification of existing medical/mental health problems, and promotion of healthy lifestyle habits essential to reducing or preventing risk factors for various disease processes. As such, the well-woman care visit is inclusive of the following:

- A physical exam (well exam) that assesses overall health
- Clinical breast exam
- Pelvic exam
- Review and administration of immunizations, screenings and testing as appropriate for age and risk factors
- Screening and counseling is included as part of the well-woman preventative care visit and is focused on maintaining a healthy lifestyle and minimizing health risks, that addresses at a minimum the following:
 - Proper nutrition
 - Physical activity
 - Elevated BMI indicative of obesity
 - Tobacco/substance use, abuse and/or dependency
 - Depression screening
 - Interpersonal and domestic violence screening
 - Sexually transmitted infections
 - HIV
 - Family planning counseling
 - Preconception counseling that includes discussion regarding a healthy lifestyle before and between pregnancies that includes:
- Reproductive history and sexual practices
- Health weight, including diet and nutrition, as well as the use of nutritional supplements and folic acid intake
- Physical activity or exercise
- Oral health care
- Chronic disease management
- Emotional wellness
- Tobacco and substance use (caffeine, alcohol, marijuana and other drugs), including prescription drug use
- Recommended intervals between pregnancies

Note: Preconception counseling does not include genetic testing.

- Initiation of necessary referrals when the need for further evaluation, diagnosis, and/or treatment is identified

Clinical Practice Guidelines

The Health Plan has adopted nationally recognized clinical practice guidelines as well as practice guidelines for pharmacy use, referral guidance or other medical topics such as these associated with AHCCCS, Quality Improvement topics.

The Health Plan endorses or develops clinical practice guidelines in order to support physicians and other clinical providers in the assessment, diagnosis and treatment of our Health Plan members.

The Health Plan Clinical Guidelines are:

- Based on valid and reliable clinical evidence or a consensus of health care professionals in their respective field.
- Selected with consideration of the needs of the Health Plan members.
- Adopted in consultation with the Health Plan providers.
- Based upon National Practice Standards.
- Developed by health care professionals and based upon a review of peer-reviewed articles published in the United States when national practice guidelines are not available.

The Health Plan Clinical Practice Guidelines are recommendations to support clinical decision-making. Primary Care Providers, specialists and other health care providers are expected to collaborate with their patient and/or patient surrogate to develop and implement treatment plans that are individualized to meet the specific needs of each patient. This collaboration allows possible deviation from the guidelines in unique clinical situations and should be clearly substantiated in the medical record.

The Health Plan Clinical Practice Guidelines are endorsed or developed with designated, desired outcomes and associated, standardized measures of effectiveness. These guidelines will be disseminated to all affected providers and are available to all providers, members and affiliated allied health professionals upon request.

As these guidelines may include treatment that requires prior authorization and/or is not covered by the member's benefit structure, please refer to the *Prior Authorization Grid and Referral Guidelines* on our provider website.

The Health Plan Practice Guidelines are reviewed by the Quality Management/Performance Improvement (QM/PI) Committee at least annually to determine if the guidelines remain applicable, represent best practice standards and reflect current medical standards.

The Medical Management Department is available as a clinical resource to providers that request additional information related to the Health Plan Clinical Practice Guidelines. Clinical Practice Guidelines can also be found on our health plan websites.

Transportation

The Health Plan provides non-emergency transportation for AHCCCS eligible members who are unable to provide their own transportation for medically necessary services using the appropriate mode based on the needs of the member.

Please use the following guidelines:

Same Day Transportation Needs

Transportation service requests require a 3-day advance notice, to ensure adequate scheduling. However, same day transportation services can be arranged under the following guidelines:

- To ensure timely in-patient or emergency room discharges
- To ensure transport to an urgent care facility

- To ensure that members are afforded emergent and urgent PCP appointments in lieu of an emergency or urgent care visit

Members and or providers shall use the Transportation Guidelines and Overview to set up non- emergency medically necessary transportation.

Future Transportation Needs

Transportation services are to be scheduled with a minimum of 3 business days prior to the scheduled appointment. The transportation vendor uses the *Transportation Guidelines and Overview* to set up the transportation request. The contracted transportation vendor will complete up to 2 future transport requests within one call.

Recurring Transportation Order or Blanket Transportation Requests

At times, members are required to establish recurring transportation requests for continuous medical treatment such as dialysis, physical therapy, wound care, chemotherapy, etc. Should a member require recurring transportation, call our Customer Care Center.

The Customer Care Center will work with the contracted transportation vendor to establish the recurring/blanket transportation request. Additionally, the Customer Care Center may request that the provider send a FAX to the Customer Care Center with pertinent information regarding the request. The FAX/Order requires at a minimum the following information:

Member Name & Address	Date Service Starts/Ends
Member AHCCCS ID	Time of Appointment
Member's PCP	Time Appointment Ends
Provider Rendering Service	Location of Appointment
Type of Service	Key Contact at Facility

Non-Emergent Ambulance Transportation

An AHCCCS member may be transported from a provider office to the hospital or from a hospital to another facility for care. This type of transport should be arranged by calling the Customer Care Center and selecting the option for transportation. Prior Authorization is not required if using a contracted vendor. All air transportation requires Prior Authorization.

Emergency transportation is also available. Instruct the member to call 9-1-1 for emergency transportation.

Mainstreaming the Health Plan Members

American's with Disabilities Act (ADA)

Health Plan contracted providers must adhere to the American's with Disabilities Act (ADA). The Act of 1990 gives civil rights protections to individuals with disabilities similar to those provided to individuals on the basis of race, color, sex, national origin, age and religion. While the ADA is a Federal law, Arizona does have a mirror statute regarding disabilities, giving the Attorney General the authority to enforce this law. In accordance with the Act, a member will not be discriminated against based on his/her disability. Contracted providers will make reasonable accommodations, without undue hardship, in order to provide quality care for a member with a disability.

B – UHP will ensure all contracted providers are complaint with AHCCCS requirements which includes providing physical access, accessible equipment, reasonable accommodations, and culturally competent communications for all members including those with physical or cognitive disabilities. B – UHP will provide the minimum criteria utilized to all providers via the provider manual. All providers will be required to submit a completed AZAHP application and complete the section related to accessibility, in accordance with the state Alliance requirements.

Furthermore, providers who have been identified as meeting the accessibility requirements will be flagged and identified in the B – UHP Provider Directory, and in our online Provider Look-up tool. The availability of these resources will be communicated to members, within their member material documentation.

Civil Rights Act of 1964, Title VI

The Civil Rights act of 1964, Title VI, prohibits discrimination on the basis of race, color or national origin. Health Plan providers will mainstream all Health Plan members so that they are provided covered services without regard to payer source, evidence of insurability, race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, genetic information, medical condition, physical or intellectual disability. Restriction of appointment availability standards may not occur.

Members must be treated with dignity and respect and have equal access and appointment time availability as other patients in the providers' office. The Health Plan will promptly intervene if it is identified that discrimination was involved with a member. The Health Plan will require a corrective action plan from the provider. If you have any questions or are interested in receiving additional information, please contact your Provider Relations Representative.

Cultural Competency

The Health Plan promotes Cultural Competency for its staff, provider network and members. Cultural Competency is an awareness and appreciation of customs, values and beliefs and the ability to incorporate them into the assessment, treatment and interaction with members. We have a Cultural Competency Committee and Program as well as a Cultural Competency Liaison who creates education programs for the specific audiences of staff, providers and members. This education comes in the form of provider education sessions and in- services; member and provider newsletter articles, staff in- services and many other forms of communication forums.

The goal of the Cultural Competency Committee is to ensure that members are provided with culturally competent care and services by the health plan staff and the provider network. The purpose is to increase awareness of how our cultural assumptions and language affect interactions with others, including but not limited to, patient care. This does not mean each person will be competent in all cultures, but that each person should be aware that people may have different perceptions of health care based on their respective cultures. The Cultural Competency Plan follows the guidelines set forth by Section 1557 of the Patient Protection and Affordable Care Act, which is the nondiscrimination provision. This law prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health program or activities. Section 1557 builds on standing Federal Civil Rights laws.

Additionally, the Cultural Competency Plan addresses the following:

- Ethnicity
- Religion
- Limited English Proficiency (LEP)
Area of the country one is from
- Sexual orientation
- Life Experience
Age
- Language(s) spoken
- Socioeconomic status
Gender
- Family
- Length of residency in the United States

The Health plan will provide member education related to available services offered e.g. translation and interpretation which the Health Plan and provider experiences and the results on their health outcome. Providers must maintain compliance with the Cultural Competency Plan (CCP) and Limited English Proficiency requirements.

Interpretation and Translation Services

The Health Plan provides interpretive and translation services for its members. If you have a member who is in need of these services, please contact the Customer Care Center. Interpretive services are not based upon the non-availability of a family member or friend for translation. Members may choose to use family or friends; however, they should not be encouraged to substitute them for the interpretation service.

If you have questions or are interested in receiving additional information, please contact your Provider Relations Representative.

- An interpreter renders SPOKEN word from one language to another.
- A translator renders WRITTEN word from one language to another.

Interpretation Services for B – UHP

1. Call B – UHP's – Customer Care Center
2. Provide the representative with member's AHCCCS ID number and the nature of the interpretation services required.
3. You will be placed on hold while the representative connects you with the interpretation services.

Important Tips

Working with an Interpreter – Give the interpreter specific questions to relay. Group your thoughts or questions to help conversation flow quickly.

Length of call – Expect interpreted comments to run a bit longer than English phrases. Interpreters convey meaning-for-meaning, not word-for-word. Concepts familiar to English speakers often require explanation or elaboration in other languages and cultures.

Interpreter identification – Interpreters identify themselves by first name only. For reasons of confidentiality, they do not divulge either their full names or phone numbers.

Document translation – University Family Care is responsible for translating written documents for our members. If you have a written document that needs to be translated for a member, call the Customer Care Center.

National Standards for Culturally and Linguistically Appropriate Services (CLAS)

Culturally Competent Care:

1. Health care organizations should ensure that patients/consumers receive from all staff member's effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.
2. Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.
3. Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.
4. Language Access Services:
5. Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

6. Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
7. Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).
8. Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Organizational Supports:

1. Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.
2. Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.
3. Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.
4. Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.
5. Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.
6. Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.
7. Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

Office of Minority Health, U.S. Department of Health and Human Services. (March 2001) National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care. Federal Register, 65(247), 80865-80879.

<http://www.minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf>Warm

Warm Health – A Value Added Benefit for Members

The Health Plans offers Warm Health to all of its members. The purpose of Warm Health is to build relationships between the Health Plan and its members with a primary goal of improving health outcomes. Warm Health offers interactive care management programs for chronic conditions, maternal health, preventive care, and Star and HEDIS initiatives. Warm Health's comprehensive library of healthcare communications supports both our Medicare and Medicaid populations.

Through Warm Health, members across the entire risk pyramid are contacted at varying intervals via an Interactive Voice Response (IVR) system. Mary Beth, the friendly voice of Warm Health communications, establishes familiarity and consistency with the members. Personalized education content along with questions that determine the case management needs of members are delivered at different frequencies depending upon the conditions, needs and preferences of individual members.

When members with potential problems are identified, alerts are generated to case managers through the Warm Health Care Dashboard. Case managers proactively follow-up with the members to assess concerns and avoid escalation of health problems and increased medical costs.

Warm Health achieves improved results by increasing the frequency of outreach, by monitoring highest risk members and by extending communications and monitoring to members who would not typically receive the attention of care management. The result allows case managers the ability to support more members, improve member compliance and reduce overall medical costs.

Featured Warm Health programs include Diabetes, Million Hearts, Depression, Maternal Health, Well- Baby, and ER Avoidance. In addition to connecting members in need of assistance with a Case Manager, each program has specific goals to improve the health of the member.

- **Diabetes Program:** The Diabetes Program engages members in self-care delivering educational content designed to improve the health of members with both type 1 and type 2 diabetes. Members learn to control their diabetes through the establishment of healthy habits. Compliance with A1c testing, cholesterol screening, diabetic retinopathy exams and proper foot care are emphasized.
- **Million Hearts Program:** The Million Hearts Program promotes healthier lifestyles with an emphasis on cardiovascular health. The content supports the national Million Hearts initiative promoting the ABCs of heart health: appropriate aspirin therapy, blood pressure control, cholesterol management and smoking cessation. Medication adherence is another key objective of the Million Hearts Program.
- **Depression Program:** The purpose of the Depression Program is to provide members with education about depression recovery and improve antidepressant medication adherence. The highly motivational content encourages positive thinking and stress management with an emphasis on exercise, socialization and increasing pleasurable activities.
- **Maternal Health Program:** The Maternal Health Program encourages pregnant members to take the steps necessary to have a healthy baby including the importance of prenatal care. Members receive education relevant to each week of pregnancy and into the weeks after delivery including well baby tips.
- **Well Baby Program:** The Well Baby Program reminds moms about the importance of check-ups and immunizations during the first 15 months of life. Additional general education includes information on newborn care, developmental milestones, nutrition, recognizing and preventing illness and safety.
- **ER Avoidance:** The ER Avoidance Program reviews the appropriate use of emergency services for members who use the emergency room too often. The primary focus is on developing a relationship with a primary care provider along with using urgent care as an alternative to an emergency room visit.

Care Management/Care Coordination

Care Management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet an individual's health needs using communication and available resources to promote quality, cost-effective outcomes. Care coordination services are available to special/at-risk members in conjunction with their caregivers and providers.

Care Coordination Services

Available Care Coordination Services:

- Coordination of care for Health Plan members who are involved in multi-disciplinary systems
- Monitoring of health care services as needed
- Member advocacy
- Member resources/needs assessment
- Facilitation of appropriate referrals

- Member education
- Assistance with transition of care for care coordinated members as they move in or out of plans
- Members with Special Health Care Needs (SHCN)

Special/at-risk members may include, but are not limited to the following:

- Members who over/under utilize the health care system
- Members who are non-adherent with their treatment plan
- Members who have complex or prolonged, high risk medical problems
- Members with behavioral health issues that complicate their care

AHCCCS/SNP members within the following categories always receive care coordination:

- HIV-positive members
- Members who have hemophilia
- Members undergoing transplants, or who had a transplant and are new to the Health Plan

*Note: Please call the B – UHP Case Manager if you have a member diagnosed with one of these conditions.

Examples of members who are generally good candidates for referral to Case Management for care coordination are:

- Members who have frequent emergency department visits with non-emergent problems
- Members who have frequent hospital readmissions subsequent to non-compliance with treatment
- Members who are frequently readmitted to the hospital and who may stabilize/benefit with connection to appropriate community resources
- Members who use multiple providers or multiple resources without coordination or control of care by a PCP
- Victims of trauma, such as head injury, gunshot wounds, or multi-system injuries, which require special coordination and assistance
- Complex, terminally ill cancer patients
- Members with pain management concerns requiring multiple resources

Maternal Child Health

- Members with a history of pre-term labor who require home monitoring
- Members with complications as a result of gestational diabetes
- Members with pre-eclampsia who are non-adherent with their medical treatment plan
- Pregnant, substance-abusing members
- Members in the third trimester receiving late pre-natal care
- Teen pregnancies
- Other high-risk maternity cases identified by clinic, hospital, or UM personnel
- Infants with failure to thrive
- Premature infants with ongoing/complex medical problems

- Children who are asthmatic and have frequent hospitalizations
- Members within categories identified under Special/at-risk members noted above.

Behavioral Health

- Members who over-utilize medication or engage in drug seeking behavior
- Members with complex social/behavioral health problems complicating their illness, or inhibiting their ability to effectively manage their illness
- Victims of elder or child abuse
- Members with frequent hospitalizations needing substance abuse treatment
- Members with a behavioral health diagnosis involved in multiple systems requiring extensive coordination of care
- Members who are at risk for self-harm or harming others, or who have a complicated behavioral health issues
- Members having difficulty sustaining behavioral health treatment

Please notify the Care Manager if you need assistance in any of these areas.

Please note coverage is dictated by the plan that the member is enrolled in; please call our Customer Care Center for more detailed information or refer to our websites for plan specific benefit structures.

Preventive Care Checklist

Medicare Covered Test /Screening/Service	Who is Eligible & How Often	Other Information
Abdominal Aortic Aneurysm Screening	Member has at least one of the following risk factors: A family history of abdominal aortic aneurysm A man age 65 to 75 who has smoked at least 100 cigarettes in his lifetime Has never had an AAA ultrasound screening paid for by Medicare. Once in a lifetime	
Bone Mass Measurements (Dexa Scan)	All Medicare recipients who are at risk for osteoporosis and meet one of the following 6 criteria: Women being treated for estrogen-deficiency and at risk for osteoporosis based on medical history or other findings Vertebral abnormalities as demonstrated by an x-ray Getting steroid treatments Hyperparathyroidism Taking an osteoporosis drug Once every 24 months	

Cardiovascular Screening	All Medicare recipients are eligible for the following tests every five years: Total cholesterol test Cholesterol test for HDL & LDL Triglycerides test		
Colorectal Cancer Screening	All Medicare recipients are eligible for a screening colonoscopy. All other colorectal screenings are available to people with Medicare age 50 and older.		
Fecal Occult Blood Test	Once every 12 months.		FOBT G0328 FOBT G0107, 82270
Flexible Sigmoidoscopy	Generally, once every 48 months, or 120 months after a previous screening colonoscopy for people not at high risk.		G0104
Colonoscopy	Generally once every 120 months (once every 24 months if you're at high risk), or 48 months after a previous flexible sigmoidoscopy.		
Diabetes Screening	Medicare covers up to two Fasting Blood Glucose tests each year.		
	Medicare covers these tests for people who have any of the following risk factors: high blood pressure (hypertension) history of abnormal cholesterol and triglyceride levels (dyslipidemia) obesity a history of high blood sugar (glucose)	Medicare also covers these tests if member meets two or more of the following criteria: Overweight 65 or older Family history of diabetes (parents, brothers, sisters) History of gestational diabetes (diabetes during pregnancy), or delivery of a baby weighing more than 9 pounds.	
Diabetes Self-Management Training	Medicare covers diabetes self-management training. This training is for members who are at risk for complications from diabetes and requires a written order from a doctor or other health care provider.		By American Diabetes Assoc., American Assoc. of Diabetes Educators and HIS: 10 hrs. initial training 2 hrs. f/u annually
Flu Shot	All people with Medicare may receive the flu shot once per flu season. Flu shots are available starting in the fall for flu season.		Must see PCP for flu shot No copay or deductible

Glaucoma Screening	Medicare covers a glaucoma screening exam once every 12 months, which includes: A dilated eye exam with an intraocular pressure measurement. A direct ophthalmoscopy exam or a slit-lamp biomicroscopic exam. People are at high risk for the eye disease glaucoma if they have diabetes, a family history of glaucoma, are African-American and 50 or older, or are Hispanic and 65 or older.	
Hepatitis B Shot	People at medium to high risk for Hepatitis B are eligible for this immunization: Members with hemophilia, End-Stage Renal Disease (ESRD), live with someone who has Hepatitis B or healthcare workers that have frequent contact with blood or body fluids.	
HIV Screening (Human Immunodeficiency Virus)	Medicare covers HIV screening once every 12 months for people at increased risk infection, or up to 3 times during a pregnancy.	
Mammogram	All women with Medicare ages 35-39 for one baseline mammogram; ages 40 and older can get a breast cancer screening mammogram every 12 months.	NO PHYSICIAN REFERRAL REQUIRED
Medical Nutrition Therapy Services (Performed by Provider)	Medicare may cover medical nutrition therapy and certain related services if member has diabetes or kidney disease, or has had a kidney transplant in the last 3 years and doctor refers member for the service.	Performed by dietitian: 3 hrs. one on one 2 hrs. f/u annually
Well Woman Exam – Includes, Pap, Pelvic and Breast Exams	Medicare covers one Pap test and pelvic exam to check for cervical, vaginal, and breast cancers every year for women who: Are of childbearing age and who had an exam that indicated cervical or vaginal cancer or other abnormalities in the past 3 years. Are considered high risk for developing cervical or vaginal cancer. Medicare covers one pap test and pelvic exam every 2 years for women who are at low risk for cervical cancer. A clinical breast exam is included as part of the pelvic exam.	
Welcome to Medicare Preventive Visit	All Medicare Part B members may have a "Welcome to Medicare" preventive visit.	G0402 - IPPE G0403 - ECG w IPPE G0404 - ECG tracing for IPPE G0405 - ECG Interp & report

Annual Wellness Visit	Members who have had Part B for longer than 12 months, can get a yearly “wellness” visit to develop or update a personalized plan to prevent disease based on current health and risk factors. This visit is covered once every 12 months.	G0438 - First Visit (once in a lifetime) G0439 - Subsequent annual well visits
Pneumococcal Shot	All people with Medicare can be given the Pneumococcal vaccine at any time of year. Most people need this shot only once in their lifetime. Medicare will also cover a booster vaccine for high risk people if 5 years have passed since the last vaccination.	
Prostate Cancer Screening	Medicare covers a digital rectal exam and Prostate Specific Antigen (PSA) test once every 12 months for all men with Medicare age 50 and older.	
Smoking Cessation Counseling	All Medicare recipients who use tobacco are eligible for up to 8 face-to-face visits during a 12-month period. These visits must be provided by a qualified doctor or other Medicare-recognized practitioner. LIMITED TO 2 CESSATION ATTEMPTS PER YEAR.	G0436 - Intermediate: 3 - 10 minutes G0437 - Intensive: > 10 minutes
Screening & Counseling in PCP Office for Alcohol Misuse	All Medicare members who misuse alcohol, but consumption does not meet criteria for alcohol dependence are eligible for counseling if they are competent and alert at the time of counseling and counseling is furnished by qualified PCP in the PCP setting.	G0442 - Annual alcohol misuse screening 15 minutes G0443 - Brief face-to-face behavioral counseling for alcohol misuse 15 minutes
Depression Screening	All Medicare recipients are eligible for a depression screening performed by a qualified Primary Care Practitioner in a Primary Care setting that has staff-assisted depression care supports in place to assure accurate diagnosis, treatment and follow-up.	G0444 - Annual depression screening 15 minutes
Sexually Transmitted Infections Screening	Screening for Chlamydia, Gonorrhea, Syphilis & Hep B available to all sexually active Medicare recipients at increased risk for STI's. Semi-Annually	G0445 - 20 to 30 minute face-to-face counseling sessions including education, skills training and guidance of changing sexual behaviors
Cardiovascular Disease	Male Medicare recipients age 45 – 79 and female Medicare recipients age 55 – 79: Aspirin use for primary prevention, all Medicare recipients 18 and older with hypertension, hyperlipidemia, and other known risk factors. Bi-Annually	G0446 - Intensive behavioral therapy to reduce cardiovascular disease risk, individual face-to-face counseling: 15 minutes

High Intensity Behavioral Counseling is Available for the Following:		
Obesity	Medicare recipients with BMI >30kg/m ² who are competent and alert and whose counseling is provided by a qualified Primary Care Provider in a Primary Care setting: 1 visit per week x 1 month 1 visit every other week months 2 – 6 1 visit per mo. months 7 - 12	G0447 – Face-to-face behavioral counseling for obesity: 15 minutes

Utilization Management

The Utilization Management (UM) Program encompasses activities directed toward prospective, retrospective and concurrent utilization review. Prospective review (prior authorization) determines the medical necessity and appropriateness of the service before it is provided. Concurrent review occurs periodically throughout a member's inpatient stay to determine the appropriateness of the level of care and length of stay. Retrospective review involves the assessment of the appropriateness of medical services after services have been provided to include claims review.

Concurrent review, discharge planning, and medical review processes are described in this section. Utilization management criteria are available upon request. Requests for criteria should be directed to your Provider Relations Representative or to the Director of Clinical Services.

Concurrent Review

Concurrent utilization review is conducted on each member who is admitted to an inpatient facility, including skilled nursing facilities, and free-standing specialty hospitals.

Concurrent review activities include both admission certification and continued stay review. The review of the member's medical record assesses medical necessity for the admission, and appropriateness of the level of care, using the MCG. Admission certification is completed within 1 business day of notification. Notification is required within 24 hours of admission. Continued stay reviews are conducted before the expiration of any assigned or anticipated length of stay. These reviews are performed by registered nurses who work closely with the Manager of UM and Medical Director throughout the concurrent review process.

MCG

MCG (formerly Milliman Care Guidelines) are evidence-based clinical guidelines that span the continuum of care from outpatient to inpatient, including chronic care and behavioral health management and are updated annually. A copy of the criteria used is available upon request. Requests for criteria should be directed to the Medical Management Department.

Discharge Planning Coordination

Effective and timely discharge planning and coordination of care are key factors in the appropriate utilization of services and prevention of re-admissions. The hospital staff and the attending physician are responsible for developing a discharge plan for the member and involving the member and family in implementing the plan.

The Concurrent Review Nurse works peripherally with the hospital discharge team and attending physicians to ensure that cost-effective and quality services are provided at the appropriate level of care. This may include, but not be limited to:

- Assuring early discharge planning.
- Facilitating or attending discharge planning meetings for members with complex and/or multiple discharge needs.
- Providing hospital staff and attending provider with names of contracted providers (i.e., home health

agencies, DME/medical supply companies, other outpatient providers).

- Assisting with necessary authorization of post discharge services.
- Informing hospital staff and attending provider of covered benefits as indicated.
- Referring member to Care Management as necessary.

Provider Medical Review

The Medical Director/designee conducts a medical review for each case with the potential for an adverse decision. The Concurrent Review Nurses (inpatient) or the Prior Authorization Nurse (outpatient) reviews the documentation for evidence of medical necessity according to established criteria. The Health Plan utilizes MCG for admission appropriateness and length of stay. When the criteria are not met, the case is referred to the Medical Director/designee, who reviews the documentation, discusses the case with the nurse, and may call the attending or referring provider for more information. Based on the discussion with the provider or additional documentation submitted, the Medical Director will decide to approve, deny, modify, reduce, suspend, or terminate an existing or pending service.

Utilization management decisions are based only upon appropriateness of care and service. Practitioners or other individuals involved in utilization review are not rewarded for issuing denials of coverage or service. The final decision to deny a service request will only be made by the Medical Director.

For pre-service denials specific to long term acute care requests, skilled nursing facility requests, or inpatient rehabilitation facility requests; the member, attending provider, and facility are notified in writing. An Integrated Denial Notice form, noting the reason for denial, is provided to the member and requester with a copy sent to the attending physician within 1 business day. The member is also given a letter outlining the denial and the grievance and appeal process. For inpatient level of care denials, the facility and/or requester is notified via fax.

For denial of outpatient authorizations, the referring providers, the PCP (if not the referring provider), and the member are notified in writing. A standard appeal may be initiated by the member or practitioner acting on behalf of the member with the member's written consent for any treatment denial, suspension, or reduction in services.

Medical Review of Claims

The clinical claims review process is utilized to evaluate the quality and efficiency of care provided. The Clinical Programs and Systems, Claims Coder and/or Compliance Department staff completes a Clinical Claims Review before payment of certain claims. This process validates or non-validates actual medical services rendered. Areas reviewed may include but are not limited to:

- Hospitalization that was not prior-authorized
- Inpatient rehabilitation services
- Medical appropriateness of care
- Out-of-area hospitalizations
- Emergency air ambulance services
- Skilled nursing facility services
- DME

Pattern and trend analyses make it possible to review service utilization and appropriate use of resources and billing practices. Retrospective reviews against national benchmark and performance standards are carried out in a number of areas, including:

- Pharmacy
- Specialty referrals

- Inpatient stays

Medical Technology

The Health Plan utilize resources such as Hayes and AHCCCS technology guidelines when considering requests for services with new applications of established technology, medical procedures, devices or drugs. The Medical Director shall review such requests. To begin the review process to add new technology or expand use of existing technology, please contact your Provider Relations Representative or the Medical Management Department.

Compliance Program

The Health Plan's commitment to compliance includes ensuring that our providers are in compliance with applicable state and federal regulations. All contracted providers are responsible for complying with all federal laws, regulations including but not limited to, B – UHP's policies and procedures, Compliance and Fraud Waste and Abuse Plan, Compliance guide for staff and business partners and the Code of Conduct. All of these documents are available at www.bannerUHP.com, or through eServices (<https://eservices.uph.org>), or upon request.

The Health Plans has incorporated requirements outlined by Medicaid and Medicare in these documents. Providers must review the respective guidelines and ensure appropriate protocols are in place to demonstrate compliance.

CMS and Medicaid Requirements

For Medicare Contracted Providers:

To assist you in understanding the requirements please access the CMS website at:

<https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/fwa.html>

For AHCCCS Contracted Providers:

To assist you in understanding your requirements, please refer to the AHCCCS Contractor Operations Manual (ACOM) and the AHCCCS Medical Policy Manual (AMPM):

<http://www.azahcccs.gov/shared/ACOM/default.aspx>

<http://www.azahcccs.gov/shared/MedicalPolicyManual/MedicalPolicyManual.aspx?ID=providermanuals>

B – UHP Compliance Program Requirements

Requirements of all Health Plan contracted providers include, but are not limited to:

- Providers are expected to adhere to B – UHP's compliance requirements relating to FWA, which have been outlined in B – UHP's Compliance and FWA Plan, Compliance Guide for staff and business partners and CMS general compliance and FWA trainings.
- Ensure monitoring and oversight is in place for all employees.
- Implement monitoring and oversight of compliance requirements for all relationships with subcontractors.
- Complying with Offshore requirements.
- Report all suspected and/ or detected FWA.
- Establish and maintain policies and procedures for preventing, detecting, correcting and reporting FWA, in addition to other requirements listed below.
- To ensure employees, managers, officers and directors responsible for the administration or delivery of Medicaid and Medicare benefits are free from any conflict of interest and provide B – UHP with full disclosure on any situation that may present a conflict of interest.
- Completion of the B – UHP Compliance Attestation is required upon contract and annually thereafter. Completion of the form will confirm that your internal processes are compliant with Medicare and Medicaid

Compliance Program requirements.

Additional information about these requirements is discussed below and can also be found at www.BannerUHP.com.

Written Policies and Procedures and Code of Conduct

B – UHP requires that all providers supporting the Medicare Advantage and Part D Prescription Drug Program adopt and abide by the B – UHP Code of Conduct and Policies and Procedures. Providers may also implement a code of conduct and policies and procedures that incorporates requirements consistent with B – UHP's Code of Conduct and Policies and Procedures. The code of conduct states your Organization's over-arching principles and values by which your Organization operates and defines the underlying framework for the compliance policies and procedures. The code of conduct must provide the standards by which providers and staff will conduct themselves, including the responsibility to perform duties in an ethical manner and in compliance with laws, regulations and policies. Providers and staff are required to comply with all applicable laws, whether or not specifically addressed in the code of conduct.

As stipulated in the B – UHP Code of Conduct, Providers and staff are required to report issues of noncompliance and potential FWA through the appropriate mechanisms and ensure that all reported issues will be addressed and corrected. Your processes must include detailed and specific guidance for employees regarding how to report potential compliance issues. Anonymous reports can be made to B – UHP's toll-free alert line at 1-888-747-7989.

Policies and Procedures should include provisions and procedures that, at a minimum, outline the following:

- Require that all employees and downstream entities immediately report suspected and /or detected FWA.
- Ensure all B – UHP confidential and proprietary information is safeguarded.
- Screen all employees and downstream entities against federal government exclusion lists, including the CMS Preclusion List and Office of Inspector General "OIG" list of excluded Individuals and Entities, and the General Services Administration's "Excluded Parties Lists System. Anyone listed on one or both of these lists is not eligible to support B – UHP's Medicaid or Medicare plans, must be removed immediately from providing services. Upon identification of an excluded individual B – UHP must be notified immediately.
- Cooperate fully with any investigation of alleged, suspected or detected violation of state or federal laws or regulations.
- Distribute compliance and FWA training to employees and downstream entities.
- Implement and publicize disciplinary standards and take action upon discovery of FWA or actions that could lead to FWA.

The code of conduct and policies and procedures should be distributed to employees within 90 days of hire, when there are updates to the policies, and annually thereafter. You should ensure that employees, as a condition of employment, read and agree to comply with all written compliance policies and procedures and code of conduct within 90 days of date of hire and annually thereafter. Employee statements or certifications should be retained and be available to B – UHP, CMS and AHCCCS.

This information must be available upon request by B – UHP, CMS, AHCCCS and records should be maintained for 10 years.

Your Organization may make B – UHP's Code of Conduct available to all employees. The B – UHP Code of Conduct is available online at www.bannerufc.com/acc.

Providers are given access to applicable B – UHP Policies and Procedures via eServices or upon request by contacting the B – UHP Compliance Department at BUHPCompliance@bannerhealth.com.

Conflicts of Interest

Your Organization's code of conduct should include provisions to ensure employees, managers, officers and

directors responsible for the administration or delivery of the Medicare and Medicaid benefits are free from any conflict of interest in administering or delivering Medicare and Medicaid benefits. Conflicts of interest are created when an activity or relationship renders a person unable or potentially unable to provide impartial assistance or advice, impairs a person's objectivity, or provides a person with an unfair competitive or monetary advantage.

Disclosure of Ownership and Control

The federal regulations set forth in 42 CFR §455.101; 106; 436 requires B – UHP to identify all persons associated with B – UHP, its subcontracted providers and fiscal agents that have an ownership, control interest or managing employee interest and determine if they have been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program. [42 CFR 455.104 through 106] (SMDL09-001)

B – UHP must obtain the following information regarding ownership, control interest or managing employee interest [42 CFR 455.106]:

- Business Entity Name, City, State and Zip code
- Name of the business entity or individual that has Ownership, Control Interest or is a Managing Employee.
- Business Address, including all locations and Post Office Box Address. Include Home Addresses of all Managing Employees.
- The Social Security Number (if Individual), Tax Identification Number (TIN) (if Corporation)
- The % of Ownership or Controlling Interest.
- The Relationship to Owner (i.e. spouse, parent, child or sibling).

The Health Plan will, on a monthly basis, confirm the identity and determine the exclusion status through routine checks of:

- a. The List of Excluded Individuals (LEIE)
- b. The System of Award Management (SAM) formerly known as The Excluded Parties List (EPLS)
- c. Any other databases directed by AHCCCS or CMS

Note: B – UHP is required to immediately notify AHCCCS-OIG of any person who has been excluded through these checks in accordance with the 42 CFR 455.106 (2)(b).

Federal Health Care Program Requirement

As a contracted provider, you are obligated under 42 C.F.R.100.1.1901, to screen all employees, contractors, temporary employees, volunteers, consultants, governing board members, and /or subcontractors, to determine whether any of them have been excluded from participation in Federal health care programs upon hire or contracting and monthly thereafter. The Organization is required to verify their employees (including temporary and volunteer) are not excluded by comparing them against the CMS Preclusion List, Department of Health and Human Services (DHHS) Office of the Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) and the General Services Administration (GSA) System of Award Management (SAM) formerly known as the Excluded Parties List (EPLS) and any other databases directed by AHCCCS or CMS. Monthly screening is essential to prevent the Health Plan from making inappropriate payment to providers, pharmacies or other entities that have been added to the exclusions lists since the last time the list was checked. Upon discovery of an excluded individual, the Organization must provide immediate disclosure to B – UHP. No payment will be made by Medicare, Medicaid or any other Federal or State of Arizona health care programs for any item or service furnished on or after the effective date specified in the notice period, by an excluded individual or entity, or at the medical direction or on the prescription of a physician or other authorized individual who is excluded when the person furnishing such item or service knew or had reason to know of the exclusion.

For providers found on the CMS Preclusion List, as documented in the 2020 Final Rule CMS 4185-F, 42 CFR 422.504 and after the expiration of the 60-day period specified in § 422.222:

- The provider will no longer be eligible for payment from the plan and will be prohibited from pursuing payment from the beneficiary as stipulated by the terms of the contract between CMS and the plan per § 422.504(g)(1)(iv); and
- The provider will hold financial liability for services, items, and drugs that are furnished, ordered, or prescribed after this 60-day period, at which point the provider and the beneficiary will have already received notification of the preclusion.

To assist you with implementation of your CMS/OIG/GSA Exclusion process, links to the exclusion websites are below.

- The List of Excluded Individuals (LEIE): https://oig.hhs.gov/exclusions/exclusions_list.asp
- The System of Award Management (SAM) formerly known as The Excluded Parties List (EPLS): <https://www.sam.gov/portal/SAM/#1>
- CMS Preclusion List: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/PreclusionList.html>
- Any other databases directed by AHCCCS or CMS

Offshore Requirements

The term “Offshore” refers to any country that is not one of the 50 United States or one of the United States Territories (American Samoa, Guam, Northern Marianas, Puerto Rico and Virgin Islands). Subcontractors that are considered Offshore can be either American-owned companies with certain portions of their operations performed outside of the United States or foreign-owned companies with their operations performed outside of the United States. Offshore subcontractors provide services that are performed by workers located in offshore countries, regardless of whether the workers are employees of American or foreign companies.

Providers must ensure its employees and downstream and related entities have read and understand all requirements pertaining to the regulations for services that are performed by workers located in Offshore countries, regardless of whether the workers are employees of American or foreign companies. Consistent with CMS direction, this applies to entities the Organization may contract or sub-contract with to receive process, transfer, handle, store, or access beneficiary protected health information (PHI) in oral, written, or electronic form. In the event the Organization sub-delegates any B – UHP Medicare activities to an offshore subcontractor, the Organization will be required to adhere to the approval process outlined for sub-delegation activities and complete an additional offshore attestation.

For the State of Arizona’s Medicaid Program, AHCCCS, any Organization services that are described in the specifications or scope of work that directly serve the State of Arizona, its clients, or AHCCCS members, and involve access to secure or sensitive data or personal client data shall only be performed within the defined territories of the United States. Unless specifically stated otherwise in the specifications, this requirement does not apply to indirect or “overhead” services, redundant back-up services or services that are incidental to the performance of the contract. This provision applies to work performed by the Organization and its subcontractors at all tiers.

To ensure that B – UHP is compliant with CMS regulations for offshore subcontracting, B – UHP’s contract with Organizations based in the United States and its territories and includes contract language that the Organization will inform B – UHP 90 days in advance from the date Organization plans to outsource part or all of its responsibilities that includes providing Health Plan member PHI to an Offshore company. B – UHP will evaluate the specific circumstances and may be required to terminate its contract with the Organization.

Fraud, Waste and Abuse Requirements

Overview:

In support of the B – UHP Compliance Program, it is the policy of the Health Plan to detect, prevent and control member and provider related Fraud, Waste and Abuse within the Medicare and Medicaid systems. The Health Plan

is committed to comply with applicable statutory, regulatory and other requirements, sub-regulatory guidance and contractual commitments related to the delivery of Medicaid and Medicare benefits. The Health Plan has a written Fraud, Waste and Abuse plan to employ controls to prevent, detect and control potential cases of Fraud, Waste and Abuse.

Consistent with AHCCCS guidelines as stipulated within the AHCCCS Registration Agreement pertaining to fraud, waste and abuse, B-UHP will reimburse Medicare or AHCCCS at the AHCCCS By-Report (BR) percentage for covered services billed with a code that does not have an established fee. Such codes payable at the BR percentage could be for unlisted and/or NOC (Not Otherwise Classified) codes. As a payer of Medicare and AHCCCS claims, any BR code found, after pre-payment or retrospective review, to be excessive based on billed charges will be priced by another means than at the BR percentage in order to prevent waste. B-UHP has defined excessive to be any amount that is greater than invoice, greater than similar relative value units of listed codes or in excess of Average Wholesale Price (AWP) + 15% for those codes that have a NDC (National Drug Code). B-UHP will monitor provider billing patterns to avoid excessive reimbursements that contribute to potential fraud, waste and/or abuse.

Our Goal: Eliminating Fraud, Waste and Abuse

The Health Plan will strictly enforce fraud and abuse prevention policies. Specific controls are in place to prevent and/or detect potential cases of fraud and abuse.

It is our policy to educate providers and their staff on how to prevent, detect and report potential cases of fraud and abuse. To eliminate fraud and abuse successfully, everyone must work together to prevent, identify, and report inappropriate and potentially fraudulent practices. This can be accomplished by:

- Monitoring claims submitted for compliance with billing and coding guidelines
- Adherence by providers and facilities to Treatment Record Standards
- Education of all staff members who have any contact with PHI
- Referring cases of suspected fraud and abuse

What is a Fraud & Abuse Violation?

- Fraud & Abuse violations occur when a person deliberately uses a misrepresentation or other deceitful means to obtain something to which he/she is not otherwise entitled.
- Any employee, member, vendor or provider has the right to make a Fraud & Abuse-related complaint to B – UHP if he/she feels that there have been suspicious activities.

Examples of Provider, Fraud, Waste and/or Abuse:

Individual participating or non-participating providers who deliberately submit claims for services not actually rendered, or bill for higher-priced services than those actually provided.

- Providers of medical equipment and home health services who defraud the Medicare program and private payers, often paying kickbacks to dishonest physicians who prescribe unnecessary products and services.
- Charges are submitted for payment for which there is no supporting documentation available, such as x-rays or lab results.

Laws that Regulate Fraud and Abuse

False Claims Act

Under the False Claims Act (FCA), 31 U.S.C. §§3729-3733, those who knowingly submit, or cause another person or entity to submit, false claims for payment of government funds are liable for three times the government's damages plus civil penalties of \$10,957 to \$21,916 per false claim for violations occurring after November 2, 2015, and the costs of the civil action against the entity that submitted the false claims.

Stark Law

Self-Referral (Stark Law) Statutes, Social Security Act, §1877, pertains to physician referrals under Medicare and Medicaid. Referrals for the provision of health care services, if the referring physician or an immediate family member has a financial relationship with the entity that receives the referral, is not permitted.

Anti-Kickback Statute

Under the Anti-Kickback Statute, 41 U.S.C, it is a criminal offense to knowingly and willfully offer, pay, solicit or receive any remuneration for any item or service that is reimbursable by any Federal healthcare program. Penalties may include exclusion from Federal health care programs, criminal penalties, jail and civil penalties for each violation. Examples of kick-backs:

Money	Discounts	Gratuities	Gifts	Credits	Commissions
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Violation of this law is a felony, with possible punishment including a criminal fine of up to \$25,000 and/or imprisonment for up to five years. Violations can also be punished civilly with fines of up to \$50,000. Persons and entities convicted of violating this law are also subject to mandatory exclusion from participating in Covered Health Care Programs. Finally, health care items or services billed to a Covered Health Care Program as the result of an arrangement that violates that Anti-Kickback Statute may be violations of the health care False Claims Act and may be separately punishable as a felony resulting in criminal fines of up to \$25,000 and/or imprisonment for up to five years or both, or civil fines up to three times the amount improperly received from the government health care programs plus up to \$21,916 per improperly filed claims.

HIPAA

The Health Insurance Portability and Accountability Act (HIPAA), 45 CFR, Title II, §201-250, provides clear definition for Fraud & Abuse control programs, establishment of criminal and civil penalties and sanctions for noncompliance. This act protects the privacy of the patient. Under the U.S. Department of Health and Human Services, the Office of Civil Rights (OCR) investigates and enforces HIPAA violations. In January 2018, the OCR reported they received over 173,426 HIPAA complaints since the initiation of the Privacy Rule in April 2003. They investigated and resolved over 25,695 cases by requiring changes in privacy practices and corrective actions, or by giving technical assistance to covered entities or business associates. The OCR indicated that the compliance issues investigated most often in order of occurrence are as follows:

- Impermissible uses and disclosures of protected health information
- Lack of safeguards of protected health information
- Lack of patient access to their protected health information
- Lack of administrative safeguards of electronic protected health information
- Use or disclosure of more than then minimum necessary protected information.

The most common kinds of covered entities that have been required to take corrective action in order of frequency are the following:

- General Hospitals
- Private Practices and Physicians
- Outpatient Facilities
- Pharmacies
- Health Plans (group health plans and health insurance issuers)

The OCR does make referrals to the Department of Justice (DOJ) for criminal investigations regarding cases that involve the knowing disclosure or obtaining of protected health information in violation of the Rules. The OCR has made 668 referrals to DOJ to date.

