Banner
University Health Plans

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Provider Update

Mar. 10, 2023

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Thousands of AHCCCS Providers to be Terminated for Non-Compliance

In the first month of its planned process to terminate non-compliant providers, AHCCCS has identified 5,288 providers who have not taken the required action to maintain their registered status.

The process to re-validate registered providers began in November 2022 with letters mailed to the first group of providers. They were asked to re-validate in the AHCCCS Provider Enrollment Portal (APEP) within 90 days. Only 8% took the action requested to maintain their registration, the 5,288 who did not comply were set to be terminated in February.

Any provider who has not completed the revalidation process in the AHCCCS Provider Enrollment Portal will receive notification to submit an application. Providers who do not respond will receive written notification of pending dis-enrollment and appeal rights.

To avoid termination and/or loss of billing privileges, providers must respond and take action, following specific actions outlined in the letter, with the noted time frames. Failure to complete these actions will result in dis-enrollment and claim denials.

To learn more about the actions AHCCCS has taken to address the COVID-19 emergency, visit https://www.azahcccs.gov/AHCCCS/AboutUs/covid19.html and the accompanying FAQs section (https://www.azahcccs.gov/AHCCCS/AboutUs/covid19FAQ.html)

What AHCCCS Providers Need to Know:

- Providers who need to complete the revalidation process or meet additional screening requirements will be notified in writing through the United States Postal Service mail.
- AHCCCS will review the submitted application and issue a written notice upon completion.
- Providers that have an expired license will be notified in writing to submit the current license or certification.
- Providers who fail to respond to the request could experience delays such as termination and/or loss of billing privileges.

Providers with questions, those who are no longer participating as a Medicaid provider, and those no longer employed with an organization are asked to contact APEPTrainingQuestions@azahcccs.gov.

B – UFC/ACC and B – UFC/ALTCS Receives Accreditation from NCQA

The National Committee for Quality Assurance (NCQA) has awarded B – UFC/ACC and B – UFC/ALTCS a three-year Medicaid Health Maintenance Organization (HMO) Accreditation effective February 22, 2023. This is the highest level of accreditation that can be given to an organization. In addition, the health plans earned the Long - Term Services and Supports Distinction and Medicaid deeming status.

To receive the NCQA accreditation, staff demonstrated their commitment to offering high quality services with measurable results. They worked diligently over the last two years through rigorous reviews of policies, reports and files to align our process with NCQA's requirements. The NCQA surveyor pointed out specific strengths of the team including:

- Dedicated and engaged health plan staff
- Overall submission of program documents compiled and bookmarked comprehensively
- Credentialing and appeal files well prepared
- LTSS Care Management System

NCQA standards are a road map for improvement. The Health Plan standards evaluate plans on: Quality Management and Improvement, Population Health Management, Network Management, Utilization Management, Credentialing and Re-credentialing, Members' Rights and Responsibilities, Member Connections and Medicaid Benefits and Services. The Long-Term Services and Supports Distinction standards provide a framework for organizations to deliver effective person-centered care that meets member's needs and aligns with state requirements.

The Medicaid Module helps health plans maximize alignment with the Medicaid Managed Care Rule and positions an organization for a streamlined state compliance review.

Achieving this accreditation for the health plans, along with our existing accreditation for our other lines of business, shows we adhere to the highest quality standards for our members, partners and community.

COVID-19 Variants Updates

New COVID-19 variants began circulating in October and November of 2022. None of the monoclonal antibodies, including Evusheld, are effective against these variants including the rapidly rising variant XBB.1.5.

Prevalence

- As of Jan. 28, 2023, XBB.1.5 makes up 61% of the COVID cases in the US, with BQ.1.1 making up ~22% and BQ.1 making up 9%.
- CDC updates the variant tracker weekly: Go to https://covid.cdc.gov/covid-data-tracker/
- In the California and Arizona region, XBB.1.5 makes up 35% of the COVID cases, BQ.1.1 makes up 34%, and BQ.1 makes up 19%.
    - XBB.1.5 prevalence has been doubling weekly and is expected to rise.

Monoclonal Antibodies

- All of the monoclonal antibodies are ineffective against XBB.1.5, BQ.1, and BQ.1.1.
- Evusheld, used for pre-exposure prophylaxis for immunocompromised patients, will not neutralize XBB.1.5, BQ.1, or BQ.1.1.
    - FDA has removed Evusheld's Emergency Use Authorization (EUA) and should no longer be used.

Oral Antiretroviral

- Both molnupiravir (Lagevrio) and nirmatrelvir/ritonavir (Paxlovid) remain effective against XBB.1.5, BQ.1, and BQ.1.1.

Remdesivir

- Remdesivir remains effective against XBB.1.5, BQ.1, and BQ.1.1.

Prior Authorization Updates (eviCore and Banner)

If you need to submit a request with multiple CPTs/HCPC codes going to both eviCore and Banner, according to the prior authorization grid, please do not split these cases up. Send all codes (even those that will go to eviCore) to Banner for review. We do not want to delay member care and will review the entire case.

Note: CPT 81528 (Cologuard test) has been removed from the Prior Authorization grid effective Feb. 23, 2023 (no authorization is required for the test with Exact Sciences).

The online prior authorization grids can be found here: https://www.banneruhp.com/-/media/files/project/uahp/prior-authorization-grids/2023/buhp_medical-prior-auth-grid_eff01123_en.ashx?la=en

Claim Update for CPT Code T1016

Recently, our health plan has received claims billed for code T1016 under the ALTCS line of business. Per AHCCCS regulations, behavioral health case management provides this service for ALTCS members therefore, not a reimbursable service for providers.

Case Management for ACC members

Case Management (provider level) is a supportive service provided to improve treatment outcomes.

Coding Units for ACC members

For case management services (T1016), with billing units of 15 minutes, the first unit of service can be encountered/billed when 1 or more minutes are spent providing the service.

To encounter/bill an additional unit of the service, the provider must provide service for at least one half of the billing unit's time frame for the additional unit to be encountered/billed. If less than one half of the additional billing unit is spent providing the service, then only the initial unit of service can be encountered/billed.

Modifiers for ACC members

For provider case management used to facilitate a Child and Family Team (CFT), the modifier U1 is required.

