mercy care

Mercy Care Provider Manual



Visit: **www.MercyCareAZ.org**

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MC Chapter 1 – Introduction to Mercy Care

1.00 - Welcome

Welcome to Mercy Care (MC)! Our ability to supply excellent service to our members is dependent on the quality of our provider network. By joining our network, you are helping us serve those Arizonans who need us most.

1.01 - About Mercy Care

MC is a local Arizona health plan serving people enrolled in Medicaid, Medicare, and other government-sponsored health care programs since 1985. We are committed to walking alongside children, adults, seniors, people with disabilities and others facing serious health challenges to support their health, independence, and quality of life. We are Arizona-led, pairing local accountability and relationships with national expertise, technology, analytics, and support.

MC holds contracts with the Arizona Health Care Cost Containment System (AHCCCS), the Centers for Medicare and Medicaid Services (CMS), The Arizona Division of Developmental Disabilities (DDD), and the Arizona Department of Children's Services Comprehensive Health Plan (DCS-CHP). AHCCCS is Arizona's Medicaid agency.

MC has an established, comprehensive model to accommodate service needs within the communities served. This section of the provider manual contains general requirements about MC that apply to all lines of business which all Participating Healthcare Professionals (PHPs) must adhere. Please refer to MC's website for a listing of **Forms** and **Provider Notifications**. You can print the **MC Provider Manual** from your desktop by accessing the **MC Provider Manual** on the MC website.

MC includes the following lines of business:

- MC Complete Care (herein MCCC)
- MC Advantage (herein MCA)
- MC Long Term Care (herein MCLTC)
- MC AHCCCS Complete Care-Regional Behavioral Health Agreement (herein MC ACC-RBHA)
- MC DD (herein MC DD)
- MC Department of Child Safety Comprehensive Health Plan (MC DCS CHP)
- KidsCare – Children's Health Insurance Program (CHIP)

Our phone number will remain the same: **602-263-3000** or **1-800-624-3879** (TTY/TDD **711**).

Member benefits will remain the same.

The plan year for all MC Medicaid lines of business runs from October 1 through September 30.

The plan year for MCA runs from January 1 through December 31.

1.02 - Disclaimer

Providers are contractually obligated to adhere to and comply with all terms of the plan and provider contract, including all requirements described in this manual in addition to all federal and state regulations governing the plan and the provider. MC may or may not specifically communicate such terms in forms other than the contract and this provider manual. While this manual contains basic information about the Arizona Health Care Cost Containment System (AHCCCS), providers are required to fully understand and apply AHCCCS requirements when administering covered services.

According to 42 CFR 438.3 - Standard Contract Requirements:
AHCCCS, CMS, the Office of the Inspector General, the Comptroller General, and their designees may, at any time, inspect and audit any records or documents of MC, or its subcontractors, and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit under this section exists for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

Please refer to the **AHCCCS** website for further information on AHCCCS.

Please refer to the **Division of Developmental Disabilities** (DDD) website for further information on DDD.

Please refer to the **Department of Child Safety** website for further information on DCS CHP.

To assist in providing a better understanding of the provider manual, the following definitions are provided:

Contractor: An organization, or entity that has a prepaid capitated contract with AHCCCS pursuant to A.R.S. §36-2904, §36-2940, or §36-2944 to provide goods and services to members either directly or through subcontracts with providers, in conformance with contractual requirements, AHCCCS Statute and Rules, and Federal law and regulations.

Provider:

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 a fiscal agent that has entered a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the AHCCCS agreement.

1.03 - MC Policies and Procedures

MC has robust and comprehensive policies and procedures in place throughout its departments that ensure all compliance and regulatory standards are met. These proprietary policies and procedures are reviewed on an annual basis and required updates made as needed.

MC has established, and from time to time may establish and revise policies and procedures for activities related to management of Covered Services under the Plan Contract. These policies cover, by way of example and limitation, the following areas: network management, quality management, utilization review, credentialing, peer review, claims, billing and reimbursement, member rights and responsibilities and grievances and appeals. Prior to providing services, providers should review all policies that apply to the services they plan to provide.

MC collaborates with other governmental/state agencies. The collaboration is guided through collaborative protocols and/or Memos of Understanding (MOUs). These documents can be found in the **Availity** portal.

1.04 – Eligibility and PCP Assignment

Eligibility

The Department of Economic Security, Social Security Administration or AHCCCS determines eligibility. Member ID cards are generated by MC.

PCP Assignments

Each member is assigned a primary care physician to:

- Promote continuity of care for members by facilitating an effective and ongoing linkage between members and providers.
- Encourage individual members to choose a PCP, while maintaining an auto-assignment process that assigns all members to a network PCP.
- Promote freedom of choice for members, while assisting members in maintaining relationships with PCPs.

Provider participation in Value-Based Purchasing (VBP) initiatives impacts member assignments to a PCP, as specified in **AMPM Policy 510**.

PCP assignments occur in one of two ways:

- Through freedom of choice members are allowed to select and/or change their PCP.
- Through PCP Auto-Assignment when a new member is enrolled in MC, he/she will be automatically assigned a PCP. The auto-assignment process usually occurs before and until a member can select a PCP, or as an alternative when a member does not make a choice.

MC's Enrollment Services department assumes primary responsibility for assignment for new members and mass changes initiated by the Plan. MC members receive written notification of their initial PCP assignment in a welcome letter, which must reach new members within twelve (12) business days. Included with the enrollment notification is the process for changing PCP assignment, if desired. A list of available PCPs can be found in print format or on the MC website through a user-friendly search tool.

MC's Member Services department assumes responsibility for PCP changes if the member requests, accepting requests only from the affected member, his/her designated representative or the member's PCP.

Other departments that interact with members and/or providers (e.g., Enrollment Services, Care Management, Quality Management, and Network Management) may submit written or oral PCP change requests to Member Services for processing as well.

Member-Initiated PCP Changes

Members can request a PCP change by contacting Member Services at any time. Members can select a PCP following their initial auto assignment and are encouraged to remain with their selected PCP for continuity of care.

Plan-initiated PCP Changes

Plan initiated PCP changes may occur without limitation for reasons including, but not limited to:

- Member need for specialized care
- Member or provider relocation
- Member or provider change in age criterion
- Termination of relationship between MC and provider

- Legal action by the member against the provider
- Deterioration of relationship between the PCP and member

MC members are notified of Plan initiated PCP changes within 15 days prior to the effective date, when possible, of the change and offered an opportunity to select a different PCP. If MC members do not choose another PCP, one will be auto assigned.

Effective Date of PCP Changes

Whether requested by the member or initiated by MC, PCP changes are effective the day of the request or as indicated in the member notification. Member Services staff are responsible for informing members that they must continue receiving care from their current PCP until the change is effective. A PCP change confirmation letter is mailed to the member as well as the former PCP with instructions to forward medical records to the new PCP when applicable.

Tracking and Evaluating PCP Changes

MC is responsible for monitoring and tracking PCP changes. PCP changes are categorized as related to:

- Clinical issues
- Convenience/preference changes
- Service issues

Service-related or clinical-related issues that precipitate PCP changes are treated as grievances, requiring documentation and completion of a member grievance form or call transferred to Member Grievance.

1.05 – Hospital Presumptive Eligibility

Based on provisions in the Affordable Care Act and effective January 1, 2015, Arizona has developed a Hospital Presumptive Eligibility (HPE) process that allows qualified hospitals to temporarily enroll persons who meet specific federal criteria for full Medicaid benefits in AHCCCS immediately. Hospitals will use special features in Arizona's electronic application, Health-e-Arizona Plus (HEAplus), to process HPE applications.

Hospitals that choose to participate in HPE must meet performance standards for continued participation. Details about performance standards are included in the **Hospital Presumptive Eligibility Agreement**.

HPE provides eligible persons with temporary full Medicaid coverage. Persons who are approved for HPE may receive Medicaid services from any registered AHCCCS provider.

For additional detail regarding Hospital Presumptive Eligibility, please review AHCCCS' **Hospital Presumptive Eligibility** website.

1.06 – Health Information Exchange (HIE)

MC has partnered with **Contexture**, Arizona's statewide Health Information Exchange (HIE). We encourage our providers to participate with Contexture, as there are many benefits to having access to the HIE. Please click on the link to access their website. Key benefits include:

- **One connection to save time and resources**
  Making connections to other providers, hospitals, reference labs, and health plans takes time and valuable resources from your practice. One connection saves time and allows real-time transfer of data from hospital encounters, reference lab results, and other community provider encounters.
- **New patient information**
  Connection to the HIE provides the ability to view current information and historical medical records in the HIE. Additionally, this information can be queried and downloaded to the electronic health record (EHR) of your practice.
- **Timely information to coordinate care**
  Clinicians who participate in the statewide HIE can "subscribe" to a list of their high-need patients that they need to track closely. With information on more than 90% of hospital admissions, discharges, and transfers (ADTs), the HIE can send a real-time notice of ADTS as well as lab results and transcribed reports.
- **Secure communication**
  The use of the HIE's DirectTrust-certified, HIPAA-compliant secure email system facilitates the easy and secure exchange of patient information between providers, care team members, and healthcare facilities.

The following services are available through the HIE:

- **Alert**
  Notifications sent to designated clinicians or individuals based upon a patient panel. A patient panel is a practice or payer provided list of patients/members they wish to track. Alerts can be real-time or a daily/weekly summary. Alerts include:
  - Inpatient admission, discharge, transfer (ADT) Alerts
  - Emergency Department (ED) visit Alerts
  - Ambulatory Alerts – alerts your organization that a specific patient/member has been registered at an ambulatory facility or practice
  - Clinical / Laboratory Test Result Alerts

    - Patient Centered Data Home TM (PCDH) Alerts – ideal when treating patients who travel to other states
- **Direct Email**
  Secure email accounts that provide the means for registered users to exchange patient protected health information with other DirectTrust-certified email accounts. Direct Email is often used to receive Alerts.
- **Portal**
  Secure web-based access that allows detailed patient data to be viewed through an online portal.
- **Data Exchange**
  Electronic interfaces between patient tracking systems and the HIE. Data exchange services include:
    - Unidirectional Exchange
    - Bidirectional Exchange
- **Clinical Summary**
  A comprehensive Continuity of Care Document (CCD) containing up to 90 days of the patient's most recent clinical and encounter information. Clinical Summaries include:
    - Automated Clinical Summary
    - Query/Response Clinical Summary
    - Patient Centered Data Home Clinical Summary
      For more information on the HIE Services, visit **https://contexture.org/arizona-health-information-exchange/**
    - New patient labs and records only a few clicks away
    - Real-time alerts when your high-needs patients are admitted or discharged from the hospital
    - Better coordination of patient care teams through secure electronic sharing of messages, notes, and records

Based on the changing landscape of health care, MC is responding to the needs of our members by expanding our focus to include Health Related Social Needs (HRSN), population health, and primary prevention to promote health and well-being among our members. MC has adopted the Unite Us Closed Loop Referral System to ensure members referred to community organizations receive timely follow up and resolution to their specific need.

Providers are required to have bi-directional connections to the HIE and use of the closed-loop referral system (CLRS). Appropriate staff should have access to the CLRS. Members should be

assessed for HRSN, and providers should have culturally appropriate HRSN screening tools and policies in place. HRSN should be incorporated into a member's treatment planning and individual service plan based on member need. CLRS should be utilized to facilitate referrals for HRSN identified in the member's service plan.

Contexture, Arizona's health information exchange, teamed up with AHCCCS, 2-1-1 Arizona and Solari Crisis Human Services to implement a single, statewide referral system called CommunityCares, which streamlines the community services referrals process and provides confirmation when these services have been delivered. When a member requests information on a community service/referral, the care manager can use this portal to identify community supports/services and make referrals to appropriate organizations/agencies. Providers can access this portal and make referrals on behalf of the member which can be viewed and monitored within the applications.

MC Chapter 2 – Mercy Care Contact Information

2.00 – Mercy Care Contact Information

Health Plan	Telephone Number	Health Plan Web Address
MC	602-263-3000 or 800-624-3879 toll free	www.MercyCareAZ.org

Internal Contact	Telephone Number/Fax
Claims Inquiry Claims Research (CICR)	**MC Complete Care Phone**: 800-624-3879 **MC ACC-RBHA Phone**: 800-564-5465
MC DD Liaison	**Phone**: 602-453-6026
MC DD Behavioral Health Coordinator	**Phone**: 480-340-5205
Claim Disputes	**Phone**: 602-453-6098 or 800-624-3879 **Fax**: 860-907-3511
Referrals	**Phone**: 602-263-3000 or 800-624-3879 **Fax**: 844-424-3975
Behavioral Health	**Phone**: 602-263-3000 or 800-624-3879
Care Management	**Fax**: 860-975-3275
Medical Care Management	**Phone**: 602-453-8391
Member Outreach Team	**Phone**: 602-263-3000 or 800-624-3879 **Fax**: 844-745-8477
Network Management	**Phone**: 602-263-3000 or 800-624-3879 **Fax**: 860-975-3201 MercyCareNetworkManagement@MercyCareAZ.org
Dental	**Liberty Dental Plan Phone**: 888-352-7924 **Liberty Dental Plan Website**: www.libertydentalplan.com
Inpatient Hospital and Hospice Services	**Fax**: 800-217-9345
Transplant and ETI	**Phone**: 602-263-3000 or 800-624-3879 **Transplant Fax**: 855-671-5914 **ETI Fax**: 855-671-5915
Newborn Notification	**Phone**: 602-263-3000 or 800-624-3879 **Fax**: 844-525-2221
Solari- Statewide Crisis Line	**Phone**: 844-534-4673

2.01 - Health Plan Authorization Services Table

MC Prior Authorization Information

Department	Telephone Number/Fax
Medical Prior Authorization	**Phone**: 602-263-3000 or 800-624-3879 **Fax**: 800-217-9345
Utilization Management	**Phone**: 602-263-3000 or 800-624-3879 **Physical Health Admission Fax**: 866-300-3926 **Behavioral Health Admission Fax**: 855-825-3165 **Concurrent Review Fax**: 855-773-9287
Family Planning Prior Authorization	**Phone**: 602-798-2745 **Fax**: 800-573-4165

(Family planning for DES/DDD - Members should also submit their requests to the Family Planning fax number. Final approval determination will be made by the DES/DDD medical director prior to providing sterilization and pregnancy termination procedures for members enrolled in DES/DDD.)

2.02 - Community Resources Contact Information Table

Community Resource	Contact Information
Arizona Early Intervention Program (AzEIP)	**Address**: 1789 W. Jefferson, Mail Drop 2HP1, Phoenix, AZ 85007 **Phone**: 602-532-9960 or 888-439-5609 toll free **Fax**: 602-200-9820 **Email**: AzEIP@azdes.gov **Website**: https://des.az.gov/azeip
Arizona's Smokers Helpline (Ashline)	**Phone**: 800-556-6222 **Fax**: 800-261-6259 **Website**: www.azdhs.gov/ashline/
Arizona Women, Infants & Children (WIC)	**Address**: 150 N. 18th Ave., Ste. 310, Phoenix, AZ 85007 **Phone**: 800-252-5942 or 800-2525-WIC To report WIC Fraud & Abuse, call the WIC Fraud Hotline at 866-229-6561 or email azwiccomplaints@azdhs.gov **Website**: www.azdhs.gov/prevention/azwic

Community Information and Referral	**Address**: 1275 W. Washington St., Ste. 210, Tempe, AZ 85288 **Phone**: 602-263-8856 or 800-352-3792 (area codes 520 and 928) **Website**: https://211arizona.org/
Arizona Department of Economic Security – Aging and Adult Service	**Phone**: 602-542-4446 **Website**: https://des.az.org/services/older-adults

MC Chapter 3 – Network Management

3.00 – Network Management Overview

The Network Management department serves as a liaison between MC and the provider community. They build, facilitate, and maintain professional and positive relations with the provider network, stakeholders, and community partners. Their responsibilities also include provider training and education, maintaining the provider network, and strengthening the provider network in accordance with applicable regulations.

Provider Training and Education includes:

- Provider onboarding training and orientation for new providers to MC, which provides an overview of these topics in addition to some of the topics listed below:
    - How to use the Provider website
    - Where to find the Provider Outreach Manual, including that it is a reference guidance for topics such as EPSDT, CRS, DD/DCS CHP, Women's Health, Maternity Services, Family Planning and Tobacco Cessation
    - Vaccines for Children (VFC) Program
    - Transportation and Language/Interpretation Services
- Comprehensive provider in-services conducted as completion of the Provider onboarding process within 30 days of contract effective date
- Established provider in-services
- Provider Manual overview, including how to locate manual on website
- Claims Processing Manual
- Provider Website
- **Availity**
- Prior Authorization requirements
- Fraud, Waste and Abuse
- Behavioral Health referrals
- Specialty referrals
- Cultural Competency
- Coordination of Benefits
- Where to mail claims
- Grievances and Appeals
- Review of provider contracts and amendments
- Contractual responsibilities and contract compliance
- Provider deliverables
- Claims dashboards

- Appointment Availability and Access to Care requirements
- Provider communications, including Provider Notifications and Provider Newsletters

Network Management's staff may conduct face-to-face visits or use telephonic and/or electronic methods when educating and communicating with providers. Staff also assist providers with specific training needs, problem identification and resolution, claims assistance, and perform accessibility audits.

A Network Management Representative is assigned to each provider's office. You may reach your representative by calling 602-263-3000 or 800-624-3879. Please review our Network Management website to find a list of your assigned Network Management Representative along with their detailed contact information.

To meet Regulatory Compliance Standards, all provider inquiries must be acknowledged within three business days of receipt, and all issues must be resolved and/or state the results communicated to the provider within 30 business days.

The Network Management department conducts at least two provider forums per year which providers are encouraged to attend. The purpose of the forums is to improve communications with the providers and provide training and education on new policies and/or regulations or topics of interest. In addition, Network Management conducts frequent webinars on specific topics or areas of concern that providers may have. Providers will receive information regarding any upcoming forums or webinars through communication with their Provider Representative, a Provider Notification, or via the Provider website.

Please contact the Network Management department for:

- Recent practice or provider updates, including adding new providers to your existing practice
- Assistance in finding a participating provider or specialist
- Termination from the health plan
- Notifying the plan of changes to your practice
- Tax ID change
- Change of location
- Obtaining an **Availity** Login ID
- Electronic Data Information, Electronic Fund Transfer, Electronic Remittance Advice
- Requests for contract updates
- Change of ownership, mergers, or stock purchases

3.01 Contract Process

Providers can request to join the MC network by submitting a Letter of Interest (LOI) and completing a W-9 Form (PDF)

What to include in the Letter of Interest (LOI)

- Provider specialty — any specialty services that you provide
- Geographic area(s) you serve
- Medicare ID number (if applicable)
- Arizona Health Care Cost Containment System (AHCCCS) ID number: All providers must have completed **AHCCCS ID Provider Enrollment**; call the Provider Assistance Unit if you need help at **602-417-7670**, **option 6**
- A summary description of programs
- Target populations and specific age categories
- Specific models of care and therapies you use
- Frequency of programming treatment
- Appointment availability

Submit a complete request to **Network Management**. Make sure your request includes all the information on the LOI list. If anything is missing, you will have to resubmit a complete LOI and W-9.

If we deny your request for network participation, you can reapply in one year. We evaluate our network regularly. We will contact you directly if our needs change.

If we approve your request to join the network, we will contact you to start the contracting process.

If we approve your network participation

An onboarding specialist will contact you to get the credentialing form we require for your provider type. Initial credentialing (and continued recredentialing) is required for participation in the MC network. If you are a practitioner, provide your updated Council for Affordable Quality Healthcare (CAQH) information. Be sure we can access your information. Otherwise, delays will result.

A contract negotiator will send a MC Agreement for review and electronic signature. After we approve credentialing and you have completed and signed the MC Agreement, we will move forward with countersignature.

Wait to schedule MC members until:

- We let you know your participation effective date
- You receive a copy of the fully executed Agreement
- A member of your staff has **completed orientation** with the Workforce Development (WFD) team (your training manager or MC Care WFD contact)

Be ready to respond to requests from our network management team. If we don't receive a timely response, we may deny your contract.

3.02 – Contract Changes – Change of Ownership, Mergers, or Stock Purchases

Contracts are not automatically assigned to new owners and require review and approval of the health plan. We will need the following information submitted to the Network Management email box at **MercyCareNetworkManagement@mercycareaz.org** in writing 90 days prior to execution to begin the review process:

1. Effective date of ownership change
2. Name of new owner
3. TIN, NPI, AHCCCS ID the new owner plans to use
4. W-9
5. Any supporting legal documentation which outlines the ownership change including any financial liabilities between the buyer and seller.

Please note: Notification of ownership changes also need to be sent to AHCCCS for updates.

MC Chapter 4 – Provider Responsibilities

General Provider Responsibilities

4.00 - Provider Responsibilities Overview

These responsibilities are minimum requirements to comply with contract terms and all applicable laws. Providers are contractually obligated to adhere to and comply with all terms of the plan, provider contract, and requirements in this Provider Manual. Please click on the link to access the **MC Provider Manual** website. MC may or may not specifically communicate such terms in forms other than the contract and this manual. This section outlines general provider responsibilities; however, additional responsibilities are included throughout the manual. Additional contractual terms include:

- AHCCCS Minimum Subcontract Provisions
- Medicaid Regulatory Compliance Addendum

These documents are available for your review on under **Notices** on the MC website.

Providing Member Care

4.01 - AHCCCS Registration

Each provider must first be registered with AHCCCS and obtain an AHCCCS provider ID number. This also includes non-participating providers. For additional information on registering to get an AHCCCS provider ID, please refer to the **AHCCCS Provider Registration Applications and Revalidations** web page or the **MC Claims Processing Manual, Chapter 9 - Non-Par Provider Registration** available on the MC website.

As of August 31, 2020, all new providers, as well as existing providers who need to update their accounts will use the AHCCCS Provider Enrollment Portal (APEP). This is an online, electronic portal which is available 24/7. It streamlines the provider enrollment process and eliminates the need for paper-based applications. APEP allows providers a means to electronically submit a new enrollment or modify an existing provider ID anytime of the day. MC will ensure providers register through APEP and continue to maintain their provider ID as required by AHCCCS. To access the **AHCCCS Provider Enrollment Portal (APEP)** web page, please click on the link. This online system will allow providers to:

- Enroll as an AHCCCS Provider.
- Update information (such as phone and address).
- Update and/or update licenses and certifications.

The **AHCCCS Provider Enrollment Portal (APEP)** web page contains additional important information as follows:

- **Provider Updates**
- **Enrollment in the Portal**
- **Prerequisite Steps for Providers**
- **Provider Glossary**
- **Provider Enrollment Application and Provider Participation Agreement**
- **Provider Revalidation**
- **Enrollment Fee**

Providers must identify demographic data regarding their population group sets served to report and update any changes to these group sets within 10 days of the change, as required and outlined in **AMPM Policy 610**.

4.02 - Appointment Availability Standards

Providers are responsible for being available during regular business hours and have appropriate after-hours coverage. Providers must offer members access to covered services 24 hours per day, 7 days per week basis. Such access shall include regular business hours on weekdays and availability of practitioner or a covering practitioner by telephone outside of such regular hours, including weekends and holidays.

Providers are required to schedule appointments for eligible members in accordance with the minimum appointment availability standards below. Providers must offer the same hours of operation that are no less (in number or scope) to MC members that are offered to non-Medicaid members. If the provider serves only Medicaid recipients, hours offered to MC members are comparable to those offered to other Medicaid managed health plans or Medicaid fee-for-service members. MC will routinely monitor compliance and seek corrective action plans, such as panel or referral restrictions, sanctions, or contract termination for providers that do not meet accessibility standards.

MC conducts Provider Appointment Availability Audits as a requirement under AHCCCS Contractor Operations Manual (ACOM) Policy 417. The data collected is not only used for the regulatory requirement for AHCCCS but is also used for NCQA accreditation and as a method to ensure sufficient provider network capacity on a regular basis.

The parameters in which audits are performed are to assess the availability of routine and urgent appointments for primary care, specialist, dental, maternity care providers, behavioral

health providers, psychotropic medication appointment standards, and behavioral health appointments for persons in the legal custody of the Department of Child Safety (DCS) and adopted children. MC reviews the availability of routine and urgent appointments for maternity care providers relating to the first, second, and third trimesters, as well as high risk pregnancies. MC also conducts audits for medically necessary non-emergent transportation to ensure that a member arrives and is picked up on time for an appointment. An appointment available to be delivered through telehealth is considered an available appointment where clinically appropriate.

Appropriate methods for conducting these reviews include:

- Appointment schedule review that independently validates appointment availability.
- Secret shopper phone calls that anonymously validate appointment availability.
- Other methods approved by AHCCCS.

The appointment standards are as follows:

Non-Emergency Transportation

- Must arrive no sooner than one hour before the appointment.
- Nor must wait more than one hour after the conclusion of the treatment for transportation home.

MC will ensure the following performance targets are met by our provider network:

- 95% of all combined completed pickup and drop off trips in a quarter are completed timely.
- MC will evaluate compliance with these standards on a quarterly basis for all subcontracted transportation providers and require corrective action if standards are not met.
- MC will also track scheduled trips that were not completed for any reason.

MC will provide additional corrective action steps for any reporting quarter where the average percentage of all timely completed trips for that quarter falls below the performance target of 95%. These steps will include a timeline to meet the performance target of 95% of trips being completed timely. Please see section **4.42 Contract Enforcement.**

Primary Care Provider Appointments (includes Family Practice, General Practice, Internal Medicine, Pediatrician)

- Urgent care appointments must be scheduled as expeditiously as the member's health condition requires, but no later than two business days of request; and
- Routine care appointments must be scheduled within 21 calendar days of request.
- After-hours care may include:

- Answering service that contacts physician or covering physician.
- Answering machine that directs the caller to the office of the covering physician or directs the caller to call physician at another office.
- Call forwarding services that automatically send the call to another number that will reach the physician or his/her covering physician.
- Answering machine message will state for the caller to leave a message for non-emergencies, and the office will return the call during the next business day during regular business hours, or if this is an emergency to call 911.

Specialty Provider Appointments, including Dental Specialty

- Urgent care appointments must be scheduled as expeditiously as the member's health condition requires, but no later than two business days from the request, and
- Routine care appointments must be scheduled within 45 calendar days of referral.

Dental Provider Appointments

- Urgent appointments must be scheduled as expeditiously as the member's health condition requires, but no later than three business days of request,
- Routine care appointments within 45 calendar days of request, and
- For DCS CHP only, routine care appointments within 30 calendar days of request.

Maternity Care Provider Appointments, initial prenatal care appointments with the provider for enrolled pregnant members

- First trimester – within 14 calendar days of request;
- Second trimester - within seven calendar days of request;
- Third trimester - within three business days of request; and
- High risk pregnancies should be scheduled as expeditiously as the member's health condition requires and no later than three business days of identification of high risk by MC or maternity care provider or immediately if an emergency exists.

Psychotropic Medication Appointments

- Assess the urgency of the need immediately.
- Provide an appointment, if clinically indicated, with a practitioner who can prescribe psychotropic medications within a timeframe that ensures the member:
  - Does not run out of needed medications; or
  - Does not decline in their behavioral health condition prior to starting medication, but no later than 30 calendar days from the identification of need.