For information on the history of and details about each of the HIPAA Rules, visit <https://www.hhs.gov/hipaa/for-professionals/index.html> and click on "Privacy," "Security," or "Breach Notification" from the left-hand tool-bar.

Deficit Reduction Act The Deficit Reduction Act (DRA), Public Law No. 109-171, §6032, passed in 2005, is designed to restrain Federal spending while maintaining the commitment to the Federal program beneficiaries. The Act requires compliance for continued participation in the programs. The development of policies and education relating to false claims, whistleblower protections and procedures for detecting and preventing fraud & abuse is required. It includes provisions aimed at reducing Medicaid fraud and abuse and applies to all health care providers receiving at least \$5 million in annual Medicaid payments.

The False Claims Act - Whistleblower Employee Protection Act

Under this legislation, 31 U.S.C. §3730(h), a company is prohibited from discharging, demoting, suspending, threatening, harassing or discriminating against any employee because of lawful acts done by the employee on behalf of the employer or because the employee testifies or assists in an investigation of the employer.

A whistleblower is an employee, former employee, or member of an organization, especially a business or government agency who reports misconduct to people or entities that have the power and presumed willingness to take corrective action.

One of the unique aspects of the federal False Claims Act is the "qui tam" provision, commonly referred to as the "whistleblower" provision. This allows a private person with knowledge of a false claim to bring a civil action on behalf of the United States Government.

- The purpose of bringing the qui tam suit is to recover the funds paid by the Government as a result of the false claims. Sometimes the United States Government decides to join the qui tam suit.
- If the suit is ultimately successful, the whistleblower who initially brought the suit may be awarded a percentage of the funds recovered.
- Because the Government assumes responsibility for all of the expenses associated with a suit when it joins a false claims action, the percentage is lower when the Government joins a qui tam lawsuit.

However, regardless of whether the Government participates in the lawsuit, the court may reduce the whistleblower's share of the proceeds, if the court finds that the whistleblower planned and initiated the false claims violation.

Further, if the whistleblower is convicted of criminal conduct related to his role in the preparation or submission of the false claims, the whistleblower will be dismissed from the civil action without receiving any portion of the proceeds.

Auditing and Monitoring

B – UHP is required to perform effective auditing and monitoring in order to prevent and detect FWA. B – UHP staff and business partners are encouraged to monitor their work and interactions for any suspected FWA.

As a part of the Corporate Compliance Plan, the Health Plan has a program integrity audit/review program that is designed to identify fraud, waste and abuse and to ensure that providers' billing practices are supported by medical record documentation. This process assists the Health Plan in tracking inadequate billing practices by providers and identifying trends so that technical assistance and provider education can help avoid future occurrences of problematic billing for contracted Providers. Some of trends that have been identified with the audits include the following:

- Progress notes not signed appropriately by the provider rendering the service or signed weeks, months or even years after the services was provided or in some cases not signed at all or left in a pending status.
- Claims submitted for Medicaid Services under the NPI of one provider when the services rendered as indicated on the medical record progress note are completed by a different provider with a different NPI and oftentimes a mid-level billing under an MD. In some cases, the mid-level (NP, PA) is not credentialed or contracted or not insured with the practices. These are considered false claims under Medicaid.

- Up coding of Evaluation and Management (E/M) services as the medical record documentation does not support the level of service selected.
- Copying and pasting of information from one service to the next service when each entry is worded exactly like or similar to the previous entries. It would not be expected that every patient had the exact same problems, symptoms, and required the exact same treatment.
- Inappropriate use of modifiers.

B – UHP contracts with vendors to administer and/or deliver benefits on B – UHP's behalf. These vendors are referred to as delegated FDRs and they must abide by B – UHP contractual and regulatory requirements. B – UHP is responsible for the lawful and compliant administration of Medicare and Medicaid benefits under our contracts with AHCCCS, and CMS regardless of delegation.

B – UHP has clearly defined processes and criteria to evaluate and categorize all vendors with which B – UHP contracts and utilizes multiple methods to monitor and audit First Tier Entities to ensure that they are compliant with all applicable laws and regulations, and to ensure that the First Tier Entities are monitoring the compliance of the entities with which they contract. Methods include on-site audits, desk reviews and monitoring of self-audit reports.

Training and Documentation

AHCCCS Contracted Provider Requirements

As an AHCCCS contracted provider, you are required to train your staff and document training on the following components of the False Claims Act:

- Administrative remedies for false claims and statements
- Any State laws relating to civil or criminal penalties for false claims and Statements
- The whistleblower protections under such laws.

Medicare Contracted Provider Requirements

General Compliance and Fraud, Waste and Abuse (FWA) Training

As a contracted provider with B – UHP who provides health care services to Part C Medicare Advantage (MA) or Part D Prescription Drug Plan (PDP) enrollees on behalf of B – UHP, you are required to provide General Compliance and FWA training to your employees (including temporary employees and volunteers) and to all downstream entities within 90 days of contract with B – UHP. All employees must complete the training within 90 days of hire and annually thereafter.

The required training is completed by accessing the CMS Medicare Learning Network web-based training module for General Compliance and Fraud, Waste, and Abuse training available on the Medicare Learning Network site at: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html>.

Once you have completed the training in module you will receive a certificate of completion. The certificate of completion will be utilized as documentation to support completion. Providers can take the Medicare training and copy it into their system as long as the content is not modified, and they have a method of tracking the employee compliance with the training requirements and can submit documentation proof if requested.

The only exception is for providers who have obtained FWA certification through enrollment into the Medicare program as a health care provider or as an Accredited DMEPOS Supplier (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies); these providers are deemed and have satisfied the FWA training requirement.

The deeming exception for FWA training and education does not apply to the general compliance training and education requirement described above. Providers who have met the FWA training requirements must complete the CMS General Compliance training.

Provider Responsibilities to Report Suspicious Activity or Fraud, Waste and Abuse

Providers are required to report any suspicious activity or Fraud, Waste, and Abuse to the Health Plan and/or appropriate federal or state agency. The Health Plan adheres to a policy of non-retaliation and will make every effort to protect your identity and will not tolerate any form of retaliation against any person making such a report.

Please report to the Health Plan using one of the following methods:

- Confidential and Anonymous 24-hour compliance hotline: 1-888-747-7989
- B – UHP Compliance Officers: 520 874 2847 or 520 874 2553.
- U.S. Mail: Banner – University Health Plans, Compliance & Audit Department 2701 E. Elvira Road, Tucson, AZ 85756
- Email: BUHPCompliance@bannerhealth.com
- Secure Fax: (520) 874-7072

Reporting to AHCCCS

Providers are required to report all suspected fraud, waste, and abuse to the Health Plan or to AHCCCS directly immediately.

To report to the Health Plan, utilize the reporting avenues listed above. To report to AHCCCS, providers should complete and submit the reporting form entitled "Report Suspected Fraud or Abuse of the Program," on the AHCCCS-OIG website or contact the OIG directly at the numbers below. All pertinent documentation that would assist AHCCCS in its investigation should be attached to the form at <https://www.azahcccs.gov/Fraud/ReportFraud/onlineform.aspx>

Provider Fraud

To report suspected fraud by medical provider, please call the number below:

- In Maricopa County: 602-417-4045
- Outside of Maricopa County: 888-ITS-NOT-OK or 888-487-6686

Member Fraud

To report suspected fraud by an AHCCCS member, please call the number below:

- In Maricopa County: 602-417-4193
- Outside of Maricopa County: 888-ITS-NOT-OK or 888-487-6686

Questions

If you have questions about AHCCCS fraud, abuse of the program, or abuse of a member, please contact the AHCCCS OIG.

- Email: AHCCCSFraud@azahcccs.gov
- If a provider identifies a case of fraud, waste, or abuse that requires them to self-disclose, they are to report to AHCCCS by using the "Self-Disclosure Program for Providers" Guidelines and reporting form. The Guidelines are available on the AHCCCS website at: <https://www.azahcccs.gov/Fraud/Providers/> Issues appropriate to self-disclosure may include, but are not limited to: Substantial routine errors
- Systematic errors
- Patterns of errors
- Potential violation of state and federal laws relating to the AHCCCS program
- Providers must determine whether the repayment of an overpayment warrants a self-disclosure or

whether it would be better handled through the administrative billing process.

Reporting to Medicare

Providers are required to report all suspected fraud, waste, and abuse to the Health Plan or to Medicare directly.

Mail: US Department of Health and Human
Services Office of Inspector General
ATTN: OIG HOTLINE OPERATIONS PO Box
23489
Washington, DC 20026

Phone: 1-800-HHS-TIPS (1-300-447-8477)
Fax: 1-800-223-8164
TTY: 1-800-377-4950
Website:
<https://forms.oig.hhs.gov/hotlineoperations/>

Disciplinary Guidelines

The Health Plan may identify a contracted provider that is conducting Health Plan business in a manner that is not compliant with AHCCCS or Medicare rules, regulations, or requirements; this will be identified as a non-compliant event. If this occurs, B – UHP may take the following disciplinary action:

- Issue a Corrective Action Plan
- Contract sanction
- Immediate contract termination

Sanctions and Penalties for Fraud and Abuse Violations

B – UHP maintains and applies appropriate sanctions against providers and vendors who fail to comply with the policies and procedures of B – UHP and/or the requirements of the Federal Laws and Statutes. The Federal and State Government agencies will prosecute these providers and vendors accordingly. Conviction of Fraud and Abuse can carry civil and criminal penalties.

Civil Penalties

\$10,957 to \$21,916 per false claim plus up to 3 times the amount of damages

Criminal Penalties

Felony conviction: 5-20 years in jail

Misdemeanor conviction: 1 year in jail

Grievances and Appeals

Overview

The Health Plan Grievances and Appeals Department is available to members or providers, acting on behalf of a member, and with the member's written consent, to file an appeal. Providers do have the right to immediately appeal a claim decision, but we suggest attempting the resubmission process first. If after resubmission process the claim issue is still not resolved, then the Appeals Department will handle unresolved claim disputes for providers.

The State of Arizona, AHCCCS Administration, CMS and DOI have established laws, rules, policies and procedures that determine processes and adjudicate Appeals and requests for Fair Hearings and External Independent reviews.

Definitions:

What is a Grievance?

A grievance (complaint) is an expression by a member of dissatisfaction about any aspect of care. Examples of grievances are: service issues, transportation issues, quality of care issues and provider office issues. In addition, other possible subjects for grievances include, but are not limited to: the quality of care or services provided; aspects of interpersonal relationships; rudeness of a provider or employee or failure to respect the member's rights.

What is an Appeal?

An appeal is a request to reconsider or change a decision, also known as an adverse benefit determination.

What is an Adverse Benefit Determination?

- a. The denial or limited authorization of a requested service, including the type or level of service
- b. The reduction, suspension, or termination of previously authorized services
- c. The denial, in whole or in part, of payment for a service
- d. The failure to provide services in a timely manner as set forth in contract
- e. The failure of the Health Plan to act within the timeframes specified in contract
- f. The denial of an enrollee's request to exercise the enrollee's right to obtain services outside of the contractor's network for an enrollee residing in a rural area with only one contractor

Medicaid - Grievances and Appeals

Grievances

The Health Plan shall acknowledge receipt of each member grievance orally or in writing within five business days. Grievances will be reviewed, and a response will be provided within 90 days of receipt.

Appeals

A standard or expedited appeal must be filed either orally or in writing within 60 days from the Notice of Adverse Benefit Determination. The enrollee, their representative, or a legal representative of a deceased enrollee's estate may file an appeal or a provider acting on behalf of an enrollee may file an appeal. If the provider is filing on behalf of the member, a written consent from the member must accompany the request.

The reasons you may file an appeal are:

- Denial or limited authorization of a requested service, including the type or level of service;
- Reduction, suspension, or termination of a previously authorized service;
- Denial, in whole or in part, of payment for a service;
- Failure to provide services in a timely manner;
- Failure to act within the timeframe required for standard and expedited resolution of appeals and standard disposition of grievances;
- The denial of a rural enrollee's request to obtain services outside the contractor's network under 42 CFR 438.52 (b)(2)(ii), when the contractor is the only contractor in the rural area.

You may also call the Customer Care Center and ask to speak to an Appeals Department representative to file an oral appeal or you may also submit your request by fax or via email. The Health Plan may request additional medical information, if necessary, to complete the appeal review. The appeals will be reviewed by healthcare professionals who have the appropriate clinical expertise and who were not involved in the previous level of review.

The member or provider will be given a reasonable opportunity to present evidence and to make legal and factual arguments in person and in writing. The Health Plan will inform the member of the limited time available to provide this information sufficiently in advance of the resolution timeframe. The case file is available for review by the member or provider during the appeal process, upon request. The Health Plan provides the member and his/her representative the member's case file including medical records, other documents and any new or additional evidence considered, relied upon, or generated by the Health Plan regarding the appeal. This information will be provided at no charge to the member and sufficiently in advance of the resolution timeframe. A decision will be rendered by the Health Plan within the timeframes outlined below.

Standard Appeal

The Health Plan shall resolve standard appeals as expeditiously as the member's health condition requires but no

later than 30 calendar days from the date of receipt of the appeal, unless an extension is in effect.

Expedited Appeal

An expedited appeal may be filed by the enrollee or on the enrollee's behalf by the provider, with members written consent. If the Provider indicates (when making the request for the member or in support of the member's request) that taking the time for standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. The Health Plan shall resolve all expedited appeals as expeditiously as the member's health condition requires but not later than 72 hours from the date the Health Plan receives the expedited appeal, unless an extension is in effect.

Continuation of Benefits

Members have the right to receive continued benefits pending resolution of their appeal, continuation of benefits must be requested when filing the appeal. The member may be required to pay for the cost of these services if the appeal is denied.

How do I request a State Fair Hearing?

If you are not satisfied with the appeal decision, you may file a request for State Fair Hearing with the Health Plan. This request must be made in writing to the Health Plan within 120 days of the date of receipt of the Notice of Appeal resolution. The Health Plan will send the appeal file to AHCCCS and a hearing date will be scheduled for attendance.

Assistance with filing an Appeal or the State Fair Hearing

If you need assistance filing an appeal or a State Fair Hearing, please contact the Customer Care Center or the Grievance & Appeals Department.

Provider Claim Disputes

A Provider Claim Dispute is a dispute involving the payment or nonpayment of a claim. You may challenge the Health Plan's adjudication of a claim by filing a claim dispute, in writing, with the Grievance and Appeals Department. The claim dispute should include the following for faster processing:

1. A cover letter on appropriate letterhead indicating your reason for filing the claim dispute. Please include the following information in your letter:
 - a. Date of request;
 - b. Claim number(s);
 - c. The factual and legal basis for the claim dispute and your expected resolution;
 - d. The enrollee's AHCCCS ID number, full name, date of service, and date of birth; and
 - e. Writer's name, address, telephone number and/or email address.
2. Supporting documentation, including:
 - a. A copy of the EOB or RA from B – UFC/ACC;
 - b. A copy of the original claim(s);
 - c. Corrected claim(s), if applicable;
 - d. A copy of the Medicare or primary insurer EOB(s), if applicable;
 - e. A copy of the authorization, if applicable; and
 - f. If you are a contracted provider with specific rates in your contract, a copy of the applicable pages from your contract when challenging the rate of pay.

Please submit the claim dispute letter and supporting documentation to:

Banner – University Family Care/ACC Health Plan

Attn: Grievance & Appeals Department

2701 E. Elvira Road Tucson, AZ 85756

(Phone) 800-582-8686

(Fax) 866-465-8340

BUHPCompliance@Bannerhealth.com

Provider Claim Dispute Submission Timeframes

A claim dispute for claims payment issue must be received within 12 months from the date of service, or for a hospital claim within 12 months from the date of discharge, 12 months after the date of eligibility posting, or within 60 days after the date of a timely claim submission, whichever is later. The Health Plan ensures that no punitive action will be taken against a provider who requests a claim dispute or supports a member's appeal. All claim disputes are adjudicated in Arizona, including those claim disputes arising from claims processed through an administrative services subcontractor.

Provider Claim Dispute Acknowledgement and Resolution

We will send you an acknowledgement letter within 5 business days of receipt of your claim dispute. Within 30 calendar days, we will mail you a Notice of Decision. The Notice of Decision will explain our resolution of the dispute, and the factual and legal basis for our resolution. If our decision is to approve your dispute, we will reprocess and pay your claim within 15 days of the Notice of Decision. If our decision is not in your favor, we will explain your right to request a State Fair Hearing.

How do I request a State Fair Hearing?

If you are not satisfied with the claim dispute decision, you may file a request for State Fair Hearing with the Health Plan. This request must be made in writing to the Health Plan within 30 days of the date of receipt of the Notice of Decision or Notice of Appeal resolution. The Health Plan will send the appeal file to AHCCCS and you will receive a Notice of Hearing from the Office of Administrative Legal Services when a hearing date is set.

Medicare – Grievances and Appeals

Grievances

Any complaint or dispute, other than an organization determination, expressing dissatisfaction. An enrollee or their authorized representative may make the complaint or dispute, either orally or in writing. An Appointment of Representative (AOR) form must be on file for the authorized representative to grieve for the member.

Grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item. A grievance must be filed within 60 days of the event and be submitted in writing through mail, fax or email. An oral grievance may also be filed by calling our Customer Care Center.

A standard grievance will be reviewed and a response will be provided within 30 days of receipt. If an extension is required the Health Plan will call the member for approval of a 14-day extension. If accepted, the grievance resolution will be provided within 44 days of receipt.

Expedited (fast) Grievance

An expedited (fast) grievance may be submitted as a complaint against the health plan for refusal to expedite an organization determination or reconsideration, or upon request of a 14-day extension. For expedited grievances a response will be provided within 24 hours of receipt.

Please submit your grievances, to:

Banner – University Care Advantage

Attn: Grievance & Appeals Department

2701 E. Elvira Road Tucson, AZ 85756

(Phone) 877-874-3930

(Fax) 866-465-8340

Email: BUHPGrievances&Appeals@bannerhealth.com

If your grievance involves a quality of care issue you have a right to file a grievance with a Medicare Quality Improvement Organization (QIO). In the state of Arizona, the agency contracted for this service is:

Livanta, LLC

Phone: 1-877-588-1123

TTY: 1-855-887-6668

Fax for Appeals: 1-855-694-2929

Fax for all other reviews: 1-844-420-6672

Website: www.BFCCQIOAREA5.com

Organization Determination

Any determination made by the Health Plan with respect to any of the following:

- Payment for temporarily out of the area renal dialysis services, emergency services, post- stabilization care, or urgently needed services;
- Payment for any other health services furnished by a provider other than the Health Plan that the enrollee believes are covered under Medicare, or if not covered under Medicare, should have been furnished arranged for, or reimbursed by the Health Plan;
- The Health Plan's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the enrollee believes should be furnished or arranged for the Health Plan;
- Reduction, or premature discontinuation of a previously authorized ongoing course of treatment;
- Failure of the Health Plan to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the enrollee.

Coverage Determination

Any decision made by or on behalf of the Health Plan regarding payments or benefits to which an enrollee believes he or she is entitled.

Reconsideration

Any of the procedures that deal with the review of adverse organization determinations on the health care services an enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for a service.

An appeal must be filed in writing within 60 calendar days from the date of the notice of the organization or coverage determination. An enrollee, an enrollee's representative or a non-contracted physician or provider may request that the determination be reconsidered. If anyone other than the member or the treating physician, other physician or their office staff is appealing on behalf of the member, an Appointment of Representative (AOR) form must be in the file.

When a non-contracted physician or provider seeks a standard reconsideration, for purposes of obtaining payment only, then the non-contracted physician or provider must submit a signed waiver of liability; i.e., the non-contracted physician or provider formally agrees to waive any right to payment from the enrollee for a service.

Filing a (Part C) Reconsideration

You may also call the Customer Care Center and ask to speak to an Appeals Department representative to file an oral appeal or you may also submit your request by fax or via email. The Health Plan may request additional medical information, if necessary, to complete the appeal review. The appeals will be reviewed by healthcare professionals who have the appropriate clinical expertise and who were not involved in the previous level of review.

The member or provider will be given a reasonable opportunity to present evidence and to make legal and factual arguments in person or in writing. The Health Plan will inform the member of the limited time available to provide this information sufficiently in advance of the resolution timeframe. The case file is available for review by the member or provider during the appeal process, upon request.

Pre-Service Reconsiderations

Standard appeals for a pre-service request will be resolved as expeditiously as the enrollee's health condition requires, but no later than 30 calendar days from the date the request is received by the Health Plan. The time frame may be extended by up to 14 calendar days with the members approval if the enrollee requests the extension or if the Health Plan requires additional information and the delay is in the best interest of the enrollee.

Expedited Pre- Service Reconsiderations

An expedited reconsideration request not supported by the physician will be reviewed to determine if the life or health of the enrollee, or the enrollee's ability to regain maximum function could be seriously jeopardized by applying the standard time frame. If the request is approved, the Health Plan will resolve the request no later than 72 hours after receiving the request, unless an extension is required. If the request is not approved, the Health Plan will promptly notify the enrollee of the denial, their expedited grievance rights and that their expedited appeal was automatically transferred to the standard processing timeframes-

Claim Payment Reconsiderations

Will be resolved no later than 60 calendar days from the date the request is received by the Health Plan. *The expedited appeal process is not available for payment requests.*

All reconsideration requests should include a cover letter indicating your reason for filing the claim dispute and please include the following information in your letter:

- Member name, date of birth, ID number;
- Claim number or pre-service authorization request number;
- Date of Service;
- Denial reason;
- Reason for appeal;
- A copy of the Health Plan's Remittance Advice or Pre-Service Denial notice;
- Any additional documentation that supports your appeal
- All redeterminations must be submitted individually with all required information and/or documentation.

Independent Review for Reconsiderations (Part C)

If the Health Plan decides to uphold the original adverse decision, either in whole or in part, the Health Plan will automatically forward the entire file to the Independent Review Entity (IRE) for a new and impartial review. In addition, the Health Plan will also forward the entire file to IRE if the notice of decision is not provided within the required timeframe. The Health Plan must send IRE the file within 30 days of the request for services and 60 days of a request for payment. MAXIMUS is CMS's independent contractor for appeal reviews involving Medicare Advantage plans.

The Health Plan will notify the interested parties that the file has been forwarded for review. For cases submitted for review, IRE will make a reconsideration decision and notify the appellant in writing of their decision. If IRE decides in favor of the appellant, the Health Plan must pay for, provide or authorize the service as expeditiously as the member's health condition requires, but no later than 14 calendar days from the date it receives notice that the IRE reversed the determination and 72 hours for expedited reviews. If IRE upholds the Health Plan's decision, their notice will inform the member of rights to a hearing before an Administrative Law Judge (ALJ).

Any initial reconsideration decision made by the Plan, MAXIMUS, the ALJ or the MAC can be reopened by any party (a) within 12 months, (b) within 4 years for good cause in accordance with §120.3.

Redetermination:

The Health Plan may re-evaluate an adverse coverage determination, upon request by an enrollee, an enrollee's representative, or an enrollee's prescribing physician or other prescriber on behalf of the member with his or her knowledge and approval. If anyone other than the member or the treating physician, other physician or their office staff is appealing on behalf of the member, an Appointment of Representative (AOR) form must be in the file.

Filing a (Part D) Redetermination

You may call the Customer Care Center and ask to file an oral appeal. The Health Plan may request additional medical information and the redetermination will be reviewed by healthcare professionals who have the appropriate clinical expertise and who were not involved in the previous level of review. The member or provider will be given a reasonable opportunity to present evidence and to make legal and factual arguments in person and in writing. The Health Plan will inform the member of the limited time available to provide this information sufficiently in advance of the resolution timeframe. The case file is available for review by the member or provider during the appeal process, upon request.

Standard Redetermination

Standard redetermination will be resolved as expeditiously as the enrollee's health condition requires, but no later than 7 calendar days from the date the request is received by the Health Plan.

Expedited Redetermination

An expedited redetermination request will be reviewed when submitted by the enrollee or the enrollee's representative to determine whether the request indicates that the enrollee's life, health, or ability to regain maximum function could be jeopardized by applying the standard time frame for processing the request. If the request is not approved, the Health Plan will promptly notify the enrollee of the denial, their expedited grievance rights and that their expedited appeal will automatically transfer to the standard appeal processing timeframes.

The Health Plan must provide written notice of its decision, whether favorable or adverse, as expeditiously as the enrollee's health condition requires, but no later than 24 hours from the date the Health Plan receives the request for an expedited redetermination.

All Part D redetermination requests should include the following for faster processing:

- Member name, date of birth, ID number;
- Claim number or pre-service authorization request number;
- Date of Service, if applicable;
- Denial reason;
- Reason for appeal, include any additional documentation that supports your appeal;
- All redeterminations must be submitted individually with all required information and/or documentation.

Redetermination Denials- Next Steps

If you disagree with the Health Plans decision you have the right to request an independent review. You have 60 days from the date of the Health Plan's Redetermination Notice to ask for an independent review for MAXIMUS.

Continuation of Benefits

Members have the right to receive continued benefits pending resolution of their appeal, continuation of benefits must be requested when filing the appeal. The member may be required to pay for the cost of these services if the appeal is denied.

Reopening's

Contracted providers have reopening rights, not appeal rights. A reopening is a review of a final determination or decision of a payment (claim) decision. Reasons available for reopening are:

- Mathematical or computational mistakes;
- Inaccurate data entry;
- Denials of claims as duplicates; or
- Additional evidence for consideration which was not available at the time of the decision.

Filing a Re-opening

A request for a re-opening must be submitted in writing, to the Grievance and Appeals Department.

The reopening request should include the following for faster processing:

- Member name, date of birth, ID number;
- Claim Number;
- Date of Service;
- The specific reason for requesting the reopening
- Any additional documentation that supports the request;
- All requests must be submitted individually with all required information and/or documentation.

Reopening Timeframes

A reopening must be submitted to the Health Plan within:

- 1 year from the date of the determination or reconsideration;
- Within 4 years from the date of the determination or reconsideration for good cause; at any time if there exists reliable evidence that the determination was procured by fraud or similar fault;
- At any time if the determination is unfavorable, in whole or in part, but only for the purpose of correcting a clerical error on which the determination was based;
- At any time to effectuate a decision issued under the coverage (National Coverage Determination) appeals process.

The Health Plan ensures that no punitive action will be taken against a provider who requests a reopening or supports a member's appeal.

Please submit all your reconsideration or reopening requests to:

Banner – University Care Advantage
Attn: Grievance & Appeals Department
2701 E. Elvira Road Tucson, AZ 85756

(Phone) 877-874-3930

(Fax) 866-465-8340

Email: BUHPGrievances&Appeals@bannerhealth.com

Duty to Warn, Report Abuse, Neglect or Exploitation

The Health Plan contracted providers who have been informed of or has a reasonable basis to believe that abuse, neglect or exploitation of an incapacitated or vulnerable adult or minor child has occurred shall immediately report the incident to a peace officer, the Department of Economic Security/ Adult Protective Services (DES/APS) or the Department of Economic Security/Division of Youth and Families/Department of Child Safety (DES/DCYF/DCS) worker as appropriate, as well as to Health Plan. The Health Plan will then report it to AHCCCS Quality Management.

Duty to report healthcare acquired conditions, abuse, neglect, injuries, high profile cases, unexpected death and exploitation of incapacitated or vulnerable adults

Providers responsible for the care of an incapacitated or vulnerable adult and who have a reasonable basis to believe that abuse or neglect of the adult has occurred or that exploitation of the adult's property has occurred shall report this information immediately either in member or by telephone. This report shall be made to a peace officer or to a protective services worker within APS. Information on how to contact APS to make a report is located by going to the webpage for the [APS Central Intake Unit](#) . A written report must also be mailed or delivered within forty-eight hours or on the next working day if the forty-eight hours expire on a weekend or holiday. The report shall contain:

- The names and addresses of the adult and any members who have control or custody of the adult, if known;
- The adult's age and the nature and extent of his/her incapacity or vulnerability;
- The nature and extent of the adult's injuries or physical neglect or of the exploitation of the adult's property; and
- Any other information that the member reporting believes might be helpful in establishing the cause of the adult's injuries or physical neglect or of the exploitation of the adult's property.

Upon written and signed request for records from the investigating peace officer or APS worker, the member who has custody or control of medical or financial records of the incapacitated or vulnerable adult for whom a report is required shall make such records or a copy of such records available. Records disclosed are confidential and may be used only in a judicial or administrative proceeding or investigation resulting from the report. If psychiatric records are requested, the custodian of the records shall notify the attending psychiatrist, who may remove the following information from the records before they are made available:

- Personal information about individuals other than the patient; and
- Information regarding specific diagnoses or treatment of a psychiatric condition, if the attending psychiatrist certifies in writing that release of the information would be detrimental to the patient's health or treatment.

If any portion of a psychiatric record is removed, a court, upon request of a peace officer or APS worker, may order that the entire record or any portion of such record containing information relevant to the reported abuse or neglect be made available to the peace officer or APS worker investigating the abuse or neglect.

Additionally, providers must report to the Health Plan healthcare acquired conditions, abuse, neglect, exploitation, injuries, high profile cases and unexpected death of adults.

Duty to Report Abuse, Neglect, Exploitation, Injuries, Denial or Deprivation of Medical or Surgical Care or Nourishment, and Unexpected Death of a Minor

Any provider who reasonably believes that any of the following incidents has occurred shall immediately report this information to a peace officer or to a Department of Child Safety (DCS) worker by calling the Arizona Child Abuse Hotline, and must also notify the Health Plan of:

- Any physical injury, abuse, reportable offense or neglect involving a minor that cannot be identified as accidental by the available medical history; or
- A denial or deprivation of necessary medical treatment, surgical care or nourishment with the intent to cause or allow the death of an infant.

In the event that a report concerns a person who does not have care, custody or control of the minor, the report shall be made to a peace officer only. Reports shall be made immediately by telephone or in person and shall be followed by a same-day progress note in the member's Health Record. The report shall contain:

- The names and addresses of the minor and the minor's parents or the person(s) having custody of the minor, if known;
- The minor's age and the nature and extent of the minor's abuse, physical injury or neglect, including any evidence of previous abuse, physical injury or neglect; and
- Any other information that the person believes might be helpful in establishing the cause of the abuse, physical injury or neglect.

If a physician, psychologist, or behavioral health professional receives a statement from a person other than a parent, stepparent, or guardian of the minor during the course of providing sex offender treatment that is not court ordered or that does not occur while the offender is incarcerated in the State Department of Corrections or the Department of Juvenile Corrections, the physician, psychologist, or behavioral health professional may withhold the reporting of that statement if the physician, psychologist, or behavioral health professional determines it is reasonable and necessary to accomplish the purposes of the treatment.

Upon written request by the investigating peace officer or DCS worker, the person who has custody or control of medical records of a minor for whom a report is required shall make the records, or a copy of the records, available. Records are confidential and may be used only in a judicial or administrative proceeding or investigation resulting from the required report. If psychiatric records are requested, the custodian of the records shall notify the attending psychiatrist, who may remove the following information before the records are made available:

- Personal information about individuals other than the patient; and
- Information regarding specific diagnoses or treatment of a psychiatric condition, if the attending psychiatrist certifies in writing that release of the information would be detrimental to the patient's health or treatment.

If any portion of a psychiatric record is removed, a court, upon request by a peace officer or DCS worker, may order that the entire record or any portion of the record that contains information relevant to the reported abuse, physical injury or neglect be made available for purposes of investigation.

Additionally, providers must report to the Health Plan healthcare acquired conditions, abuse, neglect, exploitation, injuries, high profile cases, denial or deprivation of medical or surgical care or nourishment, and unexpected death of minors as required.

Duty to Warn

Any Health Plan contracted provider, having determined that a member poses a serious danger of violence to others, shall take reasonable actions to protect the potential victim(s) of that danger under A.R.S. §36-517.02. With respect to the legal liability of a behavioral health provider, A.R.S. §36-517.02 provides that no cause of action or legal liability may be imposed against a provider for breaching a duty to prevent harm to a person caused by a patient unless both of the following occur:

- The member has communicated to the Health Plan contracted provider an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim or victims, and the member has the apparent intent and ability to carry out such threat, and
- The Health Plan contracted provider fails to take reasonable precautions.

Duty to Protect Potential Victims of Physical Harm

All Health Plan contracted providers have a duty to protect others against the violent conduct of a member. When a Health Plan contracted provider determines, or under applicable professional standards, reasonably should have determined that a member poses a serious danger to others, he/she bears a duty to exercise care to protect the foreseeable victim of that danger. The foreseeable victim need not be specifically identified by the member but may be someone who would be the most likely victim of the member's violent conduct.

While the discharge of this duty may take various forms, Health Plan contracted providers need only exercise that reasonable degree of skill, knowledge and care ordinarily possessed and exercised by members of that professional specialty under similar circumstances. Any duty owed by a Health Plan contracted provider to take reasonable precautions to prevent harm threatened by a member can be discharged by any of the following, depending upon the circumstances:

- Communicating, when possible, the threat to all identifiable victims;
- Notifying a law enforcement agency in the vicinity where the patient or any potential victim resides;
- Taking reasonable steps to initiate proceedings for voluntary or involuntary hospitalization, if appropriate, and in accordance with Pre-petition Screening, Court Ordered Evaluation and Court Ordered Treatment; or
- Taking any other precautions that a reasonable and prudent behavioral health provider would take under the circumstances.

The Health Plan contracted providers are required to immediately notify by telephone the Health Plan crisis line providers when a member is identified to be a potential danger to self or others and update the crisis line provider as appropriate based on the level of risk to the member and the community. Health Plan contracted providers are required to report to the crisis line all relevant information:

- Information about the member's access to weapons,
- Names and addresses of potential victims,
- Attempts to protect victims,
- Police involvement,
- Relevant clinical information and
- Support system information.

For Maricopa County call the **Crisis Response Network** at 1-800-631-1314.

For Pima, Graham, Greenlee, Santa Cruz, Yuma, Pinal, Cochise, La Paz Counties call **Nursewise** at 1-866-495-6735.

For Gila County call the **Crisis Response Network** at 1-800-631-1314.

AHCCCS Registration Overview

The Health Plan providers must be registered as an AHCCCS provider in order to render medical services to members. All providers must be registered under a provider type (i.e., hospital, physician, etc.) established by AHCCCS and/or Medicare. Providers are required to complete a Provider Registration Form, sign an AHCCCS

Provider Agreement and complete and submit all applicable forms and required licenses and/or certification.

Within each provider type, Categories of Service (COS) are identified. A provider profile maintained by AHCCCS identifies the mandatory and optional COS for the provider type, the licensure/certification requirements for each, and the applicable procedure codes for the provider type.

Provider Registration Form

The provider must complete a Provider Registration Form prior to approval of the provider's participation as an AHCCCS provider. The Provider Registration Form is a packet of forms required by AHCCCS. This packet must be completed in its entirety and signed by the provider and sent to AHCCCS. Incomplete forms will be returned to the provider by AHCCCS.

For Provider Registration instructions, specific requirements and forms, refer to the AHCCCS website at: http://www.azahcccs.gov/commercial/ProviderRegistration/packet.aspx#Registration_Packets.

Note: The provider is also required to inform your Provider Relations Representative in writing of any changes. Untimely notification may result in payment denials.

Credentialing Process

As a quality measure, B – UHP requires providers to complete the credentialing process prior to rendering care to our members. The initial credentialing process includes extensive review and verification of education, training, previous work history, licensure, professional liability coverage, and malpractice claims history, as well as all other information relevant to the qualifications and ability of any provider to render quality medical care to members in accordance with our policies and procedures. The credentialing process is based on the standards of the National Committee for Quality Assurance (NCQA) as well as the standards set forth by AHCCCS. Procedures are also in compliance with all applicable State and Federal legal requirements.

Health Plan providers are recredentialed every three years, at a minimum. The recredentiaing process consists of updating all of the applicable expirable information, review of licensure, board certification, screening for sanctions, review of medical malpractice history, and site reviews if necessary. In addition, the recredentiaing process includes thorough review of performance information to include grievance and appeals date, quality of care indicators, Medicaid performance measures and utilization management.

B – UHP are participating in the AzAHP credentialing alliance in order to streamline the credentialing and recredentiaing process, reduce the administrative burden and eliminate duplication for our providers.

As part of the streamlined process, B – UHP has agreed to utilize the Council for Affordable Quality Healthcare (CAQH) Universal Provider Datasource for all practitioner credentialing applications and a common paper application for all facility credentialing applications. A common practitioner data form and organizational data form has been developed to collect information necessary for the contract review process and system loading requirements.

On behalf of the participating plans, AzAHP has contracted with Aperture™ Credentialing (Aperture™) for primary source verification (PSV) services for the alliance. Aperture™ will perform the PSV once and share the results with each participating plan that you have authorized to receive it.

Following are additional details related to the AzAHP credentialing alliance and some of the benefits that you can expect to see from it.

Practitioners and Facilities CURRENTLY Contracted with more than one of the Participating Plans

1. A single date will be established that allows one recredentiaing process to satisfy the recredentiaing requirement for each of the participating plans with which you are contracted. That date will be the earliest date that you were set to be re-credentialed by any of the participating plans. Following the initial alliance recredentiaing event, your next recredentiaing date will be set 3 years out.
2. For practitioner groups that are adding a new practitioner, you will simply complete the common

Practitioner Data Form (found on our websites) once and send to each of the participating plans you are contracted with. Practitioners must also make sure CAQH is updated and each of the participating plans that you are contracted with are approved to access your CAQH application.

Practitioners and Facilities REQUESTING Contracts with one or more of the participating plans

1. Complete the appropriate common data form (Practitioner or Organizational forms, found on our websites) once and send to the participating plan(s) you wish to contract with.
2. Practitioners who are registered with CAQH are encouraged to make sure CAQH is updated and each of the participating plans that you wish to contract with is approved to access your CAQH application. Practitioners who are not currently registered with CAQH and Facilities will be contacted by the plan or Aperture™ regarding the need for a credentialing application.

If you are a practitioner that requires a site visit as part of the initial credentialing event (Primary Care Provider or Obstetrician) or a facility that requires a site visit as part of the initial credentialing event (facilities that are not accredited or surveyed), the participating plan(s) that you are requesting to contract with will have access to any site visit already performed under the alliance. If a site visit has already been performed by another participating plan in the AzAHP credentialing alliance, another site visit will not be necessary. If no site visit has been performed by a participating plan in the AzAHP credentialing alliance, a single site visit will be performed as part of the initial credentialing event and made available to all participating plans.

NOTE: Each participating plan retains the right to make their own contracting decisions (whether or not to add practitioners and facilities to their network) and will make their own credentialing committee decisions (review of the primary source verification information obtained by Aperture™ resulting in approval/denial by the plan's committee).

Information About the AzAHP Credentialing Alliance Partners



Aperture Credentialing is the nation's largest Credentials Verification Organization (CVO) performing approximately 550,000 credentialing events each year. They are certified by NCQA, accredited by URAC, and compliant with JCAHO standards. Aperture™ has experience as the CVO of other credentialing alliances similar to the AzAHP credentialing alliance and works closely with CAQH.

You will receive correspondence from Aperture™ on behalf of the plans participating in the AzAHP credentialing alliance requesting that you complete or update a credentialing application and/or provide additional documentation in order to complete your application process. Likewise, if your application process includes CAQH, it will be imperative that you continue to update and re-attest to your information on a regular and timely basis.

Any requests from Aperture™ are legitimate and vital to the timely completion of your initial credentialing or recredentialing event.



Launched in 2002, CAQH's data-collection initiative, the Universal Provider DataSource® (UPD) allows registered physicians and other health professionals in all 50 states and the District of Columbia to enter their credentialing information free of charge into a single, uniform online system that meets the credentialing needs of most health plans, hospitals and other healthcare organizations. In April 2012, CAQH surpassed 1 million registered healthcare providers. More than 550 health plans/organizations currently participate in UPD, and approximately 10,000 new providers register in the service each month.

All data submitted by providers through B – UHP is maintained by CAQH in a secure, state-of-the-art data center.

Providers authorize health plans and other organizations access to the information. Providers needing more information about registering with the service or completing the UPD application should visit <https://proview.caqh.org/>.

Section 6 – Substance Use Disorder Data Submission

Federal law gives heightened privacy protections to certain types of Substance Use Disorder (SUD) information. Congress enacted the legislation in the 1970s to encourage individuals with SUDs to enter and remain in treatment, see 42 U.S.C. § 290dd-2. The regulations implementing the law are at 42 C.F.R. (Code of Federal Regulations) Part 2 and are commonly referred to as the Part 2 regulations. Part 2 protects patient identifying information that directly or indirectly identifies a patient as having (or having had) a SUD and that originates from federally assisted SUD treatment programs (called Part 2 Programs). SUD information that is protected by Part 2 is referred to in this policy as “Part 2 Protected SUD Information.”

Part 2 prohibits the disclosure of Part 2 Protected SUD Information without a Member’s Part 2 Consent, except in limited circumstances. This policy describes the circumstances under which Part 2 Protected SUD Information may be submitted to B – UHP and related requirements.

Identification of Part 2 Programs and Notice Requirements

You are responsible for determining whether you operate a Part 2 Program. You must promptly notify the Network Development team at PHSO_Network_Development@bannerhealth.com within five (5) days of starting any Part 2 Program operations. You may use B – UHP’s Part 2 Program Designation Questionnaire to assist with, and give notice of, your Part 2 Program determination.

If you cease operating a Part 2 Program, you must promptly notify the Network Development team at PHSO_Network_Development@bannerhealth.com.

Your written notification must contain the following information: (a) the Tax Identification Number for each facility that operates (or ceased operating) a Part 2 Program; and (b) when the facility began operating (or ceased operating) the Part 2 Program.

Part 2 Programs: Requirements for Part 2 Protected SUD Information Transmissions to B – UHP

If you are or operate a Part 2 Program, you may disclose Part 2 Protected SUD Information of the Part 2 Program to B – UHP in compliance with Part 2 and this policy. Specifically:

- You must request Members’ Part 2 Consent in order to disclose their Part 2 Protected SUD Information to B – UHP for treatment, payment and health care operations (TPO) purposes.
- If requested by B – UHP, you must request Members’ Part 2 Consent in order to disclose their Part 2 Protected SUD Information to other third parties for TPO and/or any other purposes.
- If requested by B – UHP, you must enter into a Qualified Service Organization Agreement (QSOA) with B – UHP so that B – UHP can receive Part 2 Protected SUD Information without Members’ Part 2 Consent in order to provide services to, or on behalf of, the Part 2 Program.

Non-Part 2 Programs: Prohibition on Part 2 Protected SUD Information Transmissions to B – UHP

If you are not a Part 2 Program, but are in lawful possession of Part 2 Protected SUD Information, you must NOT transmit any of the Part 2 Protected SUD Information to B – UHP, unless all of the following requirements are met:

- You are able to separate appropriately the Part 2 Protected SUD Information from other Member health information; and
- B – UHP has given its advance written consent for the disclosure of Part 2 Protected SUD Information to B – UHP.

Section 7 – Claims

It is B – UHP's commitment to ensure claims payments are accurate and timely. The guidelines presented on the following pages contain information and instructions that should be followed in order to ensure timely and accurate payment.

Providers must submit claims for all services including those that are capitated. Any provider who renders services to AHCCCS members must be registered with AHCCCS and have an active AHCCCS provider number. If the member is dual eligible, you should be registered with AHCCCS to ensure secondary payment.

Provider registration packets are available on the AHCCCS website:

<http://www.azahcccs.gov/commercial/ProviderRegistration/packet.aspx>

For additional information, contact the AHCCCS Provider Registration Unit: In Maricopa County: (602) 417-7670 and select option 5, Outside Maricopa County: 1-800-794-6862 Out-of-State: 1-800-523-0231

Claim Submission Guidelines

Submission of Claims

The Claims Department will adjudicate all properly submitted, authorized claims that meet "clean claims criteria" within 45 days of receipt unless otherwise stipulated in your contract. A claim is considered a "clean claim" if it is submitted on the appropriate form, contains the correct billing information according to CMS 1500, ADA 2002 and UB-04 requirements and has all the supporting documentation as required for medical and claims review. If any standard information is omitted on the claim, it may be denied or returned for correction. Handwritten claims may be accepted but require pre-approval. Claims with whiteout visible will not be accepted to protect you and us from potential instances of fraud. If the claim form is returned to the provider for correction without being adjudicated (i.e. entered into B – UHP's claim system), the original filing limit still applies from the date of service, not the date of return. These claim forms should be resubmitted with a copy of the original return letter attached. Detailed requirements for CMS 1500, ADA 2002 and UB-04 forms are in this section.