For provider case management utilized when assisting members in applying for Social Security benefits (using the SSI/SSDI Outreach, Access, and Recovery (SOAR) approach) the modifier HK is required. Billing T1016 with an HK modifier indicates the specific usage of the SOAR approach, and it cannot be used for any other service.

Case Management Limitations:

i. Billing for case management is limited to providers who are directly involved with providing services to the member.
ii. **Provider Case Management is not a reimbursable service for ALTCS E/PD, including Tribal ALTCS. Case Management is provided through the ALTCS E/PD Contractors or Tribal ALTCS Program.**
iii. Provider Case management services provided by licensed inpatient, residential (BHRF) or day program providers are included in the rate for these settings and cannot be billed separately. However, providers other than the inpatient, residential (BHRF) facility or day program can bill case management services provided to the member.
iv. A single practitioner may not bill case management simultaneously with any other service.
v. For assessments, the provider may bill all time spent in direct or indirect contact (e.g., indirect contact may include email or phone communication specific to a member's services) with the member and other involved parties involved in implementing the member's Treatment/Service Plan
vi. More than one provider agency may bill for case management at the same time if it is clinically necessary and documented within the member's Treatment/Service Plan.
vii. More than one individual within the same agency may bill for case management at the same time if it is clinically necessary and documented within the member's Treatment/Service Plan.

viii. When a provider is picking up and dropping off medications for more than one member, the provider shall divide the time spent and bill the appropriate case management code for each involved member.

ix. Written electronic communication (email) is an allowable method for providing case management services with the following requirements:
- The email must be addressing a specific member's service needs, and
- A copy of the email communication shall be included in the member's medical record.

x. SOAR services shall only be provided by staff who have been certified in SOAR through the SAMHSA SOAR Technical Assistance Center. Additionally, when using the SOAR approach, billable activities do not include:
- Completion of SOAR paperwork without member present,
- Copying or faxing paperwork,
- Assisting members with applying for benefits without using the SOAR approach, and
- Email.

Please reference https://www.azahcccs.gov/PlansProviders/Downloads/FFSIHStribalbillingManualDrafts/Chapter_19_Behavioral_Health_Services.pdf

Arizona Disability Benefits 101 (DB101)

AZ DB101 is a tool that can both assist our members in making informed choices about working and help providers give the most accurate information possible. AZDB101 helps our members to understand how working can impact their benefits, learn about programs that can help them to work and understand their different health coverage and education options. If you struggle, as a provider, to help a member see that working is a viable option for them, AZ DB101 may be a solution to reduce the myths about barriers to employment.

Visit https://az.db101.org/ today! Provider employment staff should be creating a profile, offering to assist members in creating their own account, completing estimator sessions with members, and using that information to help members access the different AHCCCS and/or Social Security Work Incentives.

The next AZ DB101 for Professionals Training is tentatively scheduled for Thursday, Mar. 23 from 1 – 4 p.m. For more information and/or training on using DB101, please contact Sara Hernandez at sara.hernandez@bannerhealth.com or visit https://wid.org.

Myths and Facts About Working (Part 1)

Please consider the following while working with members who are not employed; there are many options for assistance within the B – UHP network.

Myth #1: People with disabilities can't work.

Fact: While a person's disability may hinder how many hours they can work or what kind of occupation they may have, working is an option for people with disabilities. There are also many resources to help people get a job.

Myth #2: People on SSDI/SSI risk will lose their benefits if they start working.

Fact: Both SSDI and SSI have programs that can help people to try out working without risking losing their benefits. To learn more about these options you can speak with a work incentives consultant in your area at (866) 304-WORK (9675).

Myth #3: There is no help for people looking for work.
Fact: There are many places to go for help in finding work. Arizona One-Stop Centers (https://arizonaatwork.com/locations), Arizona@Work (ARIZONA@WORK | Innovative Workforce Solutions (arizonaatwork.com), and Vocational Rehabilitation (Arizona Rehabilitation Services | Arizona Department of Economic Security (az.gov)) are just a few that can help in the community. If you have a member who would like assistance preparing for work, finding a job or getting support to maintain their current job and you do not provide these services internally, there are many providers in the B – UHP network that can assist.

Visit Banner's Employment website at: https://www.bannerufc.com/acc/resources/employment-services to find a list of employment providers by county. Additionally, we encourage you to refer to our Centers of Rehabilitative Excellence. These CORE programs provide exceptional services to our members and have outstanding outcomes.

Maricopa County

ValleyLife
Lesli Stern, Program Manager, Vocational Services
lstern@valleylifeaz.org
(602) 216-6344

Copa Health
Joy Mullins, Program Director
Joy.Mullins@copahealth.org
(480) 969-3800 x1335

Pima County

Coyote TaskForce
Joanna Keyl, Intake/Admissions Coordinator
referrals@ctftucson.org
(520) 884-5553

La Frontera Center
Miranda Callahan-Gould, Clinical Coordinator of Employment & Specialty Services
Miranda.Callahan@lafrontera.org
Office: (520) 258-5042
Cell: (520) 262-1727

Yuma County

Achieve
Lucia Wilson
lwilson@achievehs.org
(928) 341-4147
(928) 581-8412

AHCCCS EVV (Electronic Visit Verification)

This notice is intended for providers subject to the Electronic Visit Verification requirements

Contingency Planning FAQ
AHCCCS is pleased to announce that a Contingency Planning FAQ has been posted to the EVV web page (https://www/azahcccs.gov/AHCCCS/Initiatives/EVV/ under General Resources

and Frequently Asked Questions). In response to provider stakeholder engagement, AHCCCS has provided guidance regarding the purpose and process for contingency planning to help identify member's preferences to support tracking and monitoring access to care with EVV systems.

Differential Adjusted Payment (DAP) Opportunity

AHCCCS intends to offer a Differential Adjusted Payment (DAP) opportunity for providers who are subject to EVV. Please note, there are two EVV DAPs, but providers may only qualify for one. If a provider qualifies for both DAPs, AHCCCS will award the DAP with the higher percentage increase.

- **DAP 1** – HCBS providers that participate in the EVV system will qualify for a DAP increase of 0.5% if the provider has at least 85% of processed visits with dates of service from Sept. 1, 2022, to Nov. 30, 2022.
- **DAP 2** – HCBS providers that participate in EVV will qualify for a DAP increase of 2.0% if the provider has at least 85% of claims submitted with dates of service from Jan. 1, 2023, to Mar. 30, 2023 pass claims validation on the first claim submission.