General Behavioral Health Appointments

- Care for a non-life-threatening emergency within six (6) hours.
- **Urgent Need Appointments** - As expeditiously as the member's health condition requires but no later than 24 hours from identification of need
- **Initial Assessment -** Within seven calendar days after the initial referral or for behavioral health services.
- **Initial Appointment -** Within timeframes indicated by clinical need:
    - **For members aged 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.
- **Subsequent Behavioral Health Services -** Within the timeframes according to the needs of the person, but no later than 45 calendar days from identification of need.
- **For Behavioral Health Provider Appointments:**
    - **Urgent need appointments** as expeditiously as the member's health condition requires but no later than 24 hours from identification of need.
- **For 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 aged 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.
        - **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.
- **After-hours care** may include:
    - Answering service that contacts physician or covering physician.
    - Answering machine that directs the caller to the office of the covered physician or directs the caller to call physician at another office.
    - Call forwarding services that automatically send the call to another number that will reach the physician or his/her covering physician.
    - Answering machine messages will state for the caller to leave a message for non-emergencies, and the office will return the call during the next business day during regular business hours, or if this is an emergency to call 911 or 988.

Behavioral Health Appointments for Persons in Legal Custody of the Department of Child Safety and Adopted Children in Accordance with A.R.S. § 8-512.01.

- **Rapid response** - When a child enters out-of-home placement within the timeframe indicated by the behavioral health condition, but no later than 72 hours after notification by DCS that a child has been or will be removed from their home;
- **Initial assessment** - Within seven calendar days after referral or request for behavioral health services;
- **Initial appointment** - Within timeframes indicated by clinical need, but no later than 21 calendar days after the initial assessment; and
- **Subsequent Behavioral Health Services** - Within the timeframes according to the needs of the person, but no longer than 21 calendar days from the identification of need.

The appointment standards for members in the legal custody of DCS and adopted children are intended to monitor appointment accessibility and availability. For additional information on behavioral health services for persons in the legal custody of DCS and adopted children in accordance with A.R.S. § 8-512.01, refer to ACOM Policy 449.

For review of ACOM Policy 417 and all other Administrative, Claims, Financial, and Operational Policies of the AHCCCS Administration feel free to visit: **https://www.azahcccs.gov/shared/ACOM/.**

The AHCCCS Medical Policy Manual (AMPM) provides information to Contractors and Providers regarding services that are covered within the AHCCCS program. The AMPM should be referenced in conjunction with State and Federal regulations, other Agency manuals [AHCCCS Contractors' Operations Manual (ACOM) and the AHCCCS Fee-for-Service Manual], and applicable contracts. For review of AMPM Policies visit: **https://www.azahcccs.gov/shared/MedicalPolicyManual/**

4.03 - Telephone Accessibility Standards

PCPs and Behavioral Health providers are required to provide members with telephone access 24 hours a day, 7 days a week including weekends and holidays. The telephone service may be answered by a designee, such as an on-call physician or a nurse practitioner with physician backup.

Examples of after-hours coverage that will result in follow-up from MC:

- An answering machine that directs the caller to leave a message (unless the machine will then automatically page the provider to retrieve the message).
- An answering machine that directs the caller to go to the emergency department.

- An answering machine that has only a message regarding office hours, etc., without directing the caller appropriately, as outlined above.
- An answering machine that directs the caller to page a beeper number.
- No answering machine or service.
- If your answering machine directs callers to a cellular phone, it is not acceptable for charges to be directed to the caller (i.e., members should not receive a telephone bill for contacting their physician in an emergency).
- Telephones should be answered within five rings and hold time should not exceed five minutes. Callers should not get a busy signal.

4.04 - Covering Physicians

MC Network Management must be notified if a covering provider is not contracted or affiliated with MC. This notification must occur in advance of providing coverage and MC must provide authorization. Reimbursement to covering physicians is based on the MC Fee Schedule. The covering physician must bill under their own Tax Identification Number. Failure to notify MC of covering physician affiliations may result in claim denials and the provider may be responsible for reimbursing the covering provider.

4.05 – Locum Tenens

AHCCCS requires credentialing of individual providers or those through an organization such as a Federally Qualified Health Center (FQHC) who is contracted with a health plan. This includes the registration and credentialing of Locum Tenens.

Locum Tenens will be provisionally credentialed to expedite the credentialing process.

4.06 - Verifying Member Eligibility

All providers, regardless of contract status, must verify a member's enrollment status prior to the delivery of non-emergent, covered services. A member's assigned provider must also be verified prior to rendering primary care services. MC will not reimburse providers for services rendered to members that have lost eligibility.

Member eligibility may be verified through one of the following ways:

> ***Availity:*** We have teamed up with Availity® to streamline the eligibility process and provide one efficient workflow to communicate with payers. For more information regarding Availity, please review **Section 4.48 – Availity** in this manual.
>
> ***Website*:*** ***Availity***

MediFax: MediFax is an electronic product available through AHCCCS that stores key member information. It is used to verify MC member eligibility for pharmacy, dental, transportation, and specialty care. In Maricopa County only, providers can request faxed documentation through MediFax EDI: 800-444-4336.

AHCCCS Interactive Voice Response (IVR): To use, dial 602-417-7200. For providers outside of Maricopa County only please dial 1-800-331-5090.

MC Telephone Verification: Use as a last resort. Call Member Services to verify eligibility at 602-263-3000. To protect member confidentiality, providers are asked for at least three pieces of identifying information such as member identification number, date of birth and address, before any eligibility information can be released. When calling MC, use the prompt for the providers.

Monthly Roster: Monthly rosters are found on **Availity**. Contact your Network Relations Specialist/Consultant for more information. Note that rosters are only updated once a month.

MC shall maintain a current file of member PCP assignments. It is critical that MC maintains accurate tracking of PCP assignments to facilitate continuity of care, control utilization, and obtain encounter data. MC shall make PCP assignment rosters available to providers within 10 business days of a provider's request, and include, at a minimum:

- Assigned members' name,
- Assigned members' date of birth,
- Assigned members' AHCCCS ID,
- AHCCCS ID of the assigned PCP, and
- Effective date of member assignment to the PCP.

4.07 - Preventive or Routine Services

Providers are responsible for providing appropriate preventive care for eligible members. Preventive health guidelines are located on the MC website as follows:

- **MCCC Member Handbook**
- **MCLTC Member Handbook**
- **MC ACC-RBHA Member Handbook**
- **DCS CHP Member Handbook**

Preventive health guideline details can also be found in AHCCCS AMPM Chapter 300 and 400, on the AHCCCS Website:

- **AMPM Chapter 300 - Medical Policy for Covered Services**
- **AMPM Chapter 400 - Maternal and Child Health Policy**

These preventive services include, but are not limited to:

- Disease risk assessment
- Medically necessary and age-appropriate immunizations, screenings, and physical examinations
- Early and Periodic Screening, Diagnostic and Testing (EPSDT) services
- Well Woman preventive visits and screenings
- Maternal Mental health screenings
- Family Planning services and supplies
- Sexually transmitted infection (STI) screenings
- Substance use disorder (SUD) screenings and referrals
- Behavioral health screenings and referrals

4.08 - Well-Woman Preventive Care Service Standards

Covered Services included as part of a Well-Woman Preventive Care Visit

An annual well-woman preventive 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 preventive care visit is inclusive of a minimum of the following:

- A physical exam (well exam) that assesses overall health
- Clinical breast exam
- Pelvic exam (as necessary, according to current recommendations and best standards of practice)
- Review and administration of immunizations, screenings and testing as appropriate for age and risk factors as specified in the **AHCCCS AMPM Chapter 300 and 400 Policies**
    - **NOTE:** Genetic screening and testing is not covered, except as described in the **AHCCCS AMPM Chapter 300, Medical Policy for Covered Services**.
- Screening and counseling are included as part of the well-woman preventive care visit and are focused on maintaining a healthy lifestyle and minimizing health risks, which addresses at a minimum the following:
    - Proper nutrition
    - Physical activity
    - Elevated BMI indicative of obesity

- Tobacco, e-cigarettes, vaping, and substance use and/or dependency (including alcohol, prescription drugs, and street drugs)
- Screening for mood disorders, such as depression and anxiety
- Interpersonal and domestic violence screening, which includes counseling involving elicitation of information from women and adolescents about current/past violence and abuse, in a culturally sensitive and supportive manner to address current health concerns about safety and other current or future health problems
- Sexually Transmitted Infections (STI) testing, treatment, and counseling
- Human Immunodeficiency Virus (HIV) testing, treatment, and counseling
- Annual syphilis testing beginning at age 15 years old
- Family planning services and supplies (refer to AMPM Chapter 420)
- Preconception counseling that includes discussion regarding a healthy lifestyle before and between pregnancies that includes:
  - Reproductive history and sexual practices
  - Healthy 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.

Immunizations, Screenings, and Testing requirements are outlined in the AHCCCS AMPM Policies:

- **AMPM Chapter 300 – Medical Policy of Covered Services**
- **AMPM Chapter 411 – Women's Preventive Care Policy**
- **AMPM Chapter 420 – Family Planning Services and Supplies**
- **AMPM Chapter 430 – EPSDT Services (for members under 21 years of age)**

HPV Vaccine

MC will cover the Human Papilloma Virus (HPV) vaccine for members 9 to 45 years of age, as described in **AHCCCS AMPM Chapter 300 and 400 Policies.**

Immunization Details for EPSDT-aged Members (under 21 years of age)

Any provider that administers the HPV vaccination to EPSDT-aged members between 9 and 18 years of age must coordinate with The Arizona Department of Health Services (ADHS) Vaccines for Children (VFC) Program. Providers must enroll and re-enroll annually with the VFC program, in accordance with AHCCCS contract requirements when providing immunizations for these EPSDT-aged members.

Any provider that administers the HPV vaccine to EPSDT-aged members between 9 and 18 years of age must also document that immunization in the Arizona State Immunization Information System (ASIIS) registry. AHCCCS also requires providers to document the HPV vaccine in ASIIS for members who are 19 and 20 years of age. Immunizations must be entered into the ASIIS system within 30 days of providing the vaccine. MC audits provider compliance on immunization ASIIS registry reporting requirements and will provide education when issues are identified. For more information on the ASIIS requirements, see section **5.15 – Immunizations/Vaccines for Children (VFC) Program and ASIIS.**

4.09 - Educating Members on their own Health Care

MC does not restrict or prohibit providers, acting within the lawful scope of their practice, from advising or advocating on behalf of a member who is a patient for:

- The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;
- Any information the member needs to decide among all relevant treatment options;
- The risks, benefits, and consequences of treatment or non-treatment; and,
- 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.

4.10 - Urgent Care Services

While providers serve as the medical home to members and are required to adhere to the AHCCCS and MC appointment availability standards, in some cases, it may be necessary to refer members to one of MC's contracted urgent care centers (after hours in most cases). Please reference **Find a Provider/Pharmacy** on MC's website and select Urgent Care Facility in the specialty drop down list to view a list of contracted urgent care centers.

MC reviews urgent care and emergency room utilization for each provider panel. Unusual trends will be shared and may result in increased monitoring of appointment availability.

MC educates its members regarding the appropriate use of Urgent Care Services. Urgent Care Services are to be used when a member needs care right away but is not in danger of lasting harm or of loss of life. Examples of this may include medical care for:

- Flu, colds, sore throats, earaches
- Urinary tract infections
- Prescription refills or requests
- Long-term health conditions
- Back strain
- Migraine headaches

4.11 - Emergency Services

Prior authorization is not required for emergency services. In an emergency, members should go to the nearest emergency department. Emergency medical services are provided for the treatment of an emergent physical or behavioral health condition. MC is also responsible for post-stabilization services related to that emergency condition. Post stabilization care services are covered services related to an emergency medical condition that are provided after a member is stabilized to maintain the stabilized condition, or under the circumstances described in 432 CFR §438.114(), to improve or resolve the member's condition.

MC educates its members regarding the appropriate use of Emergency Services An emergency is a medical or behavioral health condition, including labor and delivery, which manifests itself by acute symptoms of enough 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:

- Placing the health of the person, including mental health, in serious jeopardy,
- Serious impairment of bodily functions,
- Serious dysfunction of any bodily organ or part, or
- Serious physical harm to another person. Examples of this may include:
    - Poisoning
    - Sudden chest pains - heart attack
    - Car accident
    - Convulsions
    - Very bad bleeding, especially if you are pregnant
    - Broken bones
    - Serious burns
    - Trouble breathing
    - Overdose

When an MC member enters the ED for behavioral health needs, inclusive of substance use, the outpatient provider is responsible for the member's post-discharge follow up. If the MC member is not paneled to a behavioral health provider, the member's PCP will be responsible for the member's post-discharge follow-up (AMPM 1020).

Non-emergency service examples are also provided under section **4.10 – Urgent Care Services** and may include:

- Flu, colds, sore throats, earaches
- Urinary tract infections
- Prescription refills or requests
- Long-term health conditions
- Back strain
- Migraine headaches

This above list is not all inclusive but only provided as examples of non-emergency care.

4.12 – Monitoring Controlled and Non-Controlled Medication Utilization

Minimum Monitoring Requirements

To ensure members, receive clinically appropriate prescriptions, minimum monitoring requirements are in place in accordance with **AMPM 310-FF – Monitoring Controlled and Non-Controlled Medication Utilization.**

- MC, for all Medicaid lines of business, are required to monitor controlled and non-controlled medications on an ongoing basis. Monitoring shall include, at a minimum, the evaluation of prescription utilization by members, prescribing patterns by clinicians and dispensing by pharmacies. Drug utilization data shall be used to identify and screen high-risk members and providers who may facilitate drug diversion. The monitoring requirements are to determine potential misuse of the drugs used in the following therapeutic classes:
    - Atypical Antipsychotics;
    - Benzodiazepines;
    - Hypnotics;
    - Muscle Relaxants;
    - Opioids; and
    - Stimulants.
- MC shall utilize the following resources, when available, for monitoring activities:
    - Prescription claims data;
    - Arizona State Board of Pharmacy CSPMP;

- Indian Health Service (IHS) and Tribal 638 pharmacy data;
- ACC-RBHA/TRBHA prescription claims data; and
- Other pertinent data.

- MC shall evaluate the prescription claims data at a minimum, quarterly, to identify:
  - Medications filled prior to the calculated days-supply;
  - Number of prescribing clinicians;
  - Number of different pharmacies utilized by the member; and
  - Other potential indicators of medication misuse.

Minimum Intervention Requirements

- MC shall implement the following interventions to ensure members receive the appropriate medication, dosage, quantity, and frequency. Interventions required include:
  - Provider education in accordance with **AMPM Policy 310-V**.
  - Point-of-Sale (POS) safety edits and quantity limits.
  - Care management.
- Referral to, or coordination of care with, a behavioral health service provider(s) or other appropriate specialist.
- Assignment of members who meet any of the evaluation parameters below to an exclusive pharmacy, in accordance with 42 CFR 431.54, for up to a 12-month period except for the following members.
  - Members in treatment for an active oncology diagnosis,
  - Members receiving hospice care, or
  - Members residing in a skilled nursing facility.

Evaluation Criteria Parameter	**Minimum Criteria for Initiating Interventions**
Over-utilization	Member utilized the following in a 3-month period: > 4 prescribers; and > 4 different abuse potential drugs; and > 4 Pharmacies. OR Member has received 12 or more prescriptions of the medications listed above in the past three months.
Fraud	Member has presented a forged or altered prescription to the pharmacy.

4.13 – Controlled Substances Prescription Monitoring Program (CSPMP)

The Arizona State Board of Pharmacy Controlled Substances Prescription Monitoring Program (PMP) grants access to prescribers and pharmacists so they may review controlled substance dispensing information for patients. Access is granted to individuals only, not to clinics, hospitals, pharmacies, or any other health care facility.

Arizona Revised Statute (A.R.S.) § 36-2606 requires each medical practitioner licensed under Title 32 (i.e., MD, DO, DDS, DMD, DPM, HMD, PA, NP, ND, and OD) and who possesses a DEA license to review the preceding 12 months of a patient's PMP record before prescribing an opioid analgesic or benzodiazepine-controlled substance listed in schedule II, III or IV.

Exceptions to reviewing a patient record are described in A.R.S. § 36-2606. Medical residents may register using the hospital DEA number and appropriate suffix.

Prescribers must register at: **https://arizona.pmpaware.net/login**

Please review the 2018 Arizona Opioid Epidemic Act FAQs and other important information at **https://pharmacypmp.az.gov/sites/default/files/2022-03/Opioid%20Epidemic%20Act%20FAQs%20022819.pdf.**

4.14 - Primary Care Providers (PCPs)

The primary role and responsibilities of primary care providers participating in MC include, but are not limited to:

- Providing initial and primary care services to assigned members;
- Initiating, supervising, and coordinating referrals for specialty care, inpatient services, behavioral health services, as necessary, and maintaining continuity of member care;
- Maintaining the member's medical record – refer to **AMPM Policy 940** for requirements.
- Adhere to requirements outlined in **AMPM 510 - Primary Care Providers.**

Primary Care Provider (PCP) services are covered when provided by a physician, physician assistant, nurse practitioner, or Clinical Nurse Specialist (CNS) selected by, or assigned to, the member. The PCP provides primary health care and serves as a coordinator in referring the member for specialty medical services and behavioral health [42 CFR 438.208(b)(1)]. MC will ensure that the PCP maintains the member's primary medical record and includes all documentation of all health risk assessments and health care services whether or not they were provided by the PCP.

The PCP is responsible for rendering, or ensuring the provision of, covered preventive and primary care services to the member. These services will include, at a minimum, the treatment of routine illness, age-appropriate family planning services and supplies, maternity services if applicable, immunizations, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services for eligible members under age 21, adult health screening services and medically necessary treatments for conditions identified in an EPSDT or adult health screening.

All members under the age of 21 are eligible for EPSDT services and shall receive health screening and services to "correct or ameliorate" defects or physical and behavioral illnesses or conditions identified in an EPSDT screening, as specified in **AMPM 430**. Members 21 years of age and over shall receive adult health screenings and medically necessary treatments as specified in **AMPM Chapter 300**. Providers that treat members 18 years old and younger must participate in the Vaccines for Children (VFC) Program. See Section 5.15 – Immunizations/Vaccines for Children (VFC) Program and ASIIS for details.

The PCP, within their scope of practice, may provide behavioral health services, and should use standardized screening tools (i.e., PHQ, GAD-7, PRAPARE, etc.). This includes the monitoring and adjustments of behavioral health medications as well as medication-assisted treatment (MAT) for those with opioid or alcohol use disorders. If MAT services are being provided by the PCP, the PCP is responsible for coordinating care with a behavioral health provider to address the behavioral components of addiction and substance use. The PCP shall ensure coordination and collaboration with any involved behavioral health providers.

PCPs in their care coordination role serve as the referral agent for specialty and referral treatments and services for physical and/or behavioral health services as needed, that are provided to MC members assigned to them and attempt to ensure coordinated quality care that is efficient and cost effective. Coordination responsibilities include, but are not limited to:

- Referring members to providers or hospitals within the MC network, as appropriate, and if necessary, referring members to out-of-network specialty providers and non-contracted community benefit organizations;
- Coordinating with MC's Prior Authorization Department about prior authorization procedures for members;
- Conducting follow-up (including maintaining records of services provided) for referral services that are rendered to their assigned members by other providers, specialty providers, and/or hospitals;
- Coordinating the medical care of the MC members assigned to them, including at a minimum:

    - Oversight of drug regimens to prevent negative interactive effects;
    - Follow-up for all emergency services;
    - Coordination of inpatient care;
    - Coordination of services provided on a referral basis;
    - Home visits if medically necessary;
    - Member education;
    - Preventive health services, (i.e., well-visits, immunizations, and PAP smears);
    - Screening and referral for health-related social needs;
    - Coordination of services; and
    - Assurance that care rendered by specialty providers is appropriate and consistent with each member's health care needs.
- The Controlled Substance Prescription Monitoring Program (CSPMP) will be checked 100% of the time prior to prescribing controlled substances.
- Coordinate with AzEIP to identify children birth up to three years of age with developmental disabilities needing services.
- Refer eligible members to available community resources such as Head Start/Early Head Start, WIC, and home visiting programs, and assist them with navigating the healthcare system if needed.
- Coordination with a member's MC case manager, provider case manager, or ALTCS case manager. Refer to AMPM Policy 570 for case management responsibilities.

When a PCP has initiated medication management services for a member to treat a behavioral health disorder, and it is subsequently determined by the PCP that the member should be referred to a behavioral health provider for evaluation and/or continued medication management services, PCPs are required to provide care coordination which includes the referral and/or transition of members to behavioral health care. Examples of when a referral to behavioral health services should occur is for members who:

- Have been admitted to an inpatient hospital for a behavioral health diagnosis.
- Do not respond to treatment and therefore need additional behavioral health services such as counseling and/or more intense medication monitoring.
- Present with a behavioral health diagnosis that causes significant impairment in cognitive and/or functional abilities.
- Receive medication-assisted treatment from the PCP and need behavioral health services to address the behavioral components of substance use.
- Have experienced a sentinel event (e.g., attempted suicide, danger-to-self, danger-to-others).
- Require services outside the PCP's scope of practice.

- To facilitate a member's access to behavioral health services in a timely manner, PCP's must call MC member services for BH provider identification or coordinate with "in-network" providers directly for coordination after considering member's clinical presentation, preferred locations, and cultural preferences. They should assist the member with scheduling an intake appointment with the identified BH provider, as necessary.
- **Transfer of Care**: When a PCP has initiated medication management services for a member to treat a behavioral health disorder, and it is subsequently determined by the PCP that the member should be transferred to a behavioral health provider for evaluation and/or continued medication management services, MC shall require and ensure that the PCP coordinates the transfer of care. All affected subcontracts shall include this provision. MC shall establish policies and procedures for the transition of these members for ongoing treatment. MC shall ensure that PCPs maintain continuity of care for these members. Please refer to AMPM Policy 510 and 520 for more details.
- Additionally, PCPs are responsible for the collecting of basic information about the member to determine the urgency of the situation and assist with the subsequent scheduling of intake session within the required timeframes and with an appropriate provider. Keeping information or documents gathered in the referral process confidential and protected in accordance with applicable federal and state statutes, regulations, and policies.
- Informing, as appropriate, any changes in referrals (refusing services, change in need, etc.) to referred organizations. Including notification to behavioral health providers, if known, when a member's health status changes, medication change, or new medications are prescribed.
- **PCP Assignment and Appointment Standards** – MC will make provisions to ensure that newly enrolled members are assigned to a PCP and notified within 12 business days of the enrollment notification.
- MC will maintain a current file of member PCP assignments, maintain accurate tracking of PCP assignments to facilitate continuity of care, control utilization, and obtain encounter data.
- MC shall make PCP assignment rosters, clinical information regarding member's health and medications, including behavioral health providers, available to the PCP within 10 business days of a provider's request, as specified in **ACOM Policy 416**.
- For additional information related to responsibilities and PCP assignments pertaining to providers participating in Targeted Investments 2.0 -refer to **ACOM Policy 325**.

- MC allows the member freedom of choice of the PCPs available within the network. If the member does not select a PCP, MC will automatically assign the member to a PCP.
- MC will ensure that newly enrolled pregnant members are assigned to a PCP who provides obstetrical care or referred to an obstetrician as specified in **AMPM Policy 410**. Women may elect to use a specialist in obstetrics and/or gynecology for well woman services.
- MC will assign members with complex medical conditions, who are age 12 and younger, to board-certified pediatricians or to pediatricians that qualify for "in lieu" of board-certification through MC's Credentialing Committee. In addition, members may choose to select a PCP that is not a board-certified pediatrician.
- MC will use its methodology to assign members to those providers participating in value-based purchasing initiatives who have demonstrated high value services or improved outcomes.

4.15 - Specialist

Specialist providers are responsible for providing services in accordance with the accepted community standards of care and practices. Specialists should only provide services to members upon receipt of a written referral form from the member's primary care provider or from another MC participating specialist. Specialists are required to coordinate with the primary care provider when members need a referral to another specialist. The specialist is responsible for verifying member eligibility prior to providing services.

When a specialist refers the member to a different specialist or provider, then the original specialist must share these records, upon request, with the appropriate provider or specialist. The sharing of the documentation should occur with no cost to the member, other specialists, or other providers.

The Controlled Substance Prescription Monitoring Program (CSPMP) will be checked 100% of the time prior to prescribing controlled substances.

4.16 – Standards for Providers Managing Behaviors

MC and all servicing providers must comply with **A.A.C. R6-6-Article 9** requirements, including the use and restrictions of behavioral intervention techniques, behavior modifying medications, emergency measures, and training, as well as the development, monitoring, and approval process for a behavior treatment plan. MC will conduct service and service site monitoring that will include review of compliance with these requirements.

4.17 - Second Opinions

A member may request a second opinion from a provider within the contracted network. The provider should make a recommendation and refer the member to another provider.

4.18 - Provider Assistance Program for Non-Compliant Members

The provider is responsible for providing appropriate services so that members understand their health care needs and are compliant with prescribed treatment plans. Providers should strive to manage members and ensure compliance with treatment plans and with scheduled appointments. If you need assistance helping non-compliant members, MC's Provider Assistance Program is available to you. The purpose of the program is to help coordinate and/or manage the medical care for members at risk. You may complete the **Provider Assistance Program Form** located on MC's **Forms** website and submit it to Member Services for possible intervention.

If you elect to remove the member from your panel rather than continue to serve as the medical home, you must provide the member at least 30 days' written notice prior to removal and ask the member to contact Member Services to change their provider. **The member will NOT be removed from a provider's panel unless the provider's efforts and those of the Health Plan do not result in the member's compliance with medical instructions**. If you need more information about the Provider Assistance Program, please contact your Network Relations Specialist/Consultant.

Documenting Member Care

4.19 - Member's Medical Record

The provider serves as the member's "medical home" and is responsible for providing quality health care, coordinating all other medically necessary services, and documenting such services in the member's medical record. The member's medical record must be kept in a legible, detailed, organized, and comprehensive manner and must remain confidential and accessible and in accordance with applicable law to authorized persons only. The medical record will comply with all customary medical practice, Government Sponsor directives, applicable Federal and state laws, and accreditation standards.

a) **Access to Information and Records** - All medical records, data and information obtained, created, or collected by the provider related to member, including confidential information must be made available electronically to MC, AHCCCS or any government agency upon request. Medical records necessary for the payment of claims must be made available to MC within fourteen (14) days of request. Clinical documentation related to payment incentives and outcomes, including all pay for performance data will be made available to MC or any government entity upon request.

MC may request medical records for transitioning a member to a new health plan or provider. The medical record will be made available free of charge to MC for these purposes.

Each member is entitled to one copy of his or her medical record free of charge. Members have the right to amend or correct medical records. The record must be supplied to the member within fourteen (14) days of the receipt of the request.

When a member changes PCPs, his or her medical records or copies of medical records must be forwarded to the new PCP within 10 business days from receipt of the request for transfer of the medical records.