Providers must submit all claims for covered services provided to members within one hundred and twenty (120) days after the Covered Services are rendered, whether fee-for-service or capitation. Unless another timeframe is specified in your contract, claims initially received more than 120 days from the date of service will be denied. Non-contracted providers must submit within six months from the date of service. Secondary claims must include a copy of the primary payer's remittance advice and be received within 60 days of the primary payer's remittance advice. Non-contracted providers have 60 days from date of the primary payer's remittance advice or six months from the date of service, whichever is greater.

Acceptable proof of timely filing requirements must establish that B – UHP or its agent has received a claim or claim related correspondence.

Acceptable examples of proof of timely filing include:

- Signed courier routing form documenting specific documents contained
- Certified mail receipt that can be specifically tied to a claim or related correspondence
- Successful fax transmittal confirmation sheet documenting the specific documents faxed
- Acceptable confirmation report from the appropriate clearing house

Unacceptable examples of proof of timely filing include:

- Provider billing history
- Any form or receipt that cannot be specifically tied to a claim or related correspondence

Claims initially received outside of the timely filing deadlines will be denied as Past Filing Deadline (PFD). The

deadline will be determined by the ending date of service for claims involving hospitalization. If a claim is accepted but denied for a reason which can be corrected and resubmitted, the claim form should be resubmitted following the resubmission guidelines.

Submissions Contact Information

Electronic Data Interchange (EDI)

B – UHP encourages providers to submit their claims electronically. Claims may be submitted electronically through your clearinghouse to one of our EDI partners. Please contact your Provider Relations Representative or Customer Care for more information.

Duplicate Claims

Please allow 14 days following the initial submission to validate claims status and allow 60 days prior to resubmitting your claim. This allows B – UHP time to pay the claim and enough time for your staff to post the payment. This practice will decrease the volume of duplicate claims and reduce processing times and administrative costs.

Resubmissions

A resubmission is a claim previously denied due to unclear claim status, billing corrections, supporting documentation and/or the need for review due to an error in payment. Resubmitted claims are not considered grievances or appeals and will not be treated as such. The following documentation is required when filing resubmissions to the Claims Department:

- Clean, corrected claim with “resubmission” clearly marked on the claim with the original claim number. Claims corrections with writing, white out or marker cannot be accepted with the exception of hand writing “Resubmission”, or in those instances where hand written claims were pre-approved.
- Supporting documentation if needed.
- Brief explanation of the correction needed

The claim must be clearly marked as a resubmission. The word “resubmission” and/or the original claim number must be written on the front of the CMS 1500 (box 22), UB-04 (box 84) or ADA 2002 (box 35) claim form. When resubmitting a claim previously filed electronically, a paper claim can be resubmitted. Electronic resubmissions must reference the original claim number in the Loop 2300 Element REF02.

Resubmissions must be received within one (1) year from the date of discharge or date of service. Claims not received within the timeline will be denied as Past Filing Deadline.

Coordination of Benefits

The AHCCCS plans have members enrolled who are eligible for both Medicaid and Medicare. These members are referred to as “dual eligible”. The AHCCCS plan claims will be paid according to the AHCCCS Medicare Cost Sharing Policy. The Health Plan will have no cost sharing responsibility if the Medicare payment matches or exceeds what would have been paid per the provider’s contract. This also applies to members enrolled in other commercial insurance plans.

Effective 10/1/2018, B – UHP will coordinate the payment of both physical and behavioral health claims for members who are not assigned to the Integrated RBHA and those assigned to us through the Complete Care model. Payment for AHCCCS covered behavioral health and physical health services is determined by the primary diagnosis appearing on a claim, except in limited circumstance as described in AHCCCS ACOM 432 – Benefit Coordination and Fiscal Responsibility for Behavioral Health Services and Physical Health Services. This Matrix can be used as a tool to identify the responsible payer.

Additional information concerning benefit coordination and fiscal responsibilities for both behavioral health and physical services may be obtained at:

<https://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/400/432A.pdf>

Seeking payment from Members

The AHCCCS plan members cannot be billed for covered services in accordance with A.A.C R9-22- 702. Eligible AHCCCS members cannot be denied covered services if they are unable to pay non- mandatory applicable co- payments.

Providers cannot bill members for covered services regardless of whether the member has signed a release form for assumption of liability.

The Health Plan members may receive services from providers that are not covered by AHCCCS or Medicare. Providers must have the member sign a release form stating that he/she understands the service is not a covered benefit and he/she is responsible for payment of the charges.

Claims Customer Care Center Representatives

The Claims Customer Care Center Representatives are available to providers to answer questions regarding claims submissions and to assist in resolving problems and issues regarding the status of a claim. The representatives will explain claim adjudication and assist in tracking the disposition of specific claims. The Claims Customer Care Representative will also assist in identifying and correcting claim processing errors.

The Claims Customer Care Center Representatives are not able to correct a provider error in claims preparation and submission. The Provider must resubmit claims requiring corrected information. Corrected claims must be submitted per the resubmission guidelines.

The Claims Customer Care Center Representatives may be contacted Monday through Friday. Your call may be answered by our automated service. Please leave a message and your call will be returned within 48 hours.

Any claims received through the Claims Customer Care Center Representatives, are considered a resubmitted claim and will not be considered for the formal appeal process until it has completed the resubmission process.

Providers should NOT submit the following unless specifically requested to do so:

- Emergency Admission authorization forms
- Patient follow-up care instructions
- Nurses notes
- Blank medical documentation forms
- Consents for treatment forms
- Operative consent forms (exception: BTL & hysterectomy)
- Ultrasound/X-ray films
- Nursing care plans
- DRG/Coding forms
- Medical documentation on prior authorized procedures/Inpatient hospital stays
- Entire medical records

Anesthesia Services

AHCCCS uses the limits and guidelines as established by ASA for base and time units for most anesthesia procedures. Anesthesia times must be included. OB Billing Requirements

In order to ensure members, receive necessary prenatal and OB care and to properly document the provision of that care, B – UHP's billing requirements are as follows:

Global Billing Codes (Please Note: OB Global Billing Guidelines do not apply to FQHC's)

When appropriate, obstetrical service should be billed under a global services code. The Global Package consists of 5 or more prenatal visits, delivery and postpartum care:

- 59400 Routine obstetric care including ante partum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care
- 59510 Routine obstetric care including ante partum care, cesarean delivery and postpartum care.
- 59610 Routine obstetric care including ante partum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care after previous cesarean delivery.

59618 Routine obstetric care including ante partum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery.

Prenatal and Post-Partum Visits in Global Billing

Additional billing lines should include visit information (HEDIS line). The following includes two, suggested guidelines for diagnosis codes to be reported when billing for OB services:

- For the additional billing line (HEDIS line), provide the date range of service for each visit followed by the appropriate place of service, CPT evaluation & management (E&M) code and the number of visits (units). Please note that the visit line should contain diagnoses that are consistent with the office visit, not the delivery (e.g., prenatal care relates to a diagnosis of pregnancy not a delivery).
- Provide each date of service along with the appropriate CPT E&M code
- For B – UHP members who receive their first prenatal visit with an OB provider prior to enrolling with the health plan, the additional billing line (HEDIS line) should contain the dates of service for the member after enrollment with B – UHP
- If providers are in a group/multi-specialty practice, one package must be billed for all services whether more than one provider in the group rendered services. The billing provider is the delivering provider for the package.
- Maternal Fetal Medicine providers are excluded from the OB Package requirements
- Non-Global Billing: If less than 5 prenatal visits are provided, the OB package is not billed. The components provided are broken down into their individual billable services. The individual applicable ranges of services are:
- Ante partum Care Only:
 - 1 - 3 visits Evaluation and Management Codes (99211...15). Bill each visit individually with individual dates of service.
 - 4 – 6 visits Use 59425 Ante partum care only. Bill this as a single line item, indicate one visit in unit field, and include from/to dates. The total flat rate allowed for this code includes all visits.\
 - 7 or more visits Use 59426 Ante partum care only. Bill this as a single line item, indicate one visit in unit field and include date of service span (from/to dates). The total flat rate allowed for this code includes all visits.
- Delivery Only:
 - 59409 Vaginal delivery only (with or without episiotomy and/or forceps) 59514 Cesarean delivery only
 - 59612 Vaginal delivery only, after previous cesarean delivery (with episiotomy and/or forceps)
 - 59620 Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery
- Postpartum Care Only:

- 59430 Postpartum care only (separate procedure)
- Delivery and Postpartum Care:
- 59410 Vaginal delivery (with or without episiotomy and/or forceps), including postpartum care
- 59515 Cesarean delivery only, including postpartum care
- 59622 Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery, including postpartum care

DO NOT BILL ANY ADDITIONAL hospital admission or discharge services outside of these codes. No additional hospital E&M codes will be paid. If in doubt, call Your provider representative for more information.

Overview of Claims Editing System

The Claims Department uses the Interactive Claims Editing System (ICES) to support the AHCCCS and CMS regulatory guidelines, Correct Coding Initiative (CCI) and provider contract conditions. Here are some billing tips:

- Unbundling is the billing of multiple procedure codes for a group of services that are covered by a single comprehensive code.
- Some examples of incorrect coding include:
 - Fragmenting one service into components and coding each as if it were a separate service.
 - Billing separate codes for related services when one code includes all related services.
 - Breaking out bilateral procedures when one code is appropriate.
 - Down coding a service in order to use an additional code when one higher level, more comprehensive code is appropriate.
 - Mutually exclusive.
- All services that are integral to a procedure are considered bundled into that procedure as components of the comprehensive code when:
 - The services represent the standard of care for the overall procedure, or
 - The services are necessary to accomplish the comprehensive procedure, or
 - The service does not represent a separately identifiable procedure unrelated to the comprehensive procedure.
- Determine if the code to be billed is a comprehensive code or a component of a comprehensive code. Component codes cannot be billed if the comprehensive code is the most appropriate code. If the component code is being billed, be sure to include a modifier, if appropriate (24, 25, 50, 57, 58, 59, 78, E1-E4, F1-F9, 1T-9T, RT or LT).
 - For example, a radiologist may bill a comprehensive code identifying he/she performed the technical and the professional components of the service. It would be incorrect coding to bill separately for each piece.

However, if the radiologist only took the x-rays and someone else read the x-rays, they would each bill their piece, with the modifiers 26 (professional component) and TC (technical component), representing which service they performed.

Determine if the code to be billed is a mutually exclusive code. Mutually exclusive procedures are those that cannot reasonably be performed in the same session (e.g. codes for "initial" and "subsequent" services). If a mutually exclusive code and a subsequent code are billed on the same claim, the system will allow the code with the highest capped fee. The other code will then be denied.

Modifiers

Modifier 25 (Significant, separately identifiable E&M service by the same provider for the same day as a procedure) - Modifier identified service that is unrelated to the original procedure. This modifier is used for those services rendered on the same day as a procedure that is above or beyond the other service provided or beyond the usual pre-op and post-operative (i.e. after the date of service in question). This modifier is not used to report an E/M service that resulted in a decision to perform surgery. (See Modifier 57).

Modifier 57 (Decision for surgery) - An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding the Modifier 57 to the appropriate level of E/M service.

Modifier 59 (Distinct procedural service) - Must be attached to a component code to indicate that the procedure was distinct or separate from other services performed on the same day and was not part of the comprehensive service.

- Medical records must reflect appropriate use of the modifier.
- Modifier 59 cannot be billed with evaluation and management codes (99201-99499) or radiation therapy codes (77261-77499). (See Modifier 57).

Modifier 50 (Bilateral procedure) - May be billed with the component code if no code exists that identifies a bilateral service as bilateral.

Modifier 51 (Multiple procedures) - AHCCCS established the Outpatient Prospective Fee System (OPFS) as the methodology for reimbursement of outpatient facility claims. Included in this methodology is a fee schedule which allows payment based on procedures billing the UB-04 Form. Use the modifier 51 if more than one procedure is rendered on any secondary procedures when billing for outpatient surgery on a CMS 1500 or UB-04 form.

Modifier 58 (Staged or related procedures, same physician) or Modifier 78 (Return to operating room for related procedure) - May be used to bill separate services during the postoperative period.

Modifier 26 (Professional Component)

Modifier TC (Technical Component)

Modifier 80 (Assistant Surgeon) and similar modifiers - May be appropriately attached to comprehensive codes.

Claims Forms Instructions

Instructions for CMS 1500s Claim Form

A CMS-1500 claim form should be used to bill for non-facility services, including professional services, transportation and durable medical equipment. Claims received April 1, 2014 and after must be submitted on the revised CMS-1500 Claim Form (version 02-12). Claims submitted on the old claim form will be denied.

Instructions for UB-04 Claim Form

The UB-04 claim form is used to bill for all hospital inpatient, outpatient, emergency room, hospital-based clinic charges, pharmacy charges for services provided as part of a hospital service. Dialysis clinic, nursing home, home health (dependent on the product line), freestanding birthing center, ambulatory surgery center, residential treatment center, and hospice services also are billed on the UB-04.

Instructions for Dental Claim Form

The Dental claim form is used to bill for dental treatment and used for pre-treatment prior authorizations. The bolded fields are required when billing for dental services.

Remittance Advice

Remittance Advice uses the information from your claim and the information from the claims processing system used by Banner – University Health Plans (B – UHP) to provide you information specific to each claim you submitted. You can access this information electronically, or obtain a paper version with your paper check, to help you reconcile your outstanding accounts receivable to what the health plan determined for each claim. NOTE- if

you have access to Change Healthcare 's ECHO system, you can access copies of your paper RA as well.

The RA contains the following:

1. Date of remittance advice
2. Name of Plan/Program member is enrolled with
3. Internal number assigned to provider
4. Name/address of service provider
5. Member name
6. Member identification number
7. Referral/Authorization number
8. Referral/Authorization type
9. From – To service dates
10. Claim number
11. Service provider account number
12. Procedure code
13. Disposition reason (denial, contract adjustment, prompt pay discounts, etc.)
14. Description of procedure code
15. From – To service dates
16. Total billed amount per service line
17. Amount rejected per service line
18. Member deductible amount per service line
19. Member copay amount per service line
20. Amount approved for payment per service line
21. Amount withheld (for contracts with a withhold provision)
22. Net amount of payment per service line
23. Breakdown of adjudication (total lines for entire claim appear **claims totals**)
24. Total claim for member
25. Total amount billed for all service lines
26. Total amount rejected for all service lines
27. Total amount applied to member deductibles for all service lines
28. Total amount applied to member copays for all service lines
29. Total amount approved for payment to all service lines
30. Total amount withheld for all service lines
31. Net amount for claims for all service lines

The Remittance Advice also includes appeal rights, instructions and address for resubmission.

Remittance Notices (also known as an RA or Explanation of Benefits –EOB)

Checks and electronic funds transfers (EFT) are processed on a minimum of a bi-weekly basis. Written and

electronic notice of claims payment or denial will be reported on your remittance advice or 835 file based on your contract with the Health Plan. The Health Plan has a partnership with Change Health\ Echo, where providers are given access to ProviderPayments.com. This is a 24/7 accessible website that contains Remittance Advice, EOB, EFT/ ERA Information.

Encounter Data Validation

All paid claims data is sent to AHCCCS to be encountered. Encountered claims is how AHCCCS recognizes how members are receiving care and how providers are rendering services. AHCCCS uses this information in many ways including: rate setting, risk adjustment, and tracking quality measures.

Approximately 9 months after the end of a contract year AHCCCS is required to conduct an Encounter Data Validation Study on participating Health Plans. The purpose of the study is to ensure the accuracy of encounter data to paid claims. AHCCCS will complete a data extraction on adjudicated encounters and requires an extract of paid claims from the provider's claim system. Samples are selected at random and will include testing for all professional and facility services. The data is reviewed and indented in the following ways:

- Match – claims are in the AHCCCS encounter system and in the paid claims data. Further review is done to ensure timeliness and accuracy.
- NotENC InCIm – A sample of claims from the paid claim system that do not have an AHCCCS encounter record
- InEnc NotCIm – A sample of encounters from the AHCCCS system, not included in the paid claims data
- After the selections are made by AHCCCS and provided back to the Health Plan, copies of the claim as submitted by the provider, as well as other applicable information for processing the claims are due back to AHCCCS. Preliminary findings are sent from AHCCCS to the plans for which challenges and responses can be provided. The final report and any applicable sanctions are then issued.
- Providers are a crucial piece in providing accurate data to AHCCCS. When providers submit timely claims in accordance to AHCCCS guidelines the Health Plan can submit accurate encounter information to the state. This ensures programs are appropriately funded and that members are receiving necessary care.

Section 8 – Member Copayments

AHCCCS/Medicaid Member Copayments

The Health Plan AHCCCS members (except for TMA members discussed below) cannot be denied services because of their inability to pay their nominal copayment. Nominal copayments are non- mandatory copayments. A member may be billed for the copayment, but not sent to collections.

Nominal Copays

Prescriptions	\$2.30 per prescription drug
Outpatient services for physical occupation and speech therapy	\$2.30
Doctor or other provider outpatient office visits for evaluation and management of care	\$3.40

Copayments are collected by the facility providing services. Only one copay per provider/facility site per day may be collected.

The following are exempt from AHCCCS copayments:

- Any member under age 19
- All persons determined to be Seriously Mentally Ill (SMI) receiving RBHA services
- All members who are receiving Children's Rehabilitative Services
- Admission in the hospital, nursing home, hospice or long-term care facility
- Prenatal Care including OB doctor visits and tests
- Well Women, Well Baby and Well Child Program for children
- Services related to a pregnancy or any other medical condition that may complicate the pregnancy, including tobacco cessation treatment for a pregnant woman
- Native American Health Plan enrolled parents
- Family planning services and supplies

Please call the [Customer Care Center](#) or review member eligibility status on the Health Plan websites or AHCCCS website to determine if the AHCCCS member has a required copayment.

TMA Copayments

Transitional Medical Assistance (TMA) members are required to pay copayments. Providers may deny services if the member fails to make the required copayment. Providers may elect to reduce or waive copayments; however, it is not a requirement and is on a case-by-case basis.

Prescriptions	\$2.30 per prescription drug
Doctor or other provider outpatient office visits for evaluation and management of care	\$4.00
Outpatient physical, occupational and speech therapies	\$3.00
Outpatient non-emergency or voluntary surgical procedures	\$3.00

For current co-pay information, please contact the Customer Care Center or check eServices at <https://eservices.uph.org>. Co-Pay amounts are subject to change.

Special Needs Plan (SNP) Members

Special Needs Plan (SNP) members do not have copays. Services not paid by Medicare will be covered by their AHCCCS plan if correct referral and/or Prior Authorization are in place and the service is a covered benefit. The Health Plan SNP member's office and facility copays are determined by their AHCCCS Rate Code.

Member's Prescription Drug Copay Levels are calculated by their Low-Income Subsidy levels as determined by the Social Security Administration:

Level	Deductible	Generic Copay	Brand Copay
1	\$0	\$2.55	\$6.35
2	\$0	\$1.20	\$3.60
3	\$0	\$0	\$0
4	\$63 maximum	15%	\$2.55 generic / \$6.35 brand name

Covered and Non-Covered Services

Each of the five product lines has specific covered and non-covered services.

The Special Needs Plan (SNP), Banner – University Care Advantage, includes "Value Added" services:

- Dental
- Vision
- Hearing Aids
- Hearing Tests
- Podiatrist
- OTC Card
- Transportation for Value added (Pima County Only)

Providers must receive an authorization for services requiring Prior Authorization (PA) before rendering those services to an eligible member. All non-emergent services to a non-contracted facility or provider due to lack of participating specialty providers in the member area must be prior authorized. Referrals to non-contracted providers and facilities for non-emergent services in areas where contracted providers exist are discouraged and subject to medical review and prior authorization.

The Health Plan may offer additional benefits to our Medicare Advantage Beneficiaries. We shall reimburse these added benefits at the lesser of billed charges or at 100% of the Health Plan's current Summary of Benefits. We reserve the right to change, alter, or modify these benefits or the percentage indicated at its discretion. The Health Plan shall notify the Provider of any changes to the Health Plan's Benefit Summary via the Health Plan's Provider Resource Guide.

The Prior Authorization Grid lists services and procedures and identifies the referral and authorization process for each plan. Please note that covered benefits vary between product line (AHCCCS and SNP). This grid is intended to serve as a guideline only. If you have any questions concerning services that require Prior Authorization, please contact the Prior Authorization department.

EMERGENCY SERVICES DO NOT REQUIRE PRIOR AUTHORIZATION.

Section 9 – Covered Services

Banner – University Family Care (AHCCCS)

Our AHCCCS Plans cover medically necessary services with limitations as outlined in the AHCCCS Medical Policy Manual, Chapters 300 and 400:

Chapter 300: <http://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/Chap300.pdf>

Chapter 400: <http://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/Chap400.pdf>

All services must be provided in-network, except in emergent situations or when Prior Authorization has been obtained. Some services, even when provided in-network, require Prior Authorization. Please refer to the PA grid for a list of services that require Prior Authorization. Services that are not covered by AHCCCS may not be on the PA grid. Please refer to the AHCCCS Medical Policy Manual for a full listing of covered services or contact the Plan for further information.

AHCCCS Plans Vision Coverage

For Children (Under Age 21)

- Covered services include eye examinations and provision of glasses for members under the age of 21. Notification or Prior Authorization is not required if done in-network.
- Primary Care Providers are required to furnish initial vision screening in his/her office as part of the EPSDT program.
- Members under 21 with vision of 20/60 or greater should be referred to the Health Plan specific contracted provider for further examination and possible provision of glasses.

Adults

- Adults are not covered for routine eye exams and glasses
- Adults 21 years of age and older should be directed to a contracted ophthalmologist for the diagnosis and treatment of eye disease. Prior authorization or notification is not required for the office visit if done in-network.
- Diabetic eye screenings can be provided by qualified eye/optometry professionals for Adults 21 years of age and older, however, the member must be directed to a contracted ophthalmologist if it is determined that the member has eye disease.
- Prescriptive lenses are not covered unless they are the sole visual prosthetic device used by the member after a cataract extraction. Please see the AMPM, Chapter 310-G for details.

Note: Eye care for adults and children is covered for emergency medical conditions. Prior Authorization is not required in emergencies.

Behavioral Health

Members receive behavioral health services from their AHCCCS Complete Care Health Plan. Primary care physicians, within the scope of their practice, who wish to provide psychotropic medications and medication adjustment and monitoring services, may do so for members diagnosed with ADD/ADHD, depressive and/or anxiety disorders. Please see the AHCCCS Medical Policy Manual, section 310-B, for additional information and clinical guidelines to aid in treatment decisions.

Covered Behavioral Health Services include:

1. Behavioral Health Counseling and Therapy

2. Assessment, Evaluation and Screening Services
3. Skills Training and Development and Psychosocial Rehabilitation Living Skills Training
4. Cognitive Rehabilitation
5. Behavioral Health Prevention/Promotion Education and Medication Training and Support Services
6. Psychoeducational Services and Ongoing Support to Maintain Employment
7. Medication Services
8. Laboratory, Radiology and Medical Imaging
9. Medication Management
10. Electroconvulsive Therapy
11. Case Management
12. Personal Care Services
13. Home Care Training Family (Family Support)
14. Self Help/Peer Services (Peer Support)
15. Home Care Training to Home Care Client
16. Unskilled Respite Care
17. Supported Housing
18. Sign Language or Oral Interpretive Services
19. Transportation
20. Crisis Follow up services
21. Inpatient/Hospital
22. Subacute Services
23. Residential Treatment Center/Behavioral Health Inpatient Facility
24. Behavioral Health Residential Facility, Without Room and Board
25. Mental Health Services (Room and Board with limitations)
26. Supervised Behavioral Health Treatment and Day Programs
27. Therapeutic Behavioral Health Services and Day Programs
28. Community Psychiatric Supportive Treatment and Medical Day Programs
29. Behavioral Health Nursing Services
30. Opioid Agonist Treatment
31. Partial Care (Supervised day program, therapeutic day program and medical day program)
32. Psychosocial Rehabilitation (living skills training; health promotion; supportive employment services)
33. Substance Abuse Transitional Facility Services
34. Limited State Funds for Specific Services related to Housing and Substance Abuse services accessed through the Regional Behavioral Health Authorities

Banner – University Care Advantage (Special Needs Plan)

- Medicare Special Needs Plans are available to individuals who are entitled to Medicare Part A, enrolled in Medicare Part B and AHCCCS.

- Aligned SNP members enjoy the advantage of having care and services coordinated for both their Medicare and AHCCCS benefits.
- SNP members have the same benefits as other Medicare and AHCCCS members. Prior Authorization is required for certain services. Additional benefits are based on specific Plan type and if the member is a QMB recipient.
- Please refer to the B – UCA websites for up-to-date information, includes Part D/Pharmacy information.

Qualified Medicare Beneficiaries (QMB) recipients are Medicare eligible persons qualified under the Medicare Catastrophic Coverage Act of 1988. Medicare coverage is primary for these members.

QMB members are eligible for the following services under Medicare that the AHCCCS Health Plan usually does not cover:

- Chiropractic services
- Outpatient occupational therapy coverage
- Respite services
- Any services covered by or added to the Medicare program, which are not covered by the AHCCCS Health Plan

The Health Plan will pay claims for QMB members according to the AHCCCS Medicare Cost Sharing Policy. The Health Plan will have no cost sharing responsibility if the Medicare payment matches or exceeds what would have been paid per the provider's contract.

Section 10 – Referrals and Prior Authorizations

The following section contains detailed information for the Referral and Prior Authorization process. Topics addressed in this section are:

- Primary Care Provider's role regarding referrals
- Specialty Care Provider's role regarding referrals
- Specialty Care Providers and Ancillary Vendors - referrals or requests for Prior Authorization
- A list of services that require Prior Authorization or notification
- How to handle expedited referrals
- How to complete a referral form

Definitions

Prior Authorization Form:	The form used to request Prior Authorizations, notify specialty care providers or the Health Plan of referrals.
Referral:	Services that are outside the scope of the Primary Care Provider may be referred to a contracted specialty care provider. The Primary Care Provider will complete the Referral Form or acceptable substitute and fax it to the specialty care provider's office along with applicable test results and other pertinent documents.
No Notification:	If no notification to the Health Plan is required, the Primary Care Provider will provide written instructions (i.e. note on prescription pad or Referral Form) and applicable test results and other applicable documents to the specialty care provider.
Notification to Plan:	If notification to the Plan is required, the Primary Care Provider will complete the Prior Authorization Form, send/fax it to the specialty care provider's office and to the Prior Authorization Department.
Prior Authorization:	If Prior Authorization is required the Primary Care Provider or specialty care provider will complete the Prior Authorization Form, attach supporting documentation and fax to the Prior Authorization Department. Some medications (including non-generic medications) require Prior Authorization. For Prior Authorization please complete a non-formulary drug and fax to the Hospital and Pharmacy Coordinator.

Although administration of chemotherapy does not require Prior Authorization, in some cases the chemotherapy drugs may. Please contact Pharmacy Prior Authorization to assist in that determination.

General Guidelines

1. The Primary Care Provider is the coordinator for medical services. For services requiring authorization, all providers must receive Prior Authorization BEFORE rendering services to member. The Prior Authorization Guidelines follow in this section. Please call your Provider Relations Representative if you would like a copy of any guideline.
 - Primary care physicians, specialists, hospitals and vendors should fax Prior Authorization requests to the Prior Authorization Department.
 - If PA is not required, per the Prior Authorization Grid, the primary care physician must refer the patient with a form of written instruction (i.e. note on prescription pad or Referral Form) with reason for visit (consult only – consult & treat, diagnosis, findings, etc.) to present to the specialty care provider.

- Specialty care providers must obtain Prior Authorization from the Prior Authorization Department for all services as listed on the Prior Authorization Grid.
2. Referrals and Prior Authorizations are typically valid for at least 90 days from the date of the request. Length of approval is dependent upon the medical condition being treated.
 3. All providers should verify a member's eligibility on the day services are rendered. Contact the Customer Care Center at (800) 582-8686 to verify a member's eligibility. A Prior Authorization is not a guarantee of payment.
 4. All inpatient admissions must be called or faxed to the Utilization Management department.
 5. All referral requests must be to contracted providers. Contact the Customer Care Center at (800) 582-8686 to verify that a provider is contracted. ALL REFERRALS TO NON- CONTRACTED PROVIDERS MUST HAVE PRIOR AUTHORIZATION THROUGH THE PRIOR AUTHORIZATION DEPARTMENT.
 6. Members inquiring about the status of a referral should contact the requesting provider's office. The provider should call the Prior Authorization line for information.
 7. Requests for planned admissions, elective surgery/procedures, and specialist appointments that require authorization should be sent at least two weeks in advance whenever possible.
 8. Determinations for requested services will be made within the following timeframes:
 - For AHCCCS and Medicare members, standard requests will be completed within 14 calendar days from receipt of the request, unless an extension is requested by the Health Plan.
 - For AHCCCS and Medicare members, standard Part B medication requests will be completed within 72 hours from the time of request. Extensions cannot be granted.
 - For AHCCCS and Medicare members, expedited requests will be completed within 72 hours from the time of receipt of the request.
 - For AHCCCS and Medicare members, expedited Part B medication requests will be completed within 24 hours from the time of request. Extensions cannot be granted.
 9. To ensure timelines of determinations for your request, please submit clinical notes to support the services you are requesting. All Prior Authorization referrals must be submitted with supporting documentation and completed Prior Authorization form.
 10. Members may have a second opinion from a qualified health care professional within the network, or out of network if there is not one available in network. Prior Authorization is required for out of network referrals.

Outpatient Services, Planned, Hospital Admissions

Prior Authorization is required for many outpatient services. All planned hospital admissions require Prior Authorization. The notification requirements may vary depending upon the members plan. Please check with your assigned Provider Relations Representative for notification requirements. All Unplanned and Planned hospitalizations require Notification to the Utilization Management Department must be provided within 72 hours of inpatient admission status. If the required notification day falls on a weekend or State holiday, notification must be provided no later than the next business day.

Medical Records

Upon the request for medical records from the concurrent review nurse, medical records must be received within 72 hours of request or may be subject to denial of day, until records are received. If the required notification day falls on a weekend or State holiday, notification must be provided no later than the next business day.

To Request an Authorization

Fax your request to the health plans; use the fax number on the PA form. We use RightFax Computer System, which reproduces the referral electronically. This is the preferred method for obtaining authorization.

Submit your request on a completed Prior Authorization Form. Please ensure that the provider's name and fax number are clearly noted on the form. Please note whether the request is *Standard* or *Expedited*.

AHCCCS Requests

Standard: Under 42 CFR 438.210, a request for which a the Health Plan must provide a decision as expeditiously as the member's health condition requires, but not later than 14 calendar days with an additional possible extension up to 14 calendar days if the member or provider requests an extension or if the Contractor justifies a need for additional information and the delay is in the member's best interest.

Expedited (up to 72 hours for approval): Under 42 CFR 438.210, a request for which a provider indicates, or the Health Plan determines that using the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. The Health Plan must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 72 hours following the receipt of the authorization request, with a possible extension of up to 14 calendar days if the member or provider requests an extension or if the Health Plan justifies to AHCCCS upon request a need for additional information and the delay is in the member's best interest.

Other member plans may have different criteria and timelines associated with prior authorization requests. Please contact your Provider Relations Representative for plan specifics.

Note: If calling the Prior Authorization Department because faxing is not an option, please have the following information available for the intake staff:

- Member identification number
- Member name and date of birth
- Reason for referral (including CPT codes if possible)
- Diagnosis (including ICD-10 code)
- Specialty care providers full name (phone and fax if available)
- Supporting documentation

Making Referrals to Specialists

Primary care physicians are responsible for making appropriate referrals to specialty care providers when members have medical needs the PCP cannot reasonably be expected to treat. Primary care physicians should refer members to specialty care providers who are part of the provider network and are registered with AHCCCS if the member has an AHCCCS plan. Please call your Provider Relations Representative if you need additional information about our contracted provider network or you may access an updated Provider Directory on the plan specific websites.

Services Requiring Prior Authorization

The Prior Authorization Grid is your source for determining what services require Prior Authorization. The Prior Authorization grid can be found at www.bannerUHP.com Be sure to reference the date of the grid since revisions to the grid may occur.

Prior Authorization Guidelines

Sterilization Services

Any woman over the age of 21 years and determined to be mentally competent can consent to sterilization. Voluntary consent must be obtained without coercion. AHCCCS requires that a 420-1 Consent for Sterilization Form be filled out when a woman requests sterilization. Thirty days, but not more than 180 days must have passed between the date of informed consent and the date of sterilization. In the case of premature delivery or emergency abdominal surgery if at least 72 hours have passed since the informed consent was given, the procedure may be performed. In the case of premature delivery, the informed consent must have been given

at least 30 days before the expected delivery date.

Transplantation Referrals

Transplant requests should be submitted in writing along with the corresponding specialist's recommendation and supporting documentation of medical necessity. Members requiring a transplant are case managed by the Case Manager/Transplant Coordinator.

Prior Authorization Form Completion

The referring provider, during business hours, may obtain Prior Authorization by faxing the pre-printed referral form or calling the Prior Authorization Department. Administrator-on-call will respond after-hours and on weekends. Prior Authorization is staffed 24 hours per day, 7 days per week with both professionals and para-professionals. Referring providers must use the pre-printed referral forms. Prior Authorization can only be given for services that will be provided to eligible and enrolled members.

The following information is required on the referral form:

- a. **DATE:** The date the Prior Authorization form is initiated.
- b. **REQUESTING PROVIDER:** Name of the provider requesting the Prior Authorization.
- c. **PCP:** Name of Primary Care Provider if different from requesting provider.
- d. **OFFICE CONTACT:** Name of office staff personnel completing Prior Authorization Form. This should be a staff member that can be contacted by the Prior Authorization Nurses for further information. Staff member's direct phone, fax and office address are required.
- e. **PRIORITY:** Check either Standard or Expedited. Please note: Providers should use "Expedited" ONLY when medically necessary. Inappropriate use of the "Expedited" request may cause PA to be down-graded to Standard if appropriate.
- f. **MEMBER NAME:** Name of patient
- g. **DATE OF BIRTH:** Birth date of member
- h. **MEMBER ID#:** The identification number of the member found on member's ID card.
- i. **SPECIALIST CONSULT TO:** Name of specialist being referred to (if applicable)
- j. **SPECIALIST LOCATION:** Address of specialist (if applicable)
- k. **NAME OF PROCEDURE:** Be specific and include all CPT codes and descriptions applying to the requested services. Indicate estimated length of stay for inpatient procedures.
- l. **CONTRACTED FACILITY TO BE USED:** Place where procedure will take place
- m. **DATE SCHEDULED (IF KNOWN):** Date procedure is scheduled for. Note: It is not recommended that procedures be scheduled prior to receipt of Prior Authorization.
- n. **ANCILLARY SERVICE REQUEST:** If requesting an ancillary service, please check the appropriate box.
- o. **DIAGNOSIS/ICD-10 CODE:** Include both the description and the code numbers
- p. **PROCEDURE/CPT CODE:** Include all CPT codes that apply to the procedure listed above
- q. **COMMENTS:** Please include any comments pertinent to this request
- r. **RESPONSE:** This section is for the Health Plan use only. Please do not mark in this section.

All parties have the right to submit a grievance or an appeal. To initiate a grievance or appeal contact the Health Plan by calling Customer Service to get the specific timeframes and processes.

Section 11 – Quality Management

Goals

- a. To provide accurate, understandable data to help facilitate the maintenance and enhancement of high-quality member care and services.
- b. To assure compliance with AHCCCS and Medicare quality-related standards.
- c. To assess the quality and appropriateness of services to members through the conduction of Performance Improvement Projects.
- d. To identify opportunities for improvement through the tracking and trending of member and provider staff issues.

Quality Management Performance Improvement Committee (QM/PI)

The Quality Management Performance Improvement (QM/PI) Committee headed by the Chief Medical Officer and overseen by the Board of Directors directs the Quality Management process. The QM/PI Committee is comprised of the health plan's Medical Directors, Chief Operating Officer, Vice President Compliance, Sr. Director Medicare, Director Quality Management, Director Medical Management, Director Customer Care, Director Pharmacy, and Manager Behavioral Health.

If you would like to participate in this committee, please contact the Chief Medical Officer, the Manager of Quality Management or your Provider Relations Representative.

Performance Standards

Contracted providers are required to meet the 2015-2016 Minimum Performance Standards as defined below: The Minimum Performance Standard is the minimally expected level of performance.

The following table identifies the Minimum Performance Standards, Goals and Benchmarks for each performance measure.

ACC Contractor Performance Standards Contract	
Performance Measure	Minimum Performance Standard (MPS)
Adult Measures	
Inpatient Utilization*	TBD
Ambulatory Care - Emergency Department (ED) Visits*	TBD
Readmissions within 30 days of discharge*	TBD
Adult asthma Admission Rate*	TBD
Use of Appropriate Medications for People with Asthma	86%
Follow-up After Hospitalization (all cause) within 7 Days	50%
Follow-up After Hospitalization (all cause) within 30 Days	70%
Adults' Access to Preventive/Ambulatory Health Services	75%
Breast Cancer Screening	55%
Cervical Cancer Screening	53%
Chlamydia Screening in Women Aged 16 to 20 years, 21-24 years	57%

Comprehensive Diabetes Management – HbA1c Testing	86%
HbA1c Poor Control (>9.0%) LDL-C Screening	43%
Eye Exam	70%
Flu Shots for Adults, Ages 18+	49%
Flu Shots for Adults, Ages 18+	75%
Diabetes Admissions, short-term complications*	TBD
Chronic Obstructive Pulmonary Disease (COPD)/Asthma in Older Adults Admissions*	TBD
Asthma in Younger Adults Admissions*	TBD
Congestive Heart Failure admissions*	TBD
Annual monitoring for patients on persistent medications: Combo Rate	75%
Timeliness of Prenatal Care: Prenatal Care visit in the first trimester or within 42 days of enrollment	80%
Prenatal and Postpartum Care: Postpartum Care Rate (second component to CHIPRA core measure “Timeliness of Prenatal Care”)*	64%
Children’s Measures	
Children's Access to PCPs, by age: 12 – 24 mo.	95%
Children's Access to PCPs, by age: 25 mo. – 6 yrs.	87%
Children's Access to PCPs, by age: 7 – 11 yrs.	90%
Children's Access to PCPs, by age: 12 – 19 yrs.	89%
Well-Child Visits: 15 mo.	62%
Well-Child Visits: 3 – 6 yrs.	66%
Adolescent Well-Child Visits: 12 – 21 yrs.	41%
Children's Dental Visits: 2 – 20 yrs.	60%
Weight Assessment and Counseling...Body Mass Index (BMI) Assessment for Children/Adolescents	60%
EPSDT Participation ⁽²⁾	68%
Percentage of Eligibles Who Received Preventive Dental Services (previously titled EPSDT Dental Participation) ⁽³⁾	46%
Ambulatory Care - Emergency Department (ED) Visits*	TBD
Inpatient Utilization*	TBD
Hospital Readmission Rate*	TBD
Developmental Screening in the First Three Years of Life	55%
Childhood Immunization Status	
DTaP	76%
IPV ⁽¹⁾	88%
MMR ⁽¹⁾	89%
Hib ⁽¹⁾	88%
HBV ⁽¹⁾	88%
VZV ⁽¹⁾	88%
PCV ⁽¹⁾	77%

4:3:1:3:3:1 Series	74%
4:3:1:3:3:1:4 Series	68%
Hepatitis A (HAV)	85%
Rotavirus	65%
Influenza	45%
Immunizations for Adolescents	
Adolescent Meningococcal	85%
Adolescent Tdap	85%
Adolescent Combo	85%
Human Papillomavirus Vaccine for Female Adolescents	25%

Notes: Contractor Performance is evaluated annually on the AHCCCS-reported rate for each measure. Rates for measures that include only members less than 21 years of age are reported and evaluated separately for Title XIX and Title XXI eligibility groups.

Performance Measures

Performance measures analyze the success of the Health Plan and its providers in providing basic health screening exams (such as mammography rates) as well as service indicators (such as appointment availability standards). Member and provider satisfaction are also monitored.

The Quality Management and Network Development Departments actively disseminate information from these performance measure studies to clinics and providers in the form of bi-annual dashboards as well as through outreach activities. If there is any particular performance measure you are interested in, please let us know and we will be happy to furnish you with additional information.

Quality Management activities are called for in accordance with AHCCCS policies and requirements, and minimum standards must be achieved. Corrective action plans and interventions must be developed to achieve these standards. We will actively seek collaboration with the providers concerned in formulating such plans.

All performance measurements are reviewed by the Quality Management Department. The Quality Management Department makes recommendations to the QM/PI Committee for action based on the data.

We are eager to have provider input and participation on these work groups. If you would like to participate, please contact the Chief Medical Officer, the Manager of Quality Management, or your Provider Relations Representative.

Performance Improvement Projects

The Health Plan identifies an area each year for intensive quality improvement monitoring. These projects may be undertaken with other AHCCCS plans in order to provide a broad population base, minimize the paperwork for providers and in order to disseminate standardized, consistent information (issued by NIH or other academic agencies) regarding the treatment and monitoring of certain disease processes. The results of these Performance Improvement Projects (PIP) are reported to AHCCCS and, in turn, are reported to CMS.

Each PIP runs over a four-year period, with the following annual sequence:

Year 1	Baseline measurement, planning for possible quality interventions
Year 2	Intervention that is expected to result in improvements over the baseline values
Year 3	Re-measurement to quantify the result of the intervention
Year 4	Second re-measurement to confirm the stability of the outcomes from the intervention

The success of quality improvement projects depends greatly on the extent to which providers participate in and get involved in the design, measurement, intervention and leadership of implementation. If you would be

interested in participating in such activities, please contact the Chief Medical Officer, Quality Management Manager or your Provider Relations Representative.

Quality Management Data Processes

Most data used in generating performance standard reports are obtained from administrative databases maintained by the Health Plan; however, these reports may require validation through medical record audit. We will periodically request access to members' medical records for this purpose. Audit findings are shared with providers without violating either patient or clinic confidentiality.

Individual Quality of Care Issues

The Quality Management department also responds to quality of care concerns received from members and providers or issues identified during routine clinical review of members' care. If substantiated as a true quality of care issue, the concern may be tracked and trended or may be forwarded to the Peer Review Committee. (Policy #QM 6004)

Summary information on quality of care reviews is furnished to the credentialing committee at the time of the providers' re-credentialing. All of these activities concerning provider information may be used for future Performance Improvement Projects.

Peer Review Process

The Health Plans conducts regular and ongoing peer review of clinical practice. The Quality Management department identifies issues that may ultimately be referred for peer review. These issues may come from members, providers or clinical review activities of member care. A copy of the Evaluating Quality of Care and the Peer Review Policy are available to you by contacting the Quality Management department or your Provider Relations Representative.

- Providers must implement recommendations made by the Banner – University Health Plans Peer Review Committee. Some B – UHP Peer Review recommendations may be appealable agency actions under Arizona law. A provider may appeal such a decision through the administrative process described in A.R.S. § 41-1092, et seq. by contacting the B – UHP Chief Medical Officer.
 - The AHCCCS Peer Review Committee may also make recommendations for B – UHP Chief Medical Officer to refer cases to the Arizona Health Care Cost Containment System (AHCCCS), Department of Child Safety (DCS) or Adult Protective Services (APS), Arizona Medical Board and/or other professional regulatory review boards as applicable, for further investigation or action and notification to regulatory agencies.
- Provider Peer Review Grievance Procedure
 - All providers are given due process (grievance) rights in regard to any recommendations taken by the Peer Review Committee that may affect or limit their ability to practice within the Plan.
 - At the conclusion of the peer review process, the provider is notified if such action has been recommended.
- Such communication is sent by certified mail sent within 10 calendar days of the Peer Review Committee's recommendation.
 - The provider may file a grievance in regards to the findings of the committee.
- The grievance must be submitted to the Health Plan CMO within 14 calendar days of the notification of the recommendations of the Peer Review Committee.
 - The Health Plan CMO is responsible for reviewing the grievance submitted by the provider.
- The CMO then makes a determination on the appropriate course of action to be taken.