More detailed information can be found on the Public Notices and Opportunities for Public Comment webpage (https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/qualifyingproviders.html). *Please note – Funding for DAP rate increases is subject to the appropriation of State funds and State budget constraints. Federal funding for DAP rate increases is contingent upon federal approval. All decisions or considerations included in this notice are therefore subject to the availability of funds and federal approval.*

Technical Support

For Sandata users, please contact the Sandata Customer Care at (855) 928-1140 for any technical support for the system including, but not limited to:

- Accessing training,
- Finding your welcome kit,
- Changing your EVV Contact,
- All other technical issues experienced by users on devices or the EVV portal.

For technical issues related to the current alternate system technical specifications, please contact the Sandata Customer Support at AZAltEVV@sandata.com or (844) 289-4246.

Home Health Services Payment Concerns

We are aware of the recent concerns raised by providers regarding the payment for home health services in light of the recent AHCCCS requirement of EVV technology. We understand that this has caused some uncertainty and frustration among providers, and we want to assure you that we are taking these concerns seriously. We are working closely with our internal departments to develop an action plan to address these concerns. We are committed to finding a solution that ensures fair and accurate payment for all services rendered while complying with the AHCCCS EVV requirements. Our team will follow up with you once we have formulated our action plan. We appreciate your patience as we address these concerns and find a solution for everyone.

Sonora Quest Laboratories

For Banner - University Health Plans, Sonora Quest Laboratories is the recommended lab. For Banner Medicare Advantage HMO & PPO, Sonora Quest Laboratories is used exclusively for laboratory services for our members.

Healthcare Effectiveness Data and Information Set (HEDIS ®)

HEDIS is widely used to measure and improve health care quality and is relied on by government regulators, health plans, provider organizations, employers and others to identify quality and compare plan performance.

*Please respond quickly to **medical record requests** from the Health Plan to remain in compliance with your Banner contractual obligation.

Requests were sent beginning in **January 2023** and records need to be received no later than April 2023.

HEDIS Talk! Eye Exam for Patients with Diabetes (EED)

As result of the previous Comprehensive Diabetes Care (CDC) measure separation, we now have a new separate Eye Care measure for members with Diabetes.

Line of Business: Commercial, Medicaid and Medicare
This measure evaluates percentage of members 18–75 years of age with diabetes (Type 1 and Type 2) who had a retinal eye exam.

At a minimum, documentation in the medical record **must include one** of the following:

- A retinal or dilated eye exam by an eye care professional (*optometrist or ophthalmologist*)
- A chart or photograph indicating the date when fundus photography was performed ***and*** one of the following:
    - Evidence an eye care professional (*optometrist/ophthalmologist*) reviewed the results.
    - Evidence results were read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist.
    - Evidence results were read by a system that provides an artificial intelligence (AI) interpretation.
- Evidence that the member had bilateral eye enucleation or acquired absence of both eyes anytime in the members history

How to help this HEDIS Measure?

- Make sure ALL retinal eye exams are clearly documented
    - Include the date the exam was performed, results of the exam, and the facility or provider name who performed the eye exam

- For members who are **positive** for retinopathy, a yearly exam is required
- For members who are **negative** for retinopathy, an eye exam is recommended every 2 years
- Make sure to document any findings of Hypertensive retinopathy
- Remember- unilateral eye enucleation and blindness are not exclusions for the EED measure
- Note clearly if member is enrolled in Hospice or is receiving Hospice care

Banner – University Health Plans is here to help. Contact your Care Transformation Consultant/Specialist. If you are unsure of who your representative is, you may send an inquiry to BUHPProviderNotifications@bannerhealth.com.

Hemoglobin A1c Control for Patients with Diabetes: Closing the Gap

The hemoglobin A1c test is a blood test that measures a person's average blood sugar levels over the last three months. It's commonly used to help patients and their health care team manage diabetes. An A1c level greater than 6.5% is associated with diabetes complications, so reaching and maintaining a healthy A1c goal is especially important.

Hemoglobin A1c control (<=9%) for diabetic patients is a high-priority quality measure for NCQA HEDIS clinical performance ratings and for value-based care performance incentives. To maximize data capture for this measure, proper coding is essential. For a member to be compliant for A1c control, the coding for a member's most recent A1c test must also include a corresponding numeric value, or a CPT-II code that indicates the range of the result. If billing codes show the test was performed, but there was no result value associated with it, this creates a new "open gap" in care for the A1c control measure. The following are codes that open the gap for an A1c result:

- CPT codes (claims): 83036, 83037

Records need a CPT-II code from a claim OR a numeric A1c result value from a clinical data source to capture an A1c result. BUHP receives clinical data feeds for A1c results from the Cerner EMR, Sonora Quest Laboratories, and Arizona's health information exchange (HIE). The following codes must be used to close the gap to capture an A1c result:

- CPT-II codes (claim data). *Please note that the 3045F CPT-II code is no longer accepted for this measure*
  - 3044F (A1c<7.0%)
  - 3051F (A1c between 7.0% and 7.9%)
  - 3052F (A1c between 8.0% and 8.9%)
  - 3046F (A1c>=9.0%)
- LOINC code 4548-4 with a numeric result value populated (clinical data sources)

Maintaining lower A1c levels is critical for preventing diabetes complications and for promoting the overall health maintenance of our members. Closing this gap in care also improves Medicare and Medicaid performance ratings, which can impact payer reimbursements and incentive payments.

Valley of the Sun Heart Symposium – Updates & Innovations

Banner University Medicine Heart Institute will be hosting their first **Valley of the Sun Heart Symposium – Updates & Innovations** from 7 a.m. – 8 p.m. on Saturday, Mar. 11, 2023, at The Phoenician, A Luxury Collection, 6000 E Camelback Rd, Scottsdale, AZ. To register online, please visit www.bannerhealth.com/230care and enter **Heart Symposium** in the search bar. To register by phone, please call (602) 230-CARE (602-230-2273).

Cost to attend: Physicians $125, APPS $75, NP's PA's, Nurses, Pharmacists, PT's, OT's, Fellows & Resides- Complimentary.

Psychiatry for Non-Psychiatrists

This fully virtual conference, "Psychiatry for Non-Psychiatrists: The University of Arizona 2nd Annual Update in Behavioral Medicine for Primary Care" will provide practical and actionable knowledge to help PCPs effectively manage mental health conditions in primary care settings.