All providers must adhere to national medical record documentation standards. Below are the minimum medical record documentation and coordination requirements. This information comes from the AHCCCS *Policy 940 – Medical Records and Communication of Clinical Information* contained in **Chapter 900 – Quality Management and Performance Improvement Program**:

- Identifying demographics, including:
  - The member's name
  - Address
  - Telephone number or
  - AHCCCS identification number
  - Gender
  - Age
  - Date of birth
  - Marital Status
  - Next of kin and
  - Parent/guardian/Healthcare Decision Maker (HCDM), if applicable
- Member identification information on the first page of the medical record including:
  - Member name
  - Member AHCCCS ID or
  - Member DOB
- Subsequent pages of the medical record shall include member name and either AHCCCS ID or Member DOB
- Past medical history, including, but not limited to:
  - Disabilities
  - Any previous illness or injuries

    - Smoking
    - Alcohol/substance use
    - Allergies
    - Adverse reactions to medications
    - Hospitalizations
    - Surgeries
    - Emergent/urgent care received and
    - Immunization records (required for children, recommended for adult members if available)
- Identify the name of the treatment or consulting provider, including their signature and date of decision
- Evidence of the use of the Controlled Substances Prescription Monitoring Program (CSPMP) database prior to prescribing a controlled substance or another medication that is known to adversely interact with controlled substances
- Documentation of coordination of care activities including, but not limited to:
    - Referrals to other providers,
    - Reports from referrals, consultations, and specialists for behavioral and/or physical health, as applicable,
    - Transmission of the diagnostic, treatment, and disposition information related to a specific member to the requesting provide, as appropriate to promote continuity of care and quality management of the member's health care,
    - Emergency/urgent care reports,
    - Hospital discharge summaries,
    - Transfer of care to other providers, and
    - Any notification when a member's health status changes or new medications are prescribed.
- When telemedicine is conducted, records shall clearly identify that the visit is a telemedicine visit
- Legal documentation that includes:
    - Documentation related to requests for release of information and subsequent releases;
    - Documentation of a Health Care Power of Attorney or documentation authorizing an HCDM
    - Copies of any Advance Directives or Mental Health Care Power of Attorney

- Documentation that the adult member was provided the information on Advance Directives and whether an advance directive was executed (as specified in AMPM Policy 640);
- Documentation of general and informed consent to treatment, as specified in AMPM Policy 320-Q; and
- Authorization to disclose information.

b) **Medical Record Maintenance** – The provider must maintain member information and records for the longer of six (6) years after the last date provider services were provided to Member, or the period required by applicable law or Government Sponsor directions. The maintenance and access to the member medical record shall survive the termination of a Provider's contract with MC, regardless of the cause of the termination.

c) **PCP Medication Management and Care Coordination with Behavioral Health Providers -** When a PCP has initiated medical management services for a member to treat a behavioral health disorder, and it is subsequently determined by the PCP or MC that the member should receive care through the behavioral health system for evaluation and/or continued medication management services, MC will require and assist the PCP with the coordination of the referral and transfer of care through the behavioral health care management team at MC. The PCP will document in the medical record the care coordination activities and transition of care. The PCP must document the continuity of care.

The medical record contains clinical information pertaining to a member's physical and behavioral health. Maintaining current, accurate, and comprehensive medical records assists providers in successfully treating and supporting member care.

Physical Health Medical Record Requirements:

- Any provider delivering primary care services to a member and acting as their Primary Care Provider (PCP) shall maintain a comprehensive record that incorporates at least the following components:
- Initial history and comprehensive physical examination findings for the member that includes family medical history, social history, and preventive laboratory screenings (the initial history for members under age 21 should also include prenatal care and birth history of the member's mother while pregnant with the member, if known),
- Documentation of any requests for forwarding of behavioral health and/or other medical record information, including documenting completion of the request.
- Behavioral health history and information received from an AHCCCS Contractor, TRBHA, or other provider involved with the member's behavioral health care, 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 shall be associated with the member's medical record as soon as one is established,

- Documentation, initialed by the provider, to signify review of diagnostic information including:
    - Laboratory tests and screenings,
    - Radiology reports,
    - Physical examination notes,
    - Medications,
    - Last provider visit,
    - Recent hospitalizations, and
    - Other pertinent data.
- Evidence that PCPs are utilizing and retaining behavioral health and developmental screening tools and conducting screenings, including developmental and Autism Spectrum Disorder (ASD) screenings at their required ages, as identified in AMPM Policy 430-EPSDT Policy and as identified in AMPM Policy 430-Attachment A, EPSDT Periodicity Schedule.
- Current and complete EPSDT Clinical Sample Templates (or an electronic equivalent including, at minimum all data elements on the age specific EPSDT Clinical Sample Template) are required for all members aged zero through 20 years. For the most up-to-date templates, refer to AMPM Policy 430-Attachment E, EPSDT Clinical Sample Templates.
- Evidence that obstetric providers complete a standardized, evidence-based risk assessment tool for obstetric members. Refer to AMPM Policy 410 - Maternity Policy.
- Documentation to reflect maternity care providers screen all pregnant members once a trimester through use of the CSPMP database.

For additional information on EPSDT medical record documentation requirements, refer to **Chapter 5 – Early and Periodic Screening, Diagnostic and Treatment (EPSDT)** in this manual. Providers must maintain legible, signed, and dated medical records in paper or electronic format that are written in a detailed and comprehensive manner, conform to good professional practices; permit effective professional review and audit processes; and facilitate an adequate system for follow-up treatment.

Paper or Electronic Format

Paper medical records and documentation must include:

- Date and time;

- Signature and credentials;
- Legible text written in blue or black ink or typewritten;
- Corrections with a line drawn through the incorrect information, a notation that the incorrect information was an error, the date when the correction was made, and the initials of the member altering the record. Correction fluid or tape is not allowed; and
- If a rubber-stamp signature is used to authenticate the document/entry, the individual whose signature the stamp represents is accountable for the use of the stamp.
- A progress note is documented on the date that an event occurs. Any additional information added to the progress note is identified as a late entry.

Electronic medical records and documentation must include:

- Safeguards to prevent unauthorized access:
    - The date and time of entries in a medical record as noted by the computer's internal clock;
    - The personnel authorized to make entries using provider established policies and procedures;
    - The identity of the member making an entry; and
    - Electronic signatures to authenticate that a document is properly safeguarded and the individual whose signature is represented is accountable for the use of the electronic signature.

Electronic medical records and systems must also:

- Ensure that the information is not altered inadvertently;
- Track when, and by whom, revisions to information are made; and
- Maintain a backup system including initial and revised information.

Transportation Services Documentation

- For providers that supply transportation services for members using provider employees (i.e., facility vans, drivers, etc.) the following documentation requirements apply:
    - Complete service provider's name and address;
    - Signature and credentials of the driver who provided the service;
    - Vehicle identification (car, van, wheelchair van, etc.);
    - Member's Arizona Health Care Cost Containment System (AHCCCS) identification number;
    - Date of service, including month day and year;
    - Address of pick-up site;
    - Address of drop off destination;

  - Odometer reading at pick up;
  - Odometer reading at drop off;
  - Type of trip – round trip or one way;
  - Escort (if any) must be identified by name and relationship to the member being transported; and
  - Signature of the member, parent, and/or guardian/caregiver, verifying services were rendered. If the member refuses to sign the trip validation form, then the driver should document his/her refusal to sign in the comprehensive medical record.
- For providers that use contracted transportation services, for non-emergency transport of members, which are not direct employees of the provider (i.e., cab companies, shuttle services, etc.) see **AMPM 310-BB Transportation Policy**, Covered Services for a list of elements recommended for documenting non-emergency transportation services.
- It is the provider's responsibility to maintain documentation that supports each transport provided. Transportation providers put themselves at risk of recoupment of payment IF the required documentation is not maintained or covered services cannot be verified.
- MC communicates documentation standards listed under Covered and Non-Covered Services for each line of business to their contracted providers.

Disclosure of Records

All medical records, data and information obtained, created, or collected by the provider related to member, including confidential information, must be made available electronically to MC, AHCCCS or any government agency upon request.

When a member changes his or her PCP, the provider must forward the member's medical record or copies of it to the new PCP within ten (10) business days from receipt of the request for transfer of the record. Medical records must be made available free of charge.
Behavioral health records must be maintained as confidential and must only be disclosed according to the following provisions:

- When requested by a member's primary care provider (PCP) or the member's Department of Economic Security/Division of Developmental Disabilities/Arizona Long-Term Care System (DES/DDD/ALTCS) support coordinator, the behavioral health record or copies of behavioral health record information must be forwarded within ten (10) days of the request.
- MC and subcontracted providers must provide each member who makes a request one copy of his or her medical record free of charge annually.

- MC and subcontracted providers must allow, upon request, members to view and amend their medical record as specified in **45 C.F.R. § 164.524**, **164.526** and **A.R.S. § 12-2293**.

Health Risk Assessment

The Health Risk Assessment (HRA) is a best practice approach and key component of MC record requirements. The standardized question tool puts members in the driver seat by asking them to self-report their medical, psychosocial, cognitive, and functional needs. The assessment score is one of the tools used by the clinical and care management team to determine the member's acuity level, based on the member's perception of their health and health risks. The information provided by members via the health risk assessment is reviewed along with data from the medical record, claims, and other sources to develop a care plan. The care plan is shared with the clinical team to inform the Individual Service Plan (ISP) that provides a roadmap to the member's recovery.

The health risk assessment shall be conducted for all members with Serious Mental Illness (SMI) by the member's assigned clinic. Results shall be inputted into the clinic's electronic health record (E.H.R.) and transmitted to MC per required specifications. Every question on the assessment is required and must be answered. Responses must be entered exactly as shown on the tool provided by MC. Clinics are responsible for completing the assessment in its entirety and per the provided specifications. Failure to submit complete and accurate assessments may result in sanctions and/or corrective action.

The Centers of Medicare and Medicaid Services and MC require the health risk assessment be completed:

- Initially within 90 days of a member's enrollment.
- Annually, within 365 days of their previous health risk assessment.
- When the member experiences a change in health status or level of care.

Behavioral Health Record

For Seriously Mentally Ill (SMI), and Children (CA), the comprehensive medical record must contain the following elements:

- Intake paperwork documentation that includes:
    - For members receiving substance abuse treatment services under the Substance Use Block Grant (SUBG), documentation that notice was provided regarding the member's right to receive services from a provider to whose religious character the member does not object to (see **MC Provider Manual – Chapter 400 – ACC-RBHA, Chapter 2 – Network Provider Service Delivery Requirements, Section**

2.15 – Services with Special Circumstances – Non-Title XIX/XXI Behavioral Health Services Benefit;
    - Documentation of member's receipt of the Member Handbook and receipt of Notice of Privacy Practice; and
    - Contact information for the member's PCP if applicable.
    - Financial documentation for Non-Title XIX/XXI members receiving behavioral health services, as outlined in AMPM Policy 650. At minimum, include documentation of the results of a completed Title XIX/XXI screening at initial evaluation appointment, when the member has had a significant change in his/her income, and at least annually.
- Assessment documentation that includes:
    - Is there a screening and assessment for trauma in children and families?
    - Is there evidence of documentation of identification of trauma related needs and plans to address those needs (Children)?
    - For children in Child Welfare, if the member is displaying dangerous or threatening behaviors and a request for residential treatment is made by out of home placement, was the request submitted within 24 hours of request?
    - Documentation of all information collected in the behavioral health assessment and any applicable addenda and required demographic information. For additional requirements refer to AMPM Policy 320-O, AMPM Policy 320-U, AMPM Policy 580, and AHCCCS Technical Interface Guidelines;
    - Diagnostic information including psychiatric, psychological, and medical evaluations;
    - Evaluation of the need for reporting as required under A.R.S. §13-3620;
    - Information regarding notification of members in need of special assistance as noted in **AMPM 320-R Special Assistance for Members Determined to have a Serious Mental Illness**.
    - An English version of the assessment and/or service plan if the documents are completed in any other language other than English; and
    - For members receiving services via telemedicine, copies of electronically recorded information of direct, consultative, or collateral clinical interviews.
    - CALOCUS (CHILDREN ONLY)
        - The CALOCUS is completed with the initial assessment period;
        - The CALOCUS is completed every 6 months following the initial assessment period or as significant changes occur in the life of the child as specified in AMPM Policy 320-O. This may include, but is not limited to, hospitalization, suicidal ideation or attempt, or discharge from inpatient, behavioral health short-term residential treatment, or TFC;

        - The CALOCUS has been completed in collaboration with the child/adolescent and family and other members of the CFT;
        - For children/adolescents with CALOCUS levels of 4, 5, and 6 of service intensity, there is a designated care manager to coordinate services and activities of CFT practice; and
        - Based on all clinical and supporting documentation, the CALOCUS service intensity is appropriate to the child/adolescent's current functioning.
        - The CALOCUS is to be completed in collaboration with the child and family; it cannot be done without either the child or guardian present.
- Treatment and service plans documentation that includes:
    - The member's treatment and service plan;
    - Child and Family Team (CFT) documentation;
    - Clinically recommended service on the treatment plan is implemented within 21 days (Children);
    - Adult Recovery Team (ART) documentation; and
    - Progress reports or service plans from all other additional service providers.
- Progress notes documentation that includes:
    - Documentation of the type of services provided;
    - The diagnosis, including an indicator that clearly identifies whether the progress note is for a new diagnosis or the continuation of a previous diagnosis. After a primary diagnosis is identified, the member may be determined to have co-occurring diagnoses. The service providing clinician will place the diagnosis code in the progress note to indicate which diagnosis is being addressed during the provider session. The addition of the progress note diagnosis code should be included, if applicable;
    - The date the service was delivered;
    - The date and time the progress note was signed;
    - Duration of the service (time increments) including the code used for billing the service;
    - A description of what occurred during the provision of the service related to the member's treatment plan;
    - If more than one provider simultaneously provides the same service to a member, documentation of the need for the involvement of multiple providers including the name and roles of each provider involved in the delivery of services;
    - The member's response to service; and
    - For members receiving services via telemedicine, electronically recorded information of direct, consultative, or collateral clinical interviews.

- Medical services documentation that includes:
  - Laboratory, x-ray, and other findings related to the member's physical and behavioral health care;
  - The member's treatment plan related to medical services;
  - Physician orders;
  - Requests for service authorizations;
  - Documentation of facility-based or inpatient care;
  - Documentation of preventive care services;
  - Medication record, when applicable; and
  - Documentation of Certification of Need (CON) and Re-Certification of Need (RON)
- Reports from other agencies that include:
  - Reports from providers of services, consultations, and specialists;
  - Emergency/urgent care reports; and
  - Hospital discharge summaries.
- Paper or electronic correspondence that includes:
  - Documentation of the provision of diagnostic, treatment, and disposition information to the PCP and other providers to promote continuity of care and quality management of the member's health care;
  - Documentation of any requests for and forwarding of behavioral health record information.
  - The Controlled Substance Prescription Monitoring Program (CSPMP) will be checked 100% of the time prior to prescribing controlled substances.
- Financial documentation that includes:
  - Documentation of the results of a completed Title XIX/XXI screening
  - Information regarding establishment of any copayments assessed, if applicable
- Legal documentation including:
  - Documentation related to requests for release of information and subsequent releases
  - Copies of any advance directives or mental health care power of attorney
    - Documentation that the adult member was provided the information on advance directives and whether an advance directive was executed;
    - Documentation of authorization of any health care power of attorney that appoints a designated member to make health care decisions (not including mental health) on behalf of the member if they are found to be incapable of making these decisions;
    - Documentation of authorization of any mental health care power of attorney that appoints a designated member to make behavioral health

care decisions on behalf of the member if they are found to be incapable of making these decisions. Documentation of general and informed consent to treatment pursuant to General and Informed Consent and Pharmacy Management under each line of business;

- Authorization to disclose information pursuant to **MC Provider Manual Chapter 400 – ACC-RBHA, Chapter 14 – Contract Compliance, Section 14.00 - Confidentiality**. All applicable release of Information (ROI's) documentation to be reviewed and updated annually with the member; and,
- Any extension granted for the processing of an appeal must be documented in the case file, including the Notice regarding the extension sent to the member and his/her legal guardian or authorized representative, if applicable
- For youth in Child Welfare, documentation of verification of the Notice to Provider (Educational-Medical).

- Integrated Health Care (SMI ONLY)
  - Does documentation reflect strategies to support earlier identification and intervention that reduces the incidence and severity of serious physical, and mental illness;
  - Is use of health education and health promotion services evidenced;
  - Does documentation reflect an increased use of primary care prevention strategies;
  - Is there evidence of use of validated screening tools for early identification and intervention;
  - Evidence of focused, targeted, consultations for behavior health conditions;
  - Evidence of cross-specialty collaboration;
  - Evidence of enhanced discharge planning and follow-up care between provider visits;
  - Evidence of ongoing outcome measurement and treatment plan modification related to health promotion and prevention;
  - Evidence of care coordination through effective provider communication and management of treatment; and
  - Family and community education related to health promotion and prevention.

Medical Record Maintenance

Providers must retain the original or copies of member medical records as follows:

- For an adult, for at least six (6) years after the last date the adult member received medical or health care services from the provider; or
- For a child, either for at least three (3) years after the child's eighteenth birthday or for at least six (6) years after the last date the adult member received medical or health care services from the provider, whichever occurs later.

The maintenance and access to the member medical record shall survive the termination of a Provider's contract with MC, regardless of the cause of the termination.

PCP Medication Management and Care Coordination with Behavioral Health Providers

When a PCP has initiated medical management services for a member to treat depression, anxiety, and/or ADD/ADHD, and it is subsequently determined by the PCP or MC that the member should receive care through the behavioral health system for evaluation and/or continued medication management services, MC will require and assist the PCP with the coordination of the referral and transfer of care. The PCP will document in the medical record the care coordination activities and transition of care. The PCP must document the continuity of care.

Medical Record Audits

MC conducts routine medical record audits to assess compliance with established standards. Medical records may be requested when MC is responding to an inquiry on behalf of a member or provider, administrative responsibilities, and quality of care issues. Providers must respond to these requests within fourteen (14) days or in no event will the date exceed that of any government issues request date. Medical records must be made available to AHCCCS for quality review upon request. MC shall have access to medical records for assessing quality of care, conducting medical evaluations, audits, and performing utilization management functions.

For members living with a Serious Mental Illness (SMI) designation the MC network providers provide Substance Abuse and Mental Health Services Administration (SAMHSA) evidence-based practice (EBP) program models. The EBPs include the following:

Assertive Community Treatment (ACT)

ACT is a service delivery model with a goal of recovery through community treatment and rehabilitation. Comprehensive and effective services are delivered to members who have needs that have not been well met by traditional approaches.

Consumer Operated Service (COS)

Consumer operated services are peer-run service programs that are owned, administratively controlled, and operated by mental health consumers and emphasize self-help as their operational approach. Consumer-operated services may be called by other names such as consumer-run organization, peer support programs, peer services, or peer service agencies.

Permanent Supportive Housing (PSH)
Permanent Supportive Housing is decent, safe, and affordable housing with tenancy rights and voluntary support services that enable people to attain and maintain housing integrated into the community of choice.

Supported Employment (SE)
Supported Employment is an approach that emphasizes assisting individuals to obtain competitive employment in the community while providing the necessary support. The overriding philosophy of Supported Employment is the belief that every person with a Serious Mental Illness is capable of working competitively in the community when the member job preference is honored, and the appropriate supports are provided.

Providers of SAMHSA EBP of ACT, COS, PSH, and SE are to:

- Utilize the SAMHSA EBP Kit as a framework for developing and implementing all aspects of the EBP
- Utilize a standard intake and evaluation process
- Develop and implement outreach, engagement, and reengagement process and policies
- Accept referrals – see source list in AHCCCS AMPM 930
- Obtain training and technical assistance to implement the SAMHSA EBP

In addition to participating in formal EBP fidelity reviews, completed annually by either an identified party and/or MC, all providers are expected to:

- Participate in quality management and fidelity review processes
- Conduct ongoing self-monitoring activities according to the self-monitoring plan outlined by each provider utilizing the SAMHSA “Evaluating your program”
- Report results of Provide self-monitoring activities
- Participate in performance improvement activities, including but not limited to performance improvement/remediation plans and/or sanctions which may be imposed by MC

It is the expectation for fidelity scores to continue to improve, with a minimum expectation of sustaining fidelity scores for all the evidence-based practices listed above. MC outlines fidelity scoring thresholds to determine if services provided are consistent with fidelity standards. SAMHSA's Evidence Based Practice toolkits will be utilized to monitor program fidelity. MC monitors fidelity with a goal of achieving High Fidelity Implementation as identified in **AHCCCS AMPM 930 – Implementation and Fidelity Monitoring of SAMHSA Evidence Based Practices.**

Reviews and self-monitoring

In addition to participating in formal fidelity reviews, all providers are expected to:

- Participate in quality management and fidelity review processes.
- Conduct ongoing self-monitoring activities according to the self-monitoring plan outlined by each provider.
- Report quarterly on results of their self-monitoring activities.

Performance improvement activities, including but not limited to PIPS, CAPS and/or sanctions, may be imposed by MC.

Transition of Medical Records

Transfer of the behavioral health member's medical records, due to transitioning of the behavioral health member to a new TRBHA and/or provider, it is important to ensure that there is minimal disruption to the behavioral health member's care and provision of services. The behavioral health medical record must be transferred in a timely manner that ensures continuity of care.

Federal and state law allows for the transfer of behavioral health medical records from one provider to another, without obtaining the member's written authorization if it is for treatment purposes (**45 C.F.R. § 164.502(b)**, **164.514(d)** and **A.R.S. 12-2294(C)**). Generally, the only instance in which a provider must obtain written authorization is for the transfer of alcohol/drug and/or communicable disease treatment information. Other situations may require written authorization.

The original provider must send that portion of the medical record that is necessary to the continuing treatment of the behavioral health member. In most cases, this includes all communication that is recorded in any form or medium and that relate to patient examination, evaluation, or behavioral health treatment. Records include medical records that are prepared by a health care provider or other providers. Records do not include materials that are prepared in connection with utilization review, peer review, or quality assurance activities,

including records that a health care provider prepares pursuant to section **A.R.S. §36-441**, **36-445**, **36-2402** and **36-2917**.

Federal privacy law indicates that the Designated Record Set (DRS) is the property of the provider who generates the DRS. Therefore, originals of the medical record are retained by the terminating or transitioning provider in accordance with **Section 4.19 – Member's Medical Records in the Disclosure of Records section** of this manual. The cost of copying and transmitting the medical record to the new provider shall be the responsibility of the transitioning provider (see the **AHCCCS Contractors Operation Manual, Section 402**).

Requirements for Community Service Agencies (CSA), Therapeutic Foster Care (TFC) Providers and Habilitation Providers

MC requires that CSA, TFC Provider and Habilitation Provider clinical records to the following standards. Each record entry must be:

- Dated and signed with credentials noted;
- Legible text, written in blue or black ink or typewritten; and
- Factual and correct.

If required records are kept in more than one location, the agency/provider shall maintain a list indicating the location of the records.

CSAs, TFC Providers and Habilitation Providers must maintain a record of the services delivered to each behavioral health member. The minimum written requirement for each behavioral health member's record must include:

- The service provided (including the code used for billing the service) and the time increment;
- Signature and the date the service was provided;
- The name title and credentials of the member providing the service;
- The member's CIS identification number and AHCCCS identification number;
- MC conducts routine audits to ensure that services provided by the agency/provider are reflected in the behavioral health member's service plan. CSAs, TFC Providers and Habilitation Providers must keep a copy of each behavioral health member's service plan in the member's record; and
- Daily documentation of the service(s) provided and monthly summary of progress toward treatment goals.

Community Service Agency/TFC Provider/Habilitation Provider Daily Clinical Record

Documentation Form is a recommended format that may be utilized to meet the requirements identified in this chapter.

Every thirty (30) days, a summary of the information required in this chapter must be transmitted from the CSA, TFC Provider or Habilitation Provider to the member's clinical team for inclusion in the comprehensive clinical record.

Adequacy and Availability of Documentation

MC and subcontracted providers must maintain and store records and data that document and support the services provided to members and the associated encounters/billing for those services. In addition to any records required to comply with MC contracts, there must be adequate documentation to support that all billings or reimbursements are accurate, justified, and appropriate.

All providers must prepare, maintain, and make available to AHCCCS and MC, adequate documentation related to services provided and the associated encounters/billings.

Adequate documentation is electronic records and "hard copy" documentation that can be readily discerned and verified with reasonable certainty. Adequate documentation must establish medical necessity and support all medically necessary services rendered, and the amount of reimbursement received (encounter value/billed amount) by a provider; this includes all related clinical, financial, operational, business supporting documentation and electronic records. It also includes clinical records that support and verify that the member's assessment, diagnosis, and Individual Service Plan (ISP) are accurate and appropriate and that all services (including those not directly related to clinical care) are supported by the assessment, diagnosis, and ISP.

For monitoring, reviewing, and auditing purposes, all documentation and electronic records must be made available at the same site at which the service is rendered. If requested documents and electronic records are not available for review at the time requested, they are considered missing. All missing records are considered inadequate. If documentation is not available due to off-site storage, the provider must submit their applicable policy for off-site storage, demonstrate where the requested documentation is stored and arrange to supply the documentation at the site within 24 hours of the original request.

MC's failure to prepare, retain and provide to AHCCCS adequate documentation and electronic records for services encountered or billed may result in the recovery and/or voiding not to be

resubmitted) of the associated encounter values or payments for those services not adequately documented and/or result in financial sanctions to the provider and MC.

Inadequate documentation may be determined to be evidence of suspected fraud or program abuse that may result in notification or reporting to the appropriate law enforcement or oversight agency. These requirements continue to be applicable in the event the provider discontinues as an active participating and/or contracted provider as the result of a change of ownership or any other circumstance.

4.20 - Advance Directives

Overview

An Advance Directive is a document by which a person makes provision for health care decisions if, in the future, he/she becomes unable to make those decisions. Providers are required to comply with federal and state law regarding advance directives for adult members. Providers must maintain written policies for adult members receiving care through their organization regarding the member's ability to make decision about medical care, including the right to accept or refuse care and the right to executive an Advance Directive.

Information regarding Advance Directives can be found in **AHCCCS AMPM Policy 640** as well as the MC **website**.

The advance directive must be prominently displayed in the adult member's medical record. Requirements as noted in AHCCCS AMPM Policy 640 include:

- Providing written information to adult members regarding each individual's rights under state law to make decisions regarding medical care and any provider written policies concerning advance directives (including any conscientious objections).
- Documenting in the member's medical record whether the adult member has been provided the information and whether an advance directive has been executed.
- Prevent discrimination against a member because of a decision to execute or not execute an Advance Directive.
- Ensure that there are no conditions placed on the provision of care to a member due to a member's decision regarding executing or not executing an Advance Directive.
- Provide education to staff regarding issues related to Advance Directives including notifying staff who provide services such as home health care, and personal care services (e.g., attendant care, respite, personal care) if Advance Directives have been executed for assigned members that they serve.

- Ensure that staff working in alternative Home and Community Based Services (HCBS) locations have immediate access to Advance Directives which can be provided to first responders.
- Ensuring compliance with requirements of State law regarding Advance Directives. This includes statutory laws or laws/regulations by State courts.

Adult members, including incapacitated members or members that are unable to receive information, and the Health Care Decision Makers (HCDM) of those members (if applicable) shall be provided written information regarding Advance Directives as specified in 42 CFR 489.102(e) concerning:

- Member's rights regarding Advance Directives under Arizona State law and the organization's policies respecting the implementation of those rights.
- A description of the applicable State law and information regarding the implementation of those rights. Providers shall update and disseminate any amended information as soon as possible, but no later than 90 days from the effective date of State law changes.
- Member's right to file complaints with the Arizona Department of Health Services (ADHS) Division of Licensing.
- Written policies including a clear and precise statement of limitations if the provider cannot implement an Advance Directive as a matter of conscience. The statement shall at a minimum include:
    - Institution-wide conscientious objections and those of individual physicians,
    - Identification of State legal authority permitting such objections, and
    - A description of the range of medical conditions and procedures affected by the conscience objection(s).