Medical Record Documentation

In accordance with AHCCCS, Medicare and other quality standards, the Health Plan ensures effective and continuous patient care through accurate medical record documentation of each member's health status, changes in health status, health care needs and health care services provided.

The Health Plan has an on-going program to monitor compliance with the established Medical Record Documentation requirements. The Health Plan will monitor the medical record documentation for any provider that sees more than 50 members per contract year. This includes primary care, OB/GYN, specialty providers who have had >50 referrals in the prior calendar year.

Complete details of Medical Record Documentation requirements are available upon request from Quality Management or your Provider Relations Representative. (Policy #QM 1131A) A copy of the Medical Records Audit tool is included. A copy of the results of the Medical Record is provided to each office manager and/or provider who has been reviewed.

The Health Plan conducts a medical record audit at least every three years in accordance with the credentialing cycle.

Medical records may be documented on paper or in an electronic format:

- a. If records are documented on paper, they must be written legibly in blue or black ink, signed and dated for each entry. Electronic format records must also include the name of the provider who made the entry and the date for each entry,
- b. If records are physically altered, the stricken information must be identified as an error and initialed by the member altering the record along with the date when the change was made; correction fluid or tape is not allowed,
- c. If kept in an electronic file, the provider must establish a method of indicating the author, date, and time of added/revised information and a means to assure that information is not altered inadvertently,
- d. If revisions to information are made, a system must be in place to track when, and by whom, they are made. In addition, a backup system including initial and revised information must be maintained,
- e. Medical record requirements are applicable to both hard copy and electronic medical records. The Health Plan may go on site to review the records electronically or utilize a secure process to review electronic files received from the provider when concerns are identified. Safeguards must be in place to ensure that only authorized individuals are able to access medical records.

Credentialing and Recredentialing

The qualifications of contracted providers are obtained and reviewed through the credentialing and recredentialing process. An initial site survey is conducted prior to the completion of the providers initial credentialing. The Quality Management and Network Development departments provide the following information at the time that the provider is scheduled for recredentialing:

- Complaints and Quality of Care Concerns Information
- Member Grievance Information
- Performance Measure rates on selected Performance Measures
- Results of provider Medical Record Audit
- Results of providers most recent Appointment Availability Survey

The Credentialing Committee will review the information during the recredentialing process. A copy of the site review tool is included.

Section 12 – Behavioral Health

Introduction

Behavioral health benefits vary depending on the member plan. AHCCCS categorizes members by the following behavioral health categories: Serious Mental Illness (SMI), General Mental Health/Substance Use (GMH/SU) and Child (C). Members with a designation of SMI receive their medical and behavioral health benefits through an Integrated Regional Behavioral Health Authority. Members with a designation of GMH/SU and Children not in state/Department of Child Safety custody receive their medical and behavioral health benefits from Banner – University Family Care/ACC (B – UFC/ACC). Children in state/Department of Child Safety custody receive their medical benefits through an Integrated Regional Behavioral Health Authority. B – UFC/ACC members may obtain medication from a primary care provider for limited behavioral health disorders (Anxiety, Depression, Attention Deficit Hyperactive Disorder (ADHD) and Opioid Use Disorder). The B – UFC/ACC formulary makes available psychotropic agents for the treatment of these disorders. All other psychiatric diagnoses must be referred to a B – UHP contracted behavioral health practitioner. The Health Plan's Behavioral Health Care Managers are available to assist with all referrals. Behavioral Health Care Managers can be reached Monday through Friday during normal business hours.

The Health Plan is committed to the facilitation and coordination of care for members to ensure optimal integrated care. Many of our members have complex behavioral health and physical health conditions that require multiple providers to communicate their treatment approaches and interventions to improve the member's care. The Health Plan's providers are expected to respond and participate in these care coordination activities and are encouraged to contact the Health Plan if they have care coordination concerns.

Eligibility and Referrals

Eligibility

AHCCCS and SNP members, except for SOBRA Family Planning members, are eligible for behavioral health services with limitations and depending upon medical necessity.

Referrals

Members can access behavioral health services through the following:

- Referral by a Primary Care Provider (PCP) or the Health Plan
- Referral by a state agency, other community agency or entity
- Referral through crisis services
- Self-referral by calling a contracted provider agency in the community.

Members do not need a referral from their PCP or Health Plan approval to contact contracted behavioral health provider for services.

Primary Care Behavioral Health Screening Referral

Effective October 1, 2018 Primary Care Providers are required to routinely screen all members for depression, drug and alcohol misuse, Anxiety and suicide risk at least annually or whenever the member evidences symptoms. Assessments should be conducted with an age appropriate and standardized evidence based-based tools such as, but not limited to:

- a. Tools associated with the Social Determinants of Health (e.g. Patient-Centered Assessment Method (PCAM), Health Leads Screening Toolkit, Hennepin County Medical Center Life Style Overview, or Protocol for Responding to and Assessment Patients' Assets, Risks, and Experiences (PRAPARE)).

- b. Adverse Childhood Experiences Scale (ACES) to detect trauma that may have resulted in a mental health condition.
- c. PHQ-2 and PHQ-9 to screen for depression. Persons scoring positive on the PHQ-2 should be administered the PHQ-9. Persons scoring >10 on the PHQ-9 should be referred to a Behavioral Health Professional (BHP) for further assessment.
- d. CAGE-ID, Drug Abuse Screen Test (DAST) and the SBIRT to screen for alcohol and drug misuse. Individuals with positive results on any of these screening tests should be referred to a BHP for further assessment.
- e. GAD-7 for the detection of Anxiety. Positive results to this screening test should be followed by a referral for additional assessment by a BHP.

AHCCCS has endorsed several screening tools for children that may be utilized across physical health, public health (e.g., social determinants of health) and behavioral health through the Targeted Investment Initiative. Although the tools referenced below are not prescribed; the application of these screening tools is recommended. The intent of the screening tools for primary care providers to help screen for the presence of behavioral health conditions.

Primary Health Care Practitioner Screening for Children and adolescents to screen the following conditions are endorsed by AHCCCS through the Targeted Investment Initiative. Utilization of these tools is encouraged.

- a. Depression: Patient Health Questionnaires (PQH-2 and PQH 9).
- b. Drug & alcohol misuse: CAGE-AID is 4-question screening use over the last 3-months for adolescents and adults; Drug Abuse Screen Test (DAST) assesses use over the last 12-months; Screening, Brief Intervention and Referral to Treatment (SBIRT) is good for identifying risking behavior and providing intervention.
- c. Anxiety: Patient Health Questionnaire for Generalized Anxiety Disorder (GAD-7) measures severity of signs and symptoms across seven questions.
- d. Developmental delays in infancy and early childhood: Parents Evaluation of Developmental Status (PEDS) collects information and addresses parents' concerns on their child's development; Ages & Stages Questionnaire (ASQ) offers different questionnaires based on age and assesses along the child's developmental milestones; Modified Checklist for Autism in Toddlers-Revised (M-CHAT-R).

Developmental and behavioral health screenings for AHCCCS members up to 21 years of age are a required part of the EPSDT. AHCCCS Plans offer the *Pediatric Screening Checklist* as a tool for this purpose. If a referral is needed for behavioral health services as determined through the EPSDT screening process, discuss with the members' parent or guardian (they must give permission and agree with the referral) and then check the "Behavioral Health" box at the bottom of the EPSDT form.

If the PCP practice uses an integrated services healthcare delivery model, with onsite behavioral health professionals, an in-house referral and intake and assessment session is expected to occur within 7 days for routine situations, and immediately for urgent situations. Based upon the behavioral health assessment, the behavioral health professional will determine if an individual's behavioral health needs can be addressed within the integrated care provider, or if the individual requires more extensive or specialized services beyond the scope of the integrated care provider practice (e.g. longer-term psychotherapy, neuropsychological testing).

PCPs must have the capacity to identify and document positive results on screening tools. If the PCP does not have onsite behavioral health professionals, or if the integrated behavioral health provider's assessment determines that the member requires specialized service beyond the scope of the services provided at the integrated care practice, then the PCP is expected to initiate a referral to a culturally and linguistically appropriate behavioral health service provider.

Providers should contact the Health Plan Customer Care Center, complete the PCP Referral to Behavioral Health Provider form found on www.banneruhp.com/materials-and-services/behavioral-health, or contact a behavioral health provider directly to refer a member for behavioral health services with a contracted provider. Behavioral Health and Maternal Child Health staff review EPSDT forms to identify and follow up on behavioral health referrals

that were made to ensure the member received identified services. The provider may contact a Behavioral Health Care Manager directly to discuss referrals or instruct the member to call, if preferred.

The Health Plan provides medically necessary transportation for AHCCCS members to behavioral health and physical health appointments.

Referral Follow Up

Please forward a copy of PCP Referral to Behavioral Health Provider form by email to the Behavioral Health Email Box: BUHPCareManagementBHMailbox@bannerhealth.com

The assigned Behavioral Health Care Manager will follow up on member intake and enrollment with the behavioral health provider to ensure members have the opportunity to obtain services. When an AHCCCS member has an intake at a behavioral health provider site, the PCP's office may receive a "Notification of Intake" form indicating pertinent information, regardless of the referral source. This form must be kept even if the PCP has not seen the member yet. As the Health Plan continues to develop the technology to facilitate the streamlined referral process, contracted behavioral health providers may continue to use this form to track their referrals. When the patient establishes care, the form can then be integrated into the medical record. If the PCP makes a referral and receives no provider feedback, the medical record should reflect what follow up was initiated by the PCP's office to determine the outcome of the referral. The PCP or designated staff may contact a Behavioral Health Care Manager to request information on referral as needed.

Health plan behavioral health staff can directly assist members or providers with obtaining needed referrals for all lines of business and can provide follow-up care management services as needed. Simply call our Customer Care Center and request assistance from a Behavioral Health Care Manager.

Behavioral Health Benefits and Services

The Health Plan educates eligible members in the member handbook and other printed documents about covered behavioral health services and where and how to access them. During routine office visits, EPSDT screenings or other appropriate visits, we ask that the PCP reminds their patients that they are eligible for behavioral health services, and how to access services.

The following covered services are available for AHCCCS members, based on member eligibility and subject to benefit limitations:

- Behavioral Health Counseling and Therapy
- Assessment, Evaluation and Screening Services
- Skills Training and Development
 - Examples include behavior coaching or Meet Me Where I Am (MMWIA) services
- Psychosocial Rehabilitation Living Skills Training
- Cognitive Rehabilitation
- Behavioral Health Prevention/Promotion Education
- Medication Training and Support Services
- Psychoeducational Services and Ongoing Support to Maintain Employment
- Medication Services
- Laboratory, Radiology and Medical Imaging
- Medication Management
- Electroconvulsive Therapy
- Case Management

- Personal Care Services
- Home Care Training Family (Family Support)
- Self Help/Peer Services (Peer Support)
- Home Care Training to Home Care Client
- Unskilled Respite Care
- Supported Housing
- Sign Language or Oral Interpretive Services
- Transportation
- Crisis Follow up services
- Inpatient/Hospital
- Subacute Services
- Residential Treatment Center/Behavioral Health Inpatient Facility
- Behavioral Health Residential Facility, Without Room and Board
- Mental Health Services (Room and Board with limitations)
- Supervised Behavioral Health Treatment and Day Programs
- Therapeutic Behavioral Health Services and Day Programs
- Community Psychiatric Supportive Treatment and Medical Day Programs
- Behavioral Health Nursing Services
- Opioid Agonist Treatment
- Partial Care (Supervised day program, therapeutic day program and medical day program)
- Psychosocial Rehabilitation (living skills training; health promotion; supportive employment services)
- Substance Abuse Transitional Facility Services
- Limited State Funds for Specific Services related to Housing and Substance Abuse services accessed through the Regional Behavioral Health Authorities

SNP members are eligible for all Medicare covered behavioral health benefits with limitations. Those enrolled with and receiving services from the AHCCCS benefit plan may have co-insurance for services.

Psychotropic Medication Management

PCP's who wish to provide psychotropic medication and monitoring services are encouraged to do so for members diagnosed with Attention Deficit Hyperactive Disorder, Depression, Anxiety disorders and/or Opioid Use Disorder. If a PCP is qualified and chooses to provide medication management for Opioid Use Disorder, the PCP must refer the member to a behavioral health provider for the psychological and/or behavioral therapy component of the medication assisted treatment model and coordinate care with the behavioral health provider. At any time, the PCP may choose to transfer members to a contracted behavioral health provider if the symptoms become complicated or the member has not responded to PCP's attempts to treat. Prior Authorization is required for some psychotropic medications.

PCP's are expected to refer to the plan specific formulary for covered medications and use them prior to requesting a non-formulary medication. The Health Plan formularies offer various psychotropic medications for behavioral health disorders depending on member plan. For AHCCCS members, PCP's may choose to treat

Attention Deficit Disorder, Depression, Anxiety and Opioid Use Disorders; co-morbid behavioral health, complicated behavioral health, and all other behavioral health diagnoses require referral to a behavioral health provider. For Banner – University Care Advantage members, the PCP may choose to treat a broader range of behavioral health diagnoses and this is reflected in the formularies.

PCP's treating aforementioned behavioral health disorders are expected to choose and adhere to a nationally recognized evidence-based practices. Health Plan website contain links to evidence-based guidelines for provider convenience (<https://www.banneruhp.com/resources/clinical-practice-guidelines>). Additional guidelines may be easily accessed at the National Guideline Clearinghouse (<http://www.guideline.gov>).

Members who are receiving counseling and/or other behavioral health services at a contracted behavioral health provider can receive prescription medication through their PCP if they are not seeing a Behavioral Health Medical Professional (BHMP)/prescriber at a behavioral health provider. Members cannot receive medication from a BHMP and the PCP simultaneously. Members who present with complex behavioral health conditions must be referred to a behavioral health provider who can meet their needs.

Members being transitioned to their PCP from any behavioral health provider are exempt from any step therapy. If at any time the Health Plan becomes aware of information about the members' behavioral health condition that would indicate co-morbidity or complex behavioral health needs, we may require the member be referred to a behavioral health provider and discontinue coverage of psychotropic medication prescribed by the PCP. If this occurs, a Behavioral Health Care Manager will facilitate the behavioral health referral and transfer of medical records to ensure continuity of care.

The Health Plan's AHCCCS members must receive treatment via a health plan contracted behavioral health provider following these sentinel events:

- Medication overdose
- Suicide attempt/Homicide Attempt
- Psychiatric hospitalization

In order to achieve optimal member benefit from health care services rendered by Health Plan physical health providers and behavioral health providers, coordination of care between the PCP's office and the behavioral health provider is required for those members who are receiving behavioral health services.

Coordination of care is facilitated by an active ongoing dialogue between the primary care and behavioral health systems. The AHCCCS contract and the Arizona Administrative Code require the exchange of information between the behavioral health providers and health plan providers.

Medical Record Documentation Related to Behavioral Health

PCPs are required to maintain the following documentation:

The medical record must contain clinical/behavioral health records from other providers who also provide care/services to the enrolled member. The medical record documents provider's referral to, coordination of care with, and transfer of care to behavioral health providers, as appropriate. The medical record is legible, kept up-to-date, well organized and comprehensive with sufficient detail to promote effective member care and quality review. A member may have numerous medical records kept by various health care providers that have rendered services to the member. However, the provider must maintain a comprehensive record that incorporates behavioral health information when received from the behavioral health provider about an assigned member even if the provider has not yet seen the assigned member. In lieu of actually establishing a medical record, such information may be kept in an appropriately labeled file but must be associated with the member's medical record as soon as one is established.

Additional documentation must include:

- a. Behavioral health referrals and services provided, if applicable, including notification of behavioral health providers, if known, when a member's health status changes or new medications are prescribed, and behavioral health history and behavioral health information received from a behavioral health provider who

is also treating the member.

- b. Documentation that the provider responds to behavioral health provider information requests pertaining to behavioral health recipient members within ten business days of receiving the request. The response should include all pertinent information, including, but not limited to, current diagnoses, medications, laboratory results, last provider visit, and recent hospitalizations. Documentation must also include the provider's initials signifying review of member behavioral health information received from a behavioral health provider who is also treating the member.

Psychiatric Consultation and Evaluation Services

PCPs may obtain a psychiatric consultation for AHCCCS members they may want to continue to manage or have questions about managing. The PCP may request a telephone consultation to ask questions of a general nature, or the PCP can request the psychiatrist provide a face-to-face consultation with the member for diagnostic purposes and medication recommendations. In order to connect the member to behavioral health services the PCP can utilize the PCP Referral for Behavioral Health Services by contacting a behavioral health provider directly or by contacting the Customer Care Center.

Care Management

The Health Plan offers care management services for those members with Special Health Care Needs (SHCN), including those with serious and chronic behavioral health conditions. We appreciate your assistance in the identification of members in need of behavioral health care management services. Our Behavioral Health Care Managers can partner with the primary care office and others involved in assisting members with accessing behavioral health services, coordination of care between primary care and the behavioral health or mental health provider, facilitation of special needs referrals, and member education and advocacy. We establish agreed upon goals with the member aimed at optimizing health and wellness and provide professional assistance and support for obtaining those goals. Behavioral health Care Management services through the Health Plan are mainly telephonic or by mail; we sometimes attend case conferences or visit members at facilities or in their homes within the community.

If a provider identifies a member who could benefit from behavioral health care management assistance, please call our Customer Care Center and ask to make a Health Plan behavioral health care management referral. A Behavioral Health Care Manager will be assigned and contact your office with an update or any questions.

Copies of the Health Plan policies and procedures concerning behavioral health are available upon request from the Director of Behavioral Health including examples of members who are good candidates for referral.

Crisis and Emergency Services

Emergency Services

For all AHCCCS and B – UCA members, the health plan is responsible for all emergency behavioral health services, including emergency room psychiatric consultation.

The Integrated Regional Behavioral Health Authorities (IRBHA) continue to be responsible for the crisis service delivery system. This means that if members require a mobile crisis team interaction or require 23-hour stabilization or telephonic crisis support, the IRBHA contracts with providers to perform those interventions. After the first 24 hours of a member's behavioral health crisis, the Health Plan coordinates care and assumes responsibility for all follow up services and care coordination.

SNP members have an inpatient behavioral health benefit; including substance abuse detoxification and treatment with certain limitations. If a member exhausts inpatient psychiatric benefits, then inpatient benefit would be covered under the behavioral health provider for eligible members.

Crisis Management and Services

If a member presents with immediate impending danger to self or others and cannot be de-escalated calling 911 and having the member transported via ambulance to the nearest emergency room is an option that should be used to ensure safety. In the event that a member presents with danger to self or others and is receiving

behavioral health services immediate coordination with the behavioral health provider should occur to address the member's presenting symptoms in the least restrictive and clinically appropriate setting with a focus on ensuring safety while meeting the member's needs. For members with frequent crisis the behavioral health crisis plan must be included in the medical record.

The Health Plan has established policy and procedures to warn under ARS 36-517.02. When a patient has communicated to the mental health provider an explicit threat of imminent serious physical harm or death to a clearly identified victim or victims, and patient has the apparent intent and ability to carry out such a threat, the mental health provider will do the following: Communicate when possible the threat to all identifiable victims. Notify the law enforcement agency in the vicinity where the patient or any potential victims reside.

Behavioral Health Care Managers are available to assist with crisis management during office hours. After-hours assistance can be obtained by calling the Health Plan.

If the member can be stabilized and assessed as safely able to leave the premises, the member may be referred to crisis services through the following resources:

Crisis Services These crisis lines can be utilized by any of our members.	
Counties	Crisis Services
Gila and Maricopa	Crisis Response Network (877) 756-4090
Cochise, Graham, Greenlee, La Paz, Pima, Pinal, Santa Cruz, Yuma	Crisis Line (NurseWise) (866) 495-6735
National	
National Suicide Prevention Lifeline Hotline	1-800-273-TALK (8255) Spanish-language Hotline: 1-888-628-9454 Hearing & Speech Impaired with TTY Equipment: 1-800-799-4TTY (4889) 24/7, free & confidential, available to anyone in emotional distress http://www.suicidepreventionlifeline.org

Banner – University Family Care/ACC requires Contractors to report all Incidents, Accidents and Deaths (IADs), Health Care Acquired Conditions (HCAC) and Other Provider Preventable conditions (OPPC) according to AHCCCS requirements. The standard requires providers to report as soon as they are aware of the incident, or no later than 48 hours after learning of the incident.

Incident, Accident and Death (IADs) Reporting Requirements

Incident, Accident and Death (IADs) relate to situations that include deaths, possible abuse, neglect or denial of rights. The bulleted list below details the situations that must be reported to AHCCCS and Banner – University Family Care/ACC according to AHCCCS and contract requirements.

- Deaths;
- Medication error(s)/Adverse Drug Events;
- Abuse or neglect allegation made about staff member(s);
- Suicide attempt;
- Self-inflicted injury;
- Injury requiring emergency treatment;
- Physical injury that occurs as the result of personal, chemical or mechanical restraint;

- Unauthorized absence from a licensed behavioral health facility, group home of children or recipients under court order for treatment;
- Suspected or alleged criminal activity;
- Discovery that a client, staff member, or employee has a communicable disease as listed in R9-6-202

A Hospital Acquired Condition (HCAC) which occurs in any inpatient hospital setting and is not present on admission (Refer to the current CMS list of Hospital-Acquired Conditions.)

Other Provider Preventable Condition (OPPC) is a condition occurring in the inpatient and outpatient health care setting which AHCCCS has limited to the following: Surgery on the wrong member, wrong surgery on a member and wrong surgery site.

IAD's are reported to AHCCCS electronically via their website at

https://qmportal.azahcccs.gov/WF_Public_Default.aspx. Staff responsible for reporting must register through AHCCCS prior to submitting a report. Instructions for registering are included on the AHCCCS website. The Registration Guide is entitled IAD-QOC Web Portal – User Registration Guide. The AHCCCS website also includes a QuickStart Guide containing the instructions on how to report incidents. This guide can be reached at the following link: https://qmportal.azahcccs.gov/WF_Public_Default.aspx.

Reports are entered into <https://qmportaldev.azahcccs.gov>. If you have questions about reporting to AHCCCS, they have a technical assistance link located on their main page at the following link: https://qmportal.azahcccs.gov/WF_Public_Default.aspx

Out of State Placements

At times, it may be necessary to consider an out-of-state placement for a member to meet the member's unique circumstances or clinical needs. The following circumstances need to be taken into account by the member's Adult Recovery Team (ART) or Child & Family Team (CFT) to consider the temporary out-of-state placement:

- Member needs specialized programming not currently available in Arizona to effectively treat a specified behavioral health condition
- An out of state placement's approach to treatment incorporates and supports the unique cultural heritage of the members
- A lack of current in state bed capacity
- The geographic proximity of the out of state placement supports and facilitates family involvement in the member's treatment.
- The member's family/guardian/designated representative is in agreement with the out of state placement (for minors and members between 18 and under 21 years of age under guardianship).
- The out of state provider is an AHCCCS registered provider
- A plan for the provision of non-emergency medical care must be established prior to placement and the non-emergency care providers must be AHCCCS registered providers.
- The Out-of-State placement meets the Arizona Department of Education Academic Standards.

AHCCCS requires that decisions to place member in out-of-state placements for behavioral health care and treatment are examined closely and made after the Adult Recovery Team, Child and Family Team and the Health Plan Behavioral Health Department have reviewed all other in-state options. Other options may include single case agreements with in-state providers that would allow enhanced programming or staffing to meet the specific needs of the member or the development of an Individual Service Plan that incorporates a combination of support services and clinical interventions and takes advantage of the full extent of all available covered services to meet the clinically identified needs of the member. In the event that an out-of-state placement is necessary and is supported by the Health Plan and the Adult Recovery Team or the Child & Family Team, the steps and procedures

outlined in this section must be followed. Services provided out-of-state must meet the same requirements as those rendered in-state. Out-of-state providers must follow all AHCCCS reporting requirements and policies and procedure, including appointment standards and timelines as specified in this manual.

Conditions before a referral for out-of-state placement is made

Documentation in the medical record must indicate the following conditions have been met before a referral for an out-of-state placement is made:

- All less restrictive, clinically appropriate approaches have either been provided or considered by the Adult Recovery Team or Child & Family Team and found not to meet the member's needs;
- Referrals that have been submitted to all in state facilities that have declined admission, or it has been determined that each facility contacted cannot meet the member's needs and the reason is provided in the documentation.
- The CFT or ART has been involved in the Complete Care Planning/Individual Service Plan process and is in agreement with the out of state placement.
- The CRT or ART has documented how it will remain active and involved in the Complete Care Planning/Individual Service Planning once the out of state placement has occurred.
- A Complete Care Plan/Individual Service Planning has been developed and includes a discharge plan that addresses the needs and strengths of the member.
- All applicable prior authorizations requirements have been met.
- Coordination has occurred with all other state agencies involved with the member
- For Child/Adolescent members, the Arizona Department of Education has been consulted to ensure that the educational program in the out-of-state placement meets the Arizona Department of Education Academic Standards and the specific educational needs of the member;
- The member's primary health care provider and the Health Plan have been contacted and a plan for the provision of any necessary non-emergency medical care has been established and is included in the medical record by the assigned case manager;

The Individual Service Plan

For a member placed out-of-state, the Individual Service Plan developed by the Adult Recovery Team or Child & Family Team must require that:

- Discharge planning is initiated at the time of referral or notification of admission, including:
 - The measurable treatment goals being addressed by the out-of-state placement and the criteria necessary for discharge back to in-state services;
 - The possible or proposed in-state residence where the member will be returning;
 - The recommended services and supports required once the member returns from the out- of-state placement;
 - What needs to be changed or arranged to accept the member for subsequent in- state placement that will meet the member's needs;
 - How effective strategies implemented in the out-of-state placement will be transferred to the members' subsequent in-state placement; and
 - The actions necessary to integrate the member into family and community life upon discharge.
- The Adult Recovery Team or Child & Family Team actively reviews the member's progress with clinical staffing's occurring at least every 30 days. Clinical staffing's must include the staff of the out-of-state

facility;

- The member's family/guardian is involved throughout the duration of the placement. This may include family counseling in person or by teleconference or video- conference;
- The Adult Recovery Team or Child & Family Team must ensure that essential and necessary health care services are provided;
- Home passes are allowed as clinically appropriate and in accordance with the Health Plan Medicaid Behavioral Health Covered Services Guide; and
- The member's needs, strengths and cultural considerations have been addressed.
- Strategies and interventions to address and coordinate the care of the member's physical health needs including dental, if applicable.

Initial notification to the Health Plan Behavioral Health Care Management Department

The Health Plan contracted providers are required to notify the Health Plan Behavioral Health Care Management Department and submit an Out of Home Request Packet prior to initiating a referral for an out-of-state placement. The Health Plan contracted providers are also required to assist the Health Plan in gathering the required information to notify AHCCCS's Medical Management, if requested, prior to a referral for out-of-state placement and upon discovering that the Health Plan member is in an out-of-state placement using Out-of-State Placement, Initial Notice. Prior authorization must be obtained prior to making a referral for out-of-state placement, in accordance with the Health Plan criteria.

Process for Providing Initial Notification to the Health Plan

For providers contracted with the Health Plan, the provider notifies the Health Plan Behavioral Health Care Management Department of the intent to make a referral for out-of-state placement on the Health Plan Provider Manual Form Out-of-State placement.

The Health Plan will review the documentation and forward it to AHCCCS's Office of Medical Management, if required, for approval of the out-of-state placement request.

Periodic updates to AHCCCS Office of Medical Management

In addition to providing initial notification, the provider is required to submit updates to the Health Plan Behavioral Health Care Management for review. The updates will be forwarded to the AHCCCS Office of Medical Management regarding the member's progress in meeting the identified criteria for discharge from the out-of-state placement every 30 days. To adhere to this requirement, providers must use Provider Manual Form Out-of-State Placement, 30-Day Update. Once completed, the provider must submit the form to the Health Plan Behavioral Health Care Management Department every 30 days the member continues to remain in out-of-state placement. The 30-day update timelines will be based upon the date of admission to the out-of- state placement.

Required Reporting of an Out-of-State Provider

All out-of-state providers are required to meet the reporting requirements of all incidences of injury/accidents, abuse, neglect, exploitation, healthcare acquired conditions, and/or injuries from seclusion/restraint implementations.

Pre-Petition Screening, Court Ordered Evaluations, and Court Ordered Treatment

At times it may be necessary to initiate civil commitment proceedings to ensure the safety of a member, or the safety of others, due to a member's mental disorder, when that member is unable or unwilling to participate in treatment. In accordance with the A.A.C. R9-21-101 and A.R.S. § 36-533 any responsible person may submit an application for pre-petition screening when another person is alleged to be, as a result of a mental disorder:

- A danger to self (DTS);
- A danger to others (DTO);

- Persistently or acutely disabled (PAD); or
- Gravely disabled (GD).

If the member is subject to the jurisdiction of an Indian tribe, the laws of that tribe, rather than state law, will govern the commitment process.

Pre-petition screening includes an examination of the member's mental status and/or other relevant circumstances by a designated screening agency. Upon review of the application, examination of the member, and review of other pertinent information, a licensed screening agency's medical director or designee will determine if the member meets criteria for DTS, DTO, PAD, or GD as a result of a mental disorder.

Providers who are licensed by the Arizona Department of Health Services/Division of Licensing Services (ADHS/DLS) as a court-ordered evaluation or court-ordered treatment agency must adhere to ADHS licensing requirements.

Contracted behavioral health providers that receive an application for court-ordered evaluation must immediately refer the applicant for pre-petition screening and petitioning for court-ordered evaluation to the county designated pre-petition screening agency or county facility.

If the pre-petition screening indicates that the member may be DTS, DTO, PAD, or GD, the screening agency will file an application for a court-ordered evaluation. Based on the immediate safety of the member or others, an emergency admission for evaluation may be necessary. The screening agency, upon receipt of the application, is required to act as prescribed within 48 hours of the filing of the application, excluding weekends and holidays as described in A.R.S. §36-520.

Based on the court-ordered evaluation, the evaluating agency may petition for court-ordered treatment on behalf of the member. A hearing with the member, his/her legal representative, and the physician(s) treating the member will be conducted to determine whether the member will be released, and/or whether the agency will petition the court for court-ordered treatment. For the court to order ongoing treatment, the member must be determined, as a result of the evaluation, to be DTS, DTO, PAD, or GD. Court-ordered treatment may include a combination of inpatient and outpatient treatment. Inpatient treatment days are limited, contingent on the member's designation as DTS, DTO, PAD, or GD. Members identified as:

- DTS may be ordered up to 90 inpatient days per year;
- DTO and PAD may be ordered up to 180 inpatient days per year; and
- GD may be ordered up to 365 inpatient days per year.

If the court orders a combination of inpatient and outpatient treatment, a mental health agency may be identified by the court to supervise the member's outpatient treatment. Before the court can order a mental health agency to supervise the member's outpatient treatment, the agency's medical director must agree and accept responsibility by submitting a written treatment plan to the court.

Licensing Requirements

Behavioral health providers who are licensed by the Arizona Department of Health Services/ Division of Licensing Services as a court-ordered evaluation or court-ordered treatment agency must adhere to ADHS licensing requirements.

At every stage of the pre-petition screening, court-ordered evaluation, and court-ordered treatment process, a member is to be provided an opportunity to change his/her status to voluntary. Under voluntary status, the member is no longer considered to be at risk for DTS/DTO and agrees in writing to receive a voluntary evaluation.

Reimbursement of court-ordered screening and evaluation services are the responsibility of the County pursuant to A.R.S § 36-545. For additional information regarding behavioral health services refer to 9 A.A.C. 22, 2 & 12. The pre-petition screening includes an examination of the member's mental status and/or relevant circumstances by a designated screening agency. County agencies responsible for pre-petition screening and court-ordered evaluations must use the following forms prescribed in 9 A.A.C. 21, Article 5 for members determined to have a

Serious Mental Illness:

- AMPM Exhibit 320-U-1, Application for Involuntary Evaluation
- AMPM Exhibit 320-U-2, Application for Emergency Admission for Evaluation
- AMPM Exhibit 320-U-3, Petition for Court-Ordered Evaluation
- AMPM Exhibit 320-U-4, Petition for Court-Ordered Treatment Gravely Disabled Person
- AMPM Exhibit 320-U-5, Affidavit
- AMPM Exhibit 320-U-7, Application for Voluntary Evaluation.

Pre-Petition Screening

Arizona counties are responsible for managing, providing, and paying for pre-petition screening and court-ordered evaluations and are required to coordinate provision of services with the Health Plan. The Health Plan Behavioral Health Department is available to answer any questions the caller may have about the process and can direct to the appropriate county contracted pre-petition screening agency.

The pre-petition screening agency must follow these procedures:

- Provide pre-petition screening within forty-eight hours excluding weekends and holidays;
- Offer assistance, if needed, to the applicant in the preparation of the application for the court-ordered evaluation.
- Prepare a report of opinions and conclusions. If pre-petition screening was not possible, the screening agency must report reasons why the screening was not possible, including opinions and conclusions of staff members who attempted to conduct the pre-petition screening.
- Have the Medical Director or designee review the report if it indicates that there is no reasonable cause to believe the allegations of the applicant for the court-ordered evaluation;
- Prepare a petition for court-ordered evaluation and file the petition if the Medical Director or designee determines that the member, due to a mental disorder, including a primary diagnosis of dementia and other cognitive disorders, is DTS, DTO, PAD, or GD. AMPM Exhibit 320-U-3, Petition for Court-Ordered Evaluation;
- Document pertinent information for court-ordered evaluation;
- If the screening agency determines that there is reasonable cause to believe that the member, without immediate hospitalization, is likely to harm himself/herself or others, the screening agency must ensure completion of AMPM Exhibit 320-U-2, Application for Emergency Admission for Evaluation and take all reasonable steps to procure hospitalization on an emergency basis;
- Contact the county attorney prior to filing a petition if it alleges that a member is DTO.

Emergency Admission for Evaluation

- An application for emergency admission may be made only when a member, as a result of a mental disorder, is determined to be DTS or DTO, and there is imminent danger that precludes the use of the pre-petition screening process.
- Only applications indicating DTS and/or DTO can be filed on an emergent basis
- Application must be completed by an applicant who has directly observed or witnessed the behavior of the member that is a danger to self or others, and not based on second hand information
- The applicant must complete AMPM Policy 320-U, Application for Emergency Admission for Evaluation. An application by a doctor or nurse does not require an original signature, may be a facsimile, and does not

have to be notarized.

- The applicant and all witnesses identified in the application as direct observers of the dangerous behavior, may be called to testify in court if the application results in a petition for COE.
- A member proposed for emergency admission for evaluation may be apprehended and transported to the facility under the authority of law enforcement using the written AMPM Policy 320
- The member can be held in an inpatient setting up to 24 hours (excluding weekends and holidays) following a written application for emergency evaluation pending the filing of a petition for court-ordered evaluation. If no petition for court-ordered evaluation is filed within the 24 hours, the member must be released. If a petition is submitted, the hospital may hold the member for an additional seventy- two (72) hours to complete examinations by two (2) physicians.

During the emergency admission period of up to 24 hours the following will occur:

- The member's ability to consent to voluntary treatment will be assessed.
- The member shall be offered and receive treatment to which he/she may consent. Otherwise, the only treatment administered involuntarily will be for the safety of the member or others, i.e. seclusion/restraint or pharmacological restraint in accordance with A.R.S § 36-513.
- The psychiatrist will complete the evaluation within 24 hours of determination that the member no longer requires involuntary evaluation.

Court-Ordered Evaluation

If the pre-petition screening indicates that the member may be DTS, DTO, PAD, or GD, the screening agency will file an application for a court-ordered evaluation. The procedures for court-ordered evaluations are outlined below:

- If, upon review of a petition for court-ordered evaluation, the court agrees that there is significant evidence to warrant an involuntary evaluation, it will issue an Order for Evaluation.
- Evaluations may be conducted inpatient or outpatient.
- If outpatient, an evaluation must be completed by the fourth day following the first appointment.
- If a member is inpatient, the evaluation must be completed within seventy- two hours.
- At the conclusion of the 72-hour evaluation period, the inpatient team will determine whether the member requires court-ordered treatment for a mental disorder. If the medical director of the inpatient facility does not believe the member requires court-ordered treatment, the member must be discharged from the hospital unless he/she completes an application for further care and treatment on a voluntary basis.
- If the medical director of the inpatient facility believes the member requires court-ordered treatment, a Petition for Court-Ordered Treatment is signed and filed by the Evaluation Agency's medical director or physician designee and a hearing is scheduled. (See AMPM Exhibit 320-U-4, Petition for Court-Ordered Treatment - Gravely Disabled Person);
- Title XIX/XXI funds must not be used to reimburse court-ordered evaluation services.
- For any Title XIX enrolled member, who has been admitted to an evaluation agency under a petition for court-ordered treatment, the evaluation period is deemed to end upon the filing of a Petition for Court-Ordered Treatment and is not automatically linked to the end of the 72-hour COE period.
- At that time, the Health Plan must pay for all medically necessary services associated with the period of time between the filing of the Petition for Court-Ordered Evaluation and the hearing set for the purposes of a judicial determination for the need for Court-Ordered Treatment.
- Any contracted behavioral health provider filing a petition for court-ordered treatment must do so in

consultation with the member's clinical outpatient team prior to filing the petition;

- The petition must be accompanied by the affidavits of the two physicians who conducted the examinations during the evaluation period, and by the affidavit of the applicant for the evaluation (AMPM Exhibit 320-U-5, Affidavit, and attached addenda);
- A copy of the petition, in cases of grave disability, must be mailed to the public fiduciary in the county of the member's residence, or in which the member was found before evaluation, and to any individual nominated as guardian or conservator; and
- A copy of all petitions must be mailed to the superintendent of the Arizona State Hospital.
- During the evaluation process, a member may not be treated psychiatrically unless he/she consents. However, seclusion and mechanical or pharmacological restraints may be employed when the member's safety or the safety of others may be jeopardized.

Voluntary Evaluation

Any Health Plan subcontracted provider that receives an application for voluntary evaluation must immediately refer the member to the facility responsible for voluntary evaluations.

The Health Plan subcontracted provider must follow these procedures:

- The evaluating agency must obtain the member's informed consent prior to the evaluation (see AMPM Exhibit 320-U-7, Application for Voluntary Evaluation) and provide evaluation at a scheduled time and place within five days of the notice that the member will voluntarily receive an evaluation; and
- For inpatient evaluations, the evaluating agency must complete evaluations in less than seventy-two hours of receiving notice that the member will voluntarily receive an evaluation.
- If a provider conducts a voluntary evaluation service as described in this section, the comprehensive clinical record must include:
 - A copy of the application for voluntary evaluation, AMPM Exhibit 320-U-7,
 - Application for Voluntary Evaluation;
 - A completed informed consent form and;
 - A written statement of the member's present medical condition.

Based on the court-ordered evaluation, the evaluating agency may petition for court-ordered treatment. Behavioral health providers are required to follow these procedures:

1. Upon determination that a person is DTS, DTO, GD, or PAD, and if no alternatives to court-ordered treatment exist, the Medical Director of the agency that provided the court-ordered evaluation must file a petition with the court for court-ordered treatment (see AMPM Policy 320-U, Exhibit 320-U-4),
2. Any behavioral health provider filing a petition for court-ordered treatment must do so in consultation with the member's clinical team prior to filing the petition,
3. The petition must be accompanied by the affidavits of the two physicians who conducted the examinations during the evaluation period, and by the affidavit of the applicant for the evaluation (see AMPM Policy 320-U, Exhibit 320-U-5), and
4. A copy of the petition, in cases of grave disability, must be mailed to the public fiduciary in the county of the person's residence, or the county in which the member was found before evaluation, and to any person nominated as guardian or conservator.

Members who are Title XIX/XXI Eligible and/or Determined to have a Serious Mental Illness (SMI).

When a member referred for court-ordered treatment is Title XIX/XXI eligible and/or determined or suspected to

have a SMI, the contracted behavioral health provider shall:

1. Submit a referral to designated contractor for an evaluation to determine if the person has a Serious Mental Illness in accordance with AMPM Policy 320-P. The contracted behavioral health provider is required to conduct a behavioral health assessment to identify the member's service needs in conjunction with the member's clinical team, as specified in AMPM Policy 320-O,
2. Provide necessary court-ordered treatment and other covered behavioral health services in accordance with the member's needs, as determined by the member's clinical team, the member, family members, and other involved parties, and
3. Perform, either directly or by contract, all treatment required by A.R.S. Title 36, Chapter 5, Article 5 and 9 A.A.C. 21, Article 5.

Background

Per Arizona Revised Statutes 36-545.06-County Services: "Each County shall provide directly, or by contract the services of a screening Provider and an evaluation Provider."

Each County must have a process in place for:

- Involuntary mental health treatment requests and evaluations
- Court proceedings to satisfy the statutory requirements under Title 36 for members under court-ordered evaluation and court-ordered treatment

Every County in Arizona manages this responsibility differently based on their interpretation of the state statutes and the resources in that County. The outpatient behavioral health agency T36 proper execution of its procedures.

In serving as regional authority, the Health Plan is responsible for treatment of an eligible member* once placed under a Title 36 civil commitment or court-ordered treatment (COT). Per Arizona Administrative Code (R9-21-504) the regional authority "shall perform, either directly or by contract all treatment required by A.R.S. Title 36, Chapter 5, Article 5."

The Health Plan Court Coordinator will serve as the single point of contact for information specific to the court's disposition for eligible members, will coordinate court-ordered evaluation and treatment, and will communicate court-related follow-up/requirements to contractor staff. When a member is court-ordered for evaluation and/or treatment, they will immediately be entered into the Health Plan Care Management program, and the Health Plan Care Manager will deploy a Peer Liaison, to support the member and his/her family. Peer Liaisons will educate members about their diagnosis and symptoms, give step-by-step explanation of the COE/COT process, and share their similar history to inspire hope. The Peer Liaison will remain with the member after conclusion of the COE and/or COT inpatient stay to help the member transition to community -based care while maximizing self-determination.

Contracted Behavioral Health Provider Responsibilities

Each contracted behavioral health provider is required to designate a staff member to serve as Title 36 Liaison for Court-Ordered services.

A contracted behavioral health provider coordinates the provision of clinically appropriate covered services to members requiring court-ordered treatment and serves as the Supervising Agency for court-ordered outpatient treatment plans of the Health Plan enrolled members.

In all cases, the contracted behavioral health provider's Medical Director, or his/her physician designee, has primary responsibility for oversight of a member's court-ordered treatment and is responsible for reviewing and signing all documents filed with the court

*** Per ARS 36-501 (24) Definitions - Medical Director of a mental health treatment Provider" means a psychiatrist, or other licensed physician experienced in psychiatric matters, who is designated in writing by the governing body of the Provider as the member in charge of the medical services of the Provider for the purposes of this chapter and includes the chief medical officer of the state hospital."*

Members on COT must be seen every 30 days by the Medical Director or designee (must be a prescriber). In conducting the review, the medical director shall consider all reports and information received and may require the member to report for further evaluation. If a COT member misses an appointment, the contracted behavioral health provider must demonstrate attempts to see the member within two (2) business days. The Health Plan requires contracted behavioral health providers to consistently track all members on court-ordered treatment to facilitate continued adherence to the court order.

- Outreach and engagement with these members should be assertive and follow the reengagement processes within the Health Plan Behavioral Health Provider Manual. The goal is to avoid re-hospitalization and improve the quality of life for the member.
- A solid crisis plan must be developed that includes what works and does not work for this member, supports that can help, and types of outreach that should be attempted if the member has an increase in symptoms or disengages from treatment.
- Contracted behavioral health providers must closely monitor COT expiration dates. Pursuant to A.R.S 36-540 (D), a court order cannot exceed 365 days, but some counties may order fewer days. Contracted behavioral health providers must ensure they understand the County's interpretation of the COT Expiration date. Contracted behavioral health providers must monitor expiration dates to schedule annual reviews to determine if the member's COT should continue for another year. Additionally, it gives the contracted behavioral health providers enough time to file a Petition for Continued Treatment with court for members who were found Persistently or Acutely Disable or Gravely Disabled.
- The Health Plan will monitor and audit COT requirements and will issue Corrective Action Letters and/or Sanctions for failure to follow the requirements.

