Banner University Health Plans

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January 2020 Provider News

Respiratory Syncytial Virus (RSV) more serious, sooner than expected

AHCCCS has issued a couple of resources related to RSV and its arrival being more serious and much sooner than expected. At this time there is a significant rate of RSV infection circulating both locally and nationally. The national report indicates that there are no supplements or nutrients that can prevent RSV and reminds providers that antibiotics do not play a role in the treatment of RSV. Parents should be aware that if their child is working hard to breathe, they should be seen quickly as RSV can become quite serious.

Providers should be vigilant in promoting preventive measures with your staff and with all our members. These preventive measures include handwashing and staying home when sick. Be sure to offer masks to those in your waiting room who might be showing symptoms of RSV.

It is also important to increase awareness of this with all staff so that they can improve detection and early intervention with our vulnerable populations: children, and Adults 65 and over and those with chronic heart or lung disease or a weakened immune system.

RSV Resources:
https://www.cdc.gov/surveillance/nrevss/rsv/state.html#AZ
https://www.cdc.gov/surveillance/nrevss/rsv/state.html#AZ
https://www.today.com/health/what-rsv-respiratory-virus-particularly-bad-season-doctors-warn-t171208

Children's Rehabilitative Services (CRS) Program

Children's Rehabilitative Services (CRS) is a designation given to certain AHCCCS members, from birth until 21 years of age, who have qualifying health conditions as well as a qualifying treatment plan for program enrollment. Banner University Family Care is committed to ensuring fully integrated health care services are provided to the state's special needs population, including those that are enrolled in the CRS program.

Eligibility for a CRS designation requires completion of an application with supporting medical documentation and inclusion of the intended treatment plan. Enrollment is determined by the AHCCCS Division of Member Services (DMS) in

alignment with criteria as specified in R9-22-1301-1305. The BUHP Maternal & Child Health Department provides staff dedicated to supporting the CRS program. They are ready to assist with the process of reviewing for potential CRS eligibility as well as the preparation and submission of CRS program applications on the behalf of member, family and providers. Pediatric Care Managers are also available to provide support and care coordination for any potential or actively enrolled CRS members.

Once enrolled in the CRS program, designated members are eligible and encouraged to receive care through the Multi-Specialty Interdisciplinary Clinics (MSICs) located in Tucson, Phoenix and Yuma. These clinics bring a combination of primary care, various specialty providers, therapy services and behavioral health services, together into one location. Through this approach, the MSICs improve service accessibility and provide family-centered, coordinated care to meet the complex needs of children within the CRS program.

If you have questions about the CRS Program, eligibility requirements, or need assistance completing an application for CRS enrollment, please contact us. Referrals can be sent by email to: BUHPMaternalChildHealth@bannerhealth.com or by calling our Customer Care Center at 1-800-582-8686, and asking to speak with the Maternal & Child Health Department's CRS Eligibility Specialist.

More CRS information is also available by contacting the AHCCCS CRS Enrollment Unit at: 602-417-4545. The list of CRS qualifying medical conditions and the CRS Application are available at:
https://www.azahcccs.gov/Members/GetCovered/Categories/CRS.html

Children's Behavioral Health in Arizona

Did you know that the children's behavioral health system was expanded to its current form based on a lawsuit? In 1991, *Jason K. v. Eden*, was filed against the State of Arizona. The lawsuit alleged that the children's behavioral health system in Arizona was not adequately meeting the needs of Medicaid-eligible children. The plaintiff, Jason K., was said to have been referred for services by his therapist but those services were denied by Arizona's behavioral health system.

In 2001, 10 years after the lawsuit was filed, the court ruled in favor of Jason K. As a result, Arizona entered into a settlement agreement to improve the children's system. Some notable components included the creation of the *Arizona Vision and 12 Principles*. The *Arizona Vision* states, *"In collaboration with the child and family and others, Arizona will provide accessible behavioral health services designed to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults. Services will be tailored to the child and family and provided in the most appropriate setting, in a timely fashion, and in accordance with best practices, while respecting the child's and*

family's cultural heritage." The settlement also included implementation of the *300 Kids Project*, which led to the creation of the Child and Family Team process.

Prior to the *Jason K.* lawsuit, covered services were primarily acute care such as hospitalization, and limited outpatient services such as case management and therapy. As a result of the settlement, Arizona added additional services such as respite care, and support and rehabilitation. Respite care provides temporary rest or relief to a caregiver and the child. Support and rehabilitation offer one-to-one care to higher-acuity children in their home and community. The goal of support and rehabilitation, such as Meet Me Where I Am services, is to promote stability, self-sufficiency for the child and family, and to prevent the child from being hospitalized or entering residential treatment. The *Jason K.* lawsuit resulted in major improvements for the children's behavioral health system and we continue to work towards enhancing the system further today.