Providers are not relieved of obligations to provide information to a member once the member is no longer incapacitated or unable to receive such information. Providers shall have follow-up procedures in place to provide this information directly to a member at an appropriate time.

Providers shall provide this information to a member upon each admission to a hospital or nursing facility and each time a member comes under the care of a home health agency, hospice, or personal care provider.

Additionally, Providers shall provide a copy of a member's Advance Directive or documentation of a member's refusal to a member's PCP for inclusion in the member's medical record.

Arizona Advance Directives Registry:

The **Arizona Advance Directive Registry** is a free registry maintained by the **State of Arizona** to electronically store and access medical directives. Their secure and confidential program grants peace of mind to registrants and their families, and easy access to all health care providers. Healthcare providers must assist adult members who are interested in developing and executing an advance directive. Forms available are:

- Medical Health Care Power of Attorney
- Behavioral Health Care Power of Attorney
- Living Will

All forms are available under the **Life Care Planning** document provided by The Office of the Arizona Attorney General.

Health Care Power of Attorney

A health care power of attorney gives an adult member the right to designate another adult member to make health care treatment decisions on his or his/her behalf. The designee may make decisions on behalf of the adult member if/when he/she is found incapable of making these types of decisions. The designee, however, must not be a provider directly involved with the health treatment of the adult member at the time the health care power of attorney is executed.

Behavioral Health Care Power of Attorney

A behavioral health care power of attorney gives an adult member the right to designate another adult member to make behavioral health care treatment decisions on his or her behalf. The designee may make decisions on behalf of the adult member if/when he/she is found incapable of making these types of decisions. The designee, however, must not be a provider directly involved with the behavioral health treatment of the adult member at the time the behavioral health care power of attorney is executed.

Additional Considerations

Advance directives not only identify services a member would desire if he or she becomes unable to decide, but they are also:

- Promote individual treatment planning;
- Provide opportunities to create a team approach to treatment; and
- Foster recovery approaches.

Power and Duties of Designee(s)

The designee:

- May act in this capacity until his or her authority is revoked by the adult member or by court order;
- Has the same right as the adult member to receive information and to review the adult member's medical records regarding proposed healthcare treatment and to receive, review, and consent to the disclosure of medical records relating to the adult member's treatment;
- Must act consistently with the wishes of the adult member as expressed in the health care power of attorney or mental health care power of attorney. If, however, the adult member's wishes are not expressed in a health care power of attorney or behavioral health care power of attorney and are not otherwise known by the designee, the designee must act in good faith and consent to treatment that she or he believes to be in the adult member's best interest; and
- May consent to admitting the adult member to an inpatient behavioral health facility licensed by the Arizona Department of Health Services if this authority is expressly stated in the behavioral health care power of attorney or health care power of attorney.

See **A.R.S. §36-3283** for a complete list of the powers and duties of an agent designated under a behavioral health care power of attorney.

Requirements for Adult Member at Time of Enrollment

At the time of enrollment, all adult members, and when the individual is incapacitated or unable to receive information, the member's family, or surrogate, must receive information regarding (see **42 C.F.R. § 422.128**):

- The member's rights, in writing, regarding advance directives under Arizona State law;
- A description of the applicable state law and information regarding the implementation of these rights;
- The healthcare member's right to file complaints directly with AHCCCS; and
- Written policies including a clear and precise statement of limitations if the provider cannot implement an advance directive as a matter of conscience. This statement, at a minimum, should:
    - Clarify institution-wide conscience objections and those of individual physicians;
    - Identify state legal authority permitting such objections; and
    - Describe the range of medical conditions or procedures affected by the conscience objection.

For additional resources about Advance Directives, contact MC Member Services at 800-564-5465.

4.21 – End of Life Care

End of life care is member-centric care that includes Advance Care Planning, and the delivery of appropriate health care services and practical supports. The goals of end-of-life care focuses on providing treatment, comfort, and quality of life for the duration of the member's life. The end-of-life concept of care strives to ensure members achieve quality of life through the provision of services such as:

- Physical and/or behavioral health medical treatment to:
  - Treat the underlying illness and other comorbidities;
  - Relieve pain; and
  - Relieve stress.
- Referrals to community resources for services such as, but not limited to:
  - Pastoral/counseling services; and
  - Legal services.
- Practical supports are non-billable services provided by a family member, friend, or volunteer to assist or perform functions such as, but not limited to:
  - Housekeeping;
  - Personal Care;
  - Food preparation;
  - Shopping;
  - Pet care; and
  - Non-medical comfort

Members aged 21 years and older who receive end of life care may continue to receive curative care until they choose to receive hospice care. Members under the age of 21 may receive curative care concurrently with end-of-life care and hospice care.

Advance Care Planning

Advance Care Planning is initiated by the member's qualified health care professional for a member at any age that is currently or is expected to experience declining health or is diagnosed with a chronic, complex, or terminal illness. For the purposes of Advance Care Planning, a qualified health care professional is a MD, DO, PA, or NP. Advance Care Planning is meant to be an ongoing process for the duration of the member's life.

Advance Care Planning often results in the creation of an Advance Directive for the member. Providers must perform the following as part of the End-of-Life concept of care when treating qualifying members:

- Conduct a face-to-face discussion with the member/guardian/designated representative to develop Advance Care Planning;

- Teach the member/guardian/designated representative about the member's illness and the healthcare options that are available to the member to enable them to make educated decisions;
- Identify the member's healthcare, social, psychological, and spiritual needs;
- Develop a written member-centered plan of care that identifies the member's choices for care and treatment, as well as life goals;
- Share the member's wishes with family, friends, and his or her physicians;
- Complete Advance Directives;
- Refer to community resources based on member's needs; and
- Assist the member/guardian/designated representative in identifying practical supports to meet the member's needs.
- Refer to MCCC, MC ACC-RBHA and MCLTC Care Management team to assist with coordination of care.

MC shall provide care/case management to qualifying members and coordinate with and support the member's provider in meeting the member's needs. In addition, the care/case manager will assist the member, guardian, or designated representative in ensuring practical supports and community referrals are maintained or revised to meet the member's current needs.

Advance Care Planning is a covered, reimbursable service when provided by a qualified health care professional. The provider may bill for providing Advance Care Planning separately during a well or sick visit.

Hospice Services

For further information regarding hospice services, please refer to the **MC Claims Processing Manual** available on the MC website or the **AHCCCS AMPM Policy 310-J**.

Training

MC requires that providers and their staff must be educated in the concepts of end-of-life care, advance care planning, and advance directives.

Additional information is available by clicking the link **Advance Directives and End of Life Provider Reference Guide**.

4.22 - Documenting Member Appointments

When scheduling an appointment with a member over the telephone or in person (i.e., when a member appears at your office without an appointment), providers must verify eligibility and document the member's information in the member's medical record.

4.23 - Missed or Cancelled Appointments

Providers must document and follow-up on no show, missed, or cancelled appointments. MC encourages providers to use a recall system. MC reserves the right to request documentation supporting follow up with members related to missed appointments. To request our assistance with these members, providers can:

- Notify Member Services Department by completing a **Provider Assistance Program Form** for members who continually miss appointments.
- Notify the EPSDT/MCH Department of any EPDST member well visits, prenatal or postpartum visits, or well-woman visits by utilizing the **Missed Appointment Log** and the EPSDT/MCH Prevention and Wellness Staff will then follow-up with those members to assist them in rescheduling their visit.

Both documents can be found on the MC Provider Website in the **Forms** section.

4.24 - Documenting Referrals

The provider is responsible for initiating, coordinating, and documenting referrals to specialists, including dentists and behavioral health specialists within the MC organization. The provider must follow the respective practices for emergency room care, second opinion and noncompliant members. For additional information on referral requirements, refer to **Chapter 13 – Referrals and Authorizations** of this manual.

4.25 - Respecting Member Rights

MC is always committed to treating members with respect and dignity. Member rights and responsibilities are shared with staff, providers, and members each year. Member rights are incorporated herein and may be reviewed in the **Member Handbook** located at:

- **MCCC Member Handbook**
- **MCLTC Member Handbook**
- **MC ACC-RBHA Member Handbook**
- **MC DCS CHP Member Handbook**

Member Rights

MC member rights and responsibilities are listed below:

- Members are entitled to the name of their PCP and/or case manager.

- Members are entitled to have a copy of the MC Member Handbook, which includes a description of covered services.
- How MC provides after hours and emergency care.
- The right to file a complaint about MC.
- The right to request information about the structure and operations of MC or their subcontractors.
- How MC pays providers, controls cost and uses services. This information includes whether MC has Physician Incentive Plans (PIP) and a description of the PIP.
- The right to know whether stop loss insurance is required.
- General grievance results and a summary of member survey results.
- Member costs to get services or treatments that are not covered by MC.
- How to get services, including services requiring authorization.
- How MC evaluates new technology to include as a covered service.
- Changes to the member's services or what action to take when a member's PCP leaves MC.
- Members have the right to be treated fairly and get covered services without concern about race, ethnicity, national origin (to include those with limited English proficiency), religion, gender, age, mental or physical disability, sexual orientation, genetic information, or ability to pay or speak English.
- The member may exercise his or her rights and the exercise of those rights shall not adversely affect service delivery to the member.

Confidentiality and Privacy

- Members have a right to privacy and confidentiality regarding their health care information.
- Members have the right to talk to health care professionals privately.
- A "Privacy Rights" notice is included in the member's welcome packet. The notice has information on ways MC uses a member's records, which includes information their health plan activities and payments for services. Health care information will be kept private and confidential. It will be given out only with the member's permission or if the law allows it.

Treatment Decisions

- Members have the right to agree to, or refuse, treatment and to choose other treatment options available to them. Members can get this information in a way that helps them to better understand and is appropriate to their medical condition.
- Members can choose an MC PCP to coordinate their health care.
- Members can change their PCP.
- Members can talk with their PCP to get complete and current information about their health care and condition. This will help members and their family to better understand their condition and be a part of making decisions about their health care.
- Within the limits of applicable regulations, MC staff may help manage a member's health care by collaborating with the member, community and state agencies, schools, and their doctor.
- Members have the right to information on which procedures they will have and who will perform them.
- Members have the right to a second opinion from a qualified health care professional within the network. A second opinion can be arranged outside of the network, at no cost to the member, only if there is not adequate in-network coverage.
- Members have the right to know treatment choices or types of care available to them and the benefits and/or drawbacks of each choice.
- Members can decide who they want to be with for their treatments and exams.
- Members can have a female in the room for breast and pelvic exams.
- Member eligibility or medical care does not depend on the member's agreement to follow a treatment plan. A member can say "no" to treatment, services, or PCPs. The member will be informed about what may happen to their health if they do not have the treatment.
- MC will notify a member in writing when any health care services requested by their PCP are reduced, suspended, terminated, or denied. Members must follow the instructions in the notification letter sent to them.
- Members have the right to be provided with information about creating advance directives. Advance directives tell others how to make medical decisions for the member if the member is not able to make those decisions for themselves.

Medical Records Requests

- At no cost to themselves, the member has the right to annually request and receive one copy of their medical records and/or inspect their medical records. Members may not be able to get a copy of medical records if the record includes any of the following information: psychotherapy notes put together for a civil, criminal, or administrative action; protected health information that is subject to the Federal Clinical Laboratory

Improvements Amendments of 1988; or protected health information that is exempt due to federal codes of regulation.

- MC will reply to the member's request within 30 days. MC's reply will include a copy of the requested record or a letter denying the request. The written denial letter will include the basis for the denial and information on ways to get the denial reviewed.
- Members have the right to request an amendment to their medical records. MC may ask that the member put this request in writing. If the amendment is made, whole or in part, we will take all steps necessary to do this in a timely manner and let the member know about changes that are made.
- MC has the right to deny a member's request to amend their medical records. If the request is denied, in whole or in part, then MC will provide the member with a written denial within 60 days. The written denial includes the basis for the denial, notification of member's right to submit a written statement disagreeing with the denial and how to file the statement.

Reporting Member Concerns

- Tell MC about any complaints or issues the member has with their health care services.
- Members may file an appeal with MC and get a decision in a reasonable amount of time.
- Members can give MC suggestions about changes to policies and services.
- Members have the right to complain about MC.
- Personal rights.
- Members have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Members have the right to receive information on beneficiary and plan information.

Respect and Dignity

- Members have the right to be treated with respect and with consideration for their dignity and privacy.
- Members have the right to participate in decisions regarding their health care, including the right to refuse treatment.
- Members can get quality medical services that support their personal beliefs, medical condition, and background. Members can get these services in a language they understand. Members have the right to know about other providers who speak languages other than English.
- Members can get interpretation services if they do not speak English. Sign language services are available if you are deaf or have difficulty hearing. You may ask for materials in other formats or languages from MC Member Services.

- The type of information about a member's treatment is available to the member in a way that helps them have a better understanding given their medical condition.

Members Who are Part of Division of Developmental Disabilities

- Members have the right to get a replacement caregiver for "critical services" within two hours.

Emergency Care and Specialty Services

- Members can get emergency health care services without the approval of their PCP or MC when they have a medical emergency. Members may go to any hospital emergency room or other setting for emergency care.
- Members may get behavioral health services without the approval of their PCP or MC.
- Members can see a specialist with a referral from their PCP.
- Members can refuse care from a doctor they were referred to and can ask for a different doctor.
- Members may request a second opinion from another MC physician/specialist.

4.26 – Consent to Treat Minors or Disabled Members under Guardianship

Health care professionals and organizational providers who treat or provide services for MC members must comply with federal and state laws requiring consent for the treatment of minors or disabled members under guardianship to be HIPAA compliant.

Both participating and nonparticipating practitioners and providers are responsible for determining whether consent is needed for a service being provided to a member and must obtain appropriate consent as required. Every provider is encouraged to consult with their own legal counsel for answers to specific questions regarding consent. Since this involves Protected Health Information (PHI) and needs to be shared with the member's guardian or Durable Power of Attorney, providers are required to meet all HIPPA regulations.

If during a review or audit it is discovered that appropriate consent was not attained, it will be reported to our Quality Management Department or Chief Medical Officer.

4.27 - Health Insurance Portability and Accountability Act of 1997 (HIPAA)

The Health Insurance Portability and Accountability Act of 1997 (HIPAA) has provisions affecting the health care industry, including transaction code sets, privacy, and security provisions. HIPAA impacts what is referred to as covered entities; specifically, providers, health plans and health care clearinghouses that transmit health care information electronically. HIPAA has established national standards addressing the security and privacy of health information, as well as

standards for electronic health care transactions and national identifiers. All Participating Health Providers (PHP) are required to adhere to HIPAA regulations. For more information about these standards, please visit the **Health Information Privacy** website. In accordance with HIPAA guidelines, providers may not interview members about medical or financial issues within hearing range of other patients.

If a PHP discovers an event that resulted in impermissible use or disclosure of protected health information for MC members, please immediately notify your Network Management representative. Timely notification is required because MC and contracted PHPs must comply with the HIPAA Breach Notification Rule, 45 CFR §§ 164.400-414, which requires HIPAA covered entities and their business associates to provide notification following a breach of unsecured protected health information without unreasonable delay and in no case later than 60 calendar days after discovery of a breach. The notification required shall include, to the extent possible, the identification of each individual whose unsecured protected health information has been or is reasonably believed by the PHP to have been, accessed, acquired, used, or disclosed during the breach. Additionally, the PHP shall provide any other available information that is required to include in notification to the member under § 164.40(c) at the time of the notification required or promptly thereafter as information becomes available.

4.28 - Cultural Competency, Health Literacy and Linguistic Services

As the U.S. population becomes more diverse, medical providers and other people involved in health care delivery are interacting with members or individuals from many different cultural and linguistic backgrounds. Because culture and language are vital factors in how health care services are delivered and received, it is important that health care organizations and their staff understand and respond with sensitivity to the needs and preferences that culturally and linguistically diverse members or individuals bring to the health encounter.

Responding to Cultural and Linguistic Needs of our Members

The Institute of Medicine report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* demonstrated that racial and ethnic minorities often receive lower-quality care than their white counterparts, even after controlling for factors such as insurance, socioeconomic status, comorbidities, and stage of presentation. Among other factors found to contribute to healthcare disparities are inadequate resources, poor patient-provider communication, a lack of culturally competent care, and inadequate linguistic access. Through the application of cultural competency knowledge and health literacy techniques, providers will help remove barriers to care.

Required Culturally and Linguistically Appropriate Services (CLAS) Standards

The enhanced National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for individuals as well as health and health care organizations to implement culturally and linguistically appropriate services. The enhanced standards are a comprehensive series of guidelines that inform, guide, and facilitate practices related to culturally and linguistically appropriate health services.

MC Requirements

MC ACC-RBHA requires and monitors adherence to all areas of the CLAS standards.

MC Acute Care, Long-Term Care, MC DCS CHP, and DDD expects all providers to uphold all the CLAS standards and check for education/knowledge and monitor for non-compliance through the member complaint and grievance process.

CLAS Standards

Principal Standard (Standard 1): Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce (Standards 2-4): Provide greater clarity on the specific locus of action for each of these standards and emphasizes the importance of the implementation of CLAS as a systemic responsibility, requiring the investment, support, and training of all individuals within an organization.

Communication and Language Assistance (Standards 5-8): Provides a broader understanding and application of appropriate services to include all communication needs and services, including sign language, braille, oral interpretation, and written translation.

Engagement, Continuous Improvement, and Accountability (Standards 9-15): Underscores the importance of establishing individual responsibility in ensuring that CLAS is supported, while retaining the understanding that effective delivery of CLAS demands actions across an organization. This revision focuses on the supports necessary for adoption, implementation, and maintenance of culturally and linguistically appropriate policies and services regardless of one's role within an organization or practice. All individuals are accountable for upholding the values and intent of the National CLAS Standards.

Language Access Services (LAS)

Providers and subcontractors serve as the established points of contact for members who require language assistance services to access their agency's program and activities.

Providers must deliver information in a manner that is understood by the member. MC providers must comply with federal and state laws by offering interpreter and translation services, including sign language interpreters, to LEP members. MC strongly recommends the use of professional interpreters, rather than family or friends

To comply with the LAS requirements, MC and subcontracted providers must:

- Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services;
- Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing;
- Ensure the competence of individuals providing language assistance (qualified staff members must pass the ALTA Language Proficiency Test with a minimum score of 9 to interpret and bill the T1013 HCPCS code), recognizing that the use of untrained individuals and/or minors as interpreters should be avoided;
- Ensure providers identify the prevalent non-English language within provider service areas to ensure service capacity meets those needs;
- Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area. Have services provided in a culturally competent manner, with consideration for members with limited English proficiency or reading skills, and those with diverse cultural and ethnic backgrounds as well as members with visual or auditory limitations. Options include access to a language interpreter, a member proficient in sign language for the hearing impaired and written materials available in Braille for the blind or in different formats, as appropriate;
- Ensure qualified oral interpreters and bilingual staff as well as certified sign language interpreters provide access to oral interpretation, translation, sign language, and disability-related services, and provide auxiliary aids and alternative formats on request. Oral interpretation and sign language services are provided at no charge to AHCCCS eligible members and members determined to have a Serious Mental Illness (SMI); and
- MC will conduct evaluations of the primary non-English languages spoken within the Geographical Service Areas (GSAs) and programs that affect cultural competence, access, and quality of care.

Accessing Oral Interpretation Services

In accordance with Title VI of the Civil Rights Act, Prohibition against National Origin Discrimination, and President's Executive Order 13166, recipients of Federal financial assistance, such as Medicaid funding, must take reasonable steps to provide meaningful access to Limited English Proficient (LEP) persons. Recipients include, but are not limited to, managed care organizations, providers, and subcontractors.

MC and their subcontracted providers must make sign language and oral interpretation services available to members with Limited English Proficiency (LEP) at all points of contact. Interpretation services are provided at no charge to AHCCCS eligible members and Non-Title XIX/XXI members determined to have a Serious Mental Illness (SMI). Members must be provided with information instructing them how to access these services.

In compliance with the law, MC provides its enrolled members with interpretative services. MC contracted providers and subcontractors are also recipients of federal financial assistance. Accordingly, those providers and subcontractors are required to provide interpretative services to MC members accessing covered services through the provider or subcontractor.

If a provider is unable to meet a member's interpretive needs for an appointment, the provider may consider using MC Language Access Services. MC offers a very robust language services delivery system that provides access to over 200 languages and dialects. MC Language Access Services address interpretation needs through Qualified Bilingual Staff, Scheduled Interpretation and On-demand Interpretation. While providers are allowed to utilize MC Language Access Services to ensure members' needs are met, it does not exempt the provider from providing their own services to the members. Providers can contract out services they do not offer in-house, but this would be done directly with the companies that provide these types of services. This will be at the cost of the provider.

Effective February 1, 2022, MC providers must contact MC's Member Services department directly for scheduled interpretation service requests. Providers will no longer schedule requests with interpretation vendors directly. Interpretation services delivered outside of this new scheduling process will not be paid by MC.

Providers can call the MC Member Services numbers below to schedule interpretation services. Use the phone tree prompt for interpretation services. Note that Member Services cannot schedule interpretation appointments beyond 30 days advance notice.

MC ACC/DDD/ALTCS: 1-800-624-3879
MC ACC-RBHA: 1-800-564-5465

MC Advantage: 1-877-436-5288
MC DCS CHP: 1-833-711-0776

Once a request is submitted to MC Member Services, an email notice is sent to share the request was received and is circulated to our language vendors. Providers must review and manage all interpretation requests submitted to MC. Any modifications needed to a request must be updated through MC Member Services. Any scheduled interpretation request coordinated/scheduled outside of this process **will not** be paid by MC. Providers are responsible.

If the provider is not receiving notices regarding their request, the provider may need to have **noreply@interact.mercycareaz.org** bookmarked in their system or contact Member Services to update the requester's email address.

Whenever possible, schedule:

- No more than 30 days, and
- No less than 48 hours prior to the appointment for spoken languages
- No less than 5 business days prior to the appointment for American Sign Language (ASL) and Certified Deaf Interpreter (CDI)

MC cannot guarantee the appointment will be filled in person. Please be advised that due to interpreter workforce shortages, services may not be available upon request. On-Demand Services are available 24 hours a day, 7 days a week to assist with continuity of a member's appointment.

MC makes every effort to fulfill requests as they are received. If for whatever reason interpretation is unavailable through MC's Scheduled Services, the provider has direct access 24 hours a day/7 days a week to utilize MC On-Demand Services. If MC is not able to fulfill the request through scheduled or on demand interpretation, it remains the providers responsibility to meet the member's language needs.

On-Demand Over the Phone

Providers can connect with an interpreter for spoken languages 24 hours a day/7 days a week over the phone. Language Line's phone interpreting solution is easy to use on any phone, connecting you to an interpreter. If needed, interpreters can dial an outbound call to connect the provider to the member with limited English proficiency (LEP).

- Dial the provided toll-free telephone number from any phone
- Provide basic account information and identify the language

- Connect to an interpreter within seconds
- Our interpreter can dial an outbound call to connect your LEP client if needed
- Customizable process streamlines your call flow, improves efficiency, to meet your specific business needs

Please refer to our **Language Line Solutions Quick Reference Guide** for call-in detail. 4-Digit PIN Codes are as follows:

- MC Complete Care, MC Long Term Care, MC DD, and MC Advantage -Clinical -1203
- MC Complete Care, MC Long Term Care, MC DD, and MC Advantage -Non-Clinical -1204
- MC ACC-RBHA -Clinical -2076
- MC ACC-RBHA -Non-Clinical -1205

The determination between clinical vs. non-clinical is made by the service location and service type. If interpretive services are occurring in a clinical setting (hospital, Integrated/Behavioral Health Home, etc.), it is considered clinical interpretation. If the interpretive service occurs in a non-clinical setting (i.e., court room, school) and for a non-clinical reason (i.e., scheduling appointment), it is considered non-clinical interpretation.

On-Demand Video Remote Interpreting (VRI)
Remote services expand the pool of ASL interpreters to support member appointments and prevent cancellations or need to reschedule. On-Demand Services- VRI is only useful when the provider and the member are in the same location, and the interpreter can join remotely via cell phone, tablet, or computer. VRI has a limitation of 8 connections. If additional connections are needed, providers should contact Member Services to request Scheduled Virtual Interpreting (SVI) aka video. Staff can access MC On-Demand Services - Video Remote Interpreting (VRI) 24 hours a day, 7 days a week through Purple's VRI application or web. **Prior setup is required.** Providers interested in learning more and setting up VRI to serve MC members, please contact **CulturalCompetency@MercyCareAZ.org**.

Interpretation Roles and Requirements

MC and contracted Language Vendors strive to provide members a positive experience every time they use interpretation services. We want to ensure interpreters are meeting provider and member expectations and members have access to interpretive services.

It's also vital to remember that at no time shall a member go without interpretation services.

There are two ways to access qualified interpreters for a member's appointment: 1) OnDemand Services, and 2) Scheduled Services.

- OnDemand Services provides direct access to interpreters **without** scheduling. Interpreters are accessible through over-the-phone interpreting (OPI) for spoken languages, or video remote interpreting (VRI) for American Sign Language (ASL).
- Scheduled Services are interpretation services that require advanced set up and is managed by MC Member Services. The modalities for scheduled services include face-to-face, scheduled virtual interpreting (SVI) – aka video, or over-the-phone interpreting.

Providers are expected to follow the below guidelines when requesting interpretative services with MC. They must confirm clinical need for the interpretive service as indicated on the member's assessment and treatment plan.

Outlined below are key details to keep in mind when addressing language assistance needs:

- Confirm MC eligibility before requesting interpretive services. Providers will be responsible for paying for services delivered to non-MC eligible members.
- Providers and subcontractors are required to provide interpretive services to MC members accessing covered services through the provider or subcontractor.
- The provider of service is responsible for scheduling all interpretation sessions for behavioral and physical health services delivered by their agency.
- Member appointments that are less than or equal to one hour are required to use **OnDemand Over-the-Phone Interpreting (OPI)**, or Scheduled Virtual Interpreting (SVI). Requests for additional time should not be submitted as a means of bypassing MC's policy. If an appointment exceeds one year, OPI and SVI have the capacity to support longer service durations as needed.
- Providers must document the members preferred language and the interpretation service provided within the direct service note.
- Providers must report to MC any "red flags" regarding interpreters, including failing to show up for appointments or inappropriate conduct.

To ensure access to services, care coordination, and cost, it is the Providers' responsibility to cancel interpretive services with MC Member Services. Providers are responsible for cancelling in a timely manner to avoid late cancellation fees.

In addition, you should ensure that no interpretation services are scheduled during days and times when your agency is closed.

Group Sessions

- Interpreter time is to be billed by time and not by member; and
- When conducting group therapy sessions with 2 or more members who speak the same language, one interpreter should be utilized for interpreting the session. Interpreter time sheets should reflect the time spent providing interpretation services and should not reflect "double billing" for the additional member serviced.

Submitting Interpretation Request

- Interpretation requests should include proof of MC eligibility, AHCCCS ID and submitted to the members' payer of record.
- Interpretation services are utilized ONLY when delivering a covered service for activity listed on the member's ISP.
- Video interpretation request must include the appointment link, meeting code, and password.