Title 36 Liaisons

The Health Plan contracted behavioral health providers that serve as Supervising Agencies for court orders will appoint a Title 36 (T36) Liaison to serve as a central point of contact for all County Mental Health Defenders Office, assigned County Attorney/Office Attorney General, local hospitals and the Health Plan. The contracted behavioral health provider's Title 36 Liaison is also responsible for developing and implementing a process for ensuring that contracted provider clinical staff is aware of expectations and changes in procedures as communicated by the Health Plan. The T36 Liaison will attend quarterly meetings with the Health Plan Court Coordinator to obtain notification of changes in reporting and/or responsibilities.

Contracted Behavioral Health Provider T36 Liaison responsibilities will include:

Coordinate policies and procedures with the Health Plan for enrolled members who have been and/or are in the process of a civil commitment. Reconcile, on a monthly basis with the Health Plan, the roster of members receiving court-ordered treatment. Due date of roster will be submitted no later than the 15th of each month to BUHPTitle36@bannerhealth.com. If an agency developed roster is not available, the **Provider Manual Form B – UHP Provider COT Roster** template can be utilized. This list will include, but may not be limited to, the following:

- Member's name
- Date of birth
- Health Plan identification number
- Mental Health number
- Date of court order
- Standard(s) under which the member was court-ordered
- Due dates of Judicial Review, date Judicial Review was completed, indication if Judicial Review was requested by member

- Dates of suspensions, type of suspension, date admitted under suspension
- Due date of annual examination, date annual examination completed, recommendation of examination
- List of deputized psychiatrists/licensed physician by medical director to do or perform in his/her stead.
- Tolling Status
- Incarceration status and date of incarceration
- Termination of COT as a result of Judicial Review granted
- Status of continued treatment (renew or not)

Provide oversight and technical assistance to contracted provider staff on the T36 process, (e.g. testifying, filing of court documents, development of treatment plans), and ensure compliance with statutory requirements, (e.g. Judicial Reviews, Suspensions, Annual Examination, etc.).

Development of a current list of members under a T36 order to contracted provider team leaders, supervisors, and on-call staff to ensure communication of current treatment plan recommendations, active suspensions, and other related information.

Compliance with any additional requests by the Health Plan which will assist in tracking and monitoring of census data, the implementation of the T36 statutes, and delivery of clinical care to members under a T36 court order.

Participation in Hearings

The member's assigned case manager must attend all Title 36 hearings, including the original hearing for court-ordered treatment, judicial reviews, annual reviews and petitions for continued treatment of GD or PAD orders. The case manager should be prepared to provide information/clarification to the court regarding facts relevant to the topic of the hearing and the proposed outpatient treatment plan. The case manager must be present to receive orders set forth by the Judge/Commissioner including the dates that T-36 status reports are to be submitted to contracted legal counsel, specific orders regarding submission of the outpatient treatment plan, and the standard of the order (i.e. DTO, DTS, etc.). Designated process by the County Attorney should be followed.

The case manager should arrive 15 minutes prior to the hearing. Cell phones and electronic devices must be turned off or silenced. Chewing gum, eating food, or wearing sunglasses are not permitted in the court room. Attire must be professional: no halter tops, tee shirts, sagging pants, spaghetti straps, flip-flops or tennis shoes.

Contracted provider staff must not discuss the case in the presence of the Judge/Commissioner. Such conversations must be held outside the courtroom. The Judge/Commissioner is not to be privy to information regarding the case prior to the hearing. If this occurs the hearing may need to be rescheduled.

During testimony, the County Attorney will obtain information through a series of questions. The attorneys should be addressed as "Mr.", "Ms.", or other appropriate title and the Judge as "Your Honor". Answers must be made verbally in a clear, direct, non-argumentative and audible manner to facilitate recording of the procedures. Head shakes or nods are not permissible.

If the member is court-ordered to treatment, the Judge/Commissioner will request the name of the proposed supervising agency and whether or not a T-36 outpatient treatment plan has been prepared. The case manager is to be prepared to submit the original T-36 outpatient treatment plan to the Judge/Commissioner, with copies to the County Attorney, the Defense Attorney, the hospital T-36 Liaison, and the member.

If a T-36 Outpatient Treatment Plan has not been completed, the case manager is to inform the Court as to why the plan has not been completed, and the projected date of completion.

COCHISE COUNTY:

The case manager should not attend any Title 36 hearing unless specifically directed to do so by the County Attorney.

COCHISE AND PINAL COUNTIES:

Treatment plan and LOI are to be submitted to the County Attorney no later than the day prior to hearing.

PIMA COUNTY:

Contracted behavioral health providers are responsible for establishing a group generic email box to receive minute entries from the Court. An example is *MinuteEntries@[provider name].com*. The Health Plan has identified a law firm to provide legal representation in filing post-hearing documents and coordinating with the Pima County Superior Court on behalf of providers serving as Supervising Providers.

Treatment Plan Development and Filing

Prior to the date of the hearing, the case manager is responsible for coordinating an Adult Recovery Team (ART) meeting for enrolled members to develop discharge plans and ensure that those plans are included in the member's Complete Care Plan (CCP). The CCP must be discussed/reviewed with the Medical Director of the contracted agency, or physician designee. The member's inpatient team must be involved in, and agree to, discharge decisions.

The case manager then develops **Provider Manual Form**– Court-Ordered Treatment Plan - Individual, which incorporates the terms of the CCP.

The case manager must submit a Court-Ordered Treatment Plan to the Court at the Title 36 hearing. The plan must be signed by staff member that reviewed the plan with the member and the outpatient team. The member is not required to sign the plan. If the member does not sign the plan, the member signature line is to be left blank. Information regarding why the member did not sign the plan is not to be written on the plan.

The Court-Ordered Treatment Plan must have the member's correct address, zip code and phone number. If the member is to reside with family, friends, etc., provider staff must confirm this arrangement with family, friends, etc.

The original Court-Ordered Treatment Plan is signed by the Judge/Commissioner at the hearing.

Pima County: Total of 6 treatment plans are to be taken to hearing:

- Original for Judge/Commissioner
- Copies to the following:
 - County Attorney,
 - Defense Attorney,
 - Hospital T-36 Liaison,
 - Member
 - Health Plan Court Coordinator or other designee

Subsequent changes to treatment plans are to be followed per ARS 36-540 depending on the County process.

Pima County

Subsequent revisions regarding change in provider site, residence, psychiatrist, payee, services, etc. are developed by the member's Adult Recovery Team and included in the CCP. The CCP must be signed by the BHMP, case manager and member. If the member does not agree with the CCP ISP, he/she may file an appeal with the Health Plan. The case manager must explain the appeal process to the member. Since all revisions to the CCP are incorporated into and enforced by the original Court-Ordered Treatment Plan, a revised Court-Ordered Treatment Plan does not need to be submitted to the Court.

Upon re-hospitalization following a suspension of an outpatient treatment plan, the case manager coordinates an ART meeting to develop discharge plans and to ensure that those plans are included in a revised CCP. This plan must be reviewed with the outpatient psychiatrist. The outpatient psychiatrist must discuss the proposed plan and any additional concerns with the inpatient psychiatrist. The member's inpatient team must be involved in, and

agree to, discharge decisions. If the member does not agree with the CCP, he/she may file an appeal with the Health Plan. The case manager must explain the appeal process to the member. If there are changes in the CCP such as residence or covered services, the revised CCP must be signed by the member, case manager and outpatient psychiatrist. The original CCP is filed in the outpatient chart and a copy of the CCP is filed in the inpatient chart. A member may leave the hospital once this process is complete. Since all revisions to the CCP are incorporated into and enforced by the original Court- Ordered Treatment Plan, a revised Court- Ordered Treatment Plan does not need to be submitted to the Court.

Amendments/Suspensions

If a member fails to comply with the court-ordered outpatient treatment plan or needs to be hospitalized and refuses voluntary admission, the Medical Director of the contracted agency, or physician designee can rescind the court-ordered Outpatient Treatment Plan.

- It is important the contracted behavioral health provider track the numbers of days a member has spent in an inpatient setting, because there are a limited amount of inpatient days the court may order pursuant to A.R.S. 36-540:
 - DTS up to 90 days
 - DTO & PAD up to 180 days
 - GD up to 365 days
- If there are no more inpatient days available, the Medical Director must determine if the member requires continued court-ordered treatment. If the member is DTO/DTS the contracted behavioral health provider can follow the process for an Emergency Application for Evaluation for Admission. If the member is PAD/GD the contracted behavioral health provider can initiate the Annual Review process or follow the Pre-Petition Screening process.
- Amended outpatient treatment orders do not increase the total period of commitment originally ordered by Court.
- B – UFC/ALTCS members: Assigned ALTCS BHP is responsible for all clinical coordination with BHMP and filing with the Health Plan contracted law firm.

Emergent Amendments/Suspension/A.R. S. 36-540 (E) (5)

When the member is presenting with DTO/DTS behavior, requires immediate acute hospitalization, and refuses admission, the request to suspend the outpatient treatment plan can be telephonic (emergent). The medical director or physician designee must contact an inpatient psychiatrist, discuss, and agree that the member requires immediate acute inpatient treatment. The medical director or physician designee may authorize a peace officer to transport the member to the inpatient treatment facility.

Following the admission to a hospital based upon a telephonic suspension of a court-ordered outpatient treatment plan, the contracted behavioral health provider must file a motion for an amended court order requesting inpatient treatment no later than the next working day following the admission. If this paperwork is not filed, the member may be detained and treated for no more than 48 hours, excluding weekends and holidays. The suspension form cannot be submitted to the inpatient treatment facility in an attempt to admit the member. Admission requires coordination/contact by the medical director or physician designee.

When a member is hospitalized pursuant to an amended order, the contracted behavioral health provider must inform the member of the right to judicial review and the right to consult with counsel pursuant to A.R. S. 36-546.

Non-Emergent Amendment/Suspension A.R. S. 36-540(E) (4)

If the contracted behavioral health provider determines that the member is not complying with the terms of the order, or that the court-ordered outpatient treatment plan is no longer appropriate, the Medical Director or physician designee can petition the court to amend/revoke the outpatient treatment plan to inpatient treatment. The Court, without a hearing and based on the court record, the member's medical record, the affidavits and

recommendations of the Medical Director (must be notarized), and the advice of staff and physicians or the psychiatric and mental health nurse practitioner familiar with the treatment of the member, may enter an order amending its original order.

If the member refuses to comply with an amended order for inpatient treatment, the court may authorize and direct a peace officer, on the request of the Medical Director, to take the member into protective custody and transport the member for inpatient treatment. When a member is hospitalized pursuant to an amended order, the contracted behavioral health provider must inform the member of the right to judicial review and the right to consult with counsel pursuant to A.R.S.36-546.

If the request is written (non-emergent), **Provider Manual forms** - Law Enforcement Committal Information, and - Request for Suspension of Outpatient Treatment Plan are required. The Request for Suspension of Court-Ordered Outpatient Treatment Plan must be signed by the supervising outpatient psychiatrist and notarized. The Court requires specific information/facts regarding the member's lack of compliance with the outpatient treatment plan. The preparer of the suspension request should avoid using conclusions such as "delusional," "non-compliant," "AWOL," "disruptive," and "inappropriate". The request should contain information regarding outreach attempts, attempts to engage the member in treatment, or to offer hospitalization on a voluntary basis. If the member agrees to voluntary hospitalization, suspension paperwork is not submitted.

Pima County:

The original Request for Suspension of Outpatient Treatment Plan is submitted to the Health Plan contracted law firm and copy to the Health Plan Behavioral Health Department at BUHPTitle36@bannerhealth.com. If the documents are submitted by 10:00 a.m., they will be filed with court that day. If submitted after 10:00 a.m., documents will be filed the following day.

If contracted provider staff obtains updated information as to the member's location after suspension paperwork has been filed with the Court, they should contact law enforcement directly to provide updated information. When providing updated location information, contracted provider staff should inform the law enforcement officer that a suspension of the outpatient treatment plan has been filed with the Court.

Upon admission to the hospital, the contracted behavioral health provider is required to inform the member of the right to judicial review and right to consult with counsel, see Judicial Reviews below.

Quashing an Order to Transport/Suspension

If the member returns to treatment, the order to transport/suspension shall be quashed (terminated). The supervising outpatient psychiatrist submits a written statement providing the date when the member returned and engaged in treatment.

PIMA COUNTY:

If 90 days has expired since the last amendment, the contracted behavioral health provider is required to submit a written statement to the Health Plan contracted law firm requesting to quash the previous amendment and transport order and file a new amendment. If a member becomes incarcerated at Pima County Adult Detention Center (PCADC) during the timeframe of the amended outpatient treatment plan, a court order to quash the transport is not required if the current amendment does not indicate the address of PCADC. The contracted behavioral health provider is responsible for notifying Pima County's Mental Health Support Team (MHST) of the change in location of the member. The contracted behavioral health Provider must email the amended pleading to MHST and PCADC records.

Judicial Reviews A.R.S. 36-546

Every 60 days and upon suspension, the member is to be informed of his/her right to Judicial Review. In cases where the member's outpatient treatment plan has been suspended to an inpatient facility, he/she must be offered a Judicial Review within seventy-two (72) hours of admission. The case manager must inform the member of this right to Judicial Review and explain the process. It is the responsibility of the contracted behavioral health Provider to track the Judicial Review dates and ensure a Judicial Review is offered to a member under Court-Ordered Treatment (COT) every 60 days.

If the member requests Judicial Review, the case manager must schedule an appointment to be evaluated by the supervising BHMP. The evaluation must be completed and submitted to the Health Plan within 72 hours of the request and by the filing deadline of 10:00 a.m. It is best to schedule the appointment no later than 48 hours from request, so that the Judicial Review form is received by the Health Plan the next day, to meet the 72-hour timeframe.

If the member requests a Judicial Review, the case manager completes **Provider Manual Form** - Notification of Individual's Right to Request Judicial Review and Right to Speak to Legal Counsel. The member completes his/her current address and signs the form. Additionally, the supervising BHMP completes a psychiatric evaluation. **The Provider Manual Form** - Release from COT Worksheet contains the format for, and additional instructions, for completing the evaluation. The Court requires the psychiatric evaluation contains sufficient clinical information to render a decision regarding whether the member needs continued court-ordered treatment. This can be in the form of a progress note.

B – UFC/ALTCS members: Assigned ALTCS Behavioral Health Professional (BHP) is responsible for all clinical coordination with BHMP and filing with the Health Plan contracted law firm.

Pima County:

The completed Judicial Review Form and psychiatric report is submitted to the Health Plan contracted law firm within 72 hours of the request and by the filing deadline. Copy of the Judicial Review form is to be submitted to B – UHP at BUHPTitle36@bannerhealth.com.

For GREENLEE, GRAHAM, LA PAZ, PINAL, SANTA CRUZ AND YUMA Counties:

Designated process directed by County Attorney office should be followed. The following documents are to be submitted to designated County Attorney Office:

- Letter from Medical Director
- The Right to Notification of Judicial Review form
- The last progress note from the supervising BHMP proving the Judicial review was discussed with member, and reporting recommendations
- Pinal County also requires the most current Psychiatric Evaluation.

For COCHISE County:

The following documents are to be filed with the clerk of the court:

- The Psychiatric Report RE: Request for Judicial Review (The medical director's letter)
- The Right to Notification and Legal Counsel of Judicial Review form
- The last psychiatric evaluation that was completed

All other Counties:

Original Judicial Review Form is to be submitted to the designated county attorney office/law firm. Copy of Judicial Review form is to be submitted to the Health Plan at BUHPTitle36@bannerhealth.com. If the member declines a Judicial Review, the case manager completes the same **Provider Manual form** -Notification of Individual's Right to Request Judicial Review and Right to Speak to Legal Counsel, and the member signs this form. The member provides his/her current address and location. The contracted behavioral health provider maintains this form in the clinical record.

If the member is unavailable at the time the Judicial Review is due, the case manager completes the same Form - Notification of Individual's Right to Request Judicial Review and Right to Speak to Legal Counsel. The case manager must provide reasons why the member was not available for the Judicial Review and include a minimum of two outreach attempts made. The contracted behavioral health provider maintains this form in the clinical

record. It should match the progress notes regarding outreach.

A hearing can be set by the Judge/Commissioner on his/her own or if requested by the defense attorney.

Status Reports

At the original hearing for court order, the Judge/Commissioner may direct the contracted behavioral health provider to submit two status reports to the Health Plan. The Judge/Commissioner will set the dates when the reports are to be submitted.

- Pinal County court requires status reports due to the court at 30, 90, 180, 270 days. If the contracted behavioral health provider fails to complete the status report to the court, the judge can order the member and assigned case manager to appear in court to provide testimony regarding the treatment and process of the member.
- Yuma County requires status reports to be completed the first is 30 days, 90 days, 180 days, and lastly at 270 days.
- Maricopa County requires status reports to be completed the first 45 days and 180 days.
- At this time, the following counties do not require a status report: Cochise, Graham, Greenlee, La Paz and Pima.

The status report is completed using the Form– Court-Ordered Treatment Status form. The status report is completed by the case manager and reviewed and signed by the team supervisor and supervising BHMP.

Copy of the report is submitted to the Health Plan 7 days prior to due date ordered by the Court. Report is to be submitted to B – UHP at BUHPTitle36@bannerhealth.com. B – UFC/ALTCS members: Assigned ALTCS BHP is responsible for all clinical coordination with BHMP and filing with the Health Plan contracted law firm.

Annual Review and Examination A.R. S. 36-543

The contracted behavioral health provider shall ensure the supervising BHMP has completed an examination and review of a court-ordered member in an effective and timely manner. This must take place within 90 days but not less than 30 days prior to expiration of any court-ordered treatment (see A.R.S. 36-543 and 9 A.A.C. 21-506). To ensure this review has taken place the Health Plan requires the contracted behavioral health provider provide the Health Plan with the progress note from the contracted supervising BHMP showing the BHMP met with the member 30-90 days prior to expiration of the court order. This progress note will be collected by the Health Plan on a monthly basis.

The progress note is due on the 1st day of each month. Submit the Progress Report to BUHPTitle36@bannerhealth.com.

Additionally, the member's Adult Recovery Team shall hold a service planning meeting, not less than 30 days prior to the expiration of the court-ordered treatment to determine if the court order should continue (see A.A.C.9S21-506).

Contracted behavioral health providers can request court orders for members determined to be PAD and GD be continued for another year based on an annual review and examination conducted by the member's supervising BHMP and a petition to the court. For members determined DTS and/or DTO the contracted behavioral health provider must request a new court-ordered evaluation.

If the Medical Director believes that continuation of the court-ordered treatment is appropriate, the Medical Director appoints one or more psychiatrists (depending on the County) to carry out a psychiatric examination of the member. Each psychiatrist participating in the psychiatric examination must submit a report to the Medical Director that includes the following:

- The psychiatrist's opinions as to whether the member continues to have a grave disability or persistent or acute disability as a result of a mental disorder, and is in need of continued COT;
- A statement as to whether suitable alternatives to COT are available;

- A statement as to whether voluntary treatment would be appropriate;
- Review of the member's need for a guardian or conservator or both;
- Whether the member has a guardian with mental health powers that would not require continued COT;
- The result of any physical examination that is relevant to the psychiatric condition of the member.

The annual exam must have current contact information for the member. This includes full address, zip code, and telephone number. If the member's location and/or other contact information changes, contracted staff must contact the Health Plan with the new contact information.

A hearing is conducted if requested by the member's attorney or otherwise ordered by the court.

If set for hearing, the contracted supervising BHMP who completed the Annual Exam must testify at the hearing. The contracted behavioral health provider T-36 Liaison is responsible for informing the assigned staff and the supervising BHMP of the hearing and ensures coordination for the hearing. The contracted case manager must inform the member of the hearing and arrange for his/her transport to the hearing.

B – UFC/ALTCS members: Assigned ALTCS BHP is responsible for all clinical coordination with BHMP and filing with the Health Plan contracted law firm.

PIMA County

For continued treatment examinations for members found to be GD, utilize the Health Plan Manual Form, Psychiatric Examination for Annual Review of Gravely Disabled Members. For continued treatment examinations for members found to be PAD, utilize Form Psychiatric Examination for Annual Review of a Persistently or Acutely Disabled.

The Health Plan contracted law firm will forward to the contracted behavioral health provider conformed copies of the petition and order that was filed in court. The contracted behavioral health provider is required to provide the paperwork to the member and obtain a signed B – UHP Form Notice of Filing Confirmation of Receipt. This form provides evidence to the court and defense counsel the member is aware of the petition and his/her right to speak to his/her attorney. This original signed form must be submitted to the Health Plan's contracted law firm. A copy of this form is to be submitted to BUHPTitle36@bannerhealth.com.

Termination/Release from Court Order Treatment A.R. S. 36-541.01

The Court can order a member to be released from court-ordered treatment prior to the expiration of the period originally ordered by the Court upon the written request of the member's supervising BHMP.

Before the release or discharge of a member ordered to undergo COT, the Medical Director must notify any relative or victim of the member who has filed a demand for notice with the contracted behavioral health provider, or any member found by Court to have a legitimate reason for receiving notice of the Medical Director's intention to release or discharge the member.

A request for release can be based upon the following conditions:

- The member has become voluntarily engaged in treatment,
- Has developed insight regarding the need for treatment,
- Has moved out of state, been appointed a guardian,
- Has been sentenced to Department of Corrections,
- Has died.

A written evaluation signed by the contracted supervising BHMP must be submitted to Court for the Judge/Commissioner to review and render a decision. Criteria required by the court to render a decision are contained in the Release from COT Worksheet.

B – UFC/ALTCS members: Assigned ALTCS BHP is responsible for all clinical coordination with BHMP and filing

with the Health Plan contracted law firm.

PIMA County:

The original psychiatric evaluation is submitted to the Health Plan contracted law firm to be filed with court.

All Counties:

Copy of the psychiatric evaluation is to be submitted to the Health Plan at BUHPTitle36@bannerhealth.com.

If sufficient criteria are not provided to the court, or the evaluation is illegible, the judge may deny the request or may set a hearing to hear testimony from the supervising BHMP as to why the member should be released from court-ordered treatment. The contracted case manager is responsible for informing the member of the hearing and to arrange transport to the hearing, if needed. The case manager must be familiar with specifics of the case as he/she may be called to testify at the hearing.

If the member is released from court order, the case manager must notify the member and the Title 36 Liaison must update its systems and the Health Plan at BUHPTitle36@bannerhealth.com to indicate the court order is terminated.

Termination/Release for Lack of Contact – All Counties

For those members who have been absent and the supervising agency has been unable to administer the member's outpatient treatment plan, the T36 Liaison must notify the Health Plan Behavioral Health Department at BUHPTitle36@bannerhealth.com to review documentation of re-engagement attempts before the release or discharge of a member ordered to undergo COT.

Change of Venue Counties other than Pima

When a member transfers from one county to another, the receiving contracted behavioral health provider must agree to accept the member on COT through a Letter of Intent (LOI) and, once transferred, must request the change of venue from the county in which the COT originated. Although Change of Venue is a Court jurisdiction process, the receiving contracted behavioral health provider must follow-up with Court to ensure the change of venue is completed to ensure there is an accurate record of COT. Until venue has been changed, filing of court documents must be submitted to court that initially issued court order.

If the court order was made in a county in which the member does not reside or receive treatment, the court order will need to be changed (moved) to the county where the member resides. The request should be presented at the time of the initial COT hearing. The contracted behavioral health provider should appear in court with an outpatient treatment plan and request the judge to change the venue to the receiving County. If a change of venue needs to occur following the initial COT hearing, the contracted behavioral health provider is to follow process set forth by designated County Attorney or law firm.

B – UFC/ALTCS members: Assigned ALTCS BHP is responsible for all clinical coordination with BHMP and filing with the Health Plan contracted law firm.

PIMA COUNTY:

To change venue from Pima County to another County. The following must be submitted by the outpatient provider:

- Motion for approval of court-ordered outpatient treatment plan, accompanied by a Court-Ordered Treatment Plan
- Motion to Change Venue, Order to Change Venue, accompanied by a Letter of Intent
- The documents must be submitted to the Health Plan contracted law firm to file with Court.
- If the member is transferring from the Health Plan to a RBHA, the contracted behavioral health provider must contact the Health Plan Behavioral Health Department for assistance and coordination at BUHPTitle36@bannerhealth.com.

Change in Supervising Agencies (Transfers)

NOTE: The following are general guidelines-each County has the right to request additional or different documentation.

*Before a member under COT can be transferred from one treating contracted behavioral health provider to another, the sending contracted behavioral health provider must have verification that the Medical Director of the receiving contracted behavioral health provider has accepted the member and accepted the responsibility for overseeing treatment under the court order. This must happen before the transfer is completed.

*Standard of practice is to request a Letter of Intent to Treat (LOI). The LOI is a letter from the Medical director, or designee, of the receiving agency that includes:

- Name and DOB of the member on COT
- COT start and end date
- The standard under which the member is court-ordered (DTO, DTS, PAD, GD)
- Printed name and signature of the receiving Provider's Medical Director
- Effective transfer date (date of intake)
- The letter can read simply: "This letter is to verify that Dr. X and Provider Y has agreed to provide court-ordered treatment to member Z"
- The contracted behavioral health provider must keep a copy of the letter in the clinical record. Proposed outpatient treatment plan, signed by the contracted psychiatrist, case manager, and the member
- The Medical Director of the receiving provider notifies the court in writing that there has been a change in oversight of the member's COT. It is recommended that an official document from the court be requested that reflects the current treatment Provider/Medical Director as the responsible party overseeing the court-ordered treatment.
- The transferring contracted case manager must notify the Health Plan Behavioral Health Department of all transfers at BUHPTitle36@bannerhealth.com.

Court-Ordered Treatment for American Indian Tribal Members in Arizona

Arizona Tribes are sovereign nations, and tribal courts have jurisdiction over their members residing on reservation. Tribal court jurisdiction, however, does not extend to tribal members residing off the reservation or to State court-ordered evaluation or treatment ordered because of a behavioral health crisis occurring off reservation. Although some Arizona Tribes have adopted procedures in their tribal codes that are similar to Arizona law for court-ordered evaluation and treatment, each Tribe has its own laws which must be followed for the tribal court process. Tribal court-ordered treatment for American Indian tribal members in Arizona is initiated by tribal behavioral health staff, the tribal prosecutor, or other member authorized under tribal laws. In accordance with tribal codes, tribal members who may be a danger to themselves or others and in need of treatment due to a mental health disorder are evaluated, and recommendations are provided to the tribal judge for a determination of whether court-ordered treatment is necessary. Tribal court orders specify the type of treatment needed. Additional information on the history of the tribal court process, legal documents, and forms as well as contact information for the tribes, and tribal court representatives can be found on the AHCCCS web page titled, Tribal Court Procedures for Involuntary Commitment - Information Center. Since many Tribes do not have treatment facilities on reservation to provide the treatment ordered by the tribal court, tribes may need to secure treatment off reservation for tribal members. To secure court-ordered treatment off reservation, the court order must be "recognized" or transferred to the jurisdiction of the State. The process for establishing a tribal court order for treatment under the jurisdiction of the State is a process of recognition, or "domestication" of the tribal court order (see A.R.S. § 12-136).

Once this process occurs, the State recognized tribal court order is enforceable off reservation. The State recognition process is not a rehearing of the facts or findings of the tribal court. Treatment facilities, including the Arizona State Hospital, must provide treatment, as identified by the tribe and recognized by the State.

The Health Plan and Health Plan contracted providers must comply with State recognized tribal court orders for Title XIX/XXI members. When tribal providers are also involved in the care and treatment of court-ordered tribal members, the Health Plan and the contracted behavioral health providers must involve tribal providers to verify the coordination and continuity of care of the members for the duration of court-ordered treatment and when members are transitioned to services on the reservation, as applicable. This process must run concurrently with the tribal staff's initiation of the tribal court-ordered process in an effort to communicate and ensure clinical coordination with the appropriate Health plan. This clinical communication and coordination with the Health Plan is necessary to assure continuity of care and to avoid delays in admission to an appropriate facility for treatment upon State/county court recognition of the tribal court order. The Arizona State Hospital should be the last placement alternative considered and used in this process A.R.S. § 36-540 (B) states, "The Court shall consider all available and appropriate alternatives for the treatment and care of the patient. The Court shall order the least restrictive treatment alternative available." The Health Plan is expected to partner with American Indian Tribes and tribal courts in their geographic service areas to collaborate in finding appropriate treatment settings for American Indians in need of behavioral health services.

Due to the options American Indians have regarding their health care, including behavioral health services, behavioral health services for AHCCCS eligible American Indians may be covered and/or coordinated through a, Contractor, Tribal ALTCS, or IHS/638 provider. See on the AHCCCS website under Tribal Court Procedures for Involuntary Commitment-Tribal Court Procedures for Involuntary Commitment for a diagram of payment structures.

[Arizona State Hospital \(AzSH\)](#)

When a need for a referral to the Arizona State Hospital has been identified, the contracted provider contacts the Health Plan Behavioral Health Department to initiate and coordinate the process.

Pima County:

A transfer hearing must be set if the member objects to the transfer to AzSH.

AzSH Psychiatric Security Review Board (PSRB) GEI

If a member is being released from AzSH after serving a sentence under the guilty except insane (GEI) standard, the release of this member is generally reviewed by the PSRB. The PSRB will make recommendations for the member's release into the community. This will often include a referral to the Health Plan where the member plans to reside upon release, and often consideration for court-ordered treatment. In these situations, the local County Attorney's office is notified by AzSH to initiate the court-ordered evaluation process.

Responsibilities of contracted behavioral health provider must include at minimum the following:

- a. Coordination with AzSH for discharge planning,
- b. Participating in the development and implementation of Conditional Release Plans,
- c. Participation in the modification of an existing or the development of a new Complete Care Plan that complies with the Conditional Release Plan (CRP),
- d. Member outreach and engagement to assist the PSRB in evaluating compliance with the approved CRP,
- e. Attendance in outpatient staffing at least once per month,
- f. Care coordination with the member's treatment team, and providers of both physical and behavioral health services to implement the Complete Care Plan and the CRP,
- g. Routine delivery of comprehensive status reporting to the PSRB,
- h. Attendance in a monthly conference call with AHCCCS Medical Management (MM),

- i. In the event a member violates any term of his or her CRP the contracted behavioral health provider shall immediately notify the PSRB and provide a copy to AHCCCS and AzSH, and
- j. The contracted behavioral health provider further agrees and understands it shall follow all obligations, including those stated above, applicable to it as set forth in A.R.S. §13-3994.

Any violation of the Conditional Release, psychiatric decompensation or use of alcohol, illegal substances or prescription medications not prescribed to the member shall be reported to the PSRB and the AzSH immediately.

Contracted behavioral health providers must submit a monthly comprehensive status report for Complete Care members on Conditional Release to the PSRB, at BUHPCareMgmtBHMailbox@bannerhealth.com, and to BUFCALTCBSBHP@bannerhealth.com for ALTCS members as specified in AMPM Attachment 1020-1. Contracted behavioral health providers must provide additional documentation at the request of AHCCCS MM. In the event that a member's mental status renders him/her incapable or unwilling to manage his/her medical condition, and the member has a skilled medical need, the contracted behavioral health providers must arrange ongoing medically necessary nursing services in a timely manner.

Court-Ordered Treatment For Persons Charged with or Convicted of a Crime

The Health Plan or contracted behavioral health providers may be responsible for providing evaluation and/or treatment services when a member has been ordered by a court due to: conviction of a domestic violence offense; or upon being charged with a crime when it is determined that the member is court-ordered to treatment, or programs, as a result of being charged with a crime as a result of a primary substance abuse diagnosis.

Domestic Violence Offender Treatment

Domestic violence offender treatment may be ordered by a court when a member is convicted of a misdemeanor domestic violence offense. Although the order may indicate that the domestic violence (DV) offender treatment is the financial responsibility of the offender under A.R.S. § 13-3601.01, the Health Plan will cover DV services with Title XIX/XXI funds when the member is Title XIX/XXI eligible, the service is medically necessary, required prior authorization is obtained if necessary, and/or the service is provided by an in-network provider.

Court-ordered substance abuse evaluation and treatment

Substance abuse evaluation and/or treatment (i.e., DUI services) ordered by a court under A.R.S. § 36-2027 is the financial responsibility of the county, city, town or charter city whose court issued the order for evaluation and/or treatment. If the Health Plan receives a claim for such services, the claim will be denied with instructions to the contracted provider to bill the responsible county, city or town.

Assessment and Service Planning

The Health Plan supports a model for assessment, service planning, and service delivery that is consistent with AHCCCS Medical Policy Manual (AMPM) 320-O and driven by the Adult Service Delivery System Nine Guiding Principles and the Arizona Vision and Twelve Principles for Children's Behavioral Health Services with a focus on strength-based, member and family centered, culturally and linguistically appropriate, evidence based practice. Assessment and service planning address the member's comprehensive needs with an integrated approach to physical, behavioral and social determinants of health. This model is based on important components including the following:

- Input from the member/guardian/designated representative regarding his/her individual needs, strengths, and preferences,
- Input from other persons involved in the member's care who have integral relationships with the member,
- Development of a therapeutic alliance between the member/guardian/designated representative and behavioral health provider that promotes an ongoing partnership built on mutual respect and equality, and
- Clinical expertise/qualifications of person(s) conducting the assessment, service planning, and service delivery.

The concept of a “team”, established for each member receiving services. For adults this team is the Adult Recovery Team (ART) and for youth the Child & Family Team (CFT). The Adult Service Delivery System Nine Guiding Principles serve as a foundation for ART practice and the Arizona Vision and Twelve Principles serve as a foundation for CFT practice. The size, scope and intensity of the ART/CFT are driven by the needs of the member and as applicable family. The team may be limited to include the member, as applicable guardian and a behavioral health representative or a much broader group for members with more complex needs. Ongoing assessment of needs and service planning revisions must take place in a timely way to meet the member’s needs and always address lack of progress towards goals. At times there are delays in being able to schedule a formal ART or CFT meeting or face-to-face service. If such a delay presents, the ART/CFT process including ongoing needs assessment and service planning development must proceed remotely if needed with revisions being made in a timely way to ensure access to services without delays that can result from waiting for a formal meeting or face-to-face service. At a minimum, the functions of the ART and CFT include:

- Ongoing engagement of the member, family and others who are significant in meeting the behavioral health needs of the member, including their active participation in the decision-making process and involvement in treatment;
- An assessment process is conducted to:
 - Elicit information on the strengths, needs, and goals of the individual member and family members/guardians;
 - Identify the need for further or specialty evaluations; and
 - Support the development and updating of a service plan which effectively meets the member’s/family’s needs and results in improved health outcomes.
- Continuous evaluation of the effectiveness of treatment through the ART and CFT process, the ongoing assessment of the member, and input from the member and his/her team resulting in modification to the service plan, if necessary;
- Provision of all covered services as identified on the service plan, including assistance in accessing community resources, as appropriate and, for children, services which are provided consistent with the Arizona Vision and Principles, and for adults, services which are provided consistent with the 9 Guiding Principles for Recovery Oriented Adult Behavioral Health Services and Systems;
- Ongoing collaboration, including the communication of appropriate clinical information, with other individuals and/or entities with whom delivery and coordination of services is important to achieving positive outcomes (e.g., primary care providers, juvenile or adult probation, specialty service providers, schools, child welfare, DDD, justice system stakeholders, other involved service or other healthcare providers.);
- Oversight to ensure continuity of care by taking the necessary steps (e.g., clinical oversight, development of facility discharge plans, or after-care plans, transfer of relevant documents) to assist members who are transitioning to a different treatment program, (e.g., inpatient to outpatient setting), changing providers and/or: Transferring to another service delivery system (e.g., out-of-area, out-of-state or to an Arizona Long Term Care System (ALTCS) Contractor); and
- Development and implementation of transition plans prior to discontinuation or modification of services.

Assessments

All member’s receiving behavioral health services must have a behavioral health assessment upon initial request for services. For persons who continue to receive services, updates to the assessment must occur at least annually. A behavioral health assessment is the ongoing collection and analysis of the member’s medical, psychological, psychiatric and social conditions in order to initially determine if a health disorder exists, if there is a need for behavioral health services, and on an ongoing basis ensures that the member’s service plan is designed to meet the member (and family’s) current needs and long-term goals. Behavioral health assessments must be

utilized to collect necessary information that will inform providers of how to plan for effective care and treatment of the member.

- The behavioral health provider is responsible for maintaining the assessment and conducting periodic assessment updates to meet the changing behavioral health needs of members.
- Assessments must be updated at a minimum of annually.
- Assessments must be completed by Behavioral Health Professionals (BHPs) or Behavioral Health Technicians (BHTs) under the clinical supervision of a BHP that meets credentialing and training requirements outlined in AHCCCS AMPM Policy 950.
- The assessment process must facilitate timely service planning and access to services to meet individualized needs.
- This process must not create barriers to timely access to services.
- The assessment can be done by a variety of clinicians to support timely access to care as long as the minimum standards identified above, and the minimum assessment required elements are met.
 - Assessments may include psychiatric assessments, psychological assessments, assessments completed as part of the initiation of therapy and counseling services, completed as part of an intake or with initiation of any other covered service.
- An assessment process is conducted to:
 - Elicit information on the strengths, needs and goals of the individual member and his/her family;
 - Identify the need for further or specialty evaluations; and
 - Support the development and updating of a service plan which effectively meets the member's/family's needs and results in improved health outcomes.

The Health Plan does not mandate that a specific assessment tool or format be used but requires certain minimum elements.

Minimum elements of the Behavioral Health Assessment:

- Presenting issue; including symptoms reported by the member, guardian and other information sources
- History of present illness including review of major psychiatric symptoms (i.e., mood, depression, anxiety, psychosis, suicidal ideation, homicidal ideation, and other behavioral health symptoms) and frequency/duration of symptoms;
- Psychiatric/ Behavioral health treatment history including medications, treatment modalities, therapeutic placements and hospitalization
- Substance use history; including type of substance, duration, frequency, route of administration, longest period of sobriety, and previous treatment history;
- Medical conditions/history
- PCP including name and contact information
- Current Medications including OTC; including dosage
- Medication Allergies
- Developmental history
- Educational history/status
- Employment history/status; for adults and as applicable adolescents

- Housing status
- Social history
- Risks associated with Social Determinants of Health
- Legal history, including: Custody, Guardianship, Pending litigation, Criminal justice history; COT
- Family history
- State agency involvement (i.e. Probation, Adult Probation/ Parole, DDD, DCS etc.); current involvement or history of involvement
- Trauma History
- Sexual History- as applicable
- Cultural/Spiritual needs
- Linguistic needs for limited English proficiency
- Mental Status Examination
- Risk assessment: the potential risk of harm to self or others
- Strengths
- Goals
- Diagnosis
- Recommendations and if applicable referral for further assessment or examination of the member's needs; behavioral health services, physical health services, or ancillary services
- The signature and date signed of the personnel member conducting the behavioral health assessment documented in the member's medical record;

The following Special Circumstances Assessments Components must be completed as applicable:

- Children Age 0 to 5 – Developmental screening must be conducted by the Behavioral Health provider for children age 0-5 with a referral for further evaluation when developmental concerns are identified,
- Children Age 0-5 – The Early Childhood Service Intensity Instrument (ECSII) or an equivalent assessment must be completed by the Behavioral Health Home within the first 45 days of intake, at least bi-annually, and as significant changes occur in the life of the child,
- Children Age 6 to 18 - The Child and Adolescent Service Intensity Instrument (CASII) must be completed with the first 45 days of intake, at least bi-annually, and as significant changes occur in the life of the child,
- Children Age 6 to 18 - with CASII Score of four or Higher: Strength, Needs and Culture Discovery Document must be completed by the Behavioral Health Home, and
- Children Age 11 to 18 - Standardized substance use screen and referral for further evaluation when screened positive must be completed by the Behavioral Health Home.
- Serious Mental Illness (SMI) Determination shall be completed for persons who request an SMI determination in accordance with AMPM Policy 320-P.

Child and Adolescent Service Intensity Instrument (CASII)

The CASII shall be administered by staff person(s) trained in the administration of the CASII. All individuals administering the CASII shall complete initial training and pass initial and ongoing fidelity monitoring.

The CASII shall be administered within the first 45 days of intake, at least bi-annually, and as significant changes

occur in the life of the child. This may include but not limited to discharge from inpatient, behavioral health short term residential treatment, or therapeutic foster care.

In addition to the CASII (or other assessment, as directed by AHCCCS) level of acuity and high-need determination for children ages 6 through 17 may be assessed through clinical evaluation as well as CASII score. This evaluation and high need identification shall also trigger an updated CASII, as well as review of the current treatment/service plan.

CASII assessments can be completed by the Behavioral Health Home or a Specialty Behavioral Health Provider. Due to the potential for duplication of the CASII assessment, treating behavioral health providers shall collaborate to ensure that differences in CASII levels are addressed at the clinical level and through the CFT.

Service Planning

Service Plans: The Health Plan requires Individual Service Plans that are based on the current assessment. Service Plans must meet all the requirements for service planning in accordance with AMPM 320-O including a complete written description of all covered health services and other informal supports which includes individualized goals, family support services, care coordination activities and strategies to assist the member in achieving an improved quality of life. In addition, the Service Plan must include behavioral health and physical health diagnosis and needs, social determinants of health (SDOH), takes into consideration behavioral health and physical health diagnosis and SDOH influence on each other and includes a focus on overall health and wellness. Behavioral health providers will obtain information about physical health diagnosis by member or guardian report, review of medical records or through physical health provider assessment in integrated settings. Behavioral health providers that do not provide physical healthcare should not make physical health diagnosis.

Service Plans must be included in the member's medical record in accordance with AMPM Policy 940

The required elements of the Service Plan include the following:

- Physical Health (PH) and Behavioral Health (BH) Diagnosis
- Member strengths
- Member challenges/risks
- Social Determinants of Health (SDOH)
- Takes into consideration influence of PH/BH conditions and SDOH on one another
- Member needs/issues
- Individualized goals/progress/barriers
- Covered health services (BH and PH)
- Natural/informal/family supports
- Health and Wellness activities that address modifiable risk factors and health related behaviors
- Acknowledgement of if crisis plan has been developed
- Anticipated date of review

If a member is need of services before a Service Plan is developed an interim Service Plan must be developed to document services until a comprehensive Service Plan is completed. A Service Plan, however, must be completed no later than 45 days after the initial appointment.

At a minimum, the member, his/her guardian (if applicable), advocates (if assigned), and a qualified behavioral health representative must be included in the development of the Service Plan. In addition, family members, designated representatives, agency representatives and other involved parties, as applicable, may be invited to participate in the development of the plan. Providers must coordinate with the Health Plan contracted PCP or others involved in the care or treatment of the individual, as applicable, regarding service planning. Service Plans

must be completed by BHPs and BHTs who are trained on behavioral health service planning and meet requirements in Section Training Requirements. In the event that a BHT completes the Service Plan, a BHP must review and sign the plan. The Service Plan must be documented in the comprehensive medical record in accordance with Section Behavioral Health Medical Record Standards, be based on the current assessment, and contain the following elements:

- The member/family vision that reflects the needs and goals of the member/family;
- Identification of the member's/family's strengths;
- Measurable objectives and timeframes to address the identified needs of the member/family, including the date when the service care plan will be reviewed;
- Identification of the specific services to be provided and the frequency with which the services will be provided;
- Include services that comprehensively address the triggers, behaviors and symptoms related to the member's trauma (if applicable);
- The signature of the member/guardian and the date it was signed;
- Documentation of whether or not the member/guardian is in agreement with the plan;
- The signature of an Adult Recovery Team member and the date it was signed;
- The Service Plan Rights Acknowledgement, dated and signed by the member or guardian, the member who filled out the Service Plan, a designated representative or advocate (if any), and a behavioral health professional if a behavioral health technician fills out the service plan.