When: Saturday, Mar. 11, 2023
Time: 8:30 a.m. – 2:30 p.m.
Outcome Objectives:

- Incorporate into practice evidence-based information on safe care for common psychiatric conditions in primary care
- Implement evidence-based information on depression, anxiety, and trauma in primary care
- Screen for bipolar disorder

Cost: $100 for physician/PhDs/PharmDs, $75 for nurses/physician assistants/counselors, $50 community members (not CME eligible), $10 for residents/trainees/students (not CME eligible).

Registration at Psych4PCPs.com / Questions? Email Event Coordinator Jamie Manser, jmanser@psychiatry.arizona.edu.

Upcoming Engagement Opportunities

March B – UHP Provider Education Forums

The same information will be covered during both meetings, so you only need to attend one of them.

Noon – 2 p.m. Tuesday, Mar. 28
Noon – 2 p.m. Thursday, Mar. 30
Call in info: (480) 378–7231 **Conf ID:** 333 535 802#
Microsoft Teams: https://bit.ly/3kJnehu

Transitioning Behavioral Health Patients from ED When They Need Additional Behavioral Health Services

Emergency Departments may encounter a B – UFC/ACC or B – UFC/ALTCS member that has been evaluated in the emergency department for a behavioral health condition. The member may be considered as "medically cleared" but is unable to be safely discharged. This delay in a safe discharge may be due to the member needing additional behavioral health services that hospital staff or vendors are unable to secure for the member in a reasonable time frame. The result is the member remains in the emergency department waiting for those services to be initiated.

During these circumstances, emergency departments should contact the designated 24-hour Customer Care Department to initiate resolution of transitioning the member to the appropriate behavioral health services.

B – UFC/ACC: (800) 582-8686, TTY 711
B – UFC/ALTCS: (833) 318-4146, TTY 711
Email: BUHPCareMgmtBHMailbox@bannerhealth.com

Removal of Data (X-Waiver) Requirement to Prescribe Buprenorphine

Effective immediately, to expand access to addiction treatment, the requirement that health care providers possess a Drug Enforcement Administration (DEA) X- waiver to prescribe buprenorphine has been eliminated. The law will now require all providers who apply for a DEA license to prescribe controlled substances to complete a one-time only, 8-hour training on managing patients with opioid and other substance use disorders. The law removes the federal requirement for practitioners to submit a Notice of Intent to prescribe medications such as buprenorphine.

Office of Individuals and Family Affairs (OIFA)

Peer Run Organizations (PROs) and Family Run Organizations (FROs)

Peer Run Organizations (PROs) and Family Run Organizations (FROs) are an important component of behavioral health services.

PROs are owned, operated and administrated by persons with lived experiences in mental health and/or substance use disorders. These organizations are based in the community and provide support services.

FROs 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 you.

Banner – University Health Plan (B – UHP) members, and all AHCCCS members, have the right to be educated about, request services from, and/or participate in programs at a PROs and FROs. Below are resources to support you, our valued Providers, in educating both yourselves

and members on the availability of peer and family support services provided at PROs and FROs:

What are Peer and Family Run Organizations, How to Access Services from a Peer and Family Run Organization, and current Peer and Family Run Organizations:
https://www.bannerufc.com/acc/plan-information/oifa (under Peer and Family Resources tab are links to more information on PROs & FROs)

Peer and Family Run Organizations Training*:*
https://www.banneruhp.com/resources/provider-trainings (under Peer & Family Support Trainings tab is a Peer and Family Run Organizations Training)

For additional resources or questions regarding PROs and FROs please reach out to B – UHP's Office of Individual and Family Affairs (OIFA) through our general mailbox: OIFATeam@bannerhealth.com.

Children's System of Care

Rise of Fentanyl Training and Resources

Banner - University Health Plans is hosting a trainings series to increase provider knowledge around Fentanyl Use. The Rise of Fentanyl Training Series is ongoing through the end of April. While the series has already started, provider staff can still sign up for the remaining trainings by following the links below for each session.

Wednesday, Mar. 22, 2023
Supporting Opioid Dependency with Collective Impact
Presented by Hushaby Nursery's Director of Community Programs, Michael C. White, MSJ
Register here: https://tinyurl.com/24ubnsa6

Wednesday, Apr. 5, 2023
Gone in a Snap: Social Media's Role in the Rise of Youth Fentanyl Use
Presented by Amy Neville
Register here: https://tinyurl.com/ynfbd9m3

Wednesday, Apr. 19, 2023
What we can learn from those affected by opioid use disorder and its stigma: Findings from a multi-year evaluation study
Presented by Dr. Natalia Rodriguez and Dr. María Aguilar-Amaya
Register here: https://tinyurl.com/mve6kcv2

Increasing knowledge of the dangers of Fentanyl and what to do if an overdose is suspected is critical. Additional training resources are listed below.

- Opioid Assistance and Referral Line (OARLine) is staffed by nurses, pharmacists and physicians with expertise in medical toxicology, pharmacology and substance use disorder. The OARLine can connect people and providers with these medical experts who can provide clinical consultation, treatment resources, and support for individuals dealing with opioid addiction.
- Substance Abuse Coalition Leaders of Arizona Toolkit has several training resources available on their website: https://saclaz.org/toolkit/

- The Drug Enforcement Administration offers an Emoji Decoder Tool here: https://tinyurl.com/4em5amysAlexander Neville Foundation https://anfhelp.org

Naloxone/Narcan Resources

Naloxone/Narcan is available without prescription at local pharmacies and from community agencies.

- For more information about the standing order allowing access, copy this link to access the AZ DHS standing order: https://tinyurl.com/4edwytp9
- Narcan/Naloxone Distribution search is available at Naloxoneaz.com
- Check with your local county health department as many county health departments offer Naloxone training and resources.
- There are some coupons available on GoodRX, which can be used to find the most inexpensive option near you: https://www.goodrx.com/naloxone

Catching Psychosis Early Improves Outcomes

Psychosis impacts more people than we may realize. As many as 3 in 100 people experience psychosis and nearly 100,000 youth are diagnosed with psychosis or a psychotic disorder annually. Research has shown that people experiencing psychotic symptoms often do so for more than a year before receiving treatment. Prolonged psychosis without treatment can impact the success of treatment and recovery. Lack of treatment or delays in treatment worsen the prognosis. It is critical for psychotic symptoms to be caught and treated early to provide the best possible recovery and future management of the condition for the individual experiencing psychosis.