Preferred Interpreter

To ensure timely and efficient services, interpreters will be scheduled for member appointments at the time of the request. Members may request a specific gender for their interpreter but will not be able to request a specific interpreter. This process will ensure that all MC members will have access to interpretation services in a timely and efficient manner for appropriate service appointments.

In the event an interpreter is unable to work with a member, the provider can call **Mercy Care's Language Line Solutions** to ensure continuity of the appointment.

Cancellations

To ensure access to services, care coordination, and cost, it is the Providers' responsibility to cancel interpretive services with the vendor. Providers are responsible for cancelling in a timely manner to avoid late cancellation fees.

Please note that MC is charged for cancellations. Please utilize the following guidelines when cancelling services:

- A cancellation reason should always be given and tracked by the provider agency;
- Provide MC with a list of cancellations monthly including why the service was cancelled, who cancelled it and when the service was cancelled so that we can track how far in advance the service was cancelled;
- Whenever possible, cancellations should occur more than 48 hours prior to the service being rendered; and

- If the service is being rescheduled and not cancelled, ensure that a notation is made on the interpreter's timesheet being signed that the service was a reschedule.

MCLTC and DDD Interpretation Service
Please note that if interpretation services are required for a member, whether in a physician's office or in a Home and Community Based Service setting, they will be arranged by the member's Case Manager under MC Long Term Care or a DDD Support Coordinator under DDD.

Interpretation services are not a covered service for members residing in a Skilled Nursing Facility. The Skilled Nursing Facility must provide this service.

Providers are expected to review and adhere to the following guidelines that summarize services interpreters are expected to provide along with items outside the Interpreter Code of Conduct.

Interpreter Guidelines
The interpreter should:
Provide a professional language interpretation ensuring accurate and complete communication between a provider and the Limited English Proficient (LEP) member.

The interpreter should **NOT**:
- Act as an "advocate" for the LEP member, including:
  - Encourage provider or LEP member to request them by name.
  - Interact with the LEP member outside the role of an interpreter.
  - Socialize or communicate with the LEP member outside of the presence of the provider.
  - Provide transportation or other support to the LEP member.
  - Discuss compensation with the doctor/provider/care coordinator/case manager/LEP member.

An interpreter is not:
- Advocate
- Companion
- Chauffer
- Babysitter
- BHT
- Member of the clinical team

Hence, the interpreter is **not** responsible for a member's care, **only** a vessel for team to communicate. Please refrain from using and allowing interpreters to operate outside of this role.

If the member does not trust local interpreters, a request can be made to have the scheduled video or Language Line interpreters be out of state.

If during any encounter you observe an Interpreter's behavior to be outside of these guidelines, please contact MC Cultural Competency at **CulturalCompetency@mercycareaz.org** as soon as possible so that our team may work with the Language Vendor to take appropriate actions and as appropriate, work with the member and or on behalf of the member [to] file a grievance, appeal or complaint.

Interpreters should never be allowed to schedule appointments for members.

Providers must report to MC any "red flags" regarding interpreters, including failing to show up for appointments or inappropriate conduct, so the issues are properly and timely addressed.

Time Sheets

Interpreter time sheets are to reflect actual service time with patient and physician/clinician present. Time sheets are subject to spot audits by MC. Additionally:

- Interpreter time should not include time the interpreter is "available" or waiting and not providing a direct interpreter service;
- Interpreter time should be documented as exact start and stop time of the appointment. Time should not be rounded up by the hour, half hour or quarter hour;
- Time sheets should include the number of members serviced during documented time (interpreters may service 2 or more members simultaneously);
- Time for travel and/or prep time are not billable time; and
- Activities that are not actual service time (i.e., parking) are not billable.
- Interpreters are **not** allowed to schedule appointments.

Qualified Bilingual Staff

To qualify as bilingual staff, the staff member is required to test and meet a minimum proficiency score:

- Spoken languages

    - ALTA Language Test
        - Score of 9 or better
            - Writing and/or
            - Listening and speaking
- Sign language
    - American Sign Language Proficiency Interview (ASLPI)
        - Rating of Advanced/Level 4 or higher

After doing so, the staff member can bill for the covered service they render and bill the T1013 code. If a provider wishes to proceed to have a staff member qualified, please make the necessary arrangements to have staff tested. Providers are responsible for testing expenses.

Interpretive Services Billing

When billing Interpretive Services, the provider must bill as follows:

HCPCS Code	Modifier	Description
T1013		Qualified staff delivering services is also interpreting.
T1013	Q6	Separate but employed qualified staff are interpreting.
T1013	CR	External vendor used.

Accessing Interpretation Services for the Deaf and the Hard of Hearing

MC and their subcontracted providers must adhere to the rules established by the Arizona Commission for the Deaf and Hard of Hearing, in accordance with **A.R.S.§ 36-1946**, which covers the following:

- Classification of interpreters for the deaf and the hard of hearing based on the level of interpreting skills acquired by that member;
- Establishment of standards and procedures for the qualification and licensure of each classification of interpreters;
- Utilizing licensed interpreters for the deaf and the hard of hearing; and
- Providing auxiliary aids or licensed sign language interpreters that meet the needs of the individual upon request. Auxiliary aids include computer-aided transcriptions, written materials, assistive listening devices, or systems, closed and open captioning, and other effective methods of making aurally delivered materials available to members with hearing loss. For more information regarding this, please review Section 14.27 – Augmentative and Alternative Communication Device System in this Provider Manual. You may also refer to the **MC Claims Processing Manual, Chapter 2 – Professional Claim**

Types by Specialty, Section 2.22 – Augmentative and Alternative Communication Device Systems (AAC) available on the MC website.

The **Arizona Commission for the Deaf and the Hard of Hearing** provides a listing of licensed interpreters, information on auxiliary aids and the complete rules and regulations regarding the profession of interpreters in the State of Arizona. You can review their website or contact them at 602 542-3323 (V/TTY).

MC has a TTY line in their Member Services department for members who are hearing impaired at 866-796-5598 (TTY/TDD) 711.

Please be advised that, in accordance with industry standards established by the Registry of Interpreters for the Deaf (RID) assignments lasting longer than an hour require scheduling a team of two sign language interpreters to ensure continuous and effective interpreting services.

Translation of Written Material

MC translates written translated materials when a language is spoken by 3,000 or 10% (whichever is less) of members. MC translates all materials to all members in English and Spanish. All vital materials are translated when MC is aware that a language is spoken by 1,000 or 5% (whichever is less) of the members. Vital materials must include at a minimum:

- Notice for denials, reductions, suspensions, or termination of services;
- Service plans;
- Consent forms;
- Communications requiring a response from the healthcare member;
- Grievance notices; and
- Member Handbooks.

All written notices informing members of their right to interpretation and translation services must be translated when MC is aware that 1000 or 5% (whichever is less) of MCACC-RBHA's members speak that language and have LEP.

Members with Limited English Proficiency (LEP), whose languages are not considered commonly encountered, are provided written notice in their primary or preferred language of the right to receive competent translation of written material.

MC provides member materials in other formats to meet specific member needs. Providers must also deliver information in a manner that is understood by the member.

Culturally Competent Care

To comply with the Culturally Competent Care requirements, providers must adhere to the following requirements:

- Recruit, promote, and support culturally and linguistically diverse representation within governance, leadership, and the workforce that are responsive to the population in the service area.
- Educate and train representatives within governance, leadership, and the workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.
- MC ACC-RBHA Providers with direct care responsibilities must complete mandated Cultural Competency training.

Assessment

If the behavioral health member requests a copy of the assessment, those documents must be provided to the behavioral health member in his/her primary/preferred language. Documentation in the assessment must also be made in English; both versions must be maintained in the member's record. This will ensure that if any members, who must review the member's record for purposes such as coordination of care, emergency services, auditing, and program integrity, have an English version available.

Service plans specifically incorporate a member's rights to disagree with services identified on the plan. If the plan is not in the member's preferred language, the member has not been appropriately informed of services he/she will be provided and afforded the opportunity to exercise his/her rights when there is a disagreement.

In general, any document that requires the signature of the member, and that contains vital information such as the treatment, medications, notices, or service plans must be:

- Translated into their preferred/primary language.
- If the member or his/her guardian declines the translation, documentation of this decision must be in the member's medical record.
- If the primary/preferred language of the behavioral health member is other than English and any of the service plans have been completed in English, the provider must ensure the service plans are translated into the behavioral health member's primary/preferred language for his/her signature.

MC and subcontracted providers must also maintain documentation of the ISP in both the preferred/primary language as well as in English. If the member declines to have their service plan in their preferred language, the **provider must** document this decision in the member's medical record.

These requirements apply also to the ITDP (Inpatient Treatment and Discharge Plan), in accordance with the 9 A.A.C. 21, Article 3.

Organizational Supports for Cultural and Linguistic Need

Under AHCCCS guidance, and to comply with the Organizational Supports for Cultural Competence, MC and subcontracted providers must:

- Establish culturally and linguistically appropriate goals, policies, and management accountability and infuse them throughout the organization's planning and operations.
- Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
- Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
- Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
- Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
- Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.
- Ensure the use of multi-faceted approaches to assess satisfaction of diverse individuals, families, and communities, including the identification of minority responses in the analysis of client satisfaction surveys, the monitoring of service outcomes, member complaints, grievances, provider feedback, and/or employee surveys;
- Include prevention strategies by analyzing data to evaluate the impact on the network and service delivery system, with the goal of minimizing disparities in access to services and improving quality; and
- Consult with diverse groups to develop relevant communications, outreach and marketing strategies that review, evaluate, and improve service delivery to diverse individuals, families, and communities, and address disparities in access and utilization of services.

Documenting Clinical Cultural and Linguistic Need

To advance health literacy, reduce health disparities, and identify the individual's unique needs, MC and subcontractors must:

- Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery;
- Ensure documentation of the cultural (for example: age, ethnicity, race, national origin, sex (gender), gender identity, sexual orientation, tribal affiliation, disability) and linguistic (for example, primary language, preferred language, language spoken at home, alternative language) needs within the medical records;
- Maintain documentation within the medical record of oral interpretation services provided in a language other than English. Documentation must include the date of service, interpreter name, type of language provided, interpretation duration, and type of interpretation services provided;
- Ensure that the cultural preferences of members and their families are assessed and included in the development of treatment plans; and
- Assess the unique needs of the GSA, as communities' cultural preferences are critical in the development of goals and strategies of prevention within documentation of cultural and linguistic need.

Cultural Competence Reporting and Accountability

Reporting and accountability measures are intended to track, monitor, and ensure access to quality and effective care. Equity in the access, delivery, and utilization of services is accomplished by MC and subcontracted providers:

- Conducting annually and ongoing strategic planning in Cultural Competency with the inclusion of national level priorities, contractual requirements, stakeholder input, community involvement and initiative development in areas, including but not limited to: Continuing Education, Training, Community Involvement, Health Integration, Outreach, Prevention, Data Analysis/Reporting, Health Literacy, and Policies/Procedures Development.
- Capturing and reporting on language access services which include linguistic needs (primary language, preferred language, language spoken at home, alternative language); interpretive services; written translation services; and maintaining documentation on how to access qualified/licensed interpreters and translators.
- Assessing and developing reports quarterly, semi-annually, and annually within the areas of cultural competency and workforce development to review the initiatives, activities, and requirements impacting diverse communities, geographical services areas (GSAs), and the individuals accessing and receiving services.

- Continuous and ongoing reporting provides insight to strengths, gaps, and needs within communities served by MC and MC subcontracted providers with a goal of health and wellness for all.

Cultural Competence Administrator

MC has a Cultural Competence Administrator who acts as a point of contact to implement and oversee compliance requirements as described in the Annual Cultural Competence Plan, Cultural Competence Policy and Procedures and Provider Manual policies, and must participate in Cultural Competence Committees.

Cultural Competence Plan

MC's cultural competency plan is designed to address the needs of Arizona's diverse and underserved/underrepresented populations MC develops and implements an Annual Cultural Competence Plan based on current initiatives in the field of cultural competence, with a focus on national level priorities, contractual requirements, and initiatives developed by internal and external stakeholders, including providers and experts in cultural competence. The Annual Cultural Competence Plan is submitted to the AHCCCS Cultural Competence Manager each year upon request, and to DCS CHP (CHP) and DES DDD (DDD) as required.

Annually, MC develops and/or modifies initiatives based on the identified needs of their members, with a goal of eliminating health disparities.

Cultural Competence Reporting

MC has developed a comprehensive service structure designed to address the needs of Arizona's diverse populations and underserved/underrepresented populations. The following reports assist in the analysis and evaluation of the system.

- Annual Effectiveness Review of the Cultural Competence Plan Report:
    - MC will annually evaluate the impact of the annual cultural competence plan's initiatives and activities towards developing a culturally competent service delivery system. The report must be submitted to the AHCCCS Cultural Competence Manager in accordance with MC ACC-RBHA's contract.
- Annual Language Services Report: MC will submit annual reports to the AHCCCS Cultural Competence Manager. The report captures linguistic need (primary language, Deaf and Hard of Hearing, sign language services, interpretive services, and translation services) and provides comprehensive lists of interpreter language abilities and billing unit usage.
    - Language Access Plan: The Language Access Plan (LAS) helps establish a strategy to ensure meaningful access by individuals with LEP to services available to them at MC and contracted providers.

MC ACC-RBHA Workforce Development

MC ACC-RBHA and their subcontracted providers must:

- Ensure all staff receive training in cultural competence and culturally and linguistically appropriate services during new employee orientation;
- Provide annual training to all staff in diversity awareness and culturally relevant topics customized to meet the needs of their GSA;
- Provide continuing education in cultural competence, to include but not limited to review of CLAS standards, use of oral interpretation and translation services, and alternative formats and services for LEP clients;
- Ensure all staff have access to resources for behavioral health members with diverse cultural needs;
- Recruit, retain and promote, at all levels of the organization, a culturally competent, diverse staff and leadership;
- Maintain full compliance with all mandatory trainings; and
- Develop and implement cultural-related trainings/curriculums as determined by AHCCCS, MC, Cultural Competence Committees, policies, and contract requirements.

Laws Addressing Discrimination and Diversity

MC and provider agencies will abide by the following referenced federal and state applicable rules, regulations, and guidance documents:

- Title VI of the Civil Rights Act prohibits discrimination based on race, color, and national origin in programs and activities receiving federal financial assistance.
- Department of Health and Human Services - Guidance to Federal Financial Assistance Members Regarding Title VI Prohibition Against National Origin Discrimination affecting Limited English Proficient Members.
- Title VII of the Civil Rights Act of 1964 prohibits employment discrimination based on race, color, religion, sex, or national origin by any employer with 15 or more employees. (The Civil Rights Act of 1991 reverses in whole or in part several Supreme Court decisions interpreting Title VII, strengthening and improving the law and providing for damages in cases of intentional employment discrimination.)
- President´s Executive Order 13166 improves access to services for members with Limited English Proficiency. The Executive Order requires each Federal agency to examine the services it provides and develop and implement a system by which LEP members can meaningfully access those services consistent with, and without unduly burdening, the fundamental mission of the agency.

- State Executive Order 99-4 and President´s Executive Order 11246 mandates that all members regardless of race, color, sex, age, national origin, or political affiliation shall have equal access to employment opportunities.
- The Age Discrimination in Employment Act (ADEA) prohibits employment discrimination against employees and job applicants 40 years of age or older. The ADEA applies to employers with 20 or more employees, including state and local governments. The Older Workers Benefit Protection Act (Pub. L. 101-433) amends the ADEA to prohibit employers from denying benefits to older employees.
- The Equal Pay Act (EPA) and A.R.S. 23-341 prohibit sex-based wage discrimination between men and women in the same establishment who are performing under similar working conditions.
- Section 503 of the Rehabilitation Act prohibits discrimination in the employment or advancement of qualified members because of physical or mental disability for employers with federal contracts or subcontracts that exceed $10,000. All covered contractors and subcontractors must also include a specific equal opportunity clause in each of their nonexempt contracts and subcontracts.
- The Americans with Disabilities Act prohibits discrimination against members who have a disability. Providers are required to deliver services so that they are readily accessible to members with a disability. MC and their subcontracted providers who employ less than fifteen members and who cannot comply with the accessibility requirements without making significant changes to existing facilities may refer the member with a disability to other providers where the services are accessible. MC or its subcontracted provider who employs fifteen or more members is required to designate at least one member to coordinate its efforts to comply with federal regulations that govern anti-discrimination laws.
- Section 1157 of the Patient Protection and Affordable Care Act, which prohibits discrimination based on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, gender identity, and sex characteristics), in covered health programs or activities. 42.U.S.C. 18116

Further Information Regarding Cultural Competency

The Partnership for Clear Health Communication (PCHC) defines health literacy as the ability to read, understand and act on health information. Health literacy relates to listening, speaking, and conceptual knowledge. Health literacy plays an important role in positive patient outcomes. According to PCHC, people with low functional Health Literacy:

- Have poorer overall health status.

- Are less likely to adhere to treatment and incur a greater number of medication/treatment errors.
- Require more health-related treatment and care, including 29-69% higher hospitalization rates.
- Increase higher health care costs - health care costs as high as $7,500 more per annum for a member with limited health literacy.

In accordance with **Title VI of the 1964 Civil Rights Act**, national standards for culturally and linguistically appropriate health care services and state requirements, MC is required to ensure that Limited English Proficient (LEP) members have meaningful access to health care services. Because of language differences and inability to speak or understand English, LEP members are often excluded from programs they are eligible for, experience delays or denials of services or receive care and services based on inaccurate or incomplete information.

Members are to receive covered services without concern about race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information or medical history, ability to pay or ability to speak English. PHPs are required to treat all members with dignity and respect, in accordance with federal law. Providers must deliver services in a culturally effective manner to all members, including:

- Those with limited English proficiency (LEP) or reading skills.
- Those with diverse cultural and ethnic backgrounds.
- The homeless.
- Individuals with physical and mental disabilities.

Definitions

- "Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities" (Based on Cross, T., Bazron, B., Dennis, K., & Isaacs, M., (1989). Towards a Culturally Competent System of Care Volume I. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center)

- Health Literacy: "The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions." (Ratzan and Parker, 2000)
- Health Equities: In a report designed to increase consensus around meaning of health equity, the Robert Wood Johnson Foundation (RWJF) provides the following definition: "Health equity means that everyone has a fair and just opportunity to be healthier. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care." Robert Wood Johnson Foundation (RWJF) provides the following definition: "Health equity means that everyone has a fair and just opportunity to be healthier. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care."

4.29 - Individuals with Disabilities

Providers are required to ensure that their offices offer physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities, in compliance with 42 CFR §438.206(c)(3) and 42 CFR §457.1230(a).

Additionally, under Title III of the Americans with Disabilities Act (ADA), public accommodations such as physician offices must be accessible to individuals with disabilities. No qualified individual with a disability may be excluded from participation in, denied benefits of, or subjected to discrimination by any public entity. Provider offices must be accessible and make reasonable efforts to provide appropriate accommodations, such as large-print materials and easily accessible doorways.

4.30 - Primary Care Provider (PCP) Assignments

MC automatically assigns members to a provider upon enrollment. Members have the right to change their provider at any time. Member eligibility changes frequently, as a result, providers must verify eligibility prior to delivering services.

4.31 - Plan Changes

MC members generally are not allowed to change their health plan until their Annual Enrollment Choice (AEC) period, which occurs on the anniversary date of their enrollment. Only in certain circumstances may a member request a change outside of this timeframe:

- A member was entitled to freedom of choice but was not sent an auto-assignment/freedom of choice notice.

- A member was entitled to participate in an Annual Enrollment Choice but:
    - Was not sent an Annual Enrollment Choice notice or
    - Was sent an Annual Enrollment Choice notice but was unable to participate in the Annual Enrollment Choice due to circumstances beyond the member's control.
- Family members were inadvertently enrolled with different Contractors. A member who is enrolled in a Contractor through the auto-assignment process may inadvertently be enrolled with a different Contractor than other family members. Upon receipt of notification by AHCCCS, the member who was inadvertently enrolled will be dis-enrolled from the Contractor of assignment and enrolled in the Contractor where the other family members are enrolled when AHCCCS is notified of the problem. Other family members will not be permitted to change to the Contractor to which the new member was auto assigned. This process shall not apply if a member was afforded an enrollment choice during their Annual Enrollment Choice period.
- A member, who was enrolled with a Contractor, lost eligibility and was dis-enrolled, then was subsequently re-determined eligible and reenrolled with a different Contractor within 90 days from the date of disenrollment. In this case the member shall be reenrolled with the Contractor that the member was enrolled with prior to the loss of eligibility. If this does not occur, AHCCCS, upon notification, will enroll the member with the correct Contractor.
- Newborns will automatically be assigned to the mother's Contractor. If the mother is Title XIX or Title XXI eligible, she will be given 30 days from notification to select another Contractor for the newborn. Newborns of Federal Emergency Services (FES) mothers will be auto assigned, and the mother will be given 30 days from notification to select another Contractor.
- Adoption subsidy children will be auto assigned, and the guardian will be given 30 days from notification to select another Contractor.
- A Title XIX eligible member who is entitled to freedom of choice but becomes eligible and is auto-assigned prior to having the full choice period of 30 days will be given an opportunity to request a Contractor change following auto-assignment. The member will be given 30 days from the date of the choice letter to request a Contractor change. A member who does not select within 30 days will remain with the auto-assigned Contractor.
- A member whose eligibility category changed from Sixth Omnibus Budget Reconciliation Act (SOBRA) to the SOBRA Family Planning Extension Program may change to another available Contractor if their current primary care provider (PCP) will not be providing Family Planning Extension Program services.

Plan change requests may be granted based on continuity of medical care. Medical continuity of care situations are as follows:

Medical Continuity of Prenatal Care

A pregnant member who is enrolled with a Contractor through auto-assignment or freedom of choice, but who is receiving or has received prenatal care from a provider who is affiliated with another Contractor, may be granted a medical continuity Contractor change if the medical directors of both Contractors concur.

If there are other individuals in the pregnant member's family who are also AHCCCS eligible and enrolled, they have the option to remain with the current Contractor or transition to the new Contractor if the medical continuity plan change is granted. The member may not return to the original Contractor or change to another Contractor after the medical continuity Contractor change has been granted except during the AEC period.

Medical Continuity of Care

In unique situations, Contractor changes may be approved on a case-by-case basis, if necessary, to ensure the member access to medical/health care.

A plan change for medical continuity is not an automatic process. The member's PCP, or other medical provider, must provide documentation to both the receiving and relinquishing Contractors that supports the need for a Contractor change. The Contractors must be reasonable in the request for documentation. However, the burden of proof that a Contractor change is necessary rests with the member's medical provider. Both Contractor Medical Directors must approve the Contractor change.

When the Medical Directors of both the receiving and relinquishing Contractors have discussed the request and have not been able to come to an agreement, the relinquishing Contractor shall submit the request to the AHCCCS Chief Medical Officer (CMO) or designee. The AHCCCS Acute Care Change of Contractor Form (Attachment A) and the supporting documentation must be sent to the AHCCCS DHCM/Medical Management Manager within 14 business days from the date of the original request.

The results of the review will be shared with both Medical Directors. The relinquishing Contractor will be responsible for issuing a final decision to the member. If the member request is denied, the relinquishing Contractor will send the member a Notice of Adverse Benefit Determination.

The plan change determination will be made by the MC medical director or designee based on information provided by the PCP.

Contractor Responsibilities When a Contractor Change is Not Warranted

The current Contractor has the responsibility to promptly address the member's concerns regarding availability and accessibility of service and quality of medical care or delivery issues that may have caused a Contractor change request to be initiated. These issues include, but are not limited to:

- Quality of care delivery
- Care management responsiveness
- Transportation convenience and service availability
- Institutional care issues
- Physician or provider preference
- Physician or provider recommendation
- Physician or provider office hours
- Timing of appointments and services
- Office waiting time
- Network limitations and restrictions

When quality of care and delivery of medical service issues raised by the member cannot be solved through the normal care management process, the current Contractor must refer the issue for review by:

- The current Contractor's Quality Management Department and/or
- The AHCCCS Medical Director

Additionally, the current Contractor must explore all options available to the member, such as resolving transportation problems, provider availability issues, allowing the member to choose another PCP, or to see another medical provider, if appropriate.

Quality of care and delivery of medical services issues raised by the member must be referred to the current Contractor's quality management staff and/or the Contractor's Medical Director for review within one day of the Contractor's receipt/notification of the problem.

The delivery of covered services remains the responsibility of the current Contractor if a Contractor change for medical continuity of prenatal or other medical care is not approved.

The current Contractor must notify the member, in writing, that a Contractor change is not warranted. If the Contractor change request was the result of a member concern, the notice must include the Contractor's resolution of this concern. The notice must also advise the member of the AHCCCS and Contractor grievance policy and include timeframes for filing a grievance.

Contractors may reach an agreement with an out-of-network provider, to care for the member on a temporary basis, for the members' period of illness and/or pregnancy to provide continuity of care.

Relinquishing Contractor Responsibilities

If a member contacts the current Contractor, verbally or in writing, and states that the reason for the plan change request is due to situations outlined above, the relinquishing Contractor shall advise the member to telephone the AHCCCS Verification Unit at 602-417-7000 or 800-962-6690 for AHCCCS to process the change.

If the member contacts the relinquishing Contractor, verbally or in writing, to request a plan change for medical continuity of care, the following steps must be taken:

- The relinquishing Contractor will contact the receiving Contractor to discuss the request. If a plan change is indicated for medical continuity of care, the AHCCCS Contractor Change Request Form (Attachment A) must be completed. All the members to be affected are added to the form and the form signed by the medical directors or physician designees of both Contractors. When the AHCCCS Contractor Change Request Form is signed it is to be submitted to the AHCCCS Chief Medical Officer.
- To facilitate continuity of prenatal care for the member, Contractors shall sign off and forward the AHCCCS Contractor Change Request Form to the AHCCCS Chief Medical Officer within two business days of the member's Contractor change request. The timeframe for other continuity of care issues is 10 business days.
- The AHCCCS Chief Medical Officer will review the Contractor change documentation and forward to the Communications Center for processing.

Receiving Contractor Responsibilities

The member must be transitioned within the requirements and protocols outlined in AHCCCS' **ACOM Policy 402** and in **AMPM Chapter 500**.

Member Responsibilities

The member shall request a change of Contractor directly from AHCCCS only for situations defined in above. The member shall direct all other Contractor change requests to the member's current Contractor.

AHCCCS Administration Responsibilities

The AHCCCS Administration shall process change of Contractor requests listed above and shall send notification of the change via the daily recipient roster to the relinquishing and receiving Contractors. It is the Contractor's responsibility to identify members from the daily recipient roster who are leaving the Contractor.

If the AHCCCS Administration denies a change of Contractor request, the AHCCCS Administration will send the member a denial letter. The member will be given 60 days to file a grievance.

If the AHCCCS Administration receives a letter or verbal request from a member requesting a Contractor change, that also references other problems (i.e., transportation, accessibility, or availability of services), that information will be sent to the current Contractor.

If the AHCCCS Administration receives a letter or verbal request from a member requesting a Contractor change for reasons above, the information will be forwarded to the current Contractor.