The member must be provided with a copy of his/her plan.

The treating Behavioral Health Medical Practitioner (BHMP) as applicable must be included in development of the Service Plan through providing recommendations related to evidence based practices as well as supports to meet member's needs. If a member is not making progress towards identified goals or if complex needs present, a behavioral health representative must reach out to the treating BHMP for input into ongoing care planning. If the member does not have a treating BHMP the behavioral health representative must reach out to the provider medical director as applicable.

Appeals or Service Plan Disagreements

Every effort should be taken to ensure that the service planning process is collaborative, solicits and considers input from each team member, and results in consensus regarding the type, mix and intensity of services to be offered. In the event that a member and/or legal or designated representative disagree with any aspect of the service plan, including the inclusion or omission of services, the team should take reasonable attempts to resolve the differences and actively address the member's and/or legal or designated representative's concerns.

Providers conducting updates to the Assessment and Service Plan must complete an annual assessment update with input from the member and family/guardian, if applicable, that records a historical description of the significant events in the member's life and how the member responded to the services/treatment provided during the past year. Following this updated assessment, the Service Plan must be updated as necessary. While the assessment and Service Plans must be updated at least annually, the assessment and care plan may require more frequent updates to meet the evolving needs and goals of the member and his/her family particularly for members that have experienced crisis, required hospitalization or other therapeutic levels of care, require transitions or who have new diagnosis.

Referral and Intake Process for Behavioral Health Services

The referral process serves as the principal pathway by which members are able to gain prompt access to publicly supported services. The intake process serves to collect basic demographic information from members and determine the need for any copayments. It is critical that both the referral process and intake process are

culturally sensitive, efficient, engaging and welcoming to the member and/or family member seeking services, and leads to the provision of timely and appropriate services based on the urgency of the situation.

Members are not required to be enrolled with an "intake agency" or "behavioral health home" in order to receive behavioral health services, however the provider must be contracted and follow all guidelines to serving AHCCCS members:

- ART or CFT practices
- Provide an assessment of needs by a qualified behavioral health professional
- Health Plan contracted providers must provide or refer members for high needs care management when CASII or ECSII scores are 4 or higher per guidelines.
- Provider must refer for additional covered services when clinically indicated
- Coordinate with other providers including PCP and physical health providers

Contracted Behavioral Health Provider Appointments:

- Urgent appointments are scheduled expeditiously no later than 24 hours from identification of need
- Routine care appointments:
 - Initial assessment within seven calendar days of referral or request for service,
 - The first behavioral health service following the initial assessment as expeditiously as the member's health condition requires but:
 - For members age 18 years or older, no later than 23 calendar days after the initial assessment,
 - For members under the age of 18 years old, no later than 21 days after the initial assessment, and
 - All subsequent behavioral health services, as expeditiously as the member's health condition requires but no later than 45 calendar days from identification of need.

Psychotropic Medications:

- Assess the urgency of the need immediately, and
- Provide an appointment, if clinically indicated, with a Behavioral Health Medical Professional within a timeframe that ensures the member does not run out of needed medications or does not decline in his/her behavioral health condition prior to starting medication, but no later than 30 calendar days from the identification of need.

If the Health Plan network is unable to provide medically necessary services to Medicaid and Medicare eligible members, the Health Plan will ensure timely and adequate coverage of needed services through an out-of-network provider until a network provider is contracted.

High Needs Case Management Referral

Children with high service intensity needs who require the assignment of a high needs case manager are identified as:

- Children ages 0 to 5 years that demonstrate one or more of the following:
 - An ECSII score of 4 or higher
 - Other agency involvement; specifically: AzEIP, DCS, and/or DDD; and/or
 - Out of home placement (within past six months); and/or

- Psychotropic medication utilization (two or more psychotropic medications); and/or
- Evidence of severe psycho-social stressors (e.g. family member serious illness, disability, loss of a family member, job loss, eviction).
- Children ages 6 to 17 that have a CASII score of 4 or higher. In addition to the CASII (or other assessment as directed by AHCCCS) level of acuity and need for children ages six through 18 may be assessed through clinical evaluation. This identification shall also trigger an updated CASII assessment and review the current service plan.

If the assessment indicates that the child and family are considered to have high needs, a referral to a high needs case manager shall be initiated. To promote family choice, Health Plan contracted providers shall ensure that the following options are offered when assigning an agency to provide high needs case management:

Option 1: The member's originally assigned provider offers high needs case management. In these situations, the family may be offered to receive high needs case management and other needed services through a single provider agency. In these circumstances, the provider serves as the designated health home for that child.

Option 2: The originally assigned provider does not offer high needs case management necessitating an external referral to another provider agency to access high needs case management services. In this situation the family has two additional options:

- Responsibility for all services can be transferred to the high needs case management provider agency and this provider will become the member's designated health home. This option is ideal as it streamlines the coordination of care and medical record documentation under one entity; OR
- The child and family can choose to remain with the originally assigned provider (i.e. maintain established relationship, better alignment with family preferences or needs) and only receive high needs case management from the high needs case management provider agency. In these circumstances, the originally assigned provider shall function as the member's designated health home. Health Plan contracted providers shall be responsible for ensuring timely and efficient care coordination between all involved provider agencies. This may include referral expectations and allowable exceptions based on family preference.

The following clinical assessments are required as prescribed below:

- Children Age 0 to 5 – Developmental screening must be conducted by the Behavioral Health Home for children age 0-5 with a referral for further evaluation when developmental concerns are identified,
- Children Age 0 to 5 – The Early Childhood Service Intensity Instrument (ECSII) or an equivalent assessment must be completed within the first 45 days of intake, at least bi-annually, and as significant changes occur in the life of the child.
- In lieu of the ECSII (or as otherwise directed by AHCCCS), the following criteria shall be evaluated to determine if a child birth to five is considered high needs and requires further assessment and targeted services. Children birth through five years of age shall demonstrate one or more of the following:
 - Other agency involvement; specifically: AzEIP, DCS, and/or DDD; and/or
 - Out of home placement (within past six months); and/or
 - Psychotropic medication utilization (two or more psychotropic medications); and/or
 - Evidence of severe psycho-social stressors (e.g. family member serious illness, disability, death, job loss, eviction).
- Children Age 6 to 17 - The Child and Adolescent Service Intensity Instrument (CASII) must be completed within the first 45 days of intake, at least bi-annually, and as significant changes occur in the life of the child,
- Children Age 6 to 17 - with CASII Score of four or Higher: Strength, Needs and Culture Discovery Document must be completed, and

- Children Age 11 to 17 - Standardized substance use screen and referral for further evaluation when screened positive must be completed.

A referral is any oral, written, faxed or electronic request either to the Health Plan when applicable, by in-network providers for behavioral health or physical health services made by a member, or member's legal guardian, a family member, primary care provider, hospital, jail, court, probation and parole officer, tribal government, Indian Health Services, school or other governmental or community agency.

To facilitate a member's access to services in a timely manner, the Health Plan Contracted Providers will maintain an effective process for the referral, intake and initiation of services which includes:

- Engaging with the member and/or member's legal guardian/family member.
- Communicating to potential referral sources the process for making referrals (e.g., centralized intake, identification of providers accepting referrals);
- Keeping information or documents collected in the referral process confidential and protected in accordance with applicable federal and state statutes, regulations and policies.
- After obtaining appropriate consents, informing the referral source as appropriate about the final disposition of the referral
- Conducting intakes that ensure the accurate collection of all the required information and ensure that members who have difficulty communicating because of a disability or who require language services are afforded appropriate accommodations to assist them in fully expressing their needs.
- Collecting enough basic information about the member to determine the urgency of the situation and subsequently scheduling the initial assessment within the required timeframes and with an appropriate provider;
- Adopting a welcoming and engaging manner with the member and/or member's legal guardian/family member;
- Ensuring that intake interviews are culturally appropriate and delivered by providers that are respectful and responsive to the member's cultural needs
- Conducting intake interviews that ensure the accurate collection of all the required information necessary for the receipt of services.

Where to send referrals

The Health Plan will accept referrals in written format or provided orally. All referrals are documented.

The Health Plan maintains provider directories which can be accessed at

- Complete Care - <https://www.BannerUFC.com/ACC>
- Long Term Care - <https://www.BannerUFC.com/ALTCS>
- Medicare Advantage - <https://www.BannerUCA.com>

These directories indicate which providers are accepting referrals. Providers are required to promptly notify B – UHP's Network Provider Department, at BUHPPProviderNotifications@bannerhealth.com, of any changes that would impact the accuracy of the provider directory. Notice is required for changes in telephone number, fax number, email address, service changes, staff changes, service capacity changes or ability to accept new referrals required to be submitted three working days prior to the change.

Members may access services by directly contacting the Health Plan contracted behavioral health provider. The Health Plan contracted behavioral health providers are identified on the Health Plan website. Members may also call the **Health Plan Customer Care Department** at 1-800- 582-8686, 24 hours a day/7 day a week, and receive a referral to a contracted behavioral health provider.

Choice of Providers

The Health Plan offers members a choice in selecting providers, and providers are required to provide each member a choice in selecting a provider of services, provider agency, and direct care staff. Providers are required to allow members to exercise their right to services from an alternative In-Network provider and offer each member access to the most convenient In Network service location for the service requested by the member.

Referral to a provider for a second opinion

Members are entitled to a second opinion and providers are required to provide proof that each member is informed of the right to a second opinion. Upon member's request or at the request of the provider's treating physician, the provider must make available a second opinion from a health care professional within the network or arrange for the member to obtain one outside the network, at no cost to the member. Out-of-Network providers must have an active AHCCCS Provider Registration number to be approved.

Submit requests for out-of-network services via fax to the **Health Plan Prior Authorization Department** at 520-694-0599 for review and processing, or the behavioral health provider can arrange for a second opinion in-network or can contact **B – UHP Customer Care** at 1-800-582-8686 8:00 a.m. – 5:00 p.m. Monday – Friday, for assistance.

Accepting referrals

1. Health Plan Contracted providers are required to accept referrals for services 24 hours a day, seven days a week.
2. Timely triage and processing of referrals must not be delayed due to missing or incomplete information.
3. When psychotropic medications are a part of a member's treatment or have been identified as a need by the referral source, Contracted Health Plan provider must ensure referrals meet the time requirements
4. When a Serious Mental Illness (SMI) eligibility determination is being requested as part of the referral or by the member directly, the Health Plan provider must ensure an eligibility assessment is conducted. The SMI eligibility assessment, and pending determination, must not delay behavioral health service delivery to the member, regardless of Title XIX or Title XXI eligibility as funding allows.

The following information shall be collected from referral sources

- Date and time of referral;
- Information about the referral source including name, telephone number, fax number, affiliated agency, and relationship to the member being referred;
- Name of member being referred, address, telephone number, gender, age, date of birth and, when applicable, name and telephone number of parent or legal guardian;
- Whether or not the member, parent or legal guardian is aware of the referral;
- Special needs for assistance due to impaired mobility, visual/hearing impairments or developmental or cognitive impairment;
- Accommodations due to cultural uniqueness and/or the need for interpreter services;
- Information regarding payment source i.e., Banner – University Family Care/ACC, University Family Care, Banner – University Care Advantage, other Medicare Plan, private insurance, or self-pay.
- Name, telephone number and fax number of primary care provider (PCP);
- Reason for referral including identification of any potential risk factors such as recent hospitalization, evidence of suicidal or homicidal thoughts, pregnancy, and current supply of prescribed psychotropic medications; and
- The names and telephone numbers of individuals the member, parent or guardian may wish to invite to the initial appointment with the referred member.

Providers should act on a referral regardless of how much information you have. While the information listed above will facilitate evaluating the urgency and type of practitioner the member may need to see, timely triage and processing of referrals must not be delayed because of missing or incomplete information.

When psychotropic medications are a part of an enrolled member's treatment or have been identified as a need by the referral source, providers must respond as outlined in the Appointment Standards and Timeliness of Service section of this manual.

In situations in which the member seeking services or his/her family member, legal guardian or significant other contacts a provider directly about accessing services, the Health Plan contracted provider shall ensure that the protocol used to obtain the necessary information about the member seeking services is engaging and welcoming.

When a SMI eligibility determination is being requested as part of the referral or by the member directly, the Health Plan contracted providers must conduct an eligibility evaluation for SMI and submit the evaluation to the Determining Entity.

Responding to referrals

Follow-Up

When a request for services is initiated but the member does not appear for the initial appointment, the Health Plan contracted provider must attempt to contact the member and implement engagement activities consistent with Outreach, Engagement, Re- engagement and Closure of this manual.

Documenting and tracking referrals

Providers must ensure referrals for behavioral health services tracking and include at a minimum the following information:

- Member's name and, if available, AHCCCS identification number;
- Name and affiliation of referral source;
- Date of birth;
- Type of referral (immediate, urgent, routine) as defined in Appointment Standards and Timeliness of Service;
- Date and time the referral was received;
- If applicable, date and location of first available appointment and, if different, date and location of actual scheduled appointment; and
- Final disposition of the referral

Final Dispositions

Within 30 days of receiving the intake evaluation, or if the member declines behavioral health services, the Health Plan contracted provider shall document and ensure notification regarding the final disposition to the referring entity or individual, with appropriate release of information signed by the member, as applicable including but not limited to,

- a. Health Plan Behavioral Health Care Management Department
- b. Primary Care Provider
- c. Arizona Department of Child Safety and adoption subsidy
- d. Arizona Department of Economic Security/ Division of Developmental Disabilities
- e. Arizona Department of Corrections
- f. Arizona Department of Juvenile Corrections

- g. Administrative Offices of the Court
- h. Arizona Department of Economic Security/Rehabilitation Services
- i. Arizona Department of Education and affiliated school districts.

The final disposition must include:

- The date the member was seen for an assessment and the name and contact information of the provider who will assume primary responsibility for the member's behavioral health care, or
- If no services will be provided, the reason why. Authorization to release the information will be obtained prior to communicating the final disposition to the referral sources referenced above.

Intake

Contracted Health Plan providers are required to respond to referrals regarding members admitted to a hospital for psychiatric reasons or when requested by the Health Plan staff. Contracted Health Plan providers must attempt to conduct a face to face intake evaluation with the member prior to discharge from the hospital.

The intake process must:

Be flexible in terms of when and how the intake occurs. For example, to best meet the needs of the member seeking services, an initial interview might be conducted over the telephone prior to the visit and the provider should make use of readily available information (e.g., referral form, AHCCCS eligibility screens) in order to minimize any duplication in the information solicited from the member and his/her family.

The intake process must not delay the initiation of needed behavioral health covered services.

During the intake, the provider will collect, review and disseminate certain information to members seeking services. Examples can include:

- The collection of contact information, insurance information,
- The reason why the member is seeking services and information on any accommodations the member may require to effectively participate in treatment services (i.e., need for oral interpretation or sign language services, consent forms in large font, etc.);
- The collection of required demographic information and completion of client demographic information sheet, including the member's primary/preferred language.
- The completion of any applicable authorizations for the release of information to other parties,
- The dissemination of a Member Handbook to the member or member's representative,
- The review and completion of a general consent to treatment,
- The collection of financial information, including the identification of third-party payers and information necessary to screen and apply for Title XIX/XXI eligibility,
- Advising (ALTCS) members with an SMI designation if they are found to be Non-Title XIX/XXI they may be assessed a copayment,
- The review and dissemination of the Health Plan Notice of Privacy Practices (NPP) and the AHCCCS HIPAA Notice of Privacy Practices (NPP) located at <https://www.azahcccs.gov/Members/Downloads/privacy/PrivacyLetter-Eng.pdf> compliance with 45 CFR 164.520 (c)(1)(B); and
- The review of the member's rights and responsibilities, including an explanation of the Title XIX/XXI-member grievance and appeal process, if applicable. The member and/or the member's legal guardian/family member, advocate, and/or person providing special assistance, may complete some of the paperwork associated with the intake evaluation, if acceptable to the member and/or the member's

legal guardian/family members, advocate, and/or person providing special assistance.

Health Plan contracted providers conducting intake interviews must be appropriately trained and must approach the member and family in a strength-based manner and possess a clear understanding of the information that needs to be collected.

ELIGIBILITY SCREENING

1. Persons who are not already determined eligible for Title XIX/XXI must be screened at the time of the intake interview for Title XIX/XXI eligibility.
2. The individual conducting the intake interview must request the supporting documentation listed below and explain to the applicant supporting documentation will only be used for the purpose of assisting in applying for Title XIX/XXI benefits through AHCCCS.
 - a. Verification of gross family income for the last month and current month (e.g., pay check stubs, social security award letter, retirement pension letter),
 - b. For those who have other health insurance, bring the corresponding health insurance card (e.g., Medicare card),
 - c. For all applicants, documentation to prove United States citizenship or immigration status and identity in accordance with AHCCCS Eligibility Policy and Procedure Manual,
 - d. For those who pay for dependent care (e.g., adult or child daycare), proof of the amount paid for the dependent care, and
 - e. Verification of out-of-pocket medical expenses.

Behavioral Health Provider Requirements for Assisting Individuals with Eligibility Verification and Screening/Application for Public Health Benefits

Behavioral health providers are required to assist individuals with applying for Arizona Public Programs (Title XIX/XXI, Medicare Savings Programs, Nutrition Assistance, and Cash Assistance), and Medicare Prescription Drug Program (Medicare Part D), including the Medicare Part D “Extra Help with Medicare Prescription Drug Plan Costs” low income subsidy program, as well as verification of U.S. citizenship/lawful presence prior to receiving Non-Title XIX/XXI covered behavioral health services, at the time of intake for behavioral health services.

Refer also to this policy section regarding documentation that may be needed during the behavioral health referral and intake process.

Eligibility status is essential for identification of the types of behavioral health services an individual may be able to access.

For individuals who are not currently Title XIX/XXI eligible, a financial and eligibility screening and application shall be completed to determine eligibility. Verification of an individual’s identification and citizenship/lawful presence in the United States is completed through the AHCCCS Health-e-Arizona PLUS (HEAPlus) application process. Behavioral health providers are required to assist individuals in completing this screening and verification processes.

An individual who is not eligible for Title XIX/XXI covered services may still be eligible for Non-Title XIX/XXI services including services through the Substance Abuse Block Grant (SABG), the Mental Health Block Grant (MHBG), or the Projects for Assistance in Transition from Homelessness (PATH) Program. See this manual section on accessing Non-TXIX nondiscretionary federal grants and the delivery of behavioral health services. An individual may also be covered under another health insurance plan, including Medicare. Individuals who do not have any insurance or entitlement status may be asked to pay a percentage of the cost of services.

If the individual is in need of emergency services, the individual may begin to receive these services immediately provided that within five days from the date of service a financial screening is initiated.

Individuals presenting for and receiving crisis services are not required to provide documentation of Title XIX/XXI

eligibility nor are they required to verify U.S. citizenship/lawful presence prior to or in order to receive crisis services.

Medicare eligible individuals, including individuals who are eligible for Medicare and Medicaid (Dual Eligible(s)) are eligible for the Medicare Part D prescription drug benefit. The benefit also provides for Part D Extra Help for eligible individuals whose income and resources are limited. Dual Eligible individuals are automatically eligible for the Part D Extra H Help due to their Medicaid eligibility.

Coverage for Medicare Part D is provided by private prescription drug plans (PDPs) that offer drug-only coverage, or through Medicare Advantage health plans that offer both prescription drug and health care coverage (known as MA-PDs). Behavioral health providers are required to assist individuals in completing enrollment in Medicare Part D and with the Part D Extra Help application.

Title XIX/XXI Eligibility Verification and Screening/Application Process

Verify the individual's current Title XIX/XXI eligibility status. The following verification processes are available 24 hours a day, 7 days a week: a. AHCCCS web-based verification (Customer Support 602-417-4451) This web site allows the providers to verify eligibility and enrollment. To use the web site, providers shall create an account before using the applications. To create an account, go to: <https://azweb.statemedicaid.us/Home.asp> and follow the prompts. Once the providers have an account they can view eligibility and claim information (claim information is limited to FFS). Batch transactions are also available. There is no charge to providers to create an account or view transactions. For technical Web-based issues, contact AHCCCS Customer Support at 602-417-4451, Monday – Friday 7:00 a.m. to 5:00 p.m.

- When providers use the web-based member verification system and enter a member's social security number, the member's photo, if available from the Arizona Department of Motor Vehicles (DMV), will be displayed on the AHCCCS eligibility verification screen along with other AHCCCS coverage information. The photo image assists providers to quickly validate the identity of a member.
- Interactive Voice Response (IVR) system IVR allows unlimited verification information by entering the AHCCCS member's identification number on a touch-tone telephone. This allows providers access to the AHCCCS Prepaid Medical Management Information System (PMMIS) for up-to-date eligibility and enrollment. Providers may also request a faxed copy of eligibility for their records. There is no charge for this service. Providers may call IVR within Maricopa County at (602) 417-7200 and all other counties at 1-800-331-5090,
- Medifax -Medifax allows providers to use a PC or terminal to access PMMIS for up-to date eligibility and enrollment information. For information on Eligibility Verification Screening (EVS), contact Emdeon at 1-800-444-4336,
- If an individual's Title XIX/XXI eligibility status cannot be determined using one of the above methods the provider shall:
 - Call the B – UHP Customer Care for assistance during normal business hours (8:00 am through 5:00 pm, Monday-Friday), or
 - Call the AHCCCS Verification Unit, which is open Monday through Friday, from 8:00 a.m. to 5:00 p.m. The Unit is closed Saturdays and Sundays and on state holidays. Callers from outside Maricopa County can call 1-800-962- 6690 or call (602) 417-7000 in Maricopa County.
- When calling the AHCCCS Verification Unit, the provider shall be prepared to provide the verification unit operator the following information:
 - Provider identification number,
 - The individual's name, date of birth, AHCCCS identification number and social security number (if known), and
 - Dates of service(s).

Interpret eligibility information.

- A provider will access the AHCCCS Codes and Values (CV) 13 Reference System when using the eligibility verification methods described above. This includes a key code index that may be used by providers to interpret AHCCCS' eligibility key codes and/or AHCCCS rate codes,
- For information on the eligibility key codes and AHCCCS rate codes refer to the AHCCCS Reference Subsystem Codes and Values on the AHCCCS website, and
- If Title XIX/XXI eligibility status and provider responsibility is confirmed, the provider shall provide any needed covered behavioral health services in accordance with the AMPM and AHCCCS Covered Behavioral Health Services Guide.
- For individuals who are not identified as Title XIX/XXI eligible, providers shall assist individuals with the AHCCCS screening/application process for Title XIX/XXI or other Public Program eligibility through HEAPlus at the following times:
 - Upon initial request for behavioral health services,
 - At least annually, if still receiving behavioral health services, and
 - When significant changes occur in the individual's financial status.
- To conduct the AHCCCS screening/application for Title XIX/XXI or other Public Program eligibility through HEAPlus, behavioral health providers shall meet with the individual and complete the AHCCCS HEAPlus online application. Once completed, HEAPlus will indicate if the individual is potentially Title XXI/XXI eligible.
 - To the extent that it is practicable, the provider is expected to assist applicants in obtaining the required documentation of identification and U.S. citizenship/lawful presence within the timeframes indicated by HEAPlus,
 - For information regarding what documents are required in order to verify proof of U.S. citizenship/lawful presence refer to Arizona's Eligibility Policy Manual for Medical, Nutrition, and Cash Assistance Manual Chapter 500, Policy 507 and Policy 524,
 - Documentation of Title XIX/XXI and other Public Program eligibility screening/application shall be included in the individual's medical record including the Application Summary and final Determination of eligibility status notification printed from HEAPlus,
 - Pending the outcome of the Title XIX/XXI or other Public Program eligibility determination via HEAPlus the individual is eligible for covered Non-Title XIX/XXI services in accordance with the AHCCCS Covered Behavioral Health Services Guide and the AHCCCS Medical Policy Policy 320-T.
 - Upon the final processing of a Title XIX/XXI and other Public Program screening/application, if the individual is determined ineligible for Title XIX/XXI or other Public Program benefits, regardless of verification of US Citizenship/Lawful Presence, the individual is eligible for covered Non-Title XIX/XXI services in accordance with the AHCCCS Covered Behavioral Health Services Guide
 - An individual found not to be eligible for Title XIX/XXI or other Public Program benefits may submit the application for review by AHCCCS and/or DES. Additional information requested and verified by AHCCCS and/or DES may result in the individual subsequently receiving Title XIX/XXI or other Public Program.

Medicare Part D Enrollment and Extra Help Application

Behavioral health providers shall offer and provide assistance to Medicare-eligible individual with completing Medicare Part D enrollment and the Extra Help application as outlined below.

Medicare Part D Enrollment

- If an individual is unsure of his/her Medicare eligibility, the provider, with the individual's permission and needed personal information, may verify Medicare eligibility by calling 1-800-MEDICARE (1-800-633-4227),
- The Centers for Medicare and Medicaid Services (CMS) has developed web tools to assist with choosing a Medicare Part D plan that best meets the individual's needs. The web tools can be accessed at www.medicare.gov,
- For additional information regarding Medicare Part D Prescription Drug coverage, call Medicare at 1-800-633-4227 or Arizona's State Health Insurance Assistance Program (SHIP) at 602-542-4446 or toll free at 1-800-432-4040.

Applying for the Extra Help Subsidy

Medicare Part D Extra Help is a program in which the federal government pays all or a portion of the cost sharing requirements of Medicare Part D on behalf of the individual (42 CFR Part 422 and 42 CFR Part 423).

- The provider shall determine if an individual may be eligible for Part D Extra Help. Refer to the Social Security Administration (SSA) website at www.ssa.gov for qualifying income and resource limits,
- Dual Eligible members meeting the following conditions automatically qualify for Extra Help: a) Have full Medicaid coverage, b) AHCCCS pays Part B premiums (in a Medicare Savings Program), and c) Receive Supplemental Security Income (SSI) benefits.
- Once Part D eligibility is determined, the provider shall offer assistance with completing the Part D Extra Help application,
- The Part D Extra Help application can be obtained and submitted through the following means:
 - On-line at: <https://secure.ssa.gov/apps6z/i1020/main.html>,
 - By calling the SSA at 1-800-772-1213,
 - In person at a SSA local office, or
 - By mailing a paper application (Form SSA-1020) to the SSA.

Refusal To Participate In The Screening/Application Process

1. Arizona state law stipulates that individuals who refuse to participate in the AHCCCS screening/application process or to enroll in a Medicare Part D plan are ineligible for state funded behavioral health services. See A.R.S. §36-3408. As such, individuals who refuse to participate in the AHCCCS screening/application or enrollment in Medicare Part D, if eligible, will not be assigned a Contractor during his/her initial request for services, or will be un-assigned if the individual refuses to participate during an annual screening.
2. When an individual declines to participate in the AHCCCS screening/application process or refuses to enroll in a Medicare Part D plan, the provider shall actively encourage the individual to participate in the AHCCCS screening/application process
3. The following conditions do not constitute an individual's refusal to participate:
 - a. An individual's inability to obtain documentation required for the eligibility determination, and/or
 - b. An individual is incapable of participating as a result of their mental illness and does not have a legal guardian.
4. If an individual refuses to participate in the AHCCCS screening/application process, or to enroll in a Medicare Part D plan, the provider shall:
 - a. Request that the individual sign Decline to Participate Attachment, and
 - b. Document the refusal to sign in the individual's medical record.

5. Special considerations for individuals designated as SMI:
 - a. If the individual is unwilling to complete the AHCCCS screening/application process or to enroll in a Medicare Part D plan, and does not meet the conditions above, the provider shall request a clinical consultation by a Behavioral Health Medical Professional,
 - b. If, following the clinical consultation, the individual continues to refuse to participate, the provider shall request that the individual sign Decline to Participate Attachment.
6. Prior to the termination of behavioral health services for individuals who have been receiving behavioral health services and subsequently decline to participate in the AHCCCS screening/application process, or to enroll in a Medicare Part D plan, the Contractor shall provide written notification to the member of the intended termination as required by Contract.
7. For all individuals who refuse to cooperate with the AHCCCS screening/ application process, the provider shall inform the individual who they can contact in the behavioral health system for an appointment if the individual chooses to participate in the AHCCCS screening/application process in the future.

Outreach, Engagement, Re-Engagement, and Closure for Behavioral Health Members

The activities described within this section are an essential element of clinical practice. Outreach to vulnerable populations, establishing an inviting and non-threatening clinical environment, and re-establishing contact with members who have become temporarily disconnected from services are critical to the success of any therapeutic relationship.

This section addresses critical activities that the Health Plan contracted providers must incorporate when delivering services:

1. Expectations for the engagement of members seeking or receiving services;
2. Procedures to re-engage members in care who have withdrawn from participation in the treatment process;
3. Conditions necessary to end care for a member receiving behavioral health services and
4. Expectations for serving members who are attempting to re-engage with behavioral health services.

Community Outreach

Outreach activities conducted by the Health Plan and the Health Plan contracted behavioral health providers may include, but are not limited to:

- Participation in community events, local health fairs or health promotion activities;
- Involvement with local schools;
- Involvement with outreach activities for military veterans, such as Arizona Veterans Stand Down Coalition Events,
- Outreach programs and activities for first responders (i.e. police, fire, EMT)
- Routine contact with the Health Plan's behavioral health care management and/or primary care providers;
- Development of outreach programs to members experiencing homelessness;
- Development of outreach programs to members who are at risk, are identified as a group with high incidence or prevalence of behavioral health issues or are underserved;
- Publication and distribution of informational materials;
- Liaison activities with local, county and tribal jails, county detention facilities, and local and county Department of Child Safety Offices and programs

- Regular interaction with agencies that have contact with pregnant women/teenagers who have a substance use disorder,
- Development and implementation of outreach programs that identify members with co- morbid medical and behavioral health disorders, including those who could be determined or have been determined to have a Serious Mental Illness within the Health Plan's geographic service area, including members who reside in jails, homeless shelters, county detention facilities or other settings;
- Provision of information to mental health advocacy organizations; and
- Development of information of outreach programs to American Indian tribes in Arizona to provide services for tribal members.

Engagement

The Health Plan contracted providers are required to actively engage the following in the treatment planning process:

- The member and/or member's legal guardian;
- The member's family/significant others, if applicable and amenable to the member
- Other agencies/providers as applicable; and
- For any member with a SMI (ALTCS) who is receiving Special Assistance, the person (guardian, family member, advocate or other) designated to provide Special Assistance.

Re- Engagement

The Health Plan contracted providers are required to ensure re-engagement attempts are made with members who have withdrawn from participation in the treatment process prior to the successful completion of treatment, refused services or failed to appear for a scheduled service based on a clinical assessment of need. All attempts to re-engage members must be documented in the comprehensive clinical record. The Health Plan contracted provider must attempt to re-engage the member by:

- Communicating in the member's preferred language.
- Contacting the member or the member's legal guardian by telephone at times when the member may reasonably be expected to be available (e.g., after work or school)
- When possible, contacting the member or the member's legal guardian face to face if telephone contact insufficient to locate the member or determine acuity and risk.
- Sending a letter to the current or most recent address requesting contact. If all attempts at personal contact are unsuccessful, except when a letter is contraindicated due to safety concerns (e.g. domestic violence) or confidentiality issues. The Health Plan provider will note safety or confidentiality concerns in the progress notes section of the clinical record and include a copy of the letter sent in the comprehensive clinical record, and
- For members determined to have a SMI who are receiving Special Assistance, contacting the person designated to provide Special Assistance for his/her involvement in re-engagement efforts.

If the above activities are unsuccessful, the Health Plan contracted providers are expected to ensure further attempts are made to re-engage the following populations: persons determined to have a SMI, children, pregnant substance abusing women/teenagers, and any person determined to be at risk of relapse, decompensation, deterioration or a potential harm to self or others. Further attempts shall include at a minimum: contacting the member or member's legal guardian face to face and contacting natural supports for whom the member as given permission to the Health Plan provider to contact. All attempts to re-engage these members must be clearly documented in the comprehensive clinical record.

If face to face contact with the member is successful and the member appears to be a danger to self, danger to others, persistently and acutely disabled or gravely disabled, the Health Plan provider must determine whether it is appropriate to engage the member to seek inpatient care voluntarily. If the member declines voluntary admission, the Health Plan contracted provider must initiate the pre-petition screening or petition for treatment process.

Follow-Up after Significant and/or Critical Events

The Health Plan contracted provider is required to ensure activities are documented in the clinical record and follow-up activities are conducted to maintain engagement within the following timeframes:

- Discharged from inpatient services, in accordance with the discharge plan and within seven days of the member's release to ensure member stabilization, medication adherence and to avoid re-hospitalization,
- Involved in a behavioral health crisis within timeframes based upon the member's clinical needs, but no later than seven days,
- Refusing prescribed psychotropic medications within timeframes based upon the member's clinical needs and individual history, and
- Changes in the level of care.

Determining Serious Mental Illness (SMI)

A critical component of the service delivery system is the effective and efficient identification of members who have special behavioral health needs due to the severity of their behavioral health disorder. One such group is members with Serious Mental Illness (SMI). Without receipt of the appropriate care, these members are at high risk for further deterioration of their physical and mental condition, increased hospitalizations, potential homelessness and incarceration.

In order to ensure that B – UHP members who are eligible for SMI services are promptly identified and enrolled for services, AHCCCS requires that all SMI determinations to be determined by a statewide contractor, referred to as the Determining Entity. The Determining Entity for the service areas covered by the Health Plan is Crisis Response Network (CRN). CRN has adopted the process that Regional Behavioral Health Authorities (RBHAs) use for referral, evaluation and determination for SMI eligibility.

Health Plan Behavioral Health Contracted Provider Responsibilities

The process to determine a member to be eligible for SMI services starts with the member's behavioral health provider, or an assessment completed by a behavioral health provider (for example, if a member is hospitalized and is not engaged in outpatient services.)

All SMI evaluations must be completed by a qualified assessor. If the qualified assessor is a Behavioral Health Technician then the evaluation must be reviewed, approved, and signed by a Behavioral Health Professional. If a B – UHP contracted provider does not have the staff capacity to conduct an SMI evaluation, please contact the Health Plan for a referral to a Health Plan contracted provider that can perform this evaluation.

All members must be evaluated for SMI eligibility by a qualified assessor, and have a SMI determination made by Crisis Response Network: if the member:

- Requests a SMI determination; or
- Has a qualifying SMI diagnosis as indicated by the following (Also see AMPM 320- P- attachment B, Serious Mental Illness Diagnosis):
 - Psychotic Disorders (F20.0, F20.1, F20.2, F20.3, F20.5, F20.9, F21, F22, F25.0, F25.1, F25.8, F25.9, F28, F29);
 - Bipolar Disorders (F31.0, F31.1, F31.10, F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.81, F31.89, F31.9, F34.0);

- Obsessive-Compulsive Disorder (F42.2, F42.8, F42.9);
- Depressive Disorder (F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.89, F32.9, F33.0, F33.1, F33.2, F33.3, F33.4, F33.40, F33.41, F33.42, F33.9, F34.1);
- Other Mood Disorders (F39);
- Anxiety Disorders (F40.00, F40.01, F40.02, F41.0, F41.1, F41.8, F41.9);
- Post Traumatic Stress Disorder (F43.10, F43.11, F43.12);
- Dissociative Disorder (F44.81)
- Personality Disorders (F60.0, F60.1, F60.3, F60.4, F60.5, F60.6, F60.7, F60.81, F60.89, F60.9)

Process for completion of the initial SMI evaluation

Upon receipt of a referral for, a request, or identification of the need for an SMI determination, a provider designee, or designated Department of Corrections (DOC) staff member will schedule an appointment for an initial meeting with the member and a qualified assessor. This shall occur no later than 7 days after receiving the request or referral. For referrals seeking an SMI eligibility determination for individuals admitted to a hospital for psychiatric reasons, the entity scheduling the evaluation shall ensure that documented efforts are made to schedule a face to face SMI assessment with the member while hospitalized. This includes members at least the age of 17.5 years old.

During the initial meeting with the member by a qualified assessor, the assessor must:

- Make a clinical assessment whether the member is competent enough to participate in an assessment;
- Obtain general consent from the member or, if applicable, the member's guardian to conduct an assessment;
- Provide to the member and, if applicable, the member's guardian, the information required in R9-21-301(D)(2), a client rights brochure, and the appeal notice required by R9-21-401(B); and
- Obtain authorization for the release of information, if applicable, for any documentation that would assist in the determination of the person's eligibility for SMI services.
- Conduct an assessment if one has not been completed within the last six months
- Complete the SMI Determination form found on the AHCCCS website under the AHCCCS Medical Policy Manual - AMPM 320-P attachment A, Serious Mental Illness Determination or Crisis Response Network website
- Upon completion of the initial evaluation, submit all information to the Determining Entity within one business day.
- If, during the initial meeting with the member, the assessor is unable to obtain sufficient information to determine whether the applicant is SMI, the assessor must:
- Request the additional information in order to make a determination of whether the member is SMI and obtain an authorization for the release of information.

Criteria for SMI eligibility

The final determination of SMI requires both a qualifying SMI diagnosis and functional impairment as a result of the qualifying diagnosis (see above for a list of qualifying diagnoses).

Functional Criteria for SMI eligibility

- To meet the functional criteria for SMI status, a member must have, as a result of a qualifying SMI diagnosis, dysfunction in at least one of the following four domains, as described below, for most of the past twelve (12) months or for most of the past six (6) months with an expected continued duration of at

least six (6) months:

- Inability to live in an independent or family setting without supervision – Neglect or disruption of ability to attend to basic needs. Needs assistance in caring for self. Unable to care for self in safe or sanitary manner. Housing, food and clothing must be provided or arranged for by others. Unable to attend to the majority of basic needs of hygiene, grooming, nutrition, medical and dental care. Unwilling to seek prenatal care or necessary medical/dental care for serious medical or dental conditions. Refuses treatment for life threatening illnesses because of behavioral health disorder.
- A risk of serious harm to self or others – Seriously disruptive to family and/or community. Pervasively or imminently dangerous to self or others' bodily safety. Regularly engages in assaultive behavior. Has been arrested, incarcerated, hospitalized or at risk of confinement because of dangerous behavior. Persistently neglectful or abusive towards others in the member's care. Severe disruption of daily life due to frequent thoughts of death, suicide, or self-harm, often with behavioral intent and/or plan. Affective disruption causes significant damage to the member's education, livelihood, career, or member relationships.
- Dysfunction in role performance – Frequently disruptive or in trouble at work or at school. Frequently terminated from work or suspended/expelled from school. Major disruption of role functioning. Requires structured or supervised work or school setting. Performance significantly below expectation for cognitive/ developmental level. Unable to work, attend school, or meet other developmentally appropriate responsibilities; or
- Risk of Deterioration – A qualifying diagnosis with probable chronic, relapsing and remitting course. Co-morbidities (like mental retardation, substance dependence, personality disorders, etc.). Persistent or chronic factors such as social isolation, poverty, extreme chronic stressors (life-threatening or debilitating medical illnesses, victimization, etc.). Other (past psychiatric history; gains in functioning have not solidified or are a result of current compliance only; court-committed; care is complicated and requires multiple providers; etc.).

The following reasons shall not be sufficient in and of themselves for denial of SMI eligibility:

- An inability to obtain existing records or information; or
- Lack of a face-to-face psychiatric or psychological evaluation.

For members who have a qualifying SMI diagnosis and co-occurring substance abuse, for purposes of SMI determination, presumption of functional impairment is as follows:

- For psychotic diagnoses (bipolar I disorder with psychotic features, delusional disorder, major depression, recurrent, severe, with psychotic features, schizophrenia, schizoaffective disorder and psychotic disorder NOS) functional impairment is presumed to be due to the qualifying psychiatric diagnosis;
- For other major mental disorders (bipolar disorders, major depression and obsessive-compulsive disorder), functional impairment is presumed to be due to the psychiatric diagnosis, unless:
 - The severity, frequency, duration or characteristics of symptoms contributing to the functional impairment cannot be attributed to the qualifying mental health diagnosis; or
 - The assessor can demonstrate, based on a historical or prospective period of treatment, that the functional impairment is present only when the member is abusing substances or experiencing symptoms of withdrawal from substances.
- For all other mental disorders not covered above, functional impairment is presumed to be due to the co-occurring substance use unless:
 - The symptoms contributing to the functional impairment cannot be attributed to the substance abuse disorder
 - The functional impairment is present during a period of cessation of the co- occurring substance

use of at least thirty (30) days; or

- The functional impairment is present during a period of at least ninety (90) days of reduced use and is unlikely to cause the symptoms or level of dysfunction.

Once the SMI Evaluation has been completed, the behavioral health provider must submit the SMI evaluation and accompanying documents to the Crisis Response Network via the Provider Submission Portal (PSP) located at <http://www.crisisnetwork.org/smi/>.

CRN can be contacted at 1-800-631-1314 or (TTY) 1-800-327-9254.

The following documents, at a minimum, must be included in the SMI evaluation packet submitted to CRN:

- Consent for Assessment – signed and dated within one business day of submission of SMI application to CRN.
- Seriously Mentally Ill (SMI) Determination Form – Part C Additional Addenda of the Core Assessment, signed by a licensed clinician
- Core Assessment – dated within six months of SMI application submission
- Demographic Form
- Releases of Information – allowing contact with the member's emergency contact, and prior inpatient and outpatient care providers.
- Waiver of the Three-Day Determination Form

The most up to date versions of these forms can be obtained at

<http://www.crisisnetwork.org/smi/provider/#forms>.

Crisis Response Network Responsibilities

The SMI eligibility determination record must include all of the documentation that was considered during the review including, but not limited to current and/or historical treatment records. The record may be maintained in either hardcopy or electronic format.

Computation of time is as follows:

- Evaluation date with a qualified clinician = day zero (0), regardless of time of the evaluation
- Determination due date = Three (3) business days from day zero (0), excluding weekends and holidays
- The final determination is required three (3) business days from day 0, not 3 business days from the date of submission to the Crisis Response Network (CRN).

Contractors with the Health Plan must submit the SMI evaluation to CRN as soon as practicable, but no later than 11:59 p.m. on the next business day following the evaluation. CRN will have at least two (2) business days to complete the SMI determination.

Process for completion of final SMI determination

A licensed psychiatrist, psychologist, or psychiatric nurse practitioner designated by the CRN must make a final determination as to whether the member meets the eligibility requirements for SMI status based on:

- A face-to-face assessment or reviewing a face-to-face assessment by a qualified assessor: and
- A review of current and historical information, if any, obtained orally or in writing by the assessor from collateral sources, and/or present or previous treating clinicians.

The following must occur if the designated reviewing psychiatrist, psychologist, or psychiatric nurse practitioner has not conducted a face-to-face assessment and has a disagreement with the qualified assessor and/or the treating Behavioral Health Professional that cannot be resolved by oral or written communication:

- Disagreement regarding diagnosis: Determination that the member does not meet eligibility requirements for SMI status must be based on a face to face diagnostic evaluation conducted by a designated psychiatrist, psychologist, or nurse practitioner. The resolution of (specific reasons for) the disagreement shall be documented in the member's comprehensive medical record.
- Disagreement regarding functional impairment: Determination that the member does not meet eligibility requirements must be based upon a face-to-face functional evaluation conducted by a designated psychiatrist, psychologist, or nurse practitioner. The psychiatrist, psychologist, or nurse practitioner shall document the specific reason(s) for the disagreement in the member's medical record.

If there is sufficient information to determine SMI eligibility, the member shall be mailed written notice of the SMI eligibility determination within three (3) business days of the initial meeting with the qualified assessor in accordance with the next section of this policy.

Issues preventing timely completion of SMI eligibility determination

The time to initiate or complete the SMI eligibility determination may be extended no more than 20 days if the member agrees to the extension and:

- There is substantial difficulty in scheduling a meeting at which all necessary participants can attend;
- The member fails to keep an appointment for assessment, evaluation or any other necessary meeting
- The member is capable of, but temporarily refuses to cooperate in the preparation of the completion of an assessment or evaluation;
- The member or the member's guardian and/or designated representative requests an extension of time;
- Additional documentation has been requested, but has not yet been received; or
- There is insufficient functional or diagnostic information¹ to determine SMI eligibility within the required time periods.