If you have questions regarding children's services, please contact Children's System of Care Sr. Manager, Cameron Cobb, at cameron.cobb@bannerhealth.com.

Save the Date March - BUHP Provider Education Forums

Look for invitations to be distributed in February, but please save the date for these upcoming BUHP Provider Education Forums:

All Forums are Noon – 2 p.m. and lunch will be provided

Tuesday, Mar. 3	Banner Corporate Center Mesa, Conf. Rooms 1616 & 1617 525 W Brown Rd., Mesa
Wednesday, Mar. 4	Banner Boswell Medical Center Support Svcs Bldg Memorial Hall East/West 13180 N 103rd Dr, Sun City
Thursday, Mar. 5	Banner Thunderbird Medical Center Lower Level Conf. Rm 6 5555 W Thunderbird Rd, Glendale
Tuesday, Mar. 10	Abrams Public Health Center Conf. Rooms 1104, 1106 & 1108 3950 S Country Club Rd, Tucson
Thursday, Mar. 12	Banner Casa Grande Medical Center Discovery & Encounter Rooms – 1800 E Florence Blvd, Casa Grande
Thursday, Mar. 19	Hilton Garden Inn Yuma/Pivot Point Gila/Southern Pacific Room – 310 N Madison Ave, Yuma

Note: Dates, times and locations are subject to change; Invitations will be distributed in February

Reporting BUHP members to 23-hour Crisis Observation Units

The AHCCCS contract requires all Health Plans to be responsible for all medically necessary services and continuing care related to a crisis episode which may include follow up stabilization services, after the initial 24 hours covered by the RBHA.

In order for Banner to deploy care coordination and intervention strategies to ensure the member is able to access ongoing behavioral health services, a timely report of all Banner members admitted to a Crisis Observation Unit is required by all providers that serve Banner members.

Many 23-Hour Crisis Observation providers are notifying Banner about these members in an individual e mail, often multiple times throughout the day. To ensure accurate and timely reporting, Banner has developed a Report Template and guidelines for notification of Banner members admitted to a 23-Hour Crisis Observation Unit. This report will assist with verification of the admission for claims payment issues as well as assist in the care coordination efforts for the member's psychiatric stability.

Effective January 1, 2020, BUHP requests the following reporting method of notification for Banner members admitted to the 23-Hour Crisis Observation unit.

Template begins on next page

Report/Title:	<Name of Agcy> Banner 23-Hour Crisis Obs Weekly Report Template
Report Time Period:	Admissions from Sunday through Saturday night at midnight. For example, Sunday, Dec. 8 through Saturday, Dec. 14 at midnight is submitted on Monday, Dec. 16
Frequency of Submittal:	Every Monday before Noon
Submittal location:	BUHPCareMgmtBHMailbox@bannerhealth.com
Banner Contact Information:	Candy Barco at Candy.Barco@Bannerhealth.com
Template Format Specifications:	*COU – Name of Crisis Observation Unit (CRC, UPC, etc.)* *Member AHCCCS ID#* *Member Date of Birth* *Member Last Name* *Member First Name*

	Adult or Child *Current Behavioral Health Outpatient Provider <Outpatient BH Provider – (for example, TERROS, Southwest, Community Health Associates)>* *Urgent Engagement - <name of provider contacted for Urgent Engagement if Urgent Engagement was conducted>* *Date of Admission: <mm/dd/yyyy>* *Time of admission: <1:40 p.m.>* *Diagnoses – NO CODES (for example – Major Depressive Disorder, Anxiety, Schizophrenia, Psychosis, DTS/DTS)* *Voluntary/Involuntary - <petition, COT, etc.>* *Date of Discharge <mm/dd/yyyy>* *Time of Discharge <10:00 a.m.>* *Disposition/Discharge Information (for example, discharged to home, transitioned to Level 1, discharged to ED, discharged to Medical facility, discharged to BHRF, discharged to outpt services, member declined all services)*

For questions regarding the submittal of this report please contact us at: BUHPCareMgmtBHMailbox@bannerhealth.com

We appreciate your collaboration with ensuring Banner members receive quality and timely crisis services.

Compliance Corner: Fraud, Waste and Abuse

Fraud is defined as purposely giving wrong or misleading information in order to receive a benefit or some type of service. **Abuse of the Program** is any situation where provider practices or member practices result in unnecessary cost to the AHCCCS or Medicare programs. **Waste** is over utilizing services or misusing services, resources or practices.