Provider Guidelines and Plan Details

4.32 - Cost Sharing and Coordination of Benefits

Providers must adhere to all contract and regulatory cost sharing guidelines. When a member has other health insurance such as Medicare, a Medicare HMO or a commercial carrier, MC will coordinate payment of benefits in accordance with the terms of the PHPs contract and federal and state requirements. AHCCCS registered providers must coordinate benefits for all MC members in accordance with the terms of their contract and AHCCCS guidelines.

MC is the payer of last resort, unless specifically prohibited by State or Federal law. This means that MC shall be used as a source of payment for covered services only after all other sources of payment have been exhausted. MC will take reasonable measures to identify potentially legally liable third-party sources and reports these to AHCCCS.

MC coordinates benefits in accordance with AHCCCS regulations so that costs for services that would otherwise be payable by MC are cost avoided or recovered from a liable third party. The two methods used for coordination of benefits are cost avoidance and post-payment recovery.

Cost Avoidance

MC will take reasonable measures to determine all legally liable parties - any individual, entity or program that is or may be potentially liable to pay all or part of the expenditures for covered services. MC will cost avoid a claim if it has established the probable existence of a liable party at the time the claim is filed. For purposes of cost avoidance, establishing probably liability takes place when MC receives confirmation that another party is, by statute, contract, or agreement, legally responsible for the payment of a claim for a healthcare item or service delivered to a member. If the probable existence of a party's liability cannot be established, MC will adjudicate the claim for payment. MC will then utilize post-payment recovery, which is described in further detail below if it turns out a legally liable party is responsible for the payment of covered services.

If a third-party insurer other than Medicare requires the member to pay any copayment, coinsurance or deductible, MC is responsible for making these payments.

Claims for an inpatient stay for labor, delivery, and postpartum care, including professional fees when there is no global OB package, will be cost avoided by MC.

In addition, effective for dates of services on or after October 1, 2018, prenatal care for pregnant women, including services which are part of a global OB Package, will also be cost avoided.

MC shall not deny a claim for timely filing if the untimely claim submission results from a provider's efforts to determine the extent of liability.

Post Payment Recoveries

Post-payment recovery is necessary in cases where MC has not established the probable existence of a liable third party at the time services were rendered or paid for, was unable to cost-avoid, or post-payment recovery is required. In these instances, MC will adjudicate the claim and then utilize post-payment recovery processes which include Pay and Chase, Retroactive Recoveries Involving Commercial Insurance Payer Sources, and Other Third-Party Liability Recoveries.

Pay and Chase: MC will pay the full amount of the claim due per the contracted rate with the provider and then seek reimbursement from any third party if the claim is for the following reasons:

- Prenatal care for pregnant women, including services which are part of a global OB Package;

- Preventive pediatric services, including Early and Periodic Screening Diagnosis and Treatment (EPSDT) and administration of vaccines to children under the Vaccines for Children (VFC) program;
- Services covered by third-party liability that are derived from an absent parent whose obligation to pay support is being enforced by the Division of Child Support Enforcement; or
- Services for which MC fails to establish the existence of a liable third party at the time the claim is filed.

Retroactive Recoveries Involving Commercial Insurance Payer Sources: For a period of two years from the date of service, MC will engage in retroactive third-party recovery efforts for claims paid to determine if there are commercial insurance payer sources that were not known at the time of payment. In the event a commercial insurance payer source is identified, MC Care will seek recovery from the commercial insurance. **MC will not recoup related payments from providers, requiring providers to act, or requiring the involvement of providers in any way.**

MC has two years from the date of service to recover payments for a claim, or to identify claims having a reasonable expectation of recovery. A reasonable expectation of recovery is established when MC has affirmatively identified a commercial insurance payer source and has begun the process of recovering payment. After two years from the date of service, AHCCCS will direct recovery efforts for any claims not identified by MC.

The overall timeframe for submission of claims for recovery is limited to three years from the date of service.

Other Third-Party Liability Recoveries: MC will identify the existence of potentially liable parties using a variety of methods, including referrals, and data mining using trauma code edits, utilizing codes provided by AHCCCS. MC shall not pursue recovery in the following circumstances, unless the case has been referred to MC by AHCCCS or AHCCCS' authorized representative:

- Motor Vehicle Cases
- Other Casualty Cases
- Tortfeasors
- Restitution Recoveries
- Worker's Compensation Cases

MC works directly with AHCCCS regarding Other Third-Party Liability Recoveries.

4.33 - Copayments

Collecting Copayments

Copayments must be assessed and collected consistent with state law and Arizona Administrative Code requirements. Providers are responsible for collecting copayments. Providers may take reasonable steps to collect on delinquent accounts.

Any copayments collected are retained by the provider, but the provider must report that information to MC ACC-RBHA when submitting the encounter/claims data. All providers must report in their annual audited financial statements the separately identified amounts for copayments received from eligible members for covered behavioral health services and reported to AHCCCS in the encounter.

The collection of copayments is an administrative process, and as such, copayments must not be collected in conjunction with a member's treatment. All efforts to resolve non-payment issues, as they occur, must be clearly documented in the member's comprehensive clinical record.

Copayments

Copayments are specified dollar amounts members pay directly to a provider for each item or service they receive. There are federal limits for certain services and populations.

Copayments are never charged to the following members:

- Children under age 19;
- People determined to be Seriously Mentally Ill (SMI) by the Arizona Department of Health Services;
- Individuals up through age 20 eligible to receive services from the Children's Rehabilitative Services program;
- People who are acute care AHCCCS members and who are residing in nursing homes or residential facilities such as an Assisted Living Home and only when the acute care member's medical condition would otherwise require hospitalization. The exemption from copayments for acute care members is limited to 90 days in a contract year;
- People who are enrolled in the Arizona Long Term Care System (ALTCS);
- People who are eligible for Medicare Cost Sharing in 9 A.A.C. 29 Copayment;
- People who receive hospice care;
- American Indian members who are active or previous users of the Indian Health Service, tribal health programs operated under P.L. 93-638, or urban Indian health programs;

- Adults eligible under A.A.C. R9-22-1427(E). These individuals are known as the Adult Group. Members in the Adult Group are individuals 19-64, who are not pregnant, do not have Medicare and are not eligible in any other eligibility category and whose income does not exceed 133% of the federal poverty level (FPL). The adult group includes individuals who were previously eligible under the AHCCCS Care program with income that did not exceed 100% of the FPL as well as other adults described in A.A.C. R9-22-1427(E) with income above 100% FPL but not greater than 133% FPL;
- Individuals in the Breast & Cervical Cancer Treatment Program; and
- Individuals receiving child welfare services under Title IV-B of the Social Security Act because of being a child in foster care or receiving adoption or foster care assistance under Title IV-E.

NOTE: Copayments referenced in this chapter means copayments charged under Medicaid (AHCCCS). It does not mean a member is exempt from Medicare copayments.

Copayments are never charged for the following services for anyone:

- Inpatient hospital services and services in the Emergency Department;
- Emergency services;
- Family Planning services and supplies;
- Pregnancy related health care and health care for any other medical condition that may complicate the pregnancy, including tobacco cessation treatment for pregnant women;
- Preventive services such as well visits, immunizations, pap smears, colonoscopies, and mammograms;
- Services paid on a fee-for-service basis;
- Provider Preventable Conditions as described in the **AHCCCS Medical Policy Manual, Chapter 1020**.

Members with nominal (optional) copayments are:

- Caretaker relatives under R9-22-1427(A) (also known as AHCCCS for Families with Children under section 1931 of the Social Security Act);
- Individuals eligible under the Young Adult Transitional Insurance (YATI) for young adults who were in foster care;
- Individuals eligible for the State Adoption Assistance for Special Needs Children who are being adopted;
- Individuals receiving Supplemental Security Income (SSI) through the Social Security Administration for people who are age 65 or older, blind, or disabled;
- Individuals receiving SSI Medical Assistance Only (SSI MAO) for individuals who are age

65 or older, blind, or disabled; and
- Individual in the Freedom to Work (FTW) program.

Providers need to look up the member's eligibility to find out what copays they may have by going to **Availity**. Most people who get AHCCCS benefits are asked to pay the following nominal copayments for medical services:

Mandatory Copayments for Certain AHCCCS Members

Nominal Copay Amounts for Some Medical Services	
Service	**Copayment**
Prescriptions	$2.30
Out-patient services for physical, occupational and speech therapy	$2.30
Doctor or other provider outpatient office visits for evaluation and management of your care	$3.40

Members with higher income who are determined eligible for AHCCCS through the Transitional Medical Assistance (TMA) program will have mandatory copayments for some medical services. TMA members are described in AHCCCS rule **R9-22-1427(B)**.

When a member has a mandatory copayment, a provider can refuse to provide a service to a member who does not pay the mandatory copayment. A provider may choose to waive or reduce any copayment under this chapter. TMA members are not charged copayments if they are in a population or category listed in the above sections.

Mandatory Copayments for TMA members

Mandatory Copayments	
Service	**Copayment**
Prescriptions	$2.30

Doctor or other provider outpatient office visits for evaluation and management of care. This excludes emergency room/emergency department visits	$4.00
Physical, Occupational and Speech Therapies	$3.00
Outpatient non-emergent or voluntary surgical procedures. This excludes emergency room/emergency department visits	$3.00

5% Aggregate limit for nominal (optional) and mandatory copayments

The total aggregate number of copayments for members who have nominal (optional) and/or mandatory copayments cannot exceed 5% of the family's income on a quarterly basis. The AHCCCS Administration will review claims and encounters information to establish when a member's copayment obligation has reached 5% of the family's income and will communicate this information to providers. The member may also establish that the aggregate limit has been met on a quarterly basis by providing the AHCCCS Administration with records of copayments incurred during the quarter.

Copayments for Non-Title XIX/XXI eligible members determined to have a Serious Mental Illness (SMI)

AHCCCS Copayments for Non-Title XIX/XXI eligible members who are determined to have a Serious Mental Illness (SMI):

- For individuals who are Non-Title XIX/XXI eligible members determined to have a SMI, AHCCCS has established a copayment to be charged to these members for covered services (A.R.S. 36-3409).
- Copayment requirements in this policy are not applicable to services funded by the Substance Use Block Grant (SUBG), Mental Health Block Grant (MHBG), or Project for Assistance in Transition from Homelessness (PATH) federal block grant.
- Copayments are not assessed for crisis services or collected at the time crisis services are provided.
- Members determined to have SMI must be informed prior to the provision of services of any fees associated with the services (R9-21-202(A) (8)), and providers must document such notification to the member in his/her comprehensive clinical record.
- Copayments assessed for Non-Title XIX/XXI members determined to have SMI are intended to be payments by the member for all covered behavioral health services, but copayments are only collected at the time of the psychiatric assessment and psychiatric

follow up appointments.

- Copayments are:
  - A fixed dollar amount of $3;
  - Applied to in network services; and
  - Collected at the time services are rendered.
- Providers will be responsible for collecting copayments. Any copayments collected are reported in the encounter.

Providers will:

- Assess the fixed dollar amount per service received, regardless of the number of units encountered. Collect the $3 copayment at the time of the psychiatric assessment or the psychiatric follow up appointment.
- Take reasonable steps to collect on delinquent accounts, as necessary.
- Collect copayments as an administrative process, and not in conjunction with a member's behavioral health treatment.
- Clearly document in the member's comprehensive clinical record all efforts to resolve non-payment issues, as they occur.
- Not refuse to provide or terminate services when an individual states he or she is unable to pay copayments described in this section. MC ACC-RBHA has established methods to encourage a collaborative approach to resolve non-payment issues, which may include the following:
  - Engage in informal discussions and avoid confrontational situations;
  - Re-screen the member for AHCCCS eligibility; and
  - Present other payment options, such as payment plans or payment deferrals, and discuss additional payment options as requested by the member.

Other Payment Sources

If a member has third party liability coverage, MC and their providers must follow the requirements for third party liability.

Medicare Part D Prescription Drug Coverage

All members eligible for Medicare Part A or enrolled in Medicare Part B are eligible for Medicare Part D Prescription Drug coverage. Dual eligible members (eligible for Medicaid and Medicare) no longer receive prescription drug coverage through Medicaid. To access Medicare Part D coverage, members must enroll in either a Prescription Drug Plan (PDP – fee-for-service Medicare) or a Medicare Advantage-Prescription Drug Plan (MA-PD – managed care Medicare).

Cost sharing responsibilities for members in a Medicare Part D PDP or MA-PD

The Medicare Part D Prescription Drug standard coverage includes substantial cost sharing requirements, which include monthly premiums; an annual deductible and co-insurance (see the Part D Voluntary Prescription Drug Benefit Program Benefits and Costs for People with Medicare).

Members with limited income and resources may be eligible for the Low-Income Subsidy (LIS) or "extra help" program (see the Social Security Administration for income and resource requirements). With this "extra help," all or a portion of the member's cost sharing requirements are paid for by the federal government. Dual eligible members on a Medicare Savings Program through AHCCCS (QMB, SLMB, or QI-1) are automatically eligible for the LIS program. Other members must apply for the LIS program. Title XIX/XXI funds are not available to pay any cost sharing of Medicare Part D. MC ACC-RBHA may utilize Non-Title XIX/XXI funds for cost sharing of Medicare Part D copayments for Non-Title XIX/XXI members determined to have SMI.

4.34 - Clinical Guidelines

To help provide MC members with consistent, high-quality care that utilizes services and resources effectively, we have chosen certain clinical guidelines to help our providers. These are treatment protocols for specific conditions as well as preventive health guidelines. Please note that these guidelines are intended to clarify standards and expectations. They should not:

- Come before a provider's responsibility to provide treatment based on the member's individual needs.
- Constitute procedures for or the practice of medicine by the party distributing the guidelines.
- Guarantee coverage or payment for the type or level of care proposed or provided.

MC can mail the clinical guidelines to practitioners/providers who do not have fax, email, or internet access upon request. You can contact your Network Manager Representative in the Network Management department by calling 602-263-3000 or 800-624-3879.

Clinical Oversight and Supervision

Behavioral Health Paraprofessionals (BHPPs) that provide services in the public behavioral health system, shall receive supervision by a Behavioral Health Professional (BHP). Behavioral Health Technicians (BHTs) that provide services in the public behavioral health system shall receive clinical oversight by a BHP.

In addition to possessing the requisite licenses and other qualifications, BHPs providing clinical oversight of BHTs shall have demonstrated competence in delivering the same or similar services to members of comparable acuity and intensity of service needs as the BHTs they supervise. BHPs providing clinical oversight of BHTs shall also demonstrate the following key competencies:

- Demonstrated knowledge of the relevant best clinical practices and policies that guide the services being provided,
- Demonstrated knowledge of the policies and principles governing ethical practice,
- Demonstrated ability to develop individualized BHT competency development goals and action steps to accomplish these goals, and
- Demonstrated ability to advise, coach, and directly model behavior to improve interpersonal and service delivery skills.

4.35 - Office Administration Changes and Training Requirements

Providers are responsible for notifying MC's Network Management of changes in professional staff at their offices (physicians, physician assistants, or nurse practitioners). Administrative changes in office staff may result in the need for additional training. Contact your Network Relations Specialist/Consultant to schedule any needed staff training.

The following trainings are required for participation in the MC network:

- Medical records standards
- Fraud waste and abuse training
- Behavioral health step therapy for members with depression, post-partum depression, anxiety, and attention deficit/hyperactivity disorder (ADHD) in compliance with the AHCCCS medical policy manuals (appendices E and F)
- PCP training regarding behavioral health referral and consultation services

All providers and facilities must remain in good standing with any licensure or regulatory agency and adhere to all training requirements. This includes clinical supervision, orientation, and training requirements.

Providers caring for EPSDT members are required to employ a sufficient number of appropriately qualified local personnel in order to meet the health care needs of members and fulfill Federal and State EPSDT requirements, as well as achieve contractual compliance. Providers must also have a documented process for ensuring all applicable staff and subcontractors are appropriately trained and kept up to date with the EPSDT program and AHCCCS policies relevant to EPSDT-eligible members. (AMPM 430-EPSDT Policy).

4.36 - Consent Forms

The following consent forms are available on the AHCCCS website:

- **Certificate of Medical Necessity for Pregnancy Termination** (AHCCCS AMPM Policy 410, Attachment C)
- **Consent for Sterilization** (AHCCCS AMPM Policy 420, Attachment A)
- Hysterectomy Consent Form (AHCCCS AMPM Policy 820, Attachment A)
- Consent for the release of confidential medical records (Substance Abuse Treatment/HIV/AIDS)
- Attachment A - Informed Consent for Psychotropic Medication Treatment **(AMPM 310-V)**

For additional information on AHCCCS requirements for reviewing and obtaining general and informed consent for members receiving physical and/or behavioral health services, as well as consent for any behavioral health survey or evaluation in connections with an AHCCCS school-based prevention program, refer to AMPM Policy 320-Q – General and Informed Consent. Consent requirements specific to members with disabilities, members receiving Serious Mental Illness (SMI) services, and members in out-of-home placement can be found in **MC Provider Manual Chapter 200 - MCCC, MC DD, DCS CHP, Chapter 300 - MCLTC**, and **Chapter 400 - ACC-RBHA**.

4.37 - Contract Additions or Terminations

To meet contractual obligations and state and federal regulations, providers **must** report any terminations or additions to their contract at least 90 days prior to the change. Providers are required to continue providing services to members throughout the termination period.

4.38 - Continuity of Care

Providers terminating their contracts without cause are required to continue to treat MC members until the treatment course has been completed or care is transitioned. Authorization may be necessary for these services. Members who lose eligibility and continue to have medical needs must be referred to a facility or provider that can provide the needed care at no or low cost. MC is not responsible for payment of services rendered to members who are not eligible.

The Bureau of Health Systems Development has recently posted a new interactive website to help people easily locate a clinic that provides free or low-cost primary, mental and dental health services to people without health insurance. These Sliding Fee Schedule clinics determine, based on gross family income, the portion of billed charges that the uninsured client will be responsible for. Sliding Fee Schedules are based on current Federal Poverty Guidelines.

The **Interactive SFS Clinics** map will help you find a clinic in your community, simply by moving the cursor over your neighborhood, or by typing in your zip code or city.

The site also includes a downloadable complete listing of primary care or behavioral health SFS providers.

You can also download a **Mobile App** to find federally funded health centers on the go.

You may also contact MC's Care Management Department for assistance.

4.39 - Contract Changes or Updates

Providers **must** report any changes to demographic information to MC at least 90 days prior to the change to follow contractual obligations and state and federal regulations. Providers are required to continue providing services to members throughout the termination period. For information on where to send change information, refer to the Table 8, Provider Record Updates (below).

Not notifying MC timely of these changes could result in financial ramifications. You may mail your changes to:

Mercy Care
Attention: Network Management
4750 S. 44th Place, Ste 150
Phoenix, AZ 85040

Or you may fax any changes to:

MC - 860-975-3201
MC ACC-RBHA - 860-975-0841

Provider Record Updates Table

Type of Change	Notification Requirements	Send to	Time to Process
Individual or group name	**Must** mail updated W-9 and letter describing change and effective date	Network Management	90 days

Type of Change	Notification Requirements	Send to	Time to Process
Tax ID number	**Must** mail updated W-9 and letter describing change and effective date	Network Management	90 days
Address or Phone Number Change	**Must** mail or fax	Network Management	90 days
Staffing changes including physicians leaving the practice	**Must** mail or fax letter describing change and effective date	Network Management	90 days
Adding new office locations	**Must** mail or fax letter describing change and effective date	Network Management	90 days
Adding new physicians to current contract	**Must** mail or fax letter describing change and effective date	Network Management	90 days
Number of Beds Usage (i.e., reducing Residential Beds)	**Must** BE Pre-APPROVED	Network Administration	90 days

4.40 - Credentialing/Re-Credentialing

Providers are re-credentialed every three years and must complete the required reappointment application. Updates on malpractice coverage, state medical licenses and DEA certificates are also required. Please note that providers may not treat MC members until they are credentialed.

Temporary/Provisional Credentialing Process

MC shall have 14 calendar days from receipt of a complete application to render a decision regarding temporary or provisional credentialing. Once provisional/temporary credentialing is approved, provider information must be entered into MC's information system to allow payment to the provider effective the date the provisional credentialing is approved.

Providers working in a Federally Qualified Health Center (FQHC) and FQHC Look-alike Center, as well as hospital employed physicians (when appropriate), must be credentialed using the

temporary or provisional credentialing process even if the provider does not specifically request their application be processed as temporary or provisional.

4.41 - Licensure and Accreditation

Health delivery organizations such as hospitals, skilled nursing facilities, home health agencies, and ambulatory surgical centers must submit updated licensure and accreditation documentation at least annually or as indicated.

4.42 – Contract Enforcement

If a provider fails to meet contract requirements or demonstrates a pattern of non-compliance, the provider may be subject to a contract enforcement action, including but not limited to:

- Corrective Action
- Notice to Cure
- Sanctions
- Referral Restrictions

MC will review Provider non-compliance to determine contract enforcement action(s) that may be taken against Provider. The contract enforcement actions referenced in this section are in addition to and does not take precedence over or preclude MC from taking any other action(s) available to MC in contract or law arising from the same conduct or occurrence.

Corrective Action

When MC determines that the Provider is not in compliance with any term of its Contract, MC may request a corrective action plan (CAP) from Provider. CAP's will be due from the Provider within 15 business days of notice for non-compliance. Provider shall immediately implement an MC approved Corrective Action Plan (CAP).

Notice to Cure

When MC determines that the Provider is not in compliance with any term of its Contract, MC may issue a Notice to Cure to the Provider. Upon written Notice to Cure of the Provider's noncompliance, the Provider shall demonstrate compliance by the date specified in the Notice to Cure. If Provider is not in compliance, as determined by MC, at the end of the specified period, provider may be subject to other enforcement action or remedy available to MC.

Referral Restrictions

MC may restrict the referral of Members to a Provider when the Provider's services do not meet the standard of care for the Provider's area of practice, or the Provider has failed to meet performance standards or is otherwise out of compliance with its Contract.

Sanctions

In addition to financial sanctions permitted elsewhere in the Provider Manual or the Provider's contract with MC, the Provider may be subject to financial sanctions for failure to comply with any term of its Contract. Sanctions will also be passed down to provider that are incurred by MC from AHCCCS, CMS or another regulator and which may be attributed to Provider. Provider will be notified in writing of the basis for the sanction. A provider may file a claim dispute if MC imposes a sanction against the provider.

- $5,000 non-compliance contract requirement per location, per issue, per sanction

Referral Restrictions

MC may restrict the referral of Members to a Provider when the Provider's services do not meet the standard of care for the Provider's area of practice, or the Provider has failed to meet performance standards or is otherwise out of compliance with its Contract.

Repeat Occurrences

Repeat occurrences of untimely submission of deliverables or reports, or incomplete or inaccurate reports or deliverables will trigger a compounding sanction process. **Under this process, sanction amounts will be increased due to the provider's failure to remediate the problem through the Corrective Action, Notice to Cure or Sanction processes.**

Providers who are "Out of Compliance" with Deliverable standards will be contacted by an appropriate MC representative to re-educate the provider on compliance requirements related to Deliverable's standards. The appropriate MC representative will continue to monitor provider compliance each month. If a provider remains out of compliance with Provider Deliverables, MC will implement the following schedule of sanctions.

Untimely Deliverable or Reports: $1,000 sanction per each business day beyond the due date. For repeat untimely submission of the same Deliverable across reporting periods, MC will assess compounding sanctions in the $1,000 increments for each business day beyond the due date. For example, Deliverable A was submitted two business days late in October and was subsequently late by one business day the following reporting month, a sanction of $1,000 will be assessed for October and a sanction of $2,000 for November. Compounding sanctions will not exceed $5,000 for each business day beyond the specified deadline and will only be assessed for Deliverables.

Incomplete and/or Inaccurate Deliverables or Reports: $5,000 for each rejection of a Deliverable due to incomplete and inaccurate reporting. For each repeat rejection of Deliverables which are incomplete or inaccurate across separate reporting periods, Providers

may be subject to compounding sanctions in the $5,000 increments for each rejection, not to exceed $25,000 per rejected Deliverable. For example:

- 1st time Rejected Sanction: $5,000 per rejection
- 2nd time Rejected Sanction: $10,000 per rejection
- 3rd time Rejected Sanction: $15,000 per rejection
- 4th time Rejected Sanction: $20,000 per rejection
- 5th time Rejected Sanction: $25,000 per rejection

Disputes

Although Corrective Actions and Notice to Cures are not subject to dispute, Contracted providers are encouraged to notify MC if any of the performance deficiencies is identified as a dispute, including the factual and contractual basis for that position. Such information must be provided to your Network Management Representative with a copy to **MercyCareNetworkManagement@MercyCareAZ.org**.

A provider may file a claim dispute if MC imposes a sanction against the provider. Please refer to Provider Claim Disputes in Chapter 18 of this manual, for details regarding how to file a claim dispute related to sanctions.

4.43 – Provider Financial Reporting

The **Mercy Care Provider Financial Reporting Guide** is available under Provider Guides on our **Provider Manual page**. This document was developed to ensure that all MC subcontracted providers and vendors develop and understand the financial requirements and responsibilities inherent in their contract with MC. The primary objectives of this reporting guide are to establish consistency and uniformity in financial reporting and to provide guidelines to assist providers in meeting contractual reporting requirements.

The Guide includes:

- General Accounting Requirements
- Requirements for Reporting
- Unaudited Annual and Quarterly Reports
- Audited Financial Reporting
- Provider Delivery Schedule16
- Fee Schedule and Funding Requests

4.44 – Duty to Report Abuse, Neglect or Exploitation

Duty to Report Abuse, Neglect and Exploitation of Incapacitated/Vulnerable Adults

MC subcontracted healthcare 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 contains information relevant to the reported abuse or neglect be made available to the peace officer or APS worker investigating the abuse or neglect.

Duty to Report Abuse, Physical Injury, Neglect and Denial/Deprivation of Medical or Surgical Care or Nourishment of Minors

Any MC healthcare subcontracted provider who reasonably believes that any of the following incidents has occurred shall immediately report this information to a peace officer or to a DCS worker by calling the Arizona Child Abuse Hotline at (888) 767-2445; TDD - (602) 530-1831; or (800) 530-1831:

- 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.

If a report concerns a member 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 by member and shall be followed by a written report within seventy-two hours. The report shall contain:

- The names and addresses of the minor and the minor's parents or the member(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.
- Any other information that the member 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 member 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 Specialist, the member 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.
- 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 Specialist, 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.

4.45 – Duty to Warn

Duty to Protect Potential Victims of Physical Harm

All MC healthcare providers have a duty to protect others against the violent conduct of a patient. When a MC healthcare provider determines, or under applicable professional standards, reasonably should have determined that a patient 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 patient but may be someone who would be the most likely victim of the patient's violent conduct.

While the discharge of this duty may take various forms, the MC healthcare provider 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 MC healthcare provider to take reasonable precautions to prevent harm threatened by a patient 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; or
- Taking any other precautions that a reasonable and prudent mental health provider would take under the circumstances.

4.46 - Marketing

Providers may not market MC's name, logo, or likeness without prior approval. If a provider advertisement refers to MC's name, logo, or likeness, the advertising must be prior approved by AHCCCS.

4.47 - Provider Policies and Procedures - Health Care Acquired Conditions and Abuse

As a prerequisite to contracting with an organizational provider, MC must ensure that the organizational provider has established policies and procedures that meet AHCCCS requirements. The requirements must be met for all organizational providers (including, but not limited to, hospitals, home health agencies, attendant care agencies, group homes, nursing facilities, behavioral health facilities, dialysis centers, transportation companies, dental and medical schools, and free-standing surgi-centers); and the process by which the subcontractor reports at a minimum incidences of Health Care Acquired Conditions, abuse, neglect, exploitation, injuries, suicide attempts and unexpected death to MC.