The Crisis Response Network must:

- Document the reasons for the delay in the member's eligibility determination record when there is an administrative or other emergency that will delay the determination of SMI status; and
- Not use the delay as a waiting period before determining SMI status or as a reason for determining that the member does not meet the criteria for SMI eligibility (because the determination was not made within the time standards).

In situations in which the extension is due to insufficient information:

- CRN shall request and obtain the additional documentation needed (e.g., current and/or past medical records) and/or perform or obtain any necessary psychiatric or psychological evaluations;
- The designated reviewing psychiatrist, psychologist, or nurse practitioner for CRN must communicate with the person's current treating clinician, or appropriate clinical team member if any, prior to the determination of SMI, if there is insufficient information to determine the person's level of functioning; and
- SMI eligibility must be determined within three (3) days of obtaining sufficient information, but no later than the end date of the extension.

If the member refuses to grant an extension, SMI eligibility must be determined based on the available information. If SMI eligibility is denied, the member will be notified of his/her appeal rights and the option to reapply. If the evaluation or information cannot be obtained within the required time period because of the need for a period of observation or abstinence from substance use in order to establish a qualifying mental health diagnosis, the member shall be notified that the determination may, with the agreement of the member, be extended for up to 90 (calendar) days.

Notification of SMI eligibility determination

If the eligibility determination results in approval of SMI status, CRN must report to the member in writing, including notice of his/her right to appeal the decision.

If the eligibility determination results in a denial of SMI status, CRN shall include in the notice above:

- The reason for denial of SMI eligibility
- The right to appeal
- The statement that Title XIX/XXI eligible members will continue to receive needed Title XIX/XXI covered services.

Review of SMI Eligibility

Behavioral health providers may seek a review of a person's SMI eligibility from the Determining Entity:

- As part of an instituted, periodic review of all persons determined to have a SMI,
- When there has been a clinical assessment that supports that the person no longer meets the functional and/or diagnostic criteria, or
- As requested by a member who has been determined to meet SMI eligibility criteria, or their legally authorized representative.

SMI Decertification

There are two established methods for removing a SMI designation, one clinical and the other an administrative option, as follows:

- **SMI Clinical Decertification:** A member who has a SMI designation or an individual from the member's clinical team may request a SMI Clinical Decertification. A SMI Clinical Decertification is a determination that a member who has a SMI designation no longer meets SMI criteria. If, as a result of a review, the person is determined to no longer meet the diagnostic and/or functional requirements for SMI status:
 - The Determining Entity shall ensure that the written notice of determination and the right to appeal is provided to the affected person with an effective date of 30 days after the date the written notice is issued,
 - The provider must ensure that services are continued in the event an appeal is timely filed, and that services are appropriately transitioned as part of the discharge planning process.
- **SMI Administrative Decertification:** A member who has a SMI designation may request a SMI Administrative Decertification if the member has not received behavioral health services for a period of two or more years.
 - Upon receipt of a request for Administrative Decertification, the behavioral health provider shall direct the member to contact AHCCCS DHCM Customer Service,
 - AHCCCS will evaluate the member's request and review the data sources to determine the last date the member received a behavioral health service. AHCCCS will inform the member of changes that may result with the removal of the member's SMI designation. Based upon review, the following will occur:
- In the event the member has not received a behavioral health service within the previous two years, the member will be provided with the Administrative Serious Mental Illness Decertification Form AMPM 320-P-Attachment C. This form must be completed by the member and returned to AHCCCS.
- In the event the review finds that the member has received behavioral health services within the prior two-year period, the members will be notified that they may seek decertification of their SMI status through the Clinical Decertification process.

B – UFC/ACC Long Term Care Behavioral Health Contracted Provider Responsibilities

The process to determine a member to be eligible for SMI services starts with the member's behavioral health provider, or an assessment completed by a behavioral health provider (for example, if a member is hospitalized and is not engaged in outpatient services.)

All SMI evaluations must be completed by a qualified assessor. If the qualified assessor is a Behavioral Health Technician then the evaluation must be reviewed, approved, and signed by a Behavioral Health Professional.

All members must be evaluated for SMI eligibility by a qualified assessor, and have a SMI determination made by Crisis Response Network: if the member:

- Requests a SMI determination

Partnerships with Families and Family-Run Organizations in the Children's Behavioral Health System

Arizona holds a distinction in the United States for promoting various family roles within the children's behavioral health system. The involvement of families is credited as making a significant contribution in improving the service system. The following information addresses the types of roles available to families including parents/caregivers with children receiving services, when they are employed, volunteer, or compensated in other ways, such as stipends or subcontracted work, and the elements that help families become effective in these roles.

Three categories of roles for families:

- Families are encouraged to participate and are supported as active and respected members of their child's Child and Family Team (CFT). In this capacity, families drive the development and implementation of a service plan that will respond to the unique strengths and needs of the child and family;
- Families participate in various activities that influence the local, regional and State service system. This type of activity is commonly called "Family Involvement". In Arizona, families have a range of opportunities to offer their unique insight and experience to the development and implementation of programs and policies. This includes various advisory activities on Boards, committees, and policy making groups that work to improve children's services; and
- Family members work in a professional capacity in the children's behavioral health system. In this capacity, family members offer a special type of support (peer delivered) to the families and children that they serve. Further, families who work in the service system influence the system by contributing the family perspective.

B – UHP's contracted family-run organizations are expected to serve in a role of helping with the recruitment, training, and support of family members. Procedures outlined in this policy section are aimed at achieving the following outcomes:

- Increased adherence to statewide practice in accordance with the Twelve Principles for Children Service Delivery;
- Improved functional outcomes for children, youth, young adults, and families;
- Improved engagement and collaboration in service planning between children, youth, young adults, families, community providers and other child serving agencies;
- Improved identification and incorporation of strengths and cultural preferences into planning processes;
- Coordinated planning for seamless transitions; and
- A stronger partnership with families in the process of supporting their child's/youth's behavioral health needs.

Effective Family Participation in Service Planning and Service Delivery

Through the CFT process, parents/caregivers and youth are treated as full partners in the planning, delivery, and

evaluation of services and supports. Parents/caregivers and youth are an equal partner in the local, regional, tribal, and State representing the family perspective as participants in systems transformation. Providers must:

- Ensure that service planning and delivery is driven by family members, youth, and young adults;
- Approach services and view the enrolled child in the context of the family rather than isolated in the context of treatment;
- Provide culturally and linguistically relevant services that appropriately respond to a family's unique needs
- Offer family peer to peer support to families and make peer representation available to the CFT when requested;
- Provide information to families on how they can contact staff at all levels of the service system inclusive of the provider agency, B – UHP and AHCCCS at intake and throughout the CFT process; and
- Work with B – UHP to develop training in family engagement and participation, roles and partnerships for provider staff, parents/caregivers, youth and young

Responsibilities of B – UHP Integrated Care and Its Providers

Family members, youth, and young adults must be involved in all levels of the behavioral health system, whether it be serving on boards, committees and advisory councils, or as employees with meaningful roles within the system. To ensure that family members, youth, and young adults are provided with training and information to develop the skills needed, B – UHP and B – UHP contracted providers must:

- Support parents/caregivers, youth and young adults in roles that have influence and authority;
- Establish recruitment, hiring, and retention practices for family, youth, and young adults within the agency that reflect the cultures and languages of the communities served;
- Provide training for families, youth, and young adults in cultural competency;
- Assign resources to promote family, youth, and young adult involvement including committing money, space, time, personnel and supplies; and
- Demonstrate a commitment to shared decision making.

Organizational Commitment to Employment of Family Members

Providers must demonstrate commitment to employment of parents/caregivers, and young adults by:

- Providing positions for parents/caregivers and young adults that value the first-person experience;
- Providing compensation that values first-person experience commensurate with professional training;
- Establishing and maintaining a work environment that values the contribution of parents/caregivers, youth, and young adults;
- Providing supervision and guidance to support and promote professional growth and development of parent/caregivers and young adults in these roles; and
- Providing the flexibility needed to accommodate parents/family members and young adults employed in the system, without compromising expectations to fulfill assigned tasks/roles.

Provider Commitment to the Functions of Family-Run and Parent Support Organizations

Family-run and parent support organizations play a crucial role in supporting families, youth, and young adults involved in the children's behavioral health system. They are key partners in transforming Arizona's behavioral health system and are vital to the process of identifying meaningful roles and opportunities for family members, youth, and young adults to actively contribute to that transformation.

Family-run and parent support organizations not only support the current involvement and roles of family

members, youth, and young adults, but also work toward identifying and developing the next generation of community leaders. In order to demonstrate commitment to the importance and functions of family-run and parent support organizations, providers must:

- Establish partnerships with family-run and parent support organizations;
- Connect family members with family-run and parent support organizations as soon as the child is enrolled in the behavioral health system to provide information and parent peer-to-peer support;
- Model an environment that encourages and promotes the ability of family-run and parent support organizations to provide coaching, mentoring, and training to family members; and

Commitment to Family and Youth Involvement in the Children's Behavioral Health System

B – UHP's contracted behavioral health service providers will provide training and structural opportunities for family and youth input and involvement in the delivery of services to children and families. Behavioral Health Service Providers will:

- Have Family Advisory Committees that meet regularly that gathers family member feedback and ideas regarding services;
- Have a Youth Advisory Committee that meets regularly to solicit youth feedback and ideas regarding services;
- Offer opportunities for youth leadership education and activities regularly; and
- Utilize Certified Family Support Specialist services in the roles in which they are trained to deliver.

Self-help Peer and Family Support Services

Overview of Peer and Family Support Services

Peer and family support services are a vital part of member- and family-centered care. When you put a member and their family at the center of one's care, the individual's voice is strengthened, and recovery and resiliency can remain the primary focus for all involved in the care of an individual and those loved ones supporting that individual who is experiencing mental health or substance use challenges.

Peer and family support services usually compliment clinical services and supports, which enhances the benefits of treatment by engaging peers in services they might not otherwise accept, offering ongoing support and psychosocial rehabilitation, and encouraging peers to stay in treatment and services by sharing their stories of recovery.

Peer and family support services are a valuable addition to traditional care, and these services are known to contribute to improved outcomes in employment, education, housing stability, satisfaction, engagement and adherence and a sand decrease in the need for more costly services, such as hospitalizations. Peer-provided services help to foster recovery, increase treatment and service engagement, reduce acute care use, and improve quality of life.

Peer and family services are available to all MC Title 19 and Non-Title 19 members and their families within the clinic setting as well as at community-based, Peer and Family-run Organizations (PRO/FRO's). Based on member's choice and/or if peer and/or family support services is not available in the clinic where services are provided, a referral is needed prior to engaging in these community-based, PRO/FRO supportive services.

Families affect and are influenced by the recovery experiences of children, youth, and adults with mental or substance use disorders. As caregivers, navigators, and allies, family members play diverse roles and may require a variety of supports.

Families and family-run organizations are vital components of recovery-oriented service systems. Family members train and support other families—sharing lived experiences and insights that instill hope, increase understanding, and contribute to systems transformation.

Peer Support/Recovery Support Training, Certification and Supervision Requirements

Provision of Peer Support Services

AHCCCS has developed training and supervision requirements as well as certification standards for the provision of Peer and Family Support Services as described in the AHCCCS Medical Policy Manual, Chapter 900 – Quality Management and Performance Improvement Program Policy 963: Peer and Recovery Support Services Provision Requirements and Policy 964: Credentialed Parent/Family Support Requirements:

(<https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/900/963.pdf>)

(<https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/900/964.pdf>)

This applies to all providers delivering peer and/or family support employment training services for certification of individuals as Credentialed Peer Support Specialists/Recovery Support Specialists (CPRSS) or Credentialed Parent/Family Support Providers (CPFSP) within the AHCCCS public behavioral health system.

Peer and Family Support services include the provision of assistance to more effectively utilize the service delivery system (e.g. assistance in developing plans of care, identifying needs, accessing supports, partnering with professionals, overcoming service barriers); or understanding and coping with the stressors of the individual's disability (e.g. support groups, coaching, role modeling and mentoring). Individuals with lived experience and family members supporting their loved ones with behavioral health and/or substance use challenges serve an important role in the behavioral health work force. These services may be provided to an individual, group, or family, and are aimed at assisting in the creation of skills to promote long-term, sustainable recovery.

People who have achieved and sustained recovery can be a powerful influence for individuals seeking their own path to recovery (see Center for Mental Health Services (MHBG) Consumer Affairs E-News October 2, 2007, Vol. 07-158. By sharing personal experiences, peers help build a sense of hope and self-worth, community connectedness, and an improved quality of life to people in recovery.

Peer support services are supported on a statewide and national level. The Centers for Medicare and Medicaid Services (CMS) issued a letter to states, recognizing the importance of peer support services as a viable component in the treatment of mental health and substance abuse issues. In the letter, CMS provides guidance to states for establishing criteria for peer support services, including supervision, care-coordination and training/credentialing.

Peer Support Specialist/Recovery Support Specialist Qualifications

Individuals seeking to be certified and employed as PRSS must:

- Self-identify as a peer; and
- Meet the requirements to function as a behavioral health paraprofessional, behavioral health technician, or behavioral health professional.

Individuals meeting the above criteria may be certified as a PRSS by completing training and passing a competency test through an AHCCCS/Office of Individual & Family Affairs (OIFA) approved Peer Support Employment Training Program. AHCCCS/OIFA will oversee the approval of all certification materials including curriculum and testing tools.

Certification through an AHCCCS/OIFA approved Peer Support Employment Training Program is applicable statewide and Peer Support employment training is not a billable service for costs associated with training an agency's own employees.

Some agencies may wish to employ individuals prior to the completion of certification through a Peer Support Employment Training Program. However, certain trainings must be completed prior to delivering services. An individual must be certified as a Peer Support Specialist/Recovery Support Specialist or currently enrolled in an AHCCCS/OIFA approved Peer Support training program under the supervision of a qualified individual prior to billing Peer Support Services.

Peer Support Employment Training Program Approval Process

A Peer Support Employment Training Program must submit their program curriculum, competency exam, and exam scoring methodology (including an explanation of accommodations or alternative formats of program materials available to individuals who have special needs) to AHCCCS/OIFA, and AHCCCS/OIFA will issue feedback or approval of the curriculum, competency exam and exam scoring methodology.

Approval of curriculum is binding for no longer than three years. Three years after initial approval and thereafter, the program must resubmit their curriculum for review and re-approval. If a program makes substantial changes (meaning change to content, classroom time, etc.) to their curriculum or if there is an addition to required elements during this three-year period, the program must submit the updated curriculum to AHCCCS/OIFA for review and approval.

AHCCCS will base approval of the curriculum, competency exam and exam scoring methodology only on the elements included in this policy. If a Peer Support Employment Training Program requires regional or culturally specific training exclusive to a GSA or tribal community, the specific training cannot prevent employment or transfer of PRSS certification based on the additional elements or standards.

Competency Exam

Members must complete and pass a competency exam with a minimum score of 80% upon completion of required training. Each Peer Support Employment Training Program has the authority to develop a unique competency exam. However, all exams must include at least one question related to each of the curriculum core elements. Individuals certified in another state may obtain certification after passing a competency exam. If an individual does not pass the competency exam, the Peer Support Employment Training Program may require the individual to repeat or complete additional training prior to taking the competency exam again.

Peer Support Employment Training Curriculum Standards

A Peer Support Employment Training Program curriculum must include, at a minimum, the following core elements:

- Concepts of Hope and Recovery:
 - Instilling the belief that recovery is real and possible;
 - The history of recovery and the varied ways that behavioral health issues have been viewed and treated over time and in the present;
 - Knowing and sharing one's story of a recovery journey; how one's story can assist others in many ways;
 - Mind- Body-Spirit connection and holistic approach to recovery; and
 - Overview of the individual service plan and its purpose.
- Advocacy and Systems Perspective:
 - Overview of state and national behavioral health system infrastructure and the history of Arizona's behavioral health system;
 - Stigma and effective stigma reduction strategies: countering self-stigma; role modeling recovery and valuing the lived experience;
 - Introduction to organizational change- how to utilize member-first language and energize one's agency around recovery, hope, and the value of peer support;
 - Creating a sense of community; the role of culture in recovery;
 - Forms of advocacy and effective strategies – consumer rights and navigating behavioral health system; and
 - Introduction to the Americans with Disabilities Act (ADA).

- **Psychiatric Rehabilitation Skills and Service Delivery:**
 - Strengths based approach; identifying one's own strengths and helping others identify theirs; building resilience;
 - Distinguishing between sympathy and empathy; emotional intelligence;
 - Understanding learned helplessness; what it is, how it is taught and how to assist others in overcoming its effects;
 - Introduction to motivational interviewing; communication skills and active listening;
 - Healing relationships – building trust and creating mutual responsibility;
 - Combating negative self-talk; noticing patterns and replacing negative statements about one's self, using mindfulness to gain self-confidence and relieve stress;
 - Group facilitation skills; and
 - Introduction to Culturally & Linguistically Appropriate Services (CLAS) Standards; creating a safe and supportive environment
- **Professional Responsibilities of the Peer Support Employee and Self-Care in the Workplace:**
 - Qualified peers must receive training on the following elements prior to delivering any covered services:
- Professional boundaries & ethics- the varied roles of the helping professional; Collaborative supervision and the unique features of the Peer/Recovery Support Specialist;
- Confidentiality laws and information sharing – understanding the Health Insurance Portability and Accountability Act (HIPAA)
- Mandatory reporting requirements;
- Understanding common signs and experiences of mental illness, substance abuse, addiction and trauma; orientation to commonly used medications and potential side effects;
- Guidance on proper service documentation/billing and using recovery language throughout documentation; and
- Self-care skills and coping practices for helping professionals; the importance of ongoing supports for overcoming stress in the workplace; resources to promote personal resilience; and, understanding burnout and using self-awareness to prevent compassion fatigue, vicarious trauma and secondary traumatic stress.

Peer support employment training programs must not duplicate training required of peers for employment with a licensed agency or Community Service Agency (CSA). Training elements in this section must be specific to the peer role in the public behavioral health system and instructional for peer interactions.

Provider agencies that wish to establish a Peer Support Employment Training curriculum and need additional resources for the development of curriculum can contact B – UHP's Office of Individual and Family Affairs (OIFA) through the general mailbox listed in Section Three.

Supervision of the Credentialed Peer Support Specialist / Recovery Support Specialist & Parent/Family Support Provider

A key element of Peer and Family Support supervision is to create a supportive environment where the job role and work expectations of the CPRSS and/or CPFSP are open to collaborative discussion. The goals of supervision are to provide guidance and support to CPRSS/CPFSP in meeting treatment needs of members and families receiving care from CPRSS/CPFSPs, to create a stimulating environment that challenges the CPRSS/CPFSP to find solutions for issues, and to promote competent and ethical delivery of services and supports through the

continuing development of the CPRSS/CPFSPs application of accepted profession work knowledge, skills, and value. This requires using strength-based feedback, setting professional goals, and promoting continuing education. Supervision provides an opportunity for growth within the agency and encouragement of recovery efforts.

Agencies employing CPRSS/CPFSPs must provide supervision by individuals qualified as Behavioral Health Technicians or Behavioral Health Professionals. Supervision must be appropriate to the services being delivered and the CPRSS/CPFSPs qualifications as a Behavioral Health Technician, Behavioral Health Professional or Behavioral Health Paraprofessional. Supervision must be documented and inclusive of both clinical and administrative supervision.

The individual providing supervision must receive training, have access to continuing education and guidance to ensure current knowledge of best practices in providing supervision to Credentialed Peer/Recovery Support Specialists and/or Parent/Family Support Provider roles.

Process for Submitting Evidence of Peer and Family Support Credentialing

Agencies employing CPRSS and/or CPFSPs who are providing peer and/or family support services are responsible for keeping records of required qualifications and certification. Banner – University Health Plan (B – UHP) must ensure that Credentialed Peer Support Specialists and Parent/Family Support Providers meet qualifications and have certification, as described in this policy. All agencies employing Credentialed Peer Support/Recovery Specialists and/or Parent/Family Support Provider roles will be asked by B – UHP OIFA to submit evidence of compliance regarding their qualifications through attestation process within the Relias Learning Management System.

Continuing Education and Ongoing Learning Requirements

Provider agencies employing Credentialed Peer/Recovery Support Specialists (CPRSS) and/or Credentialed Family Support Providers (CPFSP) must allow access to a minimum of two hours of Continuing Education and Ongoing Learning relevant to Peer Support, on an annual basis. Continuing Education and Ongoing Learning opportunities can be accessed through resources such as Relias Learning Management System, the Substance Abuse and Mental Health Services Administration (SAMHSA) Bringing Recovery Supports to Scale (BRSS) Technical Assistance Center Strategy (TACS) <https://www.samhsa.gov/brss-tacs/video-trainings>. Additionally, advanced, free continuing education resources can also be accessed through the Arizona Peer and Family Career Academy <https://www.azpfca.org/>. For additional Continuing Education and Ongoing Learning Resources, please outreach B – UHP OIFA through our OIFATeam@bannerhealth.com general mailbox.

Credentialed Peer/Recovery Support Specialist and Parent/Family Support Provider Involvement in Service Delivery Deliverable Submission requirements:

Provider agencies employing, utilizing and billing for self-help Peer Support and/or Family Support Services are required, on a quarterly basis on the 5th day of each month to submit the Credentialed Peer/Recovery Support Specialist and/or Credentialed Parent/Family Involvement in Service Delivery deliverable in secure email format to B – UHP OIFA through the OIFATeam@bannerhealth.com general mailbox. Links to the deliverable template can be found on AHCCCS website and through the following links. If there are questions regarding the deliverable submission requirements, please contact B – UHP OIFA through the general mailbox address above in Section three of this Manual.

Links to deliverable templates:

ACC Report: Peer Recovery Support Specialist Involvement in Service Delivery: Attachment A:
<https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/900/963a.xlsx>

ALTCS Report: Peer Recovery Support Specialist Involvement in Service Delivery: Attachment B:
<https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/900/963b.xlsx>

ACC Report: Credentialed Parent/Family Support Specialist Involvement in Service Delivery:
<https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/900/964A.xlsx>

ALTCS Report: Credentialed Parent/Family Support Specialist Involvement in Service Delivery:
<https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/900/964A.xlsx>

AHCCCS Behavioral Health System Tools

For additional guidance please reference the following AHCCCS Practice Tools:

- Child and Family Team
- Children's Out of Home Services
- Family and Youth Involvement in the Children's Behavioral Health System.
- Psychiatric and Psychotherapeutic Best Practices for Children: Birth Through Five Years of Age
- Support and Rehabilitation Services for Children, Adolescents and Young Adults
- Transition to Adulthood
- Unique Behavioral Health Services for needs of Children, Youth and Families Involved with The Department of Child Safety
- Working with the Birth Through Five Population
- Youth Involvement in the Children's Behavioral Health System

Section 13 – Dental Care Services

Overview

DentaQuest is delegated for the benefit administration of dental services for the Health Plan's AHCCCS Plan (B – UFC/ACC) and Medicare Plan (B – UCA). Our Special Needs Plan (B – UCA) will cover oral exams, cleanings, fluoride treatment, and dental x-rays; benefit limitations.

DentaQuest is responsible for contracting with all dental providers, including clinics, and providing necessary authorizations and utilization management. Additionally, DentaQuest will process all dental claims, except claim disputes, which should be sent to the Health Plan for processing, conduct some oversight of quality of care and provide all dental network communications and provider education.

DentaQuest Claims Address:	To submit claims electronically via eclaims, the Payor ID: CX014
DentaQuest of AZ - Claims	Dedicated telephone line: 1-800-440-3408
12121 North Corporate Pkwy	DentaQuest Contact: 1-800-341-8478 or www.dentaquest.com
Mequon, WI 53092	

Please note: Outpatient and Anesthetic medical prior authorizations related to dental care will continue to be managed by the Health Plans.

Appointment Availability Standards

Dental appointments must be available within the standards mandated by AHCCCS, Medicare and community standard. The dental provider is responsible for making office appointments available based on the dental needs of the member. Appointment standards also include in-office waiting time parameters (45 minutes). The Health Plan monitors compliance with these standards as follows:

- Adult and Children – Emergency dental appointments – within 24 hours of referral
- Adult and Children – Urgent dental appointments – within 3 days of referral
- Children under 21 Years of Age – Routine dental appointments – within 45 days of referral
- Members who request routine dental services are to be scheduled within 45 days of the request.
- *Benefit amounts are subject to change. Please contact the plan for current benefit coverage.

Children's Dental Services

AHCCCS members through the age of 20 years receive comprehensive health care including medical, dental and vision services through a federally mandated program called EPSDT (Early Periodic Screening Diagnosis and Treatment). The goal of the EPSDT program is to encourage primary prevention, early intervention, diagnosis and medically necessary treatment of physical or intellectual disability. Oral health screenings conducted by a Primary Care Provider, must be part of an EPSDT/Well-Child visit. However, these screenings do not substitute for examination through direct referral to a dentist. The PCP must refer EPSDT members for routine dental care based on the AHCCCS EPSDT Periodicity Schedule, as well as for appropriate dental services based on needs identified through the screening process.

All EPSDT aged AHCCCS members must be assigned to a Dental Home by one year of age and seen by a dentist for routine preventative care according to the AHCCCS Dental Periodicity Schedule. The American Academy of Pediatric Dentistry (AAPD) defines the dental home as "the ongoing relationship between the dentist and the member, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way" that must include:

1. Comprehensive oral health care including acute care and preventive services in accordance with AHCCCS Dental Periodicity Schedule (AMPM Exhibit 431-1).

2. Comprehensive assessment for oral diseases and conditions,
3. Individualized preventive dental health program based upon a caries-risk assessment and a periodontal disease risk assessment,
4. Anticipatory guidance about growth and development issues (i.e., teething, digit or pacifier habits),
5. Plan for acute dental trauma,
6. Information about proper care of the child's teeth and gingivae. This would include the prevention, diagnosis, and treatment of disease of the supporting and surrounding tissues and the maintenance of health, function, and esthetics of those structures and tissues,
7. Dietary counseling, and
8. Referrals to dental specialists when care cannot directly be provided within the dental home.

PCPs may refer EPSDT members for dental assessment and services at an earlier age, if their oral health screening reveals potential carious lesions or other possible conditions requiring further assessment and/or treatment by a dental professional. EPSDT members are also allowed self-referral to a dentist who is in the Health Plan's network.

Summary of Covered Dental Services for EPSDT aged members.

As an AHCCCS contracted health plan, covered services are mandated by Federal and State law for AHCCCS members. Preventative dental services shall be provided in accordance with AHCCCS Medical Policy Manual Chapter 431 Oral Health Care for Early and Periodic Screening, diagnosis and Treatment Aged Members, and as specified in the AHCCCS Dental Periodicity Scheduled (AMPM Exhibit 431-1).

Depending upon the member's plan, all therapeutic dental services will be covered when they are considered medically necessary and cost effective but may be subject to prior authorization by Banner – University Health Plans or AHCCCS Division of Fee-for-Service Management for FFS members.

Non-Covered Services - Services or items furnished solely for cosmetic purposes are excluded from AHCCCS coverage.

Coordination with Children's Rehabilitative Services

Banner – University Health Plan members with a CRS (Children's Rehabilitative Service) designation, are entitled to all the same oral health services and coverages available to any EPSDT aged AHCCCS member. Additionally, for the purposes of the CRS program, the following also applies:

1. Dental Services – A full range of dental services are covered by the Health Plan for CRS members, who have at least one of the following:
 - a. Cleft lip and/or cleft palate,
 - b. A cerebral spinal fluid diversion shunt where the member is at risk for subacute bacterial endocarditis,
 - c. A cardiac condition where the member is at risk for subacute bacterial endocarditis,
 - d. Dental complications arising as a result of treatment for a CRS condition,
 - e. Documented significant functional malocclusion,
2. When the malocclusion is defined as functionally impairing in a CRS member with a craniofacial anomaly, or
3. When one of the following criteria is present:
 - a. Masticatory and swallowing abnormalities that affect the nutritional status of the individual resulting in growth abnormalities,
 - b. The malocclusion induces clinically significant respiratory problems such as dynamic or static airway obstruction, or

- c. Serious speech impairment, determined by a speech therapist, that indicates the malocclusion as the primary etiology for the speech impairment and that speech cannot be further improved by speech therapy alone.
- d. Orthodontia Services - Medically necessary orthodontia services are covered for a CRS member with a diagnosis of cleft palate or documented significant functional malocclusion as described in 1.e. above.

Adult Dental Services for AHCCCS Members

Dental coverage for AHCCCS members 21 years and older is limited to the following:

- Emergency Dental Services
- Pre-transplant dental services
- AHCCCS will cover emergency dental services for infection in mouth, or pain in tooth, or jaw for members 21 years and older. The service must be related to a treatment of a medical condition.
- Pre-Transplant Dental Services
- Dental diagnosis and elimination of oral infection prior to transplantation of organs or tissue is a covered service only after the member has been established as an appropriate candidate for transplantation.
- Non-Covered Services for Adults
 - All services not directly related to acute emergency or pre-transplant;
 - Medically necessary dentures are no longer a covered benefit for adults;
 - Any new service or procedure started before the member became ineligible with an AHCCCS plan. (Procedures involving those teeth upon which treatment has been started but not yet completed at the time eligibility is lost, must be completed by the Subcontractor).

Section 14 – EPSDT

Banner – University Family Care/ACC (B – UFC/ACC) providers are required to provide comprehensive health care and preventive services to eligible members. Those members are AHCCCS and children under the age of 21. These services are offered under the Early Periodic Screening Diagnosis and Treatment (EPSDT) program, which is governed by Federal and State regulations and community standards of practice.

Requirements

B – UFC/ACC providers are required to comply with the following:

- Provide early and periodic screening, diagnosis, and treatment services for all assigned members from birth through twenty years of age. All services must be provided according to the AHCCCS Periodicity Schedule and community standards of practice. The service intervals represent minimum requirements, and any services determined by the primary care provider, to be medically necessary, must be provided regardless of the interval.
- Document services provided and compliant with AHCCCS' standards on the AHCCCS standardized EPSDT Tracking Forms. B – UFC/ACC providers should send a copy to the Health Plan EPSDT Department at 2701 E. Elvira Road, Tucson AZ. If the member chooses not to participate in the EPSDT program, document the decision in the medical record.
- Coordinate care and refer eligible members to Children's Rehabilitative Services (CRS). The Health Plan can assist in the referral process if the need is identified on the EPSDT tracking form.
- Schedule the next EPSDT appointment at the time of the current visit for children 24 months of age and younger.
- Comply with the State requirements to report all childhood immunizations to Arizona Department of Health Services (ADHS)/Arizona State Immunization Information System (ASIS).
- Agree to participate in an annual review, which may include on-site visits and medical record audits.
- Report all EPSDT encounters on CMS 1500 claim forms, using Preventive Medicine Codes with the appropriate modifier.
- Be registered and participate in the Vaccinations for Children (VFC) Program Report blood lead levels equal to or greater than ten micrograms of lead per deciliter of whole blood to ADHS

Screening and Physical Exam Requirements

- A comprehensive health and developmental history (including growth, developmental screening, physical, nutritional, and behavioral health assessments).
- Nutritional Assessment provided by a PCP: Nutritional assessments are conducted to assist EPSDT members whose health status may improve with nutritional intervention. Payment for the assessment of nutritional status provided by the member's PCP is part of the EPSDT screening. Payment for nutritional assessments is included in the EPSDT visit and is not a separate billable service.
- Behavioral health services are covered for members eligible for EPSDT. PCPs may treat Attention Deficit Hyperactivity Disorder, depression and anxiety. All other behavioral health conditions must be referred to the Regional Behavioral Health Authority. PCPs that elect to prescribe medications to treat ADHD depression, or anxiety disorders must complete an annual assessment of the member's behavioral health condition and treatment plan. Payment for behavioral health screenings and assessments are included as part of an EPSDT visit and are not separate billable services.
- A comprehensive unclothed physical examination: Appropriate immunizations according to age and health

history: Administration of immunizations may be billed in addition to the EPSDT visit using the CPT-4 code appropriate for the immunization with an SL modifier. Providers must be registered as Vaccines for Children providers and VFC vaccines must be used.

- Immunizations must be reported at least monthly to the Arizona Department of Health Services. Immunizations must be provided according to the recommended Childhood Immunization Schedule.
- Reported immunizations are held in a central database known as the Arizona State Immunization Information System (ASIIS). Providers can access this database to obtain complete and accurate immunization records at <https://asiis.azdhs.gov/>.
- Laboratory tests (including blood lead screening and assessment appropriate to age and risk, anemia testing and diagnostic testing for, sickle cell trait if a child has been previously tested with sickle cell, preparation or hemoglobin solubility test).
- EPSDT covers blood lead screening. Required blood lead screening for children less than six years of age is based on the child's risk as determined by either the member's residential zip code or presence of other known risk-factors, as specified in the Arizona Department of Health Services Targeted Lead Screening Plan for the Prevention of Childhood Lead Poisoning.
- Providers must report blood lead levels equal to or greater than ten micrograms of lead per deciliter of whole blood to ADHS.
- Hemoglobin/Hematocrit – Must be performed according to periodicity schedule.
- Sickle cell trait – Screening should be done when indicated.
- Tuberculosis Screening – Must be performed on children who are at risk at intervals indicated in the attached EPSDT Periodicity Schedule.
- Health Education, counseling and chronic disease self-management. These are not considered separately billable services and are considered part of the EPSDT visit payment.
- Oral health screening intended to identify oral pathology, including tooth decay and/ or oral lesions and the application of fluoride varnish conducted by a physician, physician's assistant or nurse practitioner. Application of fluoride varnish may be billed separately from EPSDT using CPT Code 99188. Fluoride varnish is limited in a primary care provider's office to once every six months, during an EPSDT visit for children who have reached six months of age with at least one tooth erupted, with recurrent applications up to two years of age. Referrals to a dentist should be encouraged by one (1) year of age. AHCCCS members are assigned to a dental home within the B – UFC/ACC provider network. Covered dental services include emergency, preventive and therapeutic treatment. The dentist will perform an evaluation on members and report findings and treatment to the PCP. The PCP will include documented dental findings and treatment in the member's medical record.
- Vision, hearing and speech screenings are covered during an EPSDT visit. EPSDT covers eye examinations as appropriate to age according to the AHCCCS Periodicity Schedule and as medically necessary using standardized visual tools. Payment for vision and hearing exams, or any other procedure that may be interpreted as fulfilling the vision and hearing requirements provided in a PCP's office during an EPSDT visit are considered part of the EPSDT visit and are not separately billable services.
- Ocular photo screening with interpretation and report, bilateral (CPT code 99174) is covered for children age's three to five as part of the EPSDT visit due to challenges with a child's ability to cooperate with traditional visitation screening techniques. Limited to a lifetime coverage limit of one.

Developmental Screening Tools:

AHCCCS approved developmental screening tools should be utilized for developmental screening by all contracted PCPs who care for EPSDT-age members. PCPs must be trained in the use and scoring of the

developmental screening tools, as indicated by the American Academy of Pediatrics.

1. The developmental screening should be completed for all EPSDT members from birth through age three years of age during the 9, 18, and 24-month EPSDT visits.
2. A copy of the developmental screening tool must be kept in the medical record.
3. Use of AHCCCS approved developmental screening tools may be billed separately using CPT-4 code 96110 for a 9-month, 18-month and 24-month visit when the developmental screening tool is used.
4. A developmental screening CPT code with EP modifier must be listed in addition to the preventative medicine CPT code.
5. To receive the developmental screening tool payment, the modifier EP must be added to the 96110.
6. For claims to be eligible for payment, the provider must have satisfied the training requirements, the claim must be a 9, 18 or 24-month EPSDT visit, and an AHCCCS approved developmental screening tool must have been completed.
7. Providers should send verification of training completion directly to the Council for Affordable Quality Healthcare (CAQH)
8. AHCCCS approved developmental screening tools include:
 - a. The Parent's Evaluation of Developmental Status (PEDS) tool which may be obtained from <http://www.pedstest.com/default.aspx> or <https://pedstestonline.com/>
 - b. Ages and Stages Questionnaire (ASQ) tool which may be obtained from www.agesandstages.com
 - c. The Modified Checklist for Autism in Toddlers (MCHAT) may be used only as a screening tool by a primary care provider, for members 16-30 month of age, to screen for autism when medically indicated.

Section 15 – Arizona Early Intervention Program

Arizona Early Intervention Program (AzEIP) is the collective effort of private and public programs and community members. AzEIP provides services such as Speech, Occupational and Physical Therapy and other supports to families and children, ages 0-3, at risk of or who have a developmental delay.

The Health Plan strives to remove barriers to the implementation of EPSDT services for our youngest AHCCCS members who are 0-3 years of age in order to ensure that early developmental opportunities are maximized.

AzEIP Service Coordination Requirements:

When the primary care physician (PCP) identifies a member under the age of 21 as having a potential developmental delay, he/she may arrange an evaluation with an in-network provider and prior authorization is not required. Should the PCP arrange an evaluation with an out of network provider, prior authorization is required and medical documentation and continuity of care need, if applicable, is required.

Based on the evaluation, medically necessary services can be arranged by the PCP with an in-network provider and prior authorization may not be required. Prior authorization is required for out-of-network providers.

Regardless of member's AzEIP status, the Health Plan will pay for medically necessary services for EPSDT members.

According to the AHCCCS/AzEIP agreement, when services are identified for an AzEIP eligible child's Individual Family Service Plan (IFSP), the Health Plan will fax the PCP the AzEIP EPSDT Service Request Form for approval or denial of the services within two (2) days of receiving it from AzEIP.

THE PCP MUST RETURN THE AzEIP EPSDT SERVICE REQUEST FORM WITHIN FIVE (5) DAYS OF RECEIPT.

According to Federal law, AzEIP service implementation is required within 45 days of the IFSP origination date. The AzEIP provider and coordinator, parent or guardian and PCP are provided the completed AzEIP Request Form for EPSDT services by the Health Plan. The denied or the approved type(s) of therapy, duration and frequency is included on the form.

Section 16 – Children’s Rehabilitative Services

Children’s Rehabilitative Services (CRS) is a State program administered by the Arizona Health Care Cost Containment System (AHCCCS). Federal matching funds are available for the provision of services to Title XIX eligible children enrolled in an AHCCCS health plan. The purpose of CRS is to provide rehabilitative medical care to children with special health care needs, utilizing a multidisciplinary approach that provides medical treatment, rehabilitation, and related support services. Children must be AHCCCS enrolled, completed the CRS application and meet the medical eligibility criteria in order to receive CRS Services.

CRS members receive the same AHCCCS covered services as non-CRS AHCCCS members; however, services to treat CRS conditions for Acute Care members may only be provided to children enrolled with CRS. CRS members will be able to receive care in the community or in multispecialty interdisciplinary clinics that bring all specialties together in one location. Thus, the child receives all treatment for their CRS condition and all medical/behavioral health services in a coordinated system.

AHCCCS members are eligible for CRS services without additional fees.

Eligibility Requirements:

- Arizona resident
- Under 21 years of age
- Have a physical, chronic illness or condition that is potentially disabling and the condition requires active treatment. (See attachment for Covered Conditions)
- Title XIX (Medicaid/AHCCCS) enrollment

Referral Process:

- A PCP and/or a Specialist must perform the diagnostic work-up for the CRS eligible diagnosis.
- A PCP and/or a Specialist as well as a family member can initiate the application form.
- A member identified by nurse reviewer or case manager can be redirected to CRS when they have a CRS diagnosis and are not enrolled.
- If a child with a CRS eligible diagnosis is identified while an inpatient, social services staff may initiate a referral to CRS. The Health Plan Utilization Management Nurse may also identify a CRS eligible child during an inpatient review and request an application be initiated. Medical records will be requested from the PCP and/or specialist provider to support the potential CRS diagnosis.

Parents can choose to not enroll their child into CRS however they may be responsible for any costs associated for the treatment of the child’s CRS condition.

The CRS application must be printed, filled out, and mailed or faxed with medical documentation that supports the potential CRS condition to the CRS Enrollment Unit.

AHCCCS/Children’s Rehabilitative Services

ATTENTION: CRS Enrollment Unit

801 East Jefferson MD 3500

Phoenix, Arizona 85034

Fax: (602) 252-5286

Phone: (602) 417-4545 or 1-855-333-7828,

Monday – Friday 8:00 AM to 5:00 PM (excluding weekends and holidays)

The Care Managers at B – UHP (B – UFC/ACC) are available to assist with the CRS application process.

When the child becomes eligible for CRS and is a B – UHP (B – UFC/ACC) member, B – UHP (B – UFC/ACC) becomes the AHCCCS health plan that manages the care for CRS conditions, acute health and behavioral health services.

Section 17 – Maternity & Family Planning

B – UHP requires that quality family planning, pre-pregnancy and postpartum services are available to every member. The continuum of care is a critical component in the good health of the mother and child. Primary Care Obstetricians are responsible for the provision of comprehensive care to meet primary and obstetrical needs. Members may select or be assigned to a PCP specializing in obstetrics while they are pregnant.

Banner – University Family Care/ACC and Banner – University Care Advantage cover a full continuum of family planning and maternity care services for all eligible, enrolled members of childbearing age.

Maternity care services include, but are not limited to, identification of pregnancy, medically necessary prenatal services, the treatment of pregnancy related conditions, labor and delivery services and postpartum care.

B – UHP benefits provide a hospital stay of up to 48 hours after vaginal delivery, and up to 96 hours after cesarean section, unless, due to medical necessity, an extended stay is needed. However, for payment purposes, inpatient limits will apply.

In addition, related services such as outreach, education and family planning services are provided when appropriate.

Care Coordination

The Health Plan offers a multi-disciplinary program to assist providers in managing the care of pregnant members who are at risk because of medical conditions, social circumstances, or non-compliant behaviors. Obstetrical care coordination links expectant mothers with appropriate community resources such as WIC, parenting classes, shelters, and substance abuse counseling. Care Managers provide support and promote compliance with prenatal appointments and prescribed medical regimens (see Quick Reference Guide).

The Health Plan places critical importance on good perinatal health. The Maternal Child Health Department at the Health Plan is available to assist you in coordinating obstetrical care services:

- High Risk OB care authorization
- Referrals to perinatology and special services
- Case Management for identified high-risk members

Maternity Care Program Minimum Requirements

Covered Services B – UHP maternity members:

- Preconception counseling
- Identification of pregnancy
- Medically necessary education and prenatal services for the care of pregnancy Treatment of pregnancy related conditions
- Labor and delivery services Intrapartum and postpartum care
- Transportation when needed to assist members in accessing maternity care

In addition, related services such as outreach and family planning services are provided, whenever appropriate, based on the member's current eligibility and enrollment.

Provider Standards

All maternity care services must be delivered by qualified physicians and non-physician practitioners and must be provided in compliance with the most current American Congress of Obstetricians and Gynecologists (ACOG) standards for obstetrical and gynecological services, prenatal care, labor/delivery, and postpartum care services

may be provided by licensed midwives within their scope of practice, while adhering to ACOG guidelines.