Recognizing Symptoms of Psychosis

The onset of psychosis typically occurs for individuals between 16 and 30 years old, but it can be difficult for individuals, families, and those working with individuals to recognize the early symptoms as psychosis and be difficult for providers to diagnose as the symptoms can present gradually and be mistaken for other illnesses or issues. However, there are some behavior changes and symptoms that providers can look out for. These include:

- Sudden drop in school or work performance
- Difficulty concentrating or thinking clearly
- Abrupt or uncharacteristic mood changes
- Experiencing or demonstrating suspicion, paranoia or uneasiness around or about others
- Social withdrawal or spending more time alone than normal
- Intense new, possibly unusual ideas or strange feelings, or having no feelings at all
- Declining hygiene or decline in self-care, sometimes sudden
- Demonstrating difficulty in determining reality
- Difficulty communicating or confused speech
- False beliefs or delusions
- Hallucinations – seeing or hearing things others do not
- Behavior that is inappropriate to the situation
- Other symptoms of mental illness may be present, such as depression, anxiety, sleep issues, lack of motivation, etc.

Without treatment, individuals can experience negative consequences which may have a lifelong impact, include:

- Social isolation and alienation from family members
- Impaired functioning in multiple life domains
- Increased risk of self-harm
- Worsening symptoms over time
- Increased risk of substance abuse

Cause of Psychosis
There is no one cause of psychosis. Psychosis can result from a variety of factors including genetics, trauma, environmental factors, medical conditions, substance use, or mental illness. Because of this, getting individual treatment and support from a mental health provider skilled in treating psychosis is critical.

Treatment
Coordinated Specialty Care (CSC) is a treatment approach for treating psychosis soon after its onset that has been proven to provide significant success in recovery. CSC utilizes a multifaceted treatment approach which provides case management, family support and education, psychotherapy, medication management, education and employment services, and peer support. There are First Episode Psychosis Programs in the Banner Network using the CSC treatment approach.

If there is a suspicion that someone may be experiencing the above symptoms it is critical that they be connected to the appropriate mental health professional for diagnosis and treatment. For support call (800) 582-8686, TTY 711.

Sources:
NIMH: https://www.nimh.nih.gov/health/publications/understanding-psychosis#part_6513
NAMI: https://www.nami.org/About-Mental-Illness/Mental-Health-Conditions/Psychosis#:~:text=Signs%20of%20early%20or%20first%2Depisode%20psychosis&text=Hearing%2C%20seeing%2C%20tasting%20or%20believing,Withdrawing%20from%20family%20or%20friends
SAMHSA.GOV: https://store.samhsa.gov/sites/default/files/d7/priv/sma16-5006.pdf

Promoting Partnerships Between Behavioral Health Providers and Schools

B – University Family Care (B – UFC) is dedicated to being part of a trauma-informed community school environment where students feel safe, respected, and are encouraged to reach their fullest potential. As part of our collaboration with schools and community partners B – UFC is committed to increasing the accessibility of behavioral health services in schools.

Access to Behavioral Health Services in Schools for All Students
Arizona Health Care Cost Containment System (AHCCCS) has partnered with the Arizona Department of Education (ADE) and Project AWARE to ensure that all students have access to behavioral health services in schools. Students in Arizona can receive funding for behavioral health services through a variety of options.

In 2020, the Arizona Legislature passed Senate Bill 1523 (Jake's Law), establishing the Children's Behavioral Health Services Fund. Jake's Law offers funding through AHCCCS to

provide behavioral health services to uninsured/underinsured students who are referred for behavioral health services by a school. Funds have been allocated to behavioral health providers who can create agreements with public and charter schools to provide services on and off school campuses. Families can work directly with a local provider to identify the most appropriate funding option:

- Private Insurance
- Block Grant Funding
- Sliding Scale Payment Fees
- Private Community-Based Assistance Counseling
- Medicaid Benefits (AHCCCS Health Plans)
- Tribal Health Insurance
- Children's Behavioral Health Services Fund-Jake's Law

Behavioral Health Providers and Schools: The Benefits of Partnership
Partnerships make it possible to meet the unique needs of students and provide ongoing support to families. Building partnerships between schools and behavioral health providers that address student mental health is important to the resiliency of local communities. Partnerships allow for the sharing of information and resources that can empower school staff to meet the dynamic needs of their students.

For more information on school-based behavioral health services and resources for students and families visit the B – UFC Child and Family Support webpage at:
https://www.banneruhp.com/resources/child-and-family-support
For questions contact the B − UFC Children's System of Care Team at:
CSOC@bannerhealth.com

Upcoming Training: Understanding Support and Rehabilitation Services for Children and Teens

Support and Rehabilitation Services for Children and Adolescents are an essential part of community-based practices and culturally competent care. These services help children live successfully with their families in the community and can contribute to growth in multiple life domains. As the needs of our members continue to evolve, it is expected that demand for high quality Support and Rehabilitation Services will continue to grow.

At a minimum, the Child Family Team (CFT) should assess the underlying needs of the child/family and consider whether Support and Rehabilitation Services will help address those needs. Banner contracted providers are responsible for ensuring Support and Rehabilitation Services are discussed and offered during CFT Meetings.

There are two upcoming training options that will cover the array of Support and Rehabilitation Services available to our members.

To register for upcoming hour-long sessions, you can use the below links:
Tuesday, May 9 from 9 – 10 a.m.
https://forms.office.com/r/B50DDKV02N

Tuesday, Nov. 7 from 9 10 a.m.
https://forms.office.com/r/qwaFEUmtbi

If you have additional questions, please email CSOC@Bannerhealth.com

Youth Employment Summit

This virtual event is scheduled on Tuesday, Apr. 4, 2023 from 9:30 a.m. – Noon

In collaboration with UnitedHealthcare Community Plan and Rehabilitative Services Administration/Vocational Rehabilitation, Banner is hosting the Youth Employment Summit on Tuesday, Apr. 4, 2023. The Summit will cover the services that are available to help prepare youth for their transition to work, and the impact services can have on youth as they move into adulthood.