4.48 – Availity

Availity allows you to do the following:

- Payer Spaces
- Claims Submissions Link (Change HealthCare)
- Contact Us messaging
- Eligibility and Benefits
- Enhanced Panel Roster
- Claims status inquiry
- Provider Intake (i.e., ALTCS Referrals, Member Paneling, Crisis/State-Only Membership)
- Grievance and Appeals
    - Grievance submission
    - Appeal submission
    - Grievance and Appeal status
- Panel Roster - Panel lookup
- Reports
    - PDM/ProReports (Provider Deliverable Manager)
    - Ambient (business intelligence reporting)
- Prior Authorization - Submission and status lookup

Availity allows you to register with several payers. You simply need to select MC from your list of payers to start using the available tools and features listed above.

If you are not registered, we recommend that you do so immediately. Click on the link for **Availity Registration** to register with Availity.

For registration assistance, please call Availity Client Services at 800-282-4548 between the hours of 8:00 a.m. and 8:00 p.m. Eastern time, Monday-Friday (excluding holidays). Un-

registered providers should watch for the emails coming soon from Availity, there will be a wealth of information to assist you on what your next steps should be.

Visit the **Availity** landing page where you can find information about our new Availity Provider Portal.

4.49 – Provider Directory

MC's Provider Directory is online and can be found under **Find A Provider/Pharmacy** available on the MC website. The directory allows you to:

- Search by provider name and/or specialty.
- Indicate whether providers are accepting referrals and conducting initial assessments.
- Identify provider locations that provide physical access, accessible equipment, and/or reasonable accommodations for members with physical or cognitive disabilities.

It is very important for providers to promptly notify MC of any changes that would impact the accuracy of the provider directory (e.g., change in telephone, fax number, or no longer accepting referrals).

4.50 – Telehealth

Services delivered via telehealth shall not replace member or provider choice for healthcare delivery modality. As specified in A.R.S. § 36-3605, a provider shall make a good faith effort in determining **both** of the following:

1. Whether a service should be provided through telehealth instead of in-person.
    a. The provider shall use clinical judgement in considering whether the nature of the services necessitates physical interventions and close observation and the circumstances of the member, including:
        i. Diagnosis,
        ii. Symptoms,
        iii. History,
        iv. Age, and
        v. Physical location and access to telehealth.
2. The communication medium of telehealth, and whenever reasonably practicable, the telehealth communication medium that allows the provider to assess, diagnose, and treat the member most effectively. Factors the provider may consider in determining the communication medium include the member's lack of access to or inability to use technology or limits in telecommunication infrastructure necessary to support interactive telehealth encounters.

Requirements

1. All telehealth reimbursable services shall be provided by an AHCCCS registered provider within their scope of practice.
2. Non-Emergency Transportation (NEMT) is a covered benefit for member transport to and from the originating site where applicable.
3. Services provided through telehealth or resulting from a telehealth encounter are subject to all applicable statutes and rules that govern prescribing, dispensing, and administering prescription medication and devices.
4. Informed consent standards for telehealth services shall adhere to all applicable statutes and policies governing informed consent, including A.R.S. § 36-3602.
5. Privacy and confidentiality standards for telehealth services shall adhere to all applicable statutes and policies governing healthcare services, including the Health Insurance Portability and Accountability Act (HIPAA).

Refer to the AHCCCS coding webpage for coding requirements for telehealth services, including applicable modifiers and places of service available:
https://www.azahcccs.gov/PlansProviders/MedicalCodingResources.html

For further information on telehealth services for FFS providers, refer to Chapter 10, Individual Practitioner Services, of the AHCCCS FFS Provider Billing Manual, and Chapter 8, Individual Practitioner Services, of the AHCCCS IHS/Tribal Provider Billing Manual.

For further information on telehealth applicability for Contractor network standards, refer to **ACOM Policy 436**.

For Prior Authorization (PA) requirements for FFS Programs refer to **AMPM Policy 820**.

4.51 - Arizona Address Confidentiality Program (ACP)

Arizona's Address Confidentiality Program protects the location of individuals that are victims of stalking, domestic violence, or abuse. As an AHCCCS registered and contracted provider you must:

- **Accept and use the ACP substitute address** in all records and communications.
- **Keep actual address confidential** – do not store, share, or disclose them.
- **Use address information only for direct service delivery**.

If you need an actual address for service, submit a formal request to the ACP Office.
For details visit **azsos.gov/services/acp** or contact ACP at 602-542-1892.

MC Chapter 5 – Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

5.00 - EPSDT Program Overview

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program is comprised of screening, diagnostic, and treatment services and provides comprehensive health care through prevention, immunizations, early intervention, diagnosis, medically necessary treatment, and follow-up care of all physical and behavioral health conditions for AHCCCS members under the age of 21 as described in 42 USC 1396d (a) and (r). The EPSDT Program covers services that correct or ameliorate physical and behavioral conditions and illnesses discovered by the screening process for EPSDT-eligible members, when those services fall within one of the optional and mandatory categories of "Medical Assistance," as defined in the Medicaid Act.

EPSDT program services include, but are not limited to, coverage of: well visits, inpatient and outpatient hospital services, laboratory and x-ray services, physician services, naturopathic services, nurse practitioner services, medications, dental services, therapy services, behavioral health services, LTSS, medical equipment, medical appliances and medical supplies, orthotics, prosthetic devices, vision services, hearing services, eyeglasses, transportation, assistance with scheduling appointments, family planning services and supplies, women's preventive care services, and maternity services when applicable, as specified in AMPM Chapter 400. EPSDT also includes diagnostic, screening, preventive, and rehabilitative services.

The EPSDT program also includes prescriptive lenses and frames to correct or ameliorate defects, physical illness, and conditions discovered by EPSDT screenings or screenings performed through another modality such as Head Start, school, or childcare, subject to medical necessity. Replacement and repair of eyeglasses, for members under the age of 21 years are covered, without restrictions by AHCCCS to correct or ameliorate conditions discovered during visions screenings. The EPSDT program does not include services that are experimental, that are solely for cosmetic purposes, or that are not cost effective when compared to other interventions or treatments.

Refer to the **AHCCCS AMPM 430 - EPSDT Policy** for more details on what is covered under this program.

The EPSDT program focuses on continuum of care by assessing health needs, providing preventive screening, initiating needed referrals, and completing recommended medical treatment and appropriate follow-up.

5.01 - Requirements for EPSDT Providers

Providers are required to utilize national coding standards including the use of applicable modifier(s). For additional information regarding EPSDT Coding and Billing, review details in the **MC Claims Processing Manual, Chapter 3 - Early and Periodic Screening, Diagnostic and Treatment (EPSDT)** available on the MC website**.** Additional AHCCCS EPSDT coding requirements can be found on the **AHCCCS Medical Coding Resources website** - **EPSDT Service Code Resource**.

PCPs are required to comply with regulatory requirements and MC preventive requirements which include:

- Using the most up to date AHCCCS EPSDT Clinical Sample Template (or an electronic equivalent) to document all well visit required screenings, treatments, and services provided. These templates were created by AHCCCS to ensure providers are in compliance with AHCCCS standards. The most up-to-date **AHCCCS AMPM Policy 430-E – EPSDT Clinical Sample Templates** can be found on our **Forms** section on the MC Provider website. This document contains age-specific EPSDT Clinical Sample Templates, for members from Birth to 20 years of age, and can be used in place of ordering the forms.
- The EPSDT Supply Order Form is also available on MC's website under our **Forms** section on the MC Provider website. This order form can be used to order copies of the AHCCCS age-specific EPSDT Clinical Sample Templates.
- **Faxing the EPSDT forms to MC is the preferred delivery method. The EPSDT Form Fax number is 602-431-7157.**
- If mailing the forms, please send them to:

  Mercy Care
  Attn: Medical Management EPSDT Dept
  4750 S. 44th Place, Ste 150
  Phoenix, AZ 85040
- Using all clinical encounters to assess the need for EPSDT screening and/or services.
- Reporting all EPSDT encounters on required claim forms, using the EPSDT Preventive Medicine Codes.
- Documenting in the medical record the member's decision not to participate in the EPSDT program, if appropriate.
- Ensuring all infants receive both the first and second newborn screening tests. Specimens for the second test may be drawn at the PCP's office and mailed directly to the Arizona State Laboratory, or the member may be referred to MC's contracted laboratory for the draw.

- Scheduling the next appointment at the time of the current office visit, especially for children 30 months of age and younger.
- PCPs shall ensure that families receive evidence-based breastfeeding information and support when appropriate.
- Documenting all immunizations for every EPSDT-aged members within 30 days of administration into Arizona State Immunization Information System (ASIIS).
- All providers serving EPSDT members must be enrolled in the Vaccine for Children (VFC) Program. They must re-enroll every year into the VFC Program.
- Discuss family planning services and supplies with any members that are of reproductive age or members that are sexually active. This includes discussing safe sex, contraception, and testing for sexually transmitted infections (STIs).
- Providing all physical and behavioral health screenings and treatments according to the **AMPM 430-A AHCCCS EPSDT Periodicity Schedule** and community standards of practice.
- Utilizing current validated AHCCCS approved screening tools for developmental assessments, Autism-Specific developmental assessments, behavioral health needs, HRSN, and trauma. Providers must also be trained in the use and scoring of these screening tools.
- Initiating and coordinating referrals to behavioral health providers, as necessary.
- Providers shall refer any physical and behavioral screenings with positive results to the appropriate provider for follow-up, diagnosis, and treatment. Referrals must occur in a timely manner, and treatment is to be initiated within 60 days of the screening services and/or referral request.
- MC requires that providers, when appropriate, communicate the final disposition of each referral to the referral source within 30 days of the member receiving an initial assessment.
- Referring MC ACC and DD members to Children's Rehabilitative Services (CRS) when they have conditions covered by the CRS program.
- Assisting members in navigating the healthcare system and referring members to community resources such as WIC, Raising Special Kids, Home Visiting Programs, Early Head Start/Head Start, and the Birth to Five Helpline as appropriate.
- Refer and coordinate care with AzEIP to identify members from ages birth up to three years of age with developmental disabilities that are needing services, family education, and family support.

A well visit includes the following basic elements, some of which have additional information provided in the below sections:

- Comprehensive health and developmental history, including growth and development screenings. This includes physical, nutritional, and behavioral health assessments.
- Comprehensive unclothed physical examination.
- Health education and counseling about child development, healthy lifestyles and accident and disease prevention.
- Anticipatory Guidance, Developmental Surveillance, Vision Screenings, and Hearing Screenings.
- Medically necessary immunizations according to age and health history.
- BMI monitoring, including education on nutrition and daily physical activity.
- Nutritional screening and assess the need for metabolic medical foods, nutritional therapy, and/or nutrition referrals if necessary.
- Oral health screening and dental referrals.
- Applying fluoride varnish for children between the ages of 6 months and 5 years old, with at least one tooth erupted. It can be reapplied once every 3 months.
- Laboratory tests appropriate to age and risk for the following: blood lead, tuberculosis skin testing, anemia testing, and sickle cell trait.
- General Developmental Screening for members aged 9, 18 and 30 months.
- Autism Specific Developmental (ASD) Screening for members aged 18 and 24 months.
- Behavioral Health Screenings to assess mental health, trauma history, and social needs.
- Annual syphilis testing beginning at age 15 years old. Testing may be performed for members under the age of 15 at the discretion of the provider, based on risk.
- Testing for other sexually transmitted infections (STIs) for sexually active members such as HIV, Gonorrhea, and Chlamydia.

5.02 - Health Education

The PCP is responsible for ensuring that health counseling and education are provided at each well visit. Anticipatory guidance should be provided so that parents or guardians know what to expect in terms of the child's development. In addition, information should be provided regarding accident and disease prevention, and the benefits of a healthy lifestyle.

5.03 – Well Visits and Periodic Screenings

The AHCCCS EPSDT Periodicity Schedule specifies the screening services to be provided at each stage of development. The periodicity schedule can be viewed on the AHCCCS website under AMPM Policy 430-Attachment E, EPSDT Periodicity Schedule. This schedule follows the Center for Disease Control (CDC) and American Academy of Pediatrics (AAP) recommendations. Children may receive additional inter-periodic screening at the discretion of the provider.

MC does not limit the number of well visits for members under 21 years of age. Effective 10/1/15 and after, providers should bill their claims with the following CPT Codes and ICD-10 Diagnosis:

Codes to identify well visits – ages 0 months through 20 years of age

Well Visit Ages New Patients	CPT Codes	ICD-10 Codes		Well Visit Ages Established Patients	CPT Codes	ICD-10 Codes
Infant Younger than 1 Year	99381	Z00.110 Z00.111 Z00.121 Z00.129		**Infant Younger than 1 Year**	99391	Z00.110 Z00.111 Z00.121 Z00.129
1-4 Years	99382	Z00.121 Z00.129		**1-4 Years**	99392	Z00.121 Z00.129
5-11 Years	99383	Z00.121 Z00.129		**5-11 Years**	99393	Z00.121 Z00.129
12-17 Years	99384	Z00.121 Z00.129		**12-17 Years**	99394	Z00.121 Z00.129
18 Years of Older	99385	Z00.00 Z00.01		**18 Years of Older**	99395	Z00.00 Z00.01

Well visits for sports and other activities should be based on the most recent well visit, as the annual well visits are comprehensive and should include all the services required for sports or other activities. AHCCCS does not cover sports or other physicals solely for that purpose. If it can be combined with a regularly scheduled well visit, then it is covered. No additional payment would be allowable for completing the school or other organization paperwork that would allow the child to participate in the activity.

A “sick visit” can be performed at the same time as a well visit if an abnormality is encountered, or a preexisting problem is addressed in the process of performing an EPSDT service and the problem or abnormality is significant enough to require additional work to perform the key components of a problem-oriented Evaluation and Management (E/M) service, and/or the “sick visit” is documented on a separate note in the medical record.

All preventive screenings completed during a well visit should be submitted with the well visit claim. A full list of screening codes used during a well visit can be found in the AHCCCS EPDST Coding Resource Document on the AHCCCS website.

5.04 – Vision Screening, Eye Examinations and Prescriptive Lenses

Providers are required to perform a basic age-appropriate eye exam during well visits according to the specific ages outlined in the **AHCCCS AMPM Policy 430-A EPSDT Periodicity Schedule**. All screenings completed during a well visit should be submitted with the well visit claim. Examples of vision screening CPT codes (with the EP modifier) used are 92015, 92081, and 99173. Providers must also refer members to a MC contracted vision provider for further assessment of any abnormal results.

The EPSDT program includes eye exams, prescriptive lenses, frames for eyeglasses, as well as replacement and repair of eyeglasses, without restrictions, when provided to correct or ameliorate defects, physical illness, and conditions discovered by EPSDT screenings or screenings performed through another modality such as Head Start, school or childcare, subject to medical necessity.

Federal law [42 USC 1396d(a)] requires Medicaid to cover all services when medically necessary and cost effective for MC members. This means that MC will cover these health services if the treatment or service is necessary to “correct or ameliorate” defects or physical and behavioral illnesses or conditions.

Caregivers do not need to wait until the next regularly scheduled vision screening to replace or repair eyeglasses. If an EPSDT member breaks or loses their prescribed eyeglasses, an appointment needs to be scheduled for a vision screening with their healthcare provider.

Providers and dispensers are to caution about “upselling” equipment for members. Members are not required to agree to any upgrades. To the extent that any upgrade is not AHCCCS covered and is to be a member responsibility, the provider must ensure the member agrees to accept financial responsibility and signs a document, in advance, accepting payment responsibility. The member agreement of financial responsibility document must also provide a description and approximate cost. General requirements for member billing are discussed in AAC R9-22-701.

5.05 – Hearing/Speech Screening

Providers are required to perform age-appropriate hearing screenings during well visits according to the specific ages outlined in the **AHCCCS AMPM Policy 430-A EPSDT Periodicity Schedule**. All screenings completed during a well visit should be submitted with the well visit claim. Examples of hearing screening CPT codes (with the EP modifier) used are 92551 and 92552.

A hearing evaluation consists of history, risk factors, parental questions, and impedance testing. Providers must also refer members to a specialist for further assessment of any abnormal results.

- Pure-tone testing should be performed when medically necessary.
- Speech screenings shall be performed to assess the language development of the member at each well visit.
- Medically necessary audiology services to evaluate hearing loss for all members shall be provided on both an inpatient and outpatient basis.
- Newborn hearing screening shall be performed using a physiological hearing screening method prior to initial hospital discharge.
- Infants should be re-screening on an outpatient basis if their initial hearing screening was missed or if they are referred from the initial screening.
- Infants should be screened on an outpatient basis if they are referred from the initial screening. The outpatient re-screening shall be scheduled at the time of the initial discharge and completed between two and six weeks of age.
- Infants that may have hearing loss or a congenital disorder, the family shall be referred to the PCP for appropriate assessment, care coordination, and referral(s).
- All infants with confirmed hearing loss should receive services before turning six months of age.
- Hearing aids are covered for EPSDT members under the age of 21.

Cochlear implants are covered for EPSDT members when medically necessary. To review the medically necessary criteria, refer to the **AHCCCS AMPM 430 EPSDT Policy**.

5.06 – Oral Health Screening and Dental Homes

An oral health screening is considered an EPSDT prevention screening and must be done at every well visit and should begin by at least one years old or once the member has at least one tooth erupted. The oral health screening can be conducted by a physician, physician's assistant, or nurse practitioner. This screening is not a thorough clinical exam, and it does not take place of a visit with the dentist. This screening is intended to identify oral pathology, including tooth decay and/or oral lesions and to assess the need for a dental referral.

Dental Referrals

If any decay or lesions are seen, be sure to refer the member to their dentist or dental home. The provider may refer the member for a dental assessment prior to one years old if their oral health screening reveals potential carious lesions or other conditions requiring assessment and/or treatment by a dental professional. Providers should confirm with members and/or their caregivers if they are receiving routine dental care based on the **AHCCCS AMPM Policy 431-A Dental Periodicity Schedule**. If they are not, then a referral should be made. Evidence of all referrals must be documented in the member's medical record and on the submitted their EPSDT Form. Providers should also encourage members to make their first dental appointment at minimum by age one and be seen by a dentist every six months thereafter. This aligns with the **AHCCCS AMPM 431-Attachment A - EPSDT Dental Periodicity Schedule**.

MC assigns EPSDT members to their dental home on enrollment, however, EPSDT members are also allowed to change their dental home and/or self-refer to a dentist that is within the MC provider network. A dental home may be an office or facility where all dental services are provided in one place.

For additional information on oral health screenings, dental coverage, and dental home requirements, refer to the **AHCCCS AMPM 431 - Oral Health Care for EPSDT Members Policy.** Providers can also refer to the Liberty Dental Plan Provider Reference Guide at **https://www.libertydentalplan.com/Resources/Documents/AZ-Provider-Reference-Guide.pdf**. For dental appointment standards, refer to Section **4.02 – Appointment Availability Standards** within this provider manual.

5.07 – PCP Application of Fluoride Varnish

Providers may be reimbursed for fluoride varnish applications performed during a well visit (CPT Code: 99188) if they have completed the AHCCCS required training prior to providing the varnish application. Providers may apply fluoride varnish for members who are at least 6 months of age, with at least 1 tooth eruption. Additional applications may be applied as often as every three months (four times a year) until the child turns 5 years old.

AHCCCS recommended training for fluoride varnish application is located on the American Academy of Pediatrics (AAP) website. The training covers caries risk assessment, fluoride varnish, and counseling. Upon completion of the required training, providers must submit a copy of their training documents to the CAQH database. The training documents being placed in the CAQH will be used in the credentialing process to verify completion of training necessary for reimbursement. These documents will also be utilized for our EPSDT provider compliance audits.

For additional information on fluoride varnish requirements, refer to the **AHCCCS AMPM 431 - Oral Health Care for EPSDT Members Policy,** the **AHCCCS AMPM 430 - EPSDT Policy**, and the **American Academy of Pediatrics (AAP) website** for more details.

5.08 - Body Mass Index (BMI) Screening

Providers are required to calculate a members BMI and percentile starting at 24 months until the member is 21 years old. Their BMI should be used to assess for underweight, overweight, or adequate weight gain. BMI for children is gender and age specific. For members under 24 months old, providers should monitor the child's growth by utilizing the World Health Organization (WHO) weight-for-length growth charts. Additional information, including age and condition specific growth charts, are available on the CDC BMI website **Body Mass Index (BMI)**.

The CDC also provided these established BMI percentiles which are used to identify underweight and overweight children:

Body Mass Index (BMI)

Body Mass Index	
Underweight	BMI for age <5th percentile
Healthy Weight	BMI for age <5th percentile to <85th percentile
Overweight	BMI for age 85th percentile to <95th percentile
Obesity	BMI for age > 95th percentile
Severe Obesity (Class 2)	BMI is 120% of the 95th percentile (or ≥ 35 kg/m2)
Severe Obesity (Class 3)	BMI is 140% of the 95th percentile (or ≥ 40 kg/m2

If a member is determined to be below the 5th percentile, or above the 85th percentile, the provider should:

- Educate the member and/or their member's parent, guardian, or caregiver on:
  - Healthy eating
  - Participating in physical activity for at least 30-60 minutes every day.
  - The importance of living a healthy lifestyle.
  - The growth and development issues that may arise when a person is underweight or overweight.
- Provide the member and/or their member's parent, guardian, or caregiver with:
  - Resources on healthy eating and physical activity. A few are listed below.
  - A referral to a dietician or nutritionist, if necessary.

    - A referral to the **Special Supplementary Nutrition Program for Women, Infants, and Children (WIC) program**, if appropriate.
- Notate all nutrition education, counseling, and referrals in the members medical records and on their submitted EPSDT Forms.

Resources to support the prevention of childhood obesity:

- **AAP Institute for Healthy Childhood Weight**
- **AAP Clinical Report: The Role of the Pediatrician in Primary Prevention of Obesity**
- **ADHS – Nutrition and Physical Activity**
- **ADHS-Nutrition, Physical Activity, & Obesity Resources**
- **MyPlate.gov**
- **Nutrition.gov**

5.09 - Nutritional Assessment and Nutritional Therapy

MC covers nutritional assessment and nutritional therapy for EPSDT members on an enteral, parenteral, or oral basis when determined medically necessary to provide either complete daily dietary requirements, or to supplement a member's daily nutritional and caloric intake.

The following requirements apply:

- Nutrition and the member's weight must be assessed at each visit.
- Providers must attempt to identify any possible causes of the members growth and development issues and document this in the members medical records. If the issues cause the member to be underweight or overweight, then the provider must address these concerns with the member/caregiver.
- Members in need of nutritional therapy should be identified and referred to a registered dietician in MC's network, including our overweight and underweight members.
- For members currently receiving nutritional therapy, they must be physically assessed by their PCP, specialty provider, or registered dietitian at least annually.
- If a member qualifies for nutritional therapy/nutritional supplements due to a medical condition and:
    - The member is eligible for the Special Supplementary Nutrition Program for Women, Infants, and Children (WIC) program, and the infant formula is covered by WIC, then the PCP should refer the member to WIC.
    - The medically necessary formula is exempt from the WIC program, then the PCP should refer the member to Aveanna Healthcare, MC's contracted DME provider for these services.

- Nutritional therapy requires prior authorization and approval by MC. In order to determine prior authorization, MC requires providers to use the most-up-to-date **AHCCCS Policy 430, Attachment B, Certificate of Medical Necessity for Commercial Oral Nutritional Supplements** form, along with clinical notes, supporting documentation and evidence of required criteria as indicated in the Certificate of Medical Necessity to be sent to Aveanna Healthcare. Their fax number is 844-754-1345. Aveanna Healthcare will contact MC to request prior authorization.
- All submitted documentation must demonstrate that the member meets all of the required criteria, meets medical necessity criteria on an individual basis, and must also be dated no earlier than three months prior to the request date.
- Providers must also document their efforts, demonstrating encouragement and any assistance provided to help wean the member from supplemental nutritional feedings, when appropriate.

For detailed information regarding Nutritional Assessment and Nutritional Therapy, please refer to the **AHCCCS AMPM 430 – EPSDT Policy.**

5.10 – Metabolic Medical Foods

Children who have been diagnosed with a genetic metabolic condition and who need metabolic medical foods may receive services through their genetics provider. MC covers metabolic formulas and medical foods as specified in ARS 20-2327. If an EPSDT member has a congenital metabolic disorder identified through the Bloodspot Newborn Screening Panel refer to the requirements and limitations outlined in the **AHCCCS AMPM – 310-GG Nutritional Therapy, Metabolic Foods, and Total Parenteral Nutrition Policy**.

5.11 – Pasteurized Human Donor Milk

MC also covers Pasteurized Human Donor Milk for babies and infants who cannot tolerate breastfeeding or formula, or they have a medical condition that does not allow them to have formula. In order for babies and infants to receive this type of milk they have to meet the criteria listed in **AHCCCS AMPM - 430 EPSDT Policy**.

5.12 – Developmental Surveillance and Developmental Screening

Developmental surveillance is part of the EPSDT program and must be done at every well visit, and if concerns are noted, further screenings and/or referrals would be indicated. The sooner a delay or disability is identified, the sooner a child can receive services and support that make a real difference.

Developmental screenings are considered an EPSDT prevention screening and must be done during the age-specific well visits listed below. These screenings can also be done during any well visit at the providers discretion. EPSDT providers must use up-to-date AHCCCS approved and community accepted screening tools. Examples can be found on the American Academy of Pediatrics (AAP) and Bright Futures website. Providers shall be training in the use and scoring of these developmental screening tools, as indicated by the AAP. Accepted tools are also described in the **CMS Child Core Measure, Developmental Screening in the First Three Years of Life.** Below are some examples of accepted screening tools:

General Developmental Screening Tools (9 months, 18-months, and 30-months)

- **Ages and Stages Questionnaires™ Third Edition (ASQ-3)** is a tool which is used to identify developmental delays in the first 5 years of a child's life.
- **Parents' Evaluation of Developmental Status (PEDS-R)** is a tool used to identify developmental delay in children, from Birth to 8 years of age.

Autism Specific Developmental Screening Tools (18-months and 24-months)

- **Ages and Stages Questionnaires®: Social-Emotional-Second Edition (ASQ:SE-2)** is a tool which is used to identify developmental delays during the first 6 years of a child's life.
- **Modified Checklist for Autism in Toddlers (M-CHAT-R/F)** is a tool PCPs can use to screen for autism for members 16-30 months of age.
- **Parents' Evaluation of Developmental Status (PEDS-R)** is a tool used to identify developmental delay in children, from Birth to 8 years of age.

To receive enhanced payment associated with EPSDT developmental screenings, the provider must follow the below criteria:

- The provider must be trained in the use of the screening tool prior to the well visit.
- The approved screening tool was utilized during the age-specific well visits listed above.
- General Developmental Screenings use CPT Code 96110-EP and ICD-10 Code Z13.42.
- Autism Specific Developmental (ASD) Screenings use CPT Code 96110-EP and ICD-10 Code Z13.41. (ICD-10 Code Z13.42 is not used for ASD Screenings.)
- The 18-month visit will be the only well visit where 96110-EP may be used twice.