Health Plan providers are required to comply with the following standards in the provision of maternity care services to pregnant members:

- Adhere to the most current standards of care of the American College of Obstetrics and Gynecology, including the use of a standardized risk assessment tool and ongoing risk assessment.
- Submit Notification of Pregnancy Form to initiate maternity care services at the first and no later than the second prenatal visit. A complete Notification of Pregnancy Form (NOP) shall include the Estimated Date of Confinement (EDC), Gravida/Para (GP), Risk Status information and planned place of delivery.
- Educate members about health behaviors during pregnancy including: Proper nutrition, adverse effects of smoking and smoking cessation, alcohol and illicit drugs on the fetus, and the physiology of pregnancy.
- Provide information regarding the process of labor and delivery, breast-feeding, family planning and preconception counseling, and infant care.
- Inform all pregnant women of voluntary prenatal HIV testing and the availability of counseling and treatment if the test is positive.
- Refer and facilitate registration of members to childbirth education classes.
- Refer members under the age of 21 years for yearly diagnostic, preventive and treatment dental services (EPSDT).
- Mainstream AHCCCS members into his/her practice.
- Notify women that in the event they lose eligibility, they may contact the Arizona Department of Health Services toll free Hot Line at (800) 833-4642 for referrals to low or no cost services, such as family planning and other community resources.
- Provide patient data as requested/required by the Health Plan. Comply with all the Health Plan reporting requirements and participate in required audits.
- Refer members who lose AHCCCS eligibility to low/no cost agencies for family planning services.
- Refer members to other agencies offering support services such as Women, Infants and Children (WIC).
- Perform EPSDT screening and referral to dentists on members through the age of 20 years.
- Conduct perinatal/postpartum depression screenings at least once during the pregnancy and then again at the postpartum visit, including counseling and making appropriate referrals if a positive screening is obtained.
- Conduct screening for Sexually Transmitted Infections (STI), including syphilis at the:
 - First Prenatal Visit;
 - Third Trimester, and;
 - Time of Deliver

PLEASE NOTE: According to ACOG guidelines, cesarean section deliveries must be medically necessary. Inductions and cesarean section deliveries prior to 39 weeks must be medically necessary. Cesarean sections and inductions performed prior to 39 weeks that are not found to be medically necessary based on nationally established criteria are not eligible for payment.

Maternity Appointment Standards

Prenatal Appointments

Provide initial and routine prenatal care appointments in compliance with AHCCCS standards. Initial prenatal

appointments for enrolled pregnant members must be provided as follows:

- First trimester - within 14 days of request
- Second trimester - within 7 days of request
- Third trimester - within 3 days of request
- High risk pregnancy within 3 days of identification of high risk by PCP or maternity care provider or immediately if an emergency exists

Follow-up prenatal care appointments for pregnant members must be provided as follows:

- First 28 weeks - every 4 weeks
- 28 - 36 weeks - every 2 to 3 weeks
- After the 36th week - weekly until delivery
- High Risk maternity care members return visits intervals must be scheduled appropriately to their individual needs.

Home Uterine Monitoring (HUM)

B – UFC/ACC cover home uterine monitoring technology for members with premature labor contractions before 35 weeks as an alternative to hospitalization.

At least one of the following conditions must be present to receive authorization for HUM:

- Multiple gestations, particularly triplets or quadruplets
- One or more births before 35 weeks
- Hospitalization for premature labor before 35 weeks with a documented change in the cervix, controlled by tocolysis and ready to be discharged for bed rest at home

Loss of Coverage During Pregnancy

Sometimes members lose AHCCCS eligibility during pregnancy. Although members are responsible for their own eligibility, providers are encouraged to notify the Health Plan. We will assist in coordinating or resolving eligibility and enrollment issues, so pregnancy care may continue without lapse in coverage.

To report concerns about eligibility, contact the Maternal Child Health department.

Perinatology Care

The Health Plan may approve assignment or transfer of a pregnant woman to a perinatologist for “Total OB Care” for the following conditions:

- Insulin dependent diabetes in non-pregnant State Chronic renal disease or insufficiency
- Epilepsy requiring medications
- Chronic hypertension requiring medications
- A history of two or more preterm deliveries at 32 weeks or less Malignancy
- Current diagnosis of highly probable IUGR Rupture of Membranes (ROM) before 32 weeks Triplets or more
- Potential need for cerclage Diagnosis of Lupus Erythematosus
- Twin pregnancy with discordant growth Positive HIV mother
- Polyhydramnios

- Oligohydramnios

Pregnancy Termination

B – UHP covers pregnancy termination when it is the result of rape, incest, or in circumstances as determined by the attending provider, in collaboration with the Health Plan Medical Director or the AHCCCS Chief Medical Officer or designee, when one of the following conditions is present:

- The member suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would, as certified by a provider, place the member in danger of death unless the pregnancy is terminated.
- The pregnancy is a result of rape or incest. (This standard applies only to categorically eligible female members).
- The pregnancy termination is medically necessary according to the medical judgment of a licensed physician, who attests that continuation of the pregnancy could reasonably be expected to pose a serious physical or behavioral health problem for the pregnant member by:
 - Creating a serious physical or behavioral health problem for the pregnant member
 - Seriously impairing a bodily function of the pregnant member
 - Causing dysfunction of a bodily organ or part of the pregnant member
 - Exacerbating a health problem of the pregnant member
 - Preventing the pregnant member from obtaining treatment for a health problem

Conditions, Limitations and Exclusions

The attending provider must acknowledge that a pregnancy termination has been determined medically necessary by submitting the Certificate of Medical Necessity for Pregnancy Termination. The form must be submitted with the Prior Authorization request form to obtain the Health Plan Medical Director's signature. The certificate must certify that in the provider's professional judgment, one or more of the above criteria have been met.

A written informed consent must be obtained by the provider and kept in the member's chart for all pregnancy terminations. If the pregnant member is younger than 18 years of age or is 18 years of age or older and considered an incapacitated adult, a dated signature of the pregnant member's parent or legal guardian indicating approval of the pregnancy termination procedure is required.

When the pregnancy is the result of rape or incest, documentation must be obtained that the incident was reported to the proper authorities, including the name of the agency to which it was reported, the report number and the date the report was filed.

If the member is pregnant beyond an estimated gestational age of 24 weeks, a second opinion from an independent provider with the appropriate specialty must be submitted with the Certificate of Medical Necessity for Pregnancy Termination. The independent provider must specify the medical need for a termination of pregnancy. These members must be individually case managed throughout this process of obtaining a second opinion and until considered to be in stable condition.

If the pregnancy is the result of rape or incest, and the member is less than eighteen years of age, or is older than 18 years of age and considered an incapacitated adult, additional documentation must be included by the provider when submitting the Certificate of Medical Necessity for Pregnancy Termination. Pursuant to Federal and State law, the following information is required:

Documentation that the incident was reported to the proper authorities, including the name of the agency to which it was reported, the report number if available, and the date the report was filed.

The dated signature of the member's parent or legal guardian indicating approval of the pregnancy termination procedure.

Informed consent from an adult or a minor in the manner prescribed by law. To the extent written consent is required by law, a copy of the consent shall be provided with the Certificate of Medical Necessity for Pregnancy Termination.

Prior Authorization

Except in cases of medical emergencies, the provider must obtain prior authorization for all medically necessary pregnancy terminations from the Health Plan Medical Director or his/her designee. Prior authorization for fee-for-service members must be obtained from the AHCCCS Chief Medical Officer, or designee. A completed Certificate of Medical Necessity for Pregnancy Termination must be submitted with the request for prior authorization. The Health Plan Medical Director or AHCCCS Chief Medical Officer or designee will review the request and the Certificate, and expeditiously authorize the procedure if the documentation establishes the termination to be medically necessary.

In cases of medical emergencies, the provider must submit all documentation of medical necessity to the Health Plan Medical Director and/or the AHCCCS Chief Medical Officer within two (2) working days of the date on which the termination procedure was performed.

Family Planning Services

Family planning services are covered when provided by physicians or practitioners to members who voluntarily choose to delay or prevent pregnancy.

Family Planning Services include covered medical, surgical, pharmacological and laboratory benefits specified in the matrix on page 16.9. Covered services also include the provision of accurate information and counseling to allow members to make informed decisions about contraceptive method of their choice.

The Family Planning covered services for AHCCCS members includes:

1. Contraceptive counseling, medication and/or supplies, including but not limited to: oral and injectable contraceptives, sub-dermal implantable contraceptives, intrauterine devices, diaphragms, condoms, spermicidal foams and suppositories.
2. Natural family planning education or referral to qualified health professionals.
3. Post-coital emergency oral contraception within 72 hours after unprotected sexual intercourse (RU486 is not post-coital emergency contraception).
4. Pregnancy screening.
5. Screening and treatment for sexually transmitted infections.
6. Associated medical and laboratory examinations and radiological procedures, including ultrasound studies related to family planning.
7. Pharmaceuticals when associated with medical conditions related to family planning or other medical conditions.
8. Treatment of complications resulting from contraceptive use, including emergency treatment.
9. Sterilization services for members over 21 years of age.

Services	FP Covered Benefit
Pregnancy screening	Yes
Pharmaceuticals	Yes
Screening and Treatment for Sexually Transmitted Disease	Yes

Sterilization	Yes, including hysteroscopic tubal sterilizations for female and male members when AHCCCS eligibility requirements are met Note: member must be 21 years of age and consent must be signed at least 30 days prior to the procedure but less than 180 days.
Pregnancy Termination and Hysterectomy	Yes, per AHCCCS stipulations including Mifepristone or RU 486

Benefit Matrix

Members	OC	Depo	IUD	Dia	Con	Foam	Supp	EC	Nat.	Ster	AB	Infer	WW E	Pap	STD	STD tx	Rubella	Rubella
B –	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	Y	Y	Y	Y	Y	Y

Covered Services/Claims Requirements

AHCCCS has defined the procedure codes that require an FP modifier and those services that may be billed without an FP modifier. Claims that do not follow these guidelines will be denied.

Family Planning ACCEPTED Diagnoses	
CPT CODE	PROCEDURE
-Z30.011	Encounter for initial prescription of contraceptive pills
- Z30.013-Z30.019	Encounter for initial prescription by type of contraception
–Z30.012	Encounter for prescription of emergency contraception
Z30.09	Encounter for other general counseling and advice on contraception
Z30.430	Encounter for insertion of intrauterine contraceptive device
Z30.2	Encounter for sterilization
Z30.40	Encounter for surveillance of contraceptives, unspecified
Z30.41	Encounter for surveillance of contraceptive pills
Z30.431	Encounter for routine checking of intrauterine contraceptive device
Z30.46	Encounter for surveillance of implantable subdermal contraceptive
Z30.42, Z30.44, Z30.45, A30.49	Encounter for surveillance of previously prescribed contraceptive method
Z30.8	Encounter for other contraceptive management
Z30.9	Encounter for contraceptive management, unspecified
Z97.5	Presence of (intrauterine) contraceptive device
Z97.5	Presence of (intrauterine) contraceptive device
Z97.5	Presence of (intrauterine) contraceptive device

Family Planning ACCEPTED ICD-10 Codes	
CPT	PROCEDURE
0U5 & 0OL	Destruction / Female Reproductive System; Occlusion / Female Reproductive System
0U5; 0UL	Destruction / Female Reproductive System; Occlusion / Female Reproductive System;
0U5; 0UL	Destruction / Female Reproductive System; Occlusion / Female Reproductive System
0UL	Occlusion / Female Reproductive System
0U5; 0UL7	Destruction / Female Reproductive System; Occlusion / Fallopian Tubes, Bilateral
0UT5; 0UT6	Resection / Fallopian Tube, Right and Left;
0UT7	Resection of Bilateral Fallopian Tubes
0UT5; 0UT6	Resection / Fallopian Tube, right & left
0UB7	Excision of Bilateral Fallopian Tubes
0UB5; 0UB6	Excision / Fallopian Tube, right & left
0U55; 0U56/ 0UL5; 0UL6	Destruction / Fallopian Tube, right & left. / Occlusion / Fallopian Tube, right & left
should have been 69.7 – 0UH9; 0UHC	Insertion of intrauterine contraceptive device by site
0UHC	Insertion of Contraceptive Device into Cervix
0UPD	Removal of Contraceptive Device from Uterus and Cervix
0UPD	Removal of Contraceptive Device from Uterus and Cervix
Required 4 th digit see below	All the codes below fall in the destruction of Male Reproductive System 0V5- Destruction / Vas Deferens; 0VB-Excision / Male Reproductive System; 0VT- Resection / Male Reproductive System; 0VL- Occlusion / Male Reproductive System

The FP Modifier IS NOT REQUIRED For The Following Services	
CPT CODE	PROCEDURE
11976	Norplant Removal
57170	Diaphragm or Cervical Cap Fitting with Instructions
58300	Insertion of Intrauterine Device
58301	Removal of Intrauterine Device
58600, 58605,	Ligation of Tubes, Abdominal or Vaginal
58615	Occlusion of Fallopian Tubes by Device
58670-	Laparoscopy, Surgical with Oviducts
00851	Anesthesia for intra-peritoneal procedures in lower abdomen, including laparoscopy; ligation of tubes
A4261	Cervical Cap

The FP Modifier IS NOT REQUIRED for the following services	
CPT CODE	PROCEDURE
A4266	Diaphragm
Deleted code as of 01/01/2013	Injection 150mg Depo-Provera
Deleted code as of 01/01/2013	Injection 5mg/25mg Lunelle
J7300	Intrauterine copper contraceptive
Replaced with J7297-J7298 as of 01/01/2016	Levonorgestrel-releasing intrauterine contraceptive system,
J7303	Contraceptive supply, hormone releasing vaginal ring, each
S4989	Contraceptive intrauterine device (e.g., Progestacert IUD) including implants and supplies
55250	Vasectomy, unilateral or bilateral
Replaced with CPT code 55250 01/01/2018	Ligation, (percutaneous) of vas deferens, unilateral or bilateral

The FP Modifier IS REQUIRED for the following services	
CPT CODE	PROCEDURE
99201-99215	Office or other outpatient visit
99241-99245	Office consultation
99000	Handling and/or conveyance of specimen
36415	Venipuncture
81000	Urinalysis by Dipstick
81001	Automated with microscopy
81002	Non-automated, without microscopy
81025	Urine Pregnancy Test
82948	Glucose; Blood, Reagent Strip
82951	Glucose; Tolerance Test (GTT)
84702-84703	Gonadotropin, Chronic (hcg)
85014, 85018	Blood Count
86592-86593	Syphilis Test
86689	Antibody; HTLV or HIV Antibody, Confirmatory Test
86701-86703	Antibody; HIV
86706	Hepatitis B surface antibody (HbsAb)
86781	Antibody; Treponema Pallidum
86803-86804	Hepatitis C Antibody
87075	Culture, Bacterial, Any Source
87106	Culture, Fungi, Definitive Identification of Each Fungus

Section 18 – Pharmaceutical

Listed below are general guidelines for pharmaceutical services:

- Pharmaceutical services may be provided by a contracted inpatient or outpatient provider.
- Pharmaceutical services shall be available during customary business hours and within reasonable travel distance of a member's residence.
- Pharmaceutical services shall be covered if prescribed by the PCP, dentist, or specialty care provider (upon referral from the PCP).

The following limitations shall apply to pharmaceutical services:

- A medication dispensed by a Provider or Dentist is not covered, except in geographically remote areas where there is no participating pharmacy or when pharmacies are closed.
- A prescription in excess of a 30-day supply or a 100-unit dose is not covered unless:
 - The medication is for chronic illness and is limited to no more than 100-day supply or 100-unit dose, whichever is greater
 - The member will be out of the provider's service area for an extended period of time, not to exceed 100 days or 100-unit dose, whichever is greater
 - The medication is prescribed for birth control and the prescription is limited to no more than a 100-day supply
 - Prescriptions for narcotic medications are limited to a 30-day supply
- An over-the-counter medication may be covered for the Health Plan AHCCCS or SNP members only as an alternative to a prescription medication only if it is available and less costly than a prescribed medication. (OTC Meds are not a covered benefit under Medicare - they would only be covered under the AHCCCS plan)
- A prescription is not covered if filled or refilled in excess of the number specified, or if the initial prescription or refill is dispensed more than 1 year from the original prescribed order.
- Approval by the authorized prescriber is required for all changes in, or additions to, an original prescription. The date of a prescription change shall be clearly indicated and initialed by the dispensing pharmacist.
- Prescribed medications must be on the drug formulary.
- If generic is available, generic must be dispensed unless otherwise directed by AHCCCS.
- Prior authorization is required for medication not on the drug formulary, see the Pharmacy Prior Authorization Form.

Note: To obtain a copy of Pharmacy Listings, please contact your Provider Relations Representative.

Drug Formulary

The Banner – University Family Care/ACC Drug Formulary aligns with the AHCCCS Drug List including the preferred drugs. Additional drugs may be added as indicated by the specific needs of the population. The Health Plan Formulary is updated quarterly although more frequent changes may be made if indicated. Notification of changes will be posted on the website and reflected in the Drug Formulary. You will be notified of the quarterly changes in the formulary by fax blast. The Drug Formulary is available on the plan specific websites. If a printed copy is needed, please contact your provider representative. Non-formulary drugs are not covered without prior authorization and documentation in the patient's medical record that a formulary drug is ineffective or cannot be

taken due to an adverse reaction.

If a provider supplies sample medication to a member and the medication is not on the formulary, the provider must be willing to:

Convert the patient to a formulary medication, or Continue providing samples for the patient's use

Note: Provider shall obtain approval before prescribing medications in accordance with prior authorization policy.

The formulary process is ongoing with changes occurring at any time. For questions about formulary medications, please call Customer Care.

The comprehensive formulary for each plan can be found at <https://www.bannerufc.com/acc>

Prior Authorization Required

Prior authorization may be required:

- If the drug is not included on the formulary
- If the drug is included on the formulary but has utilization management criteria such as prior authorization, quantity limits, or step therapy

For Banner – University Family Care/AHCCCS Complete Care members, decisions will be rendered on expedited and standard prior authorization requests within 24 hours. If additional information is needed in order to make a determination, an extension of up to 7 working (business) days can be added to the turnaround time for standard and expedited requests. Please note that an expedited request will be required to meet the AHCCCS criteria which states that following the standard decision timeframe could seriously jeopardize the member's life or health or the ability to attain, maintain, or regain maximum function. For Banner - University Care Advantage members, decisions will be rendered on prior authorization requests within 24 hours for expedited requests and 72 hours for standard requests. If an exception to the formulary or criteria is being requested, an extension of 4 days can be added to expedited requests and 11 days can be added to standard requests.

In instances where a prescription is written for drugs not on the formulary, the pharmacy may contact the prescriber to either request an alternative or to advise the prescriber that prior authorization is required for non-covered drugs.

Prior authorization requests submitted for review must be evaluated for clinical appropriateness based on the strength of the scientific evidence and standards of practice that include, but are not limited, to the following:

- Food and Drug Administration (FDA) approved indications and limits
- Published practice guidelines and treatment protocols
- Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes.
- Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies
- The following references may be used in the evaluation of the request including Drug Facts and Comparisons, American Hospital Formulary Service Drug Information, DRUGDEX Information System, and UpToDate.

Pharmacy Prior Authorization requests may be submitted by fax to the Pharmacy Department at 1-866-349-0338.

Behavioral Health Medications

Primary Care Providers (PCP) are able to prescribe behavioral health medications to treat selected behavioral disorders including ADD/ADHD, depression, anxiety, and opioid use disorder (OUD).

Members who require treatment for other behavioral health diagnoses should be referred to a behavioral health provider. In addition, if you are providing medication-assisted therapy (MAT) for OUD, you must refer the member to a behavioral provider for the psychological and/or behavioral health therapy component of MAT and coordinate care with the behavioral health provider.

Members diagnosed with ADD/ADHD, depression, anxiety, or OUD transitioning from a behavioral health provider to their PCP for their behavioral health medication management shall be continued on the medication initiated by their behavioral health provider for continuity of care.

Any questions on behavioral health medications or behavioral health for B – UFC/ACC members should be directed to the Behavioral Health Coordinator.

Prescribing of Opioids

- Prior Authorization Requirements for Long-acting Opioids
- Prior authorization is required for all long-acting opioids unless the member has one of the following diagnoses:
 - Active oncology diagnosis with neoplasm related pain
 - Enrolled in hospice care
 - End of life care (other than hospice)
 - Supply Limits for Short-acting Opioids
 - Members under 18 years of age
- Prescriber shall limit the initial and refill prescriptions for short-acting opioids to no more than a 5-day supply
- Exclusions include:
- Active oncology diagnosis
- Hospice care
- End of life care (other than hospice)
- Palliative care
- Children on an opioid wean at time of hospital discharge
- Skilled nursing facility care
- Traumatic injury, excluding post-surgical care
- Chronic conditions for which the prescriber has obtained prior authorization from B – UFC/ACC
- The initial prescription for post-surgical procedures is limited to a supply of no more than 14 days. Refills should be limited to no more than a 5-day supply.
- Members 18 years of age and older
- Prescriber shall limit the initial prescription for short-acting opioids to no more than a 5-day supply
- Active oncology diagnosis
- Hospice care
- End of life care (other than hospice)
- Palliative care

- Skilled nursing facility care
- Traumatic injury, excluding post-surgical care
- Post-surgical procedures
- The initial prescription for post-surgical procedures is limited to a supply of no more than 14 days.
- Studies have not shown the benefit of long-term use of opioids in the management of chronic, non-cancer pain. So, it is important to:
 - Limit use and duration of opioids
 - Dosage should be limited to morphine milligram equivalent (MME) of no more than 90
 - Optimize non-opioid medications indicated for the treatment of pain
 - Treat any underlying disorders that may exacerbate pain such as depression, anxiety, or sleep disorders
 - Encourage exercise or physical therapy if indicated
 - Avoid co-prescribing of opioid potentiators especially benzodiazepines
- Prescribe naloxone for members on chronic opioids and educate members on naloxone use

Section 19 – Eligibility and Enrollment

The Customer Care Center provides assistance to all Health Plan members. AHCCCS and Medicare determine benefits. The Customer Care Center provides answers to member's questions, facilitates Primary Care Provider (PCP) changes and answers provider's eligibility inquiries. The main focus of the Customer Care Center is to assist and coordinate medical care for our members. All new members will receive a welcome packet which includes:

- Welcome letter identifying assigned (PCP) Including PCP address and telephone contact information
- Process to change PCP
- Process to obtain a Member handbook
- Process to obtain a Provider directory
- Family planning information including EPSDT and Well Woman
- Health history questionnaire
- Coordination of benefits (COB questionnaire)
- Notice of Privacy Practices (NOPP)
- Pre-addressed, postage paid return envelope for return of questionnaires
- Benefit Change Information
- Grievance and Appeals Information

B – UHP issues an identification card for B – UFC/ACC when a member becomes eligible for benefits. This card includes the member's name, identification number and the name of their assigned AHCCCS plan. Providers can use the plastic identification card with the Medifax system, the Health Plan website, the Customer Care Center at (800) 582-8686, or AHCCCS at (800) 962-6690, or the AHCCCS website to verify a member's eligibility. The Health Plan will provide identification cards to our dual eligible SNP members that enroll in our Special Needs Plan.

Please remember it is the provider's responsibility to verify eligibility and benefits prior to providing services.

Providers should always verify a member's PCP assignment by calling the Customer Care Center or by visiting eServices.

You may determine a member's eligibility in the following ways:

- Providers who are electronically linked to the Health Plan computer system will have access to daily membership updates.
- PCP's will receive a member roster on a regular basis. However, the Customer Care Center can provide the most current member eligibility information
- Providers can also call AHCCCS Administration at (800) 962-6690 to verify eligibility. AHCCCS Administration will inform the provider of a member's AHCCCS plan; however, they do not have PCP assignment information.

Providers who have access to the Internet can verify eligibility on the AHCCCS website at www.azahcccs.gov. Choose the Plan/Providers link and then Provider website (AHCCCS online). AHCCCS obtains photos from the Arizona Department of Transportation Motor Vehicle Division (MVD) of all AHCCCS members who have an Arizona driver's license, or a State issued Identification Card. When providers use the online member verification system and enter a member's social security number, the member's photo will be displayed on the screen along with coverage information.

Eligibility can also be verified at the Health Plan specific websites. Choose the Providers Services and then check Enrollment Inquiry. Providers must register for this service. This service is provided at no charge.

Children's Rehabilitative Services

Members under 21 years of age with handicapping or potentially handicapping conditions that are likely to improve through medical, surgical or therapy modalities are eligible for care through Children's Rehabilitative Services (CRS). This is a Statewide, State and Federally funded program that services Arizona residents who qualify based on medical and financial criteria established by the Arizona Department of Health Services.

Member's Use of Emergency and Urgent Care Services

B – UHP expects the Primary Care Provider (PCP) to educate members of the differences between urgent and emergent conditions and instruct members to contact their PCP before visiting an emergency room or calling an ambulance unless they have a life-threatening emergency. Information regarding appropriate use of the emergency room is below. This can be photocopied and distributed to members.

The Emergency Room is for Emergencies!!! Call your doctor if you have a problem that is not a threat to your life. You can call your doctor at any time. Your doctor will tell you the kind of care you need. Your doctor or an urgent care is the place to take care of earaches, colds, or flu.

Examples of Non-Emergencies are:

- Sprained ankle
- Minor burns
- A minor allergic reaction
- Rashes
- Flu
- Sore throat with a fever
- Earache

What to Do if You Have an Emergency: Emergencies are a threat to your life. Emergencies can cause death if not taken care of quickly.

Examples of Emergencies are:

- Extreme shortness of breath
- Poisoning
- Bleeding that will not stop
- Fainting
- Chest Pains
- Seizures

If you are having any of these signs, go to the nearest Emergency Room or Call 911.

Section 20 – Model of Care

Special Needs Plans Background

Special Needs Plans (SNPs) were created by the Medicare Modernization Action (MMA) of 2003. The MMA authorized SNPs to limit enrollment to specific vulnerable populations.

- Chronic Condition (C-SNP)
- Dual Eligible (D-SNP)
- Institutional(I-SNP)

B – UHP manages Banner – University Care Advantage (B – UCA) D-SNP plan (eligible for both Medicaid and Medicare). B – UHP serves dual eligible members residing in the following counties: Cochise, Gila, Graham, Greenlee, La Paz, Maricopa, Pima, Pinal, Yuma and Santa Cruz counties.

Model of Care

SNP plans were mandated by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) to have a Model of Care (MOC) to ensure that these vulnerable populations receive the care and services necessary to help them manage and improve their health status. The MOC is the framework for Provider Network, Case Management, Quality Management policies, procedures and operational systems. The MOC sets guidelines for:

- Description of the SNP Population: that includes a complete description of the most vulnerable beneficiaries;
- Care Coordination: the health plan's staff structure, completion of the health risk assessment tool, individualized care plans, the interdisciplinary care team, and care transition protocols;
- SNP Provider Network: detailed description of the specialized expertise available to the beneficiaries, provider use of appropriate clinical practice guidelines and nationally-recognized protocols, and provider training on the Model of Care;
- Quality Measurement & performance Improvement: a quality performance improvement plan, measurable goals and health outcomes, measuring patient experience of care, ongoing performance improvement evaluation, and dissemination of SNP quality performance.

Through the MOC every member is evaluated annually via a Health Risk Assessment. The Interdisciplinary Care Team (ICT) works with members, caregivers, and families as appropriate in order to develop an individualized Plan of Care that meets each member's needs. Through the assessment process members are also directed to the appropriate B – UHP case management program. The case managers and PCPs work closely together to monitor the member's progress against the goals established in the Plan of Care. The case managers also work to help members identify problems and barriers to care, provide health education, coach members, and offer community resources when appropriate.

The partnership with the providers is a critical component to the success of the MOC. The MOC offers the opportunity for B – UHP and providers to work together to benefit our members, your patients.

The Providers Role in the Model of Care

As a B – UHP contracted provider, you play an important role in the delivery of the MOC. As a key partner in the MOC your role is to:

- Know who your SNP members are
- Outreach and assist members with scheduling the annual wellness visit

- Communicate with the B – UHP case managers regarding the care needs of your member
- Collaborate with the B – UHP ICT as needed
- Contribute to the development of the member's Plan of Care
- Maintain the Plan of Care as part of the member's medical record
- Assist the member to navigate the health care delivery system, including transition of care

B – UHP has developed a comprehensive MOC document which includes information on all the required elements. Below is a summary of the approach B – UHP has taken in implementing the MOC for B – UCA plans.

- Description of SNP Population:
 - Dual eligible: members qualify for both Medicare and Medicaid;
 - Younger in comparison to the general Medicare population and tend to be single;
 - A larger percentage of minority members;
 - A population that has a high poverty rate;
 - Typically, in poor physical and mental health;
 - Over half of the population have four (4) or more chronic medical conditions;
 - Over half of the population have a positive screen for depression.
- SNP Model of Care Coordination:
 - Qualified personnel responsible for enrollment, coordination of benefits and assist with access to care;
 - Utilization of a comprehensive health Risk Assessment tool to measure all aspects of the member's physical health, cognitive status, medication regimen, medical history, surgical history, behavioral health status, cultural preferences, linguistic needs, pregnancy state, nutrition status, functional need and psychosocial needs;
 - A team of staff review, analyze and stratifies the health care needs of the members;
 - All members are assigned a case manager who oversees the member's needs and assists with the development of the individualized care plan.
 - The health plan utilizes HRAs, Medical Risk Assessments, utilization claims data, pharmacy data, input from providers, and predictive modeling with a goal of creating an Individualized Care Plan (ICP) for each enrollee.
 - The patient's primary physician is notified via phone or letter when there are changes to the ICP in order to obtain their input. The health plan has adopted an Interdisciplinary Care Team (ICT) approach The ICT is shared with the member
 - Provide coordinated planned and unplanned care transitions for the members with the assigned case manager the primary contact for the member and caregiver.
- SNP Provider Network
 - B – UHP ensures that all contracted providers are vetted through a credentialing review process. B – UHP contracts with a full spectrum of medical specialists, sub specialists, inpatient facilities, dialysis facilities, pharmacies, PCPs, nursing professionals, outpatient clinics, durable medical equipment (DME) vendors, behavioral health professionals, and other health services providers.
 - B – UHP supports physician management of chronic conditions by disseminating best practice, and evidence-based guidelines to promote the delivery of quality care to our members.

- B – UCA monitors the network on a bi-annual basis to assess, address and manage beneficiaries' access to care and ensure that the needs are met.
- Network Development utilizes GeoNetworks to ensure covered services are provided promptly and are reasonably accessible in terms of locations and hours of operation. Ninety-five percent of current members travel 5 miles or less to reach a contracted PCP or dentist.
- The PCP is the gatekeeper for members and directs services for the members.
- The health plan assures that providers use evidence-based clinical practice guidelines and nationally recognized protocols. The health plan relies on both nationally recognized evidenced based medical tools such as Milliman and Hayes and our clinical practice guidelines which are based upon nationally accepted standards.
- Quality Measurement and Performance Improvement
 - B – UHP uses standardized quality improvement outcome and process measure to assess the performance of the Model of Care and measure member health improvements. Sources for this data include but is not limited to:
 - Healthcare Effectiveness Data and Information Set (HEDIS)
 - Chronic Condition Improvement Programs (CCIP);
 - Health Outcome Survey (HOS)
 - Consumer Assessment of Health Plan and Provider Survey (CAHPS)
 - Utilization metrics
 - HEDIS: Quality Management works closely with the assigned PCP to assure the member receives needed preventative health and wellness services;
 - CCIP: the health plan offers a disease management program to assist the members manage their chronic health condition;
 - QIPs: the health plan participates in national quality improvement projects overseen by CMS, such as the reduction in hospital readmissions.
 - HOS: Quality Management assesses the members self-reported physical and mental health assessment over time and initiates quality improvement projects to improve the member's health.
 - CAHPS: Annually the SNP members are surveyed by CMS about:
 - How quickly they receive care;
 - Getting needed care
 - Care coordination
 - Overall rating of their health care
 - Care coordination
 - Getting needed prescription drugs
 - Communication with their doctor
 - Rating of specialists

Summary

B – UHP's Model of Care for B – UCA provides a comprehensive process and infrastructure to meet the unique needs of our dual eligible population. Through the establishment of measurable goals, the delivery of care through a specialized network of provider, and services B – UHP can ensure that members receive needed care. In

addition, through the assessment, interdisciplinary care team and case management services, B – UHP is able to provide individualized care that meets the unique medical, psychosocial and functional needs of our members.

If you would like more information about the B – UHP Model of Care for B – UCA or request a copy of the Model of Care document, please contact your Provider Relations Representative.

Section 21 – KidsCare

KidsCare is Arizona’s health insurance for children under 19. Children age 18 and younger that qualify, can get medical, dental and visions services – all three services combined in one simple plan.

AHCCCS Kids Care is unable to approve any new applications. Enrollment in the KidsCare Program has been frozen since January 1, 2010 due to lack of funding for the program.

The KidsCare Office is processing renewals and changes for eligible children. Families with eligible KidsCare children must complete their renewal and make their premiums on time to avoid losing KidsCare coverage.

Eligibility Requirements

- A resident of Arizona
- Either a U.S. Citizen or a qualified eligible immigrant – regardless of the status of the parents
- Has a Social Security number or applies for one
- Is under the income limit
- Is not currently covered by other health insurance
- Does not qualify for coverage through a state agency employee
- Is a member of a household that is willing to pay a premium

Eligible Services

KidsCare members are eligible for the same services covered for members under the Title XIX Program. KidsCare covers the following medically necessary services:

- Doctor’s office visits
- Specialist care, if necessary
- Hospital services
- Pregnancy care
- Laboratory and X-ray services
- 24-hour emergency medical care
- Family planning services, but not abortion or abortion counseling
- Complete physical exams
- Dental screening and treatment
- Eye exams and corrective glasses
- Hearing tests and hearing aids
- Emergency and non-emergency medical transportation
- Behavioral health services
- Immunizations
- Prescriptions

For more information call KidsCare at (877) 764-5437 or <http://www.azahcccs.gov/applicants/categories/KidsCare.aspx>.

Eligibility and Enrollment

The State AHCCCS Program determines benefits. The Customer Care Center provides answers to member's questions, facilitates PCP changes and answers provider's eligibility inquiries. The focus of the Customer Care Center is to assist and coordinate medical care for KidsCare members. All new members will receive a welcome packet which includes:

1. a letter identifying his/her assigned Primary Care Physician (PCP)
2. a member handbook
3. a PCP directory
4. a letter with their assigned dental home provider
5. educational materials

AHCCCS issues an identification card when a member becomes eligible for benefits. This card includes the member's name, identification number, and the name of the health plan they are assigned to. Providers can use the plastic identification card with the Medifax system, or on the AHCCCS web site, to verify a member's AHCCCS eligibility.

Please remember it is the provider's responsibility to verify eligibility prior to providing services.

Providers should always verify a member's PCP assignment by either calling the Customer Care Center or verifying the current eligibility roster. You may determine a member's eligibility in the following ways:

- Providers can utilize the University of Arizona Health Plans eServices website to access member enrollment information and obtain member rosters. <https://eservices.uph.org/> For more information about eServices, contact your Provider Relations Representative.
- Call the Customer Care Center for updated eligibility information.
- Providers can also call AHCCCS Administration to verify eligibility. AHCCCS Administration will inform providers of member's AHCCCS plan; however, they do not have PCP assignment information.
- Providers who have access to the Internet can verify eligibility on the AHCCCS website at www.ahcccs.State.az.us. Go to Links and choose KidsCare.

Payment is not guaranteed for services rendered to an ineligible member. Please verify eligibility each time a member presents for services.

Section 22 – Continuity of Operations Plan (COOP)

The Health Plan has created a Continuity of Operations Plan (COOP), in order to maintain the viability and integrity of the Health Plan should there be a disaster. This policy will be followed to manage any situation that significantly disrupts critical, important, or marginal business functions that have been defined as a disaster.

Critical: Health Plan functions are identified as communication with health plan staff, health plan members, contracted providers and regulatory agencies. Ensuring members continue to receive immediate medically necessary services through contracted providers, Prior Authorizations, and concurrent review. Ensuring members have minimal to no disruption of services.

Important: Health Plan functions are identified as telephone systems, voice mail, computers and software, safety and security and finance operations.

Marginal: Health Plan functions are identified as grievance/appeals, plan changes, network development and claims processing.

Command Centers are established under the direction of the Health Plan CEO in response to any disruption in critical, important or marginal functions that have been defined as a disaster.

In the event of disaster, the following alternatives will be initiated:

- Key personnel will perform functions at alternate locations
- In the event of systems failure, as soon as work can resume, each department will utilize the manual backup system to ensure workflow continues with minimal interruption
- If required, telephone calls will be re-routed to pre-designated areas
- If voice mail is not functional, messages will be taken and callers will be provided with alternate numbers (i.e.; cellular or pager numbers) to reach their parties
- Network Development staff will communicate information and any special arrangements necessary to conduct business with the Provider Network
- All medically necessary services will be covered without prior authorization until normal business operations are recovered

Healthcare Facility Closure/Loss of Provider

In the event of an unexpected change that will result in a healthcare facility closure or loss of a major network provider with less than 30 days of notification of the change to B – UFC/ACC, B – UCA, or KidsCare, the health plan will call an urgent meeting of the Contract Status Committee the same day as the notification.

A major provider is defined as one of the following:

- PCP and OB Provider
- Specialist, Ancillary Provider or Vendor
- Inpatient Facility

The Contract Status Committee will assess the situation, make recommendations and implement interventions to ensure members receive uninterrupted care.

Loss of PCP or OB

If through facility closure or any other circumstance a provider leaves the network with less than 30-day notice to the Health Plan, The Contract Strategy Committee will have an urgent meeting to assess the impact on member care and the network, communication within the Plan, and short and long-term interventions for ensuring

continuity of member care and the adequacy of the network.

Network Development Department (ND)

- The provider office will be contacted by the health plan to determine the extent of the loss, providers' ability to render care and any plan the provider has for continuation of care with another provider. We will continue to communicate with the office to inform them of the plan to transition members to another provider. Communication with the office will occur in whatever way the office is able to communicate, i.e. phone, fax, site visit, etc.
- ND will assess the loss. If a provider is leaving a group but is going to remain in the community, we will attempt to obtain contract with him/her at his/her new location. Members would be given the option of retaining the PCP or OB at his/her new location, or choosing another PCP or OB.
- If the provider is not going to continue to see members in the network or it is a loss of an entire group, ND will assess the network in the given area of town. ND will present the Contract Status Committee short and long-term recommendations for the network. Recommendations will include member reassignment, possible short-term solutions for member care and long-term solutions for member care and adequacy of the network.
- If necessary, ND will contact other contracted and non-contracted providers in the service area to discuss reassignment of members to their practice. In the case of non-contracted providers, ND will negotiate either a Letter of Agreement or Contract with the provider. ND will also assist in temporary credentialing of the providers.
- ND will communicate the loss and interventions with other network providers as necessary. Communication may include but is not limited to bulletins, newsletters, site visits and phone calls.
- With the assistance of Customer Care Center, ND will ensure that member records are transferred to the new provider.

Customer Care Center (CCC)

- CC will be responsible for identification of members assigned to the PCP.
- CC will notify members of the change. Members will be notified directly via personal letter.
- CC will assist members in the selection of a new PCP or OB if necessary.
- CC will assess any special cultural needs of the affected members and ensure the member continues to receive culturally appropriate services.

Medical Management (MM), including Maternal Child Health, Behavioral Health, Care Management and Prior Authorization (PA)

- MM will be responsible for identifying members with open referral to an OB provider.
- MM will identify any members with special health care needs. MM will ensure that members with special health care needs receive uninterrupted care during the transition period.
- In the case of an OB provider termination, the Maternal Child Health department will ensure, with assistance from CC, that current OB patients are transitioned to another OB provider

Quality Management (QM)

QM will be responsible for ensuring that the interventions developed do not interfere with quality of member care or Performance Standards.

Loss of Specialist, Ancillary Provider or Vendor

If through facility closure or other means a specialist, ancillary provider or vendor leaves the network with less than 30-day notice to the Health Plan, The Contract Strategy Committee will have an urgent meeting to assess

the impact on member care and the network, and short and long-term interventions for ensuring continuity of member care and an adequate network.

Network Development Department (ND)

- The Health Plan will call an urgent meeting of the ND and Strategy Team upon notification of the loss.
- The ND and Strategy Team will create the overall plan and strategy for the loss.
- The office will be contacted by the Health Plan to determine the loss, the providers' ability to render care and any plan the provider may have for continuation of care with another provider or vendor. We will continue to communicate with the office to inform them of the plan to transition members to another provider. Communication with the office will occur in whatever way the office is able to communicate, i.e. phone, fax, site visit, etc.
- ND will assess the loss. If a provider is leaving a group but is going to remain in practice in the community, we will attempt to obtain a contract with the provider at the new practice.
- The new provider information would be in the provider listings for the member.

If the provider is not going to continue to see members in the network or it is a loss of an entire group, ND will assess the network in the given area of town. ND will present the ND and Strategy Team and identify short and long-term recommendations for the network. Recommendations will include possible short-term solutions for member care and long-term solutions for member care and adequacy of the network.

- If necessary, ND will contact other contracted and non-contracted providers in the service area to discuss possible rendering of care to members due to the loss. If it is a single source provider and there are no providers in the community who provide the service, ND will identify other means for member care, i.e. sending a patient to another city for care if the care does not exist in that city. In the case of non-contracted providers, ND will negotiate either a Letter of Agreement or Contract with the provider. ND will also assist in the temporary credentialing of the providers.
- ND will communicate the loss and interventions with other network providers as necessary. Communication may include but is not limited to bulletins, newsletters, site visits, phone calls, etc.

Customer Care Center (CCC)

- CCC will identify potential members affected by the change by running claims data for the provider indicating members who have seen the specialist in the past six (6) months. This will occur if the contracted facility will not be able to continue to care for the members.
- CCC will notify members of the change. Notification will occur as a general letter to the members.
- CCC will assist members in obtaining services with another provider if necessary.
- CCC will assess any special cultural needs and ensure members continue to receive culturally appropriate services

Medical Management (MM), including Maternal Child Health, Behavioral Health, Case Management and Prior Authorization (PA)

- MM will be responsible for identifying members with open referrals to the specialist, ancillary provider or vendor, when a referral is required.
- MM will also review the member list obtained through claims data to identify members with special health care needs. MM will ensure that known members with special health care needs receive uninterrupted care during the transition period.
- If a member is identified as being in case management, the case manager will ensure, with assistance from MM, that the member is transitioned to another Specialty Care Provider

Quality Management (QM)

QM will be responsible for ensuring that the interventions developed do not interfere with quality of member care or Performance Standards.

Loss of an Inpatient Facility

If through facility closure or other means an inpatient facility leaves the network with less than 30-day notice to the Plan, the Contract Strategy Committee will have an urgent meeting to assess the short and long-term interventions for ensuring continuity of member care and an adequate network.

Network Development Department (ND)

- The Health Plan will contact the facility to determine the loss, the providers' ability to render care and any plan the provider may have for continuation of care with another provider or vendor, i.e. patient care diversion plans for hospitals. We will continue to communicate with the office to inform them of the plan to transition members to another provider. Communication with the office will occur in whatever way the office is able to communicate, i.e. phone, fax, site visit, etc.
- ND will assess the loss. ND will determine if it is a short term, long term or complete closure or loss of the facility.
- If it is a short-term loss, ND, with the assistance of the facility will estimate the length of time the facility will be closed. Short-term interventions will be created to supplement the network until the facility can again render care. Short-term interventions may include diversion of members to another network facility, another facility out of the service area or contracting with other facilities in the services area. ND will consider using Letters of Agreement until a contract can be negotiated with another facility.
- If it is a long-term loss, ND will first identify the short-term interventions listed above and implement these interventions. Once the short-term interventions are implemented, ND will identify long-term interventions. ND will assess the impact of the facility loss to the network. If the loss is determined to hinder the ability of the Plan to render services to the member, ND will identify facilities that can render the same or similar services. ND will contact these facilities and begin contract negotiations.
- A complete loss or closure will be handled in the same manner as a long-term loss.
- ND will communicate the loss and interventions with other network providers as necessary. Communication may include but is not limited to bulletins, newsletters, site visits, phone calls, etc.

Customer Care Center (CCC)

- CCC will notify members of the change. Notification will occur as a general letter.
- CCC will assist members in obtaining services with another provider if necessary.
- CCC will assess any special cultural needs and ensure members continue to receive culturally appropriate services.


Medical Management (MM), including Maternal Child Health, Behavioral Health, Case Management, Utilization Review (UR) and Prior Authorization (PA)

MM will be responsible for identifying inpatient members at the facility through utilization review records and inpatient notifications.

The UR nurse will work closely with The Contract Strategy Committee to ensure the members are transferred to another facility and they continue to receive appropriate care. UR nurses will report back to the Team on the status of members and transition of care.

Quality Management (QM)

QM will be responsible for ensuring that the interventions developed do not interfere with quality of member care or Performance Standards.



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