Who Should Attend?

- Behavioral Health Providers
- Case Managers
- Employment Specialists
- School Counselors and Psychologists
- Members and Families

If you would like additional information, please contact sara.hernandez@bannerhealth.com.
To register for this event, use this link:
https://azdes.zoomgov.com/meeting/register/vJIsceqvrTguGObciPxdm_tiS8qNsqYpO80

What is an SMI Designation?

Serious Mental Illness (SMI) is a designation used in Arizona to identify members 17.5 yrs old and older who need additional support because mental illness severely impacts their ability to perform day-to-day activities or interactions.

- The SMI Designation is Protected Health Information. Information about the SMI Designation can only be disclosed with member/guardian consent and/or for the purpose of coordination of care.
- With an SMI Designation, members retain all rights and freedoms.

Serious Mental Illness Functional Impairment Criteria:

- An inability to live independently without adequate support
- A risk of serious harm to self or others
- Dysfunction in role performance
- Risk of deterioration

SMI Qualifying Diagnoses Criteria:

- Psychotic Disorders, Bi-Polar disorders, Obsessive-Compulsive Disorders, Major Depression or Mood Disorders, Anxiety Disorders, Post-Traumatic Stress Disorder, Dissociative Disorder, and Personality Disorders

What are the benefits of an SMI Designation?

With an SMI Designation, members have access to services that may help improve their quality of life and increase independence. SMI is a designation not a diagnosis.

- Mental Health Services available include a designated case manager (monthly face to face contact), Medication Management, Therapy, Intensive Outpatient Programs, Crisis Services, Peer Support, Groups, supportive housing, and Transportation to behavioral health services.
- Housing depends on need, availability, and accessible funding. Housing availability and criteria depends on each Regional Behavioral Health Authority (RBHA).
- Help from a Human Rights Advocate through the Office of Human Rights (OHR). The OHR advocate can help the member understand and protect their rights.
- SMI eligibility assessments, designations and some services are available to all individuals regardless of AHCCCS eligibility.

SMI Determination Process

- After the SMI evaluation is requested, the member/guardian will need to meet with a qualified assessor within 7 days of request. The assessor will submit a completed packet to the Eligibility and Care Services (ECS) team at Solari within one business day from date of applicant consent.
- The ECS team will determine a decision within 3 days from date of consent: SMI, Not SMI, Pend (with waiver) for records or further evaluation. The member/guardian will be notified of approval or denial by mail.
- If member is determined SMI, AHCCCS notifies the T/RBHA. Member will receive a new ID card and RBHA Member Service Handbook. Member/guardian will have options to choose a clinic.
- If the member is determined Not SMI, the member/guardian has a right to appeal the decision within 60 days of the determination date. Member can receive another SMI evaluation after 6 months of determination.

Decertification

This is the term used for the decision that a member is no longer designated SMI. Decertification is based on criteria.

- Members still engaged in behavioral health services can request a decertification evaluation.
- If a member has not used their SMI services in over 2 years, they may request to be automatically decertified by AHCCCS over the phone.

AHCCS Health Plan Contacts

Regional Behavioral Health Authority (RBHA) Health Plans		
Arizona Complete Health – Complete Care Plan RBHA Customer Service (888) 788-4408 www.azcompletehealth.com/completecare	**Mercy Care RBHA** Customer Service (800) 564-5465 www.mercycareaz.org	**Health Choice Arizona RBHA** Customer Service (800) 322-8670 www.healthchoiceaz.com

New Gene Therapy: Etranacogene dezaparvovec-drlb (Hemgenix)

Hemgenix is the first gene therapy for Hemophilia B. It is approved for patients with hemophilia B who currently use factor IX prophylaxis therapy, have current or historical life-threatening

hemorrhage or have repeated, serious spontaneous bleeding episodes. Criteria has been set for Banner Medicare and Banner Medicaid plans for this indication. In addition, patients must also have close monitoring of transaminase levels once per week for 3 months after Hemgenix administration to mitigate the risk of potential hepatotoxicity. Hemgenix criteria for the health plans also requires a hematologist to prescribe, and the patient should not have active hepatitis C infection, an active HIV infection or decompensated cirrhosis. Hemgenix is the world's most expensive therapy and costs $3.5 million. Due to the ongoing costs of administering factor IX and breakthrough bleeds, Hemgenix is estimated to save the U.S. health care system $5-$5.8 million per patient treated.

Provider Services & Support

End of Public Health Emergency Update

Banner - University Health Plans providers can find up-to-date information regarding the end of the Public Health Emergency, and how it impacts members, under the Resources tab of the Provider page under Public Health Emergency at our website https://www.banneruhp.com/resources/public-health-emergency.

FQHC PPS PAYMENT CLARIFICATION

Issue found:

Currently claims are being billed to Medicare as a service by the professional, not a PPS service, then changed to bill AHCCCS as a PPS.

When billed this way, the secondary claim (AHCCCS) pays the lesser of, not the full PPS rate, for visit due to primary not billed as a PPS service.

Resolution:

To pay secondary FQHC claims (AHCCCS) at PPS rate, providers should bill Medicare and Medicare Replacement insurance as a PPS service not a professional service.

Provider Manual Updates

The B – UHP Medicaid Provider Manual has updates and changes that will be effective **Monday, Apr. 10, 2023**

Reminder: These updates are on BannerUHP.com under the Banner – University Family Care (ACC and ALTCS) Provider Manual.

Key updates and changes:

- Revised the following under Section 2, Providers:
  - Peer and Family Run Organizations (starting on page 39)
    - Overview of Peer and Family Support Services
    - Peer /Recovery Support Specialists (PRSS) and Parent Peer/Family Support Providers (PPSFP) Training and Credentialing
    - Peer /Recovery Support Specialists (PRSS) and Parent Peer/Family Support Providers (PPSFP) Qualifications
    - Peer Support Employment and Credentialed Parent Peer/Family Support Partner Training Competency Exam

- Peer Support Employment and Credentialed Parent Peer/Family Support Partner Training Program Approval Process
- Supervision Requirements for Credentialed Peer Recovery Support Specialists (PRSS's) and Parent Peer Family Support Partners (PPFSP's)
- Continuing Education and Ongoing Learning Requirements for Credentialed Peer Recovery Support Specialists (PRSS's) and Parent Peer Family Support Partners (PPFSP's)
- Submitting Evidence of Credentialing
- Partnerships with Families & Family-Run Organizations in the Children's Behavioral Health System
- Provider Commitment to the Functions of Family-Run and Parent Support Organizations
- Commitment to Family and Youth Involvement in the Children's Behavioral Health System
- Effective Member and Family Participation in Service Planning and Service Delivery
- Responsibilities of B – UHP Integrated Care and Its Providers Regarding Inclusion of Member and Family Member Voice & Choice in Service Delivery and Decision-Making Procedures

Claims Mailing Address Reminder

Please see the table below for information regarding electronic and mail submissions.