The provider must also:

- Save the completed screening tool training documents into CAQH. This is used for credentialing and for our EPSDT provider compliance audits.
- Save the completed screening tool with the score/results in the members medical records.

5.13 - Behavioral Health Screenings

Screenings for mental health and substance abuse problems are to be conducted at each well visit according to the member's age. The age requirements are listed in the chart below These screenings are a covered benefit for members under age 21. The PCP is expected to:

- Initiate and coordinate necessary referrals for behavioral health and/or crisis services. PCPs may provide behavioral health services to eligible EPSDT members as long as it is within their scope of practice as specified in AMPM 510, Primary Care Provider policy.
- Monitor whether a member has received services. Treatment, if needed, is to be initiated within 60 days of screening services.
- When appropriate, providers shall communicate the final disposition of each referral to the referral source within 30 days of the member receiving an initial assessment.
- Keep any information received from a behavioral health provider regarding the member in the member's medical record.
- Initial and date copies of referrals or information sent to a behavioral health provider before placing in the member's medical record.
- If the member has not yet been seen by the PCP, this information may be kept in an appropriately labeled file in lieu of actually establishing a medical record but must be associated with the member's medical record as soon as one is established.
- Use up-to-date AHCCCS approved, and age-appropriate, screening tools as noted in AHCCCS AMPM 430 – EPSDT Policy. Screening tools and results must be saved to the member's medical records.

Required EPSDT Behavioral Health Screening

EPSDT Behavioral Health Screenings	CPT Codes	ICD-10 Codes	Screening Tool Examples
Adolescent suicide and depression screening – Annually starting at 10yo	96127	Z13.31 Z13.39	• Guidelines for Adolescent Preventive Services (GAPS) Questionnaire • Columbia Suicide Severity Rating Scale (C-SSRS) • Patient Health Questionnaire-9 Adolescent version + Ask Suicide-Screening Questions (PHQ-9A+ASQ)
Adolescent alcohol and/or substance use disorder (SUD) screening – Annually starting at 12yo	99408 99409	Z71.4 Z71.5 F10.1 – F16.9	• Guidelines for Adolescent Preventive Services (GAPS) Questionnaire • Drug Abuse Screen Test (DAST-20: Adolescent version)

EPSDT Behavioral Health Screenings	CPT Codes	ICD-10 Codes	Screening Tool Examples
			• Alcohol Use Disorders Identification Test (AUDIT) • Car, Relax, Alone, Forget, Family/Friends, and Trouble (CRAFFT)
Patient-focused health risk assessment (e.g., BH, HRSN, and/or Trauma) – Every well visit up to 21 years old	96160	Z13.39	• Well Child Care, Evaluation, Community Resources, Advocacy, Referral, Education (WE CARE) • Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences tool (PRAPARE) • Guidelines for Adolescent Preventive Services (GAPS) Questionnaire
Maternal Perinatal Mood and Anxiety Disorder (PMAD) and/or Depression Screening - 1, 2, 4, and 6-month well visits	96161	Z00.110 Z00.111 Z00.121 Z00.129	• Edinburgh Postpartum Depression Scale (EPDS) • Patient Health Questionnaire Depression Scale -9 (PHQ-9) • Beck's Depression Inventory Scale (BDI)
***Note: There are a few screening tools that cover multiple screening requirements by utilizing just one screening tool, such as** • Home, Education/Employment, Activities, Drugs, Sex, Suicide/Depression, and Safety **(HEADDSS)** • Strengths, School, Home, Activities, Drugs/Substance Use, Emotions/Eating/Depression, Sexuality, Safety **(SSHADESS)** • Guidelines for Adolescent Preventive Services **(GAPS)** Questionnaire			

Sources:

AHCCCS Medical Coding Resources website – 2025 EPSDT Service Code Resource Document
https://www.azahcccs.gov/PlansProviders/Downloads/MedicalCodingResources/AMPM430_EPSDT_ServiceCodes.pdf

AAP Bright Futures 2025 EPSDT Preventive Care CPT and ICD-10 Code Document
https://downloads.aap.org/AAP/PDF/Coding%20Preventive%20Care.pdf

5.14 - Arizona Early Intervention Program (AzEIP)

The **Arizona Early Intervention Program** (herein AzEIP) is an early intervention program that offers a statewide system of support and services for children birth through three years of age and their families who have disabilities or developmental delays. This program was jointly developed and implemented by AHCCCS and the Arizona Early Intervention Program (AzEIP) to ensure the coordination and provision of EPSDT and early intervention services, such as

physical therapy (PT), occupational therapy (OT), speech/language therapy (ST), and care coordination under Sec. 1905 [42 U.S.C 1396d]. Concerns about a child's development may be initially identified by the child's parent/guardian/caregiver, their Integrated Care Manager (ICM), their Primary Care Provider (PCP), or by AzEIP. If the concern is identified by the child's parent/guardian/caregiver, it is commonly communicated to the MC AzEIP Coordinator through the PCP or ICM.

If the PCP submits an AzEIP Evaluation Referral to MC:

- During the members well visit the PCP will determine the child's developmental status. This is done through discussion with the family/parents/guardian and by completing developmental screenings.
- The PCP then notates the AzEIP referral on the member's EPSDT Form or electronic equivalent (electronic medical record, EMR).
    - The provider should also notate which services the member would need.
    - If the provider is unsure about which services would be needed, they can still request an evaluation to be completed.
- The EPSDT Form or EMR with the PCP AzEIP Evaluation Referral notation is then sent to the MC EPSDT Department by faxing it to 602-431-7157. The request is then forwarded to the MC AzEIP Coordinator for processing.
    - The PCP also has the option of sending an AzEIP Evaluation Referral directly to the MC AzEIP Coordinator via fax at 959-900-6387. The EPSDT Form or EMR is still required to be sent to the MC EPSDT Department for processing.
- **Once the MC AzEIP Coordinator receives the referral from the PCP:**
    - They process the PCP AzEIP Evaluation Referral and request additional information from the PCP if necessary. Once all of the required information is received, the MC AzEIP Coordinator will enter the request into the AzEIP Online Portal for AzEIP to review.
- **If the MC AzEIP Coordinator receives the referral from ICM:**
    - They process the PCP AzEIP Evaluation Referral and request additional information from the care manager and the PCP if necessary. Once all of the required information is received, the MC AzEIP Coordinator will enter the request into the AzEIP Online Portal for AzEIP to review.
- **Once AzEIP receives the referral for AzEIP services**:
    - If AzEIP determines the referral to be an appropriate submission, then the referral is processed by AzEIP (AzEIP process outlined below).
        - Note: At this step, a prior authorization (PA) is not created. The PA is created once AzEIP sends MC the AzEIP approval documents.

- If AzEIP determines that the referral submission is not appropriate, then they will inform the MC AzEIP Coordinator of the decision. The MC AzEIP Coordinator will then relay that information back to the PCP.
- The PCP should then submit a PA request to MC for the services they deem to be medically necessary. The goal is to ensure the member receives their medically necessary services, whether or not they are covered under AzEIP.

- Throughout this process, the MC AzEIP Coordinator is helping to coordinate care for the member by communicating with the PCP, ICM, AzEIP, the Servicing Provider, and/or the member's parent/guardian/caregiver. This is to ensure the member receives their medically necessary services in a timely manner.

If AzEIP submits the referral to MC:

- **AzEIP will submit an AzEIP Referral to MC if:**
  - The referral bypassed MC and was sent directly to AzEIP through their Online Portal. AzEIP then reviewed the request and approved the AzEIP evaluation.
  - AzEIP has reviewed and approved a PCP AzEIP Evaluation Referral that MC entered into the AzEIP Online Portal (process outlined above).

- **Once AzEIP receives the referral for AzEIP services**:
  - AzEIP begins the initial planning process and meets with the interested parties (parents, guardians, caregivers, PCP, therapists, etc.) to retrieve the required information to evaluate if the member is eligible for AzEIP services.
  - AzEIP then completes the following AzEIP documents:
    - An Individual Family Service Plan (IFSP) which includes any assessments, evaluations, and developmental summaries completed during the IFSP evaluation process.
    - An AzEIP Member Service Request (AMSR) form.
  - Once AzEIP has completed their review and they have approved the AzEIP Referral, they submit the IFSP, the AMSR, and all other documentation to the MC AzEIP Coordinator for processing.
  - **Once the MC AzEIP Coordinator receives the ISFP and AMSR from AzEIP:**
    - The MC AzEIP Coordinator creates a PA and forwards all documents to the PCP to review for medical necessity.
  - **Once the PCP receives the ISFP and AMSR from MC AzEIP Coordinator:**
    - The PCP reviews the documents to assess for medical necessity.
    - PCP notates on the AMSR form the member's diagnosis, their final decision (Approved or Denied), the decision date, and their signature.
    - The PCP then faxes the signed AMSR form to the MC AzEIP Coordinator.

- **Once the MC AzEIP Coordinator receives the signed AMSR form from the PCP:**
  - The MC AzEIP Coordinator completes the PA with the PCP's final decision. The services can be approved, denied, suspended, reduced, or pend for an additional evaluation.
  - The decision is then communicated to the PCP, ICM, AzEIP, Servicing Provider, and/or the member's parent/guardian/caregiver.
    - If the request is pended for additional information, then depending on the AzEIP PA timeline, the request may be extended and/or denied.
    - If the request is denied, suspended, or reduced then the MC AzEIP Coordinator will follow the PA process, and the final decision will be communicated utilizing the Notice of Adverse Benefit Determination (NOA) process.

AzEIP Timeliness

Per **AMPM Ch 430 – Attachment C, Procedures for the Coordination of AzEIP Services under EPSDT**:

- **PCPs must be returned the signed AMSR form to MC no later than 10 days from the date they received the request**.
  - If the PCP does not follow this timeline, it will result in the PA being extended and/or denied, which may result in a delay in the member receiving timely services.
- **Each AzEIP service (PT, OT, and ST) that are identified on the IFSP must begin on or before the planned start date, but no later than 30 days of the IFSP.**
  - **The PCP, Servicing Provider, and MC are all responsible for coordinating care and providing follow-up to ensure this timeframe is met.**
- If a PCP asks MC to pend a request or asks for additional time to review the request for medical necessity, then depending on the AzEIP PA timeline, the request may be extended and/or denied. The request will then follow the PA process timelines.
- If the PCP's final decision for the referral is denied, suspended, or reduced, then the MC AzEIP Coordinator will follow the PA process, including sending an NOA.

Per **AMPM Ch 430 – EPSDT Policy**:

- **PCPs are required to communicate results of assessments and services provided to AzEIP enrollees within 30 days of the member's AzEIP enrollment**. *(Note: This required completion date changed from 45 days to 30 days in October 2024.)*

- In addition, MC requires that providers, when appropriate, communicate the final disposition of each referral to the referral source within 30 days of the member receiving an initial assessment.

Submission of an AzEIP Referral

Providers have multiple options available when referring a member to AzEIP. MC *prefers* that providers send the AzEIP referral to our MC AzEIP Coordinators so they can help to coordinate care. If a provider does not want to send the referral through our MC AzEIP Department, then they can submit the referral directly to AzEIP through their Online Portal. If a provider prefers to submit the request directly to AzEIP, then MC kindly requests that an email is sent to our MC AzEIP Coordinators with that information so we can continue to coordinate care.

AzEIP Referral Information and AzEIP Contact Details

- **MC AzEIP Department Email**: MCAzEIP@mercycareaz.org
- **MC AzEIP Department Fax (Preferred Method)**: (959) 900-6387
- **AzEIP - Referral Portal**
- **DES AzEIP - Phone**: (888) 592-0140
- **DES AzEIP - Fax**: (602) 357-1978
- **DES AzEIP - Email**: AzEIP.Info@raisingspecialkids.org
- **DES AzEIP Referral Status Check Email**: AzEIP@azdes.gov
- **DES AzEIP Referral Status Check Phone**: (602) 532-9960

The AzEIP process can be found in the AMPM Policy 430 and on the DES AzEIP website:

- **AMPM Policy 430 – Attachment C, AzEIP Procedures and Coordination**
- **AMPM Policy 430 – Attachment D, AzEIP Member Service Request (AMSR) Form**
- **AzEIP Website**
- **DES AzEIP Policy Manual**
- **DES AzEIP Procedure Manual**

5.15 - Immunizations/Vaccines for Children (VFC) Program and ASIIS

EPSDT covers all child and adolescent immunizations. As of 10/01/2025, for members under the age of 21, immunizations are covered as established by the Advisory Committee on Immunization Practices (ACIP) as specified by the Centers for Disease Control (CDC) and as recommended by the American Academy of Pediatrics (AAP) immunization schedule, when the health care provider determines the immunization to be medically necessary. The determination of medical necessity is based on clinical appropriateness, scientific evidence, and standards of practice, including immunization schedules and published communication from

professional medical academic associations, and evidence-based immunization practice guidelines. The vaccine schedule shall also reflect current state statutes governing school immunization requirements as listed in AAC R9-6-702 Title 9.

Vaccine counseling is also a covered service, whether or not the vaccine is not administered during the same visit. If the member or their parent/guardian/caregiver make the decision not to utilize EPSDT services or receive immunizations, then providers must document that in the member's medical record.

Vaccine for Children Program (VFC)

Any provider that administers immunizations are required to coordinate with the Arizona Department of Health Services' (ADHS) Vaccine for Children (VFC) Program. **Providers must enroll and re-enroll annually with the VFC program**, in accordance with AHCCCS contract requirements when providing immunizations for these EPSDT-aged members. For those that do not follow this guidance, risk having their MC EPSDT patients transferred to another EPSDT Provider that does participate in the VFC Program.

Be sure to monitor the VFC Program website for any updates to the program requirements.

Additional information on the VFC Program:

Phone: 602-364-3642
Website: **Vaccine for Children (VFC)**

Arizona State Immunization Information System (ASIIS)

Arizona Law requires any provider that administers immunizations to EPSDT-aged members under 19 years of age to document all immunizations provided into the Arizona State Immunization Information System (ASIIS) registry. AHCCCS also requests that providers document immunizations of members who are 19-20 years old in ASIIS. **Immunizations must be reported to ASIIS within 30 days of administration**. Additional information on the ASIIS reporting requirements can be found on the Arizona Department of Health Services (ADHS) website.

Additional information for ASIIS:

Phone: 602-364-3899
Email: **ASIISHelpDesk@azdhs.gov**
Website: **ASIIS**

VFC and ASIIS Provider Compliance Audits

MC audits provider compliance on immunization ASIIS registry reporting requirements and VFC Program annual enrollment and will provide education when issues are identified. For more information on these requirements, see the **AHCCCS AMPM Ch 430-EPSDT Policy**.

Newborn Immunizations

As of October 1, 2012, federal vaccines can no longer be used to immunize privately insured children. Although a newborn may be eligible for Medicaid, hospitals cannot make an absolute determination that a newborn is not also eligible for private insurance at the time that this immunization would be administered. Because of this, the hospitals face the potential of administering VFC vaccines to newborns against the federal requirements. Since many hospitals have dis-enrolled from the VFC program due to this new policy, newborns who are delivered at these facilities may not receive the birth dose of the Hepatitis B vaccine.

MC requests that all primary care providers and pediatricians caring for newborns review each member's immunization records fully upon their initial visit, and subsequent follow-up visits, regardless of where the child was delivered. It is our intention to ensure that the newborns receive all required vaccines, and that those who have not received the birth dose of the Hepatitis B vaccine in the hospital be "caught up" by their primary care provider.

5.16 – Lead Screening and Blood Lead Testing

Blood Lead Testing

In accordance with the AHCCCS AMPM Ch 430 - EPSDT Policy, **all children 12 months and 24 months of age must have a blood lead test**. **In addition, children between the ages of 24 months and 72 months of age (2-6 years old) who have not been previously tested, or who missed either the 12 month or 24-month test, must have a blood lead test.** Blood lead levels may be tested at times other than those specified above if thought to be medically indicated by the provider, by responses to a lead poisoning verbal risk assessment, or in response to parent/guardian/caregiver concern.

Lead Screening

Providers are required to provide a lead poisoning verbal risk assessment at each well visit for children 6 months to 6 years of age. This risk assessment includes providing anticipatory guidance on how to provide an environment safe from lead. During the lead poisoning risk assessment, providers should utilize the Arizona Department of Health Services (ADHS) Parent Questionnaire, which is based on the child's risk as determined by either the residential zip code or presence of other known risk-factors. The lead screening questionnaire results should help identify members who are at high-risk for blood lead poisoning and in need of blood lead

testing. For a complete list of high-risk zip codes, please visit the **Arizona Department of Health Services** by clicking the link.

Low risk: All verbal blood lead screening questions are answered "No."
High-risk: One or more verbal blood lead screening questions are answered "Yes" or "Unsure."

BLOOD LEAD TESTING and LEAD SCREENING REQUIREMENTS

Required Blood Lead Testing	*Required Blood Lead Screening*
• 12 months of age. • 24 months of age. • Between 24 months and 6 years of age if child has not been previously tested. • Child missed either the 12 month or 24-month test. • One or more verbal blood lead screening questions are answered "Yes" or "Unsure."	• Completed at each well visit for children 6 months to 6 years of age. • The ADHS Parent Questionnaire may be utilized to help determine if a lead test should be performed outside of the required testing ages. • Should include anticipatory guidance on how to provide an environment safe from lead.

Elevated Blood Lead Reporting Requirements

EPSDT providers must report all elevated blood lead levels (EBLL) to ADHS as required under Arizona Law, AAC R9-4-302. Per the CDC and ADHS, an EBLL is considered a result equal to or greater than 3.5 micrograms of lead per deciliter (≥3.5 ug/dL). A blood lead test result equal to or greater than ≥3.5 ug/dL of whole blood obtained by capillary specimen or fingerstick shall be confirmed using a venous blood sample. If you have questions about lead toxicity, testing, treatment or reporting, call the Arizona Department of Health Services (ADHS) at **602-364-3118** or log on to the **ADHS Lead Poisoning Health Care Provider Portal**.

To access additional Information about the **ADHS Targeted Lead Screening Plan for the Prevention of Childhood Lead Poisoning**, please click on the link.

MC aligns with the CDC and ADHS recommendations and provides appropriate care coordination for EPSDT members who have an EBLL of ≥3.5 ug/dL. MC will also assist them in finding low-cost or no-cost follow-up testing and treatment if they lose AHCCCCS eligibility.

For additional information visit the ADHS website to review the Blood Lead Prevention and Testing Requirements, providers can review the **ADHS 2018 Arizona Targeted Lead Screening Plan** and the **CDC's Childhood Lead Poisoning Prevention Program**, which outlines blood lead reference values and testing schedules.

5.17 - Tuberculin Skin Testing

Tuberculin skin testing should be performed as appropriate to age and risk. Members who received TB testing shall receive timely reading of the TB skin test and treatment, if medically necessary. Children at increased risk of tuberculosis (TB) include those who have contact with persons:

- Confirmed or suspected of TB;
- In jail during the last five years;
- Living in a household with an HIV-infected person or the child is infected with HIV; and
- Traveling/emigrating from, or having significant contact with persons indigenous to, endemic countries.

MC Chapter 6 – Children's Rehabilitative Services (CRS)

6.00 - Children's Rehabilitative Services (CRS) Overview

Arizona's Children's Rehabilitative Services (CRS) program provides medical and behavioral health care, treatment, and related support services to Arizona Health Care Cost Containment System (AHCCCS) members who meet the eligibility criteria, have completed the application to be enrolled in the CRS program, and have been determined eligible.

CRS members receive the same AHCCCS covered services as non-CRS AHCCCS members. Services are provided for the CRS condition and other medical and behavioral health services for most CRS members. CRS members can receive care in the community, or in clinics called multispecialty interdisciplinary clinics, which bring many specialty providers together in one location.

6.01 - Integration Initiatives

Arizona's Children's Rehabilitative Services (CRS) program, authorized by ARS 36-261 et seq., was originally created in 1929 to serve children with complex health care needs who required specialized services coordinated by a multidisciplinary team. The State of Arizona opted into the Medicaid program in 1982. CRS was folded under the AHCCCS umbrella to leverage federal dollars in providing medically necessary care. However, the CRS program and the services provided remained "carved out" of the AHCCCS managed care model, a model designed to facilitate accessibility to quality cost-effective care.

Historically, the CRS carve-out program provided specialty services to children with specific qualifying medical conditions. Care and services for the CRS qualifying condition(s) were provided through the sole CRS Contractor. However, that same member may also have received other acute care services through a different AHCCCS Contractor or through the American Indian Health Plan (AIHP) or received long-term care services through a different AHCCCS Long Term Care Contractor or the American Indian Fee-for-Service environment, as well as receiving behavioral health services through a AHCCCS Complete Care-Regional Behavioral Health Agreement (ACC-RBHA) or a Tribal Regional Behavioral Health Authority (TRBHA).

This fragmentation caused confusion for families and providers and created payment and care coordination responsibility issues between delivery systems. Improving the situation required a model design that reduced fragmentation and ensured optimal access to primary, specialty and behavioral care and which offers effective coordination of all service delivery through one AHCCCS Contractor.

AHCCCS proposed an alternative to the "carve out" model of service delivery and payment for services provided to CRS-eligible individuals. Specifically, proposing that the model be replaced by a payer integration model that required one contractor/payer to assume responsibility for the delivery and payment of multiple services (i.e., services related specifically to CRS conditions as well as services related to primary care and, potentially, other needs like behavioral health). Ultimately, the purpose of such a model is to ensure optimal access to important specialty care as well as effective coordination of all service delivery.

Most AHCCCS members with CRS conditions were enrolled with a single statewide health plan (UnitedHealthcare Community Plan) for all or a portion of their health care services.

Beginning on October 1, 2018, these members were given the choice of an AHCCCS Complete Care (ACC) plan for all services (including CRS, other non-CRS physical health services, and all covered behavioral health services). Members who were already seeing a provider for a CRS condition had access to the same array of covered services with ACC health plans. Providers were required to notify the Care Management department when treatment for the CRS condition was completed.

Beginning on October 1, 2019, members with a CRS condition who are also enrolled in a Medicaid plan under MC DD are be included in this integration.

6.02 - CRS Qualifying Medical Conditions

The AHCCCS published document, **Covered Conditions in the CRS Program** lists out medical conditions that are covered by CRS, as well as those conditions that are not covered.

6.03 - Who is Eligible for CRS

Any AHCCCS member under the age of 21 who has a CRS-covered condition as specified in the **Covered Conditions in the CRS Program** that requires active treatment. If the CRS applicant is not currently an AHCCCS member, they must apply for AHCCCS either online or via phone:

- Online at: **www.Healthearizonaplus.gov** or
- Call AHCCCS toll free at 1-855-HEA-PLUS (toll-free 1-855-432-7587), or you may call our Member Services at 602-263-3000 or toll-free 800-624-3879 (TTY/TDD 711).

Anyone can fill out a CRS application form, including a family member, doctor, or health plan representative. To apply for the CRS program, a CRS application, either in English or Spanish, needs to be filled out and mailed or faxed to the AHCCCS CRS Enrollment Unit, with medical documentation that supports that the applicant has a CRS qualifying condition.

The AHCCCS CRS Enrollment Unit may also assist an applicant with completing the form. You can contact them at: 602-417-4545 or 1-855-333-7828.

CRS Application with Instructions:

- **CRS application form instructions - English**
- **CRS application form - English**
- **Instrucciones para completar la solicitud para Servicios de Rehabilitación Infantil (CRS)**
- **CRS application form - Spanish**

Once approved for the CRS program, an applicant is enrolled with an ACC Health Plan or DDD Health Plan of their choice. The chosen Health Plan will manage care for the CRS condition(s), along with the physical and behavioral health services of the member.

MC Chapter 7 – Family Planning

7.00 - Family Planning Overview

Family planning services and supplies are provided through Aetna Medicaid Administrators LLC. Members may choose to obtain family planning services and supplies from an appropriate AHCCCS family planning provider regardless of whether or not the providers work with MC. Members do not need prior authorization in order to obtain family planning services and supplies from an out-of-network provider.

Healthcare providers (including PCPs, Maternity Care Providers, and Pediatricians) are required to document in the members medical record that each member of reproductive age has been notified, verbally or in writing of the availability of family planning services and supplies. These discussions must occur annually during their well visits, well woman visits, and during their prenatal and postpartum visits. This discussion should include the availability and benefits/risks of LARC (Long-Acting Reversible Contraceptive) and IPLARC (Immediate Postpartum Long-Acting Reversible Contraceptives) And the discussions must be documented in the member's medical record.

Please refer to the **MC Claims Processing Manual, Chapter 2 – Professional Claim Types by Specialty, Section 2.14 - Family Planning Claims** available on the MC website for the submission of family planning claims.

7.01 - Provider Responsibilities for Family Planning Services

All providers are responsible for:

- Contraceptives should be recommended and prescribed for sexually active members. PHPs are required to discuss the availability of family planning services annually.
    - If a member's sexual activity presents a risk or potential risk, the provider should initiate an in-depth discussion on the variety of contraceptives available and their use and effectiveness in preventing sexually transmitted infections (including HIV, syphilis, chlamydia, and gonorrhea), and STI testing. Such discussions must be documented in the member's medical record.
- Making appropriate referrals to health professionals who provide family planning services and supplies if it is outside their scope of practice.
- Keeping complete medical records regarding referrals.
- Verifying and documenting a member's willingness to receive family planning services and supplies.

- Providing medically necessary management of members with family planning complications.
- Notifying members of the available family planning services and supplies using the following guidelines:
    - Services are provided in a manner free from coercion or behavioral/mental pressure;
    - Services are available and easily accessible to members;
    - Services are provided in a manner which assures continuity and confidentiality;
    - Services are provided by, or under the direction of, a qualified physician or practitioner; and
    - Services are documented in the member's medical record. Documentation must note if each member of reproductive age was notified either verbally or in writing of the availability of family planning services and supplies.
- Providers must be educated regarding covered and non-covered family planning services and supplies, including LARC and IPLARC options.
- Prior to inserting an intrauterine and subdermal implantable contraceptive, the provider has provided proper counseling to the eligible member to increase the member's success with the device according to the member's reproductive goals. Counseling information is to include a statement to the member indicating if the implant is removed within two years of insertion, the member may not be an appropriate candidate for reinsertion for at least one year after removal.
- Providing age-appropriate counseling and education to members of all genders including information on:
    - Prevention of unplanned pregnancies.
    - Counseling for unwanted pregnancies. Counseling should include the member's short and long-term goals.
    - Spacing of births to promote better outcomes for future pregnancies.
    - Preconception counseling to assist members in deciding on the advisability and timing of pregnancy, to assess risks and to reinforce habits that promote a healthy pregnancy.
    - Sexually transmitted infections, to include methods of prevention, abstinence, and changes in sexual behavior and lifestyle that promote the development of good health habits.

7.02 - Covered and Non-Covered Services

Family planning services and supplies are covered for members, regardless of gender who voluntarily choose to delay or prevent pregnancy. Services provided should be within each provider's training and scope of practice. Family planning services and supplies include covered

medical, surgical, pharmacological, and labs. They also include the provision of accurate information and counseling to allow members to make informed decision about their available options.

The following services are not covered for the purposes of family planning:

- Treatment of infertility;
- Pregnancy termination counseling;
- Pregnancy terminations;
- Hysterectomies for the purpose of sterilization;

7.03 - Prior Authorization Requirements

Prior authorization is