Instances of Fraud continue to rise and efforts to combat these issues have also increased. In 2018, Health care fraud recoveries totaled $2.3 billion dollars. The return on investment for fraud investigations was $4 for every dollar spent. There were 1,139 criminal investigations opened and charges were filed in 572 cases against 872 defendants.

What can you do? First and foremost, know the regulations and rules surrounding coding, documentation and billing and ensure you do not submit false claims to the Health Plan.
If you suspect fraud, waste or abuse, please report it immediately.

Some examples of Provider Fraud include:

- Upcoding: Billing a higher level of service than provided to get a higher reimbursement
- Overbilling or duplicate billing including billing for a new patient code multiple times or billing a code intended for once in a lifetime, multiple times
- Billing for appointments the member failed to keep
- Unbundling: Separate pricing of goods or services that should be billed together in order to inappropriately increase revenue/billed charges
- Intentionally billing "By Report" Codes at prices well above national standards
- Billing for services outside the scope of license or not provided
- Cloning or copying/pasting records from one visit to the next or one patient to the next
- Billing for unnecessary services or overutilization –tests, prescriptions (example – ordering Vitamin D for every patient), treatment or other medical services that are medically unnecessary in order to increase payments
- Billing under the NPI of another provider for higher reimbursement or due to non-credentialing
- Balance-billing a member or charging an inappropriate co-pay
- Failing to sign and date progress notes thus not validating the service occurred
- Failure to document a service

Provider Audit Trends

The Banner University Health Plans (BUHP) Compliance Department has been conducting routine provider medical record audits. This audit compares medical record documentation to the claims submitted and paid by BUHP to ensure both are proper and accurate.

Upon completion of audits for 2019, we have identified some concerns regarding the types of errors that we are seeing. To collaborate and help providers understand the rules and regulations, and avoid costly errors, we are sending this communication out to everyone.

The Top Three Commonly Seen Errors:

1) Progress notes not signed appropriately – progress notes are required to be signed and dated by the rendering/treating provider after each appointment and/or procedure prior to being billed. What we see are notes that say

pending, notes that are signed up to a year later, notes that are signed by someone on behalf of the provider or notes with no signature or date. These examples make the note invalid. We have reported several of these cases to the AHCCCS Office of Inspector General (OIG) and CMS.

2) Services billed under the NPI of a provider who did not render the service for an AHCCCS service. For AHCCCS, providers are required to bill the claim under the NPI of the provider who rendered the service. Incident-to-services that are allowed under Medicare for mid-levels to bill under a supervising physician are not allowed under AHCCCS. For instance, the P.A. and N.P. must be registered with AHCCCS and credentialed. If it is not billed under the rendering provider, the claim is null and void; this would be a reportable offense to the AHCCCS OIG.

3) Services provided are not adequately described in the progress note. The documentation should clearly reflect the service code billed. Often, we see that a highly specific service code is used, and the documentation does not support the specificity of that service code.

Please be advised: typically, Medical Decision Making (MDM) should be used as a driving factor when determining the level of Evaluation and Management (E/M) service. If billing for a level of service that the level of MDM does not support, the reason for that level of service should be clearly documented.

Chart of Compliance Contacts continues on the next page

Banner University Health Care Contact Information	
BUHP Customer Care Banner - University Family Care – ACC (800) 582-8686 Banner - University Family Care – LTC (833) 318-4146 Banner - University Care Advantage – SNP (877) 874-3930 **BUHP Compliance Officers** (520) 874-2847 or (520) 874-2553 **BUHP Compliance Department FAX** (520) 874-7072 **BUHP Compliance Department Email** BUHPCompliance@BannerHealth.com	**BUHP Compliance Department Mail:** BUHP Compliance & Audit Dept 2701 E Elvira Rd Tucson, AZ 85756 **Confidential and Anonymous Compliance Hotline (ComplyLine)** (888) 747-7989
AHCCCS Office of the Inspector General **Providers are required to report any suspected FWA directly to AHCCCS OIG**	
Provider Fraud (602) 417-4045 (888) 487-6686	**Website** www.azahcccs.gov (select **Fraud Prevention**) **Mail:**

Member Fraud (602) 417-4193 (888) 487-6686	Inspector General 701 E Jefferson St. MD 4500 Phoenix, AZ 85034
Medicare **Providers are required to report all suspected fraud, waste and abuse to the Health Plan or to Medicare**	
Phone: (800) HHS-TIPS (800-447-8477) **FAX:** (800) 223-8164 **TYY:** (800) 377-4950 **Website:** https://forms.oig.hhs.gov/hotlineoperations	**Mail:** US Department of Health & Human Services Office of the Inspector General ATTN: OIG HOTLINE OPERATIONS PO Box 23489 Washington, DC 20026