Medicaid Plans	
Banner – University Family Care / AHCCCS Complete Care (B – UFC/ACC)	P.O. Box 35699 Phoenix, AZ 85069-7169 Electronic ID: 09830
Banner – University Family Care / Arizona Long Term Care System (B – UFC/ALTCS)	P.O. Box 37279 Phoenix, AZ 85069 Electronic ID: 66901
Medicare Plans	
Banner – University Care Advantage (B – UCA) (HMO SNP)	P.O. Box 38549 Phoenix, AZ 85069-7169 Electronic ID: 09830
Dental Claims	
DentaClaims of Arizona, LLC	DentaQuest of Arizona, LLC - Claims Office: (800) 440-3408 P.O. Box 2906 Milwaukee, WI 53201-2906 Web Site: dentaquest.com

Resubmissions

Be sure to clearly mark "Resubmission" on the claim form or select the appropriate box on the claim form if sending electronically.

Appeals

Banner – University Health Plans
Attn: Grievances and Appeals Department

2701 E. Elvira Road
Tucson, AZ 85756

Claims Electronic Visit Verification (EVV) Reminder

Claims for EVV eligible services as defined by AHCCCS are edited for correct application of EVV requirements effective with **Jan. 1, 2023** dates of service and forward. Failures to correctly apply these requirements will result in denial of claims.

Requirement to Report School ID for Claims with a School Place of Service Reminder

Effective Dates of Service Mar. 1, 2022, and after, AHCCCS requires all Professional/CMS 1500 claims billed with a School Place of Service (POS) to also include a Valid School ID as outlined. This requirement allows for the gathering and retention of information related to the actual school site where the services are performed.

The 9-digit State CTDS identifier assigned to the school shall also be reported on all claims (as outlined below). A listing of the school 9-digit CTDS identifier codes is available on the AHCCCS website - Medical Coding Resources (azahcccs.gov)

Claims Reporting requirements

CMS Form 1500 (Paper Claim): ITEM NUMBER 19 - TITLE: Additional Claim Information (Designated by NUCC).

School Identifier – 0B (State License) followed by the 9 Digit School ID
Example –
0BNNNNNNNNN

837 Professional (Electronic Claim: 2300 NTE Loop

Loop	Element	Description 837-P 5010 A1 ENC	ID	Min. Max.	Use	Note	AHCCCS Usage/Expected Value (Codes/Notes/Comments)
2300	**NTE**	**CLAIM NOTE**		**1**	**S**		
2300	NTE01	Note Reference Code	ID	3-3	R	Utilize assigned values	Expect 'ADD' – Additional Information
2300	NTE02	Claim Note Text	AN	1-80	R	Expect Claim Note Text	School Identifier – 0B (State License) followed by the School ID Example – 0BNNNNNNNNN

Provider Data Reminders

- It is important they you keep your AHCCCS Provider Registration data current and complete.
- Missing data in your Provider Registration Files can result in denial or recoupment of claims (i.e. ensuring you have all applicable optional COS for your provider type; ensuring that you have all appliable licenses updated; etc.)
- AHCCCS options to update/maintain registration data –
    - AHCCCS Provider Enrollment Portal (azahcccs.gov)
    - Email & Fax Options- fax and email address to specifically send paper-related documents. (e.g., paper provider enrollment application, etc.); Fax: (602) 256-1474; Email: PRNotice@azahcccs.gov

Reminders of Upcoming AHCCCS Changes

- Referring, Ordering, Prescribing, and Attending (ROPA) Providers Required to Register with AHCCCS
    - ROPA (azahcccs.gov)
- Expansion of Participating Provider Reporting Requirements
    - Effective for claims submissions, submitted on and after Jul. 1, 2023, Participating Provider Reporting Requirements will also apply to the following provider types and claim forms. To retain information related to the actual professional practitioner that is participating in or performing services associated with the clinic visit, this information must be reported on the claim. Claim Form Types:
        - CMS 1500 claim form, Field 19 Field Title: Additional Claim Information and ADA claim form, Field 35 Field Title: Remarks
        - Provider Types: 05 – Clinic; 77 - Outpatient Behavioral Health Clinic; IC – Integrated Clinic
        - Denial Edit - “NPI Missing or Invalid” will append to the claim if the participating provider information is not entered or is in the incorrect format.

Model of Care Training and Attestation Reminder

Important Reminder

Model of Care Training and attestation is required annually. We strongly encourage you to complete the training and submit the attestation as soon as possible, but no later than **Mar. 31, 2023**. By doing so, you will be better equipped to implement the content and incorporate the requirement into the care you provide.

Contracted providers, Subcontractors and Non-participating providers with **Banner Medicare Advantage Dual HMO D-SNP** are required to complete the **Model of Care Annual Training and submit the Attestation**.

This training and attestation take a minimal amount of time to complete (approximately 10 minutes)
Instructions:

1. Review the training content located here: https://www.banneruhp.com/resources/provider-trainings

- Select Model of Care Training to access the required training and attestation.

2. Complete the Annual Attestation: https://bannerhealth.formstack.com/forms/moc_attestations
3. When completing your online attestation, please ensure you are documenting each provider's individual NPI on the attestation form.

Seclusion and Restraint (SR) Reporting Requirements

It is the policy of the Banner – University Health Plans (B – UHP) to ensure that the organization and its providers have the necessary information to ensure that **Behavioral Health Inpatient Facilities (BHIFs) and Mental Health Agencies (MHAs) authorized to conduct Seclusion and Restraint report to the proper authorities as well as the Plan** all Seclusion and Restraints of plan members. The use of seclusion and restraint can be high-risk behavioral health interventions; facilities should only implement these interventions when less restrictive and less intrusive approaches have failed. **The Health Plan requires BHIFs and MHAs to submit each individual report of incidents of seclusion and restraint to the Plan within (5) five business days of the incident utilizing AHCCCS Seclusion and Restraint Individual Reporting Form (Attachment A)**

https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/900/962AttachmentA.docx

Please submit the completed form to B – UHP: Email: BUHPRequests@bannerhealth.com. or Fax: (520) 874-3567

Providers are required to submit a separate **Incident/Accident/Death (IAD) report for Seclusion and/or Restraints resulting in an injury to the member**, to the Health Plan and to the AHCCCS Quality Management (QM) Team. Contracted BHIFs and MHAs licensed to conduct Seclusion and Restraints must submit these IADs to the AHCCCS QM Portal **within 24 hours** of becoming aware of the incident.

All Reporting requirements are specified in the B-UHP Behavior Health Provider Manual at: https://www.banneruhp.com/materials-and-services/provider-manuals-and-directories, based upon
AHCCCS MEDICAL POLICY MANUAL (AMPM) 962

Incident, Accident and Death (IAD) Reporting Update

B - UHP Contacted Providers shall ensure that reportable IADs are submitted via the AHCCCS QM Portal **within 48 hours** of the occurrence or notification to the provider of the occurrence. Sentinel IADs shall be submitted by the Provider into the AHCCCS QM Portal **within 24 hours** of the occurrence or becoming aware of the occurrence. Please refer to the **AHCCCS MEDICAL POLICY MANUAL (AMPM) 961**-for specific reportable incidents and timeframes.

We encourage our providers of care to reach out with any questions or issues regarding submission of SR and/or IAD reports by **Email to:** BUHPRequests@bannerhealth.com

Conflicts of Interest in Supported Employment

AHCCCS maintains very specific policies related to members becoming employees of a provider. According to ACOM 447 *"Once a member begins employment/becomes an employee with a*

provider, any employment supports and services provided to that member by the provider shall cease" Members may then begin to receive employment services from a different provider, should they still desire those supports. Providers contracted with B – UFC are required to meet this requirement.

For example, "Joe" is receiving employment support from Provider X and becomes a certified Peer Support Specialist. Upon getting certified, Provider X hires Joe to work there. At this point, services must be transferred to another provider.

Please visit https://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/400/447.pdf for more information.

Compliance Corner

Fraud, Waste and Abuse and False Claims

When AHCCCS and CMS cover services or items that are provided to Medicare beneficiaries and/or Medicaid members, the Federal fraud, waste, and abuse laws pertain to those payments. The Banner Medicaid and Medicare Health Plans expect providers to provide quality care, necessary care, and cost-effective services. The documentation of those items or services provides the basis for the claims sent to Banner Medicaid and Medicare Health Plans. In turn, the payment of these claims is based upon the provider's indication of the services/items represented in the claim submissions.

When providers submit claims for services/items performed for a Medicaid member or Medicare beneficiary, the provider is filing a bill/claim with the Federal Government. In addition, as a part of the claim submission process, the provider is certifying they have both complied with billing requirements and are eligible to receive payment based upon the service/item they provided.

If the provider knew or should have known that the claim submitted was not correct or was a "false claim," then the payment is a violation of the Federal False Claims Act.

Common examples of false or improper claims include, but not limited to, the following:

- Billing for services using a code that pays a higher reimbursement even if it is not the correct code (upcoding),
- Billing for services that the provider did not render,
- Billing separately for services that were already bundled into another service code such as a global surgery fee,
- Billing for services not medically necessary,
- Billing for services the provider was not qualified to provide,
- Billing for services without proper documentation including signing and dating progress notes.
- Providing prescriptions for medications not indicated or warranted by the member/beneficiaries' condition.

Providers complete both the Medicare Enrollment Application and State-specific Medicaid Enrollment Application as well as obtain a National Provider Identifier (NPI). Once a provider becomes eligible to serve Medicaid members and Medicare beneficiaries, there is a responsibility that the provider understands that they are responsible for ensuring the claims submitted under their name and number are in fact accurate and true.

If you identify or suspect FWA or non-compliance issues, immediately notify the Banner Insurance Division Compliance Department:

24- hour hotline (confidential and anonymous reporting): (888) 747-7989

Email: BHPCompliance@BannerHealth.com

Secure Fax: (520) 874-7072

Compliance Department Mail:
Banner Medicaid and Medicare Health Plans Compliance Department
2701 E Elvira Rd
Tucson, AZ 85756

Contact the Medicaid Compliance Officer Terri Dorazio via phone (520) 874-2847(office) or (520) 548-7862 (cell) or email Theresa.Dorazio@BannerHealth.com

Contact a Medicare Compliance Officer via phone (520) 874-2553or email: BMAComplianceOfficer@BannerHealth.com

Banner Medicaid and Medicare Health Plans Customer Care Contact Information

B - UHP Customer Care
Banner - University Family Care/ACC (800) 582-8686, TTY 711
Banner - University Family Care/ALTCS (833) 318-4146, TTY 711
Banner - Medicare Advantage Dual (877) 874-3930, TTY 711

Banner Medicare Advantage Customer Care
Banner Medicare Advantage Prime HMO – (844) 549-1857, TTY 711
Banner Medicare Advantage Plus PPO - (844) 549-1859, TTY 711
Banner Medicare RX PDP – (-844) 549-1859, TTY 711

AHCCCS Office of the Inspector General
Providers are required to report any suspected FWA directly to AHCCCS OIG:
Provider Fraud

- In Arizona: (602) 417-4045
- Toll Free Outside of Arizona Only: 888-ITS-NOT-OK or (888) 487-6686

Website -www.azahcccs.gov (select Fraud Prevention)
Mail:
Inspector General
801 E Jefferson St.
MD 4500
Phoenix, AZ 85034
Member Fraud

- In Arizona: (602) 417-4193
- Toll Free Outside of Arizona Only: 888-ITS-NOT-OK or (888) 487-6686

Medicare
Providers are required to report all suspected fraud, waste, and abuse to the Banner Medicare Health Plans Compliance Department or to Medicare
Phone: 800-HHS-TIPS (800-447-8477)
Mail:

FAX: (800) 223-8164
US Department of Health & Human Services
Office of the Inspector General
ATTN: OIG HOTLINE OPERATIONS
PO Box 23489
Washington, DC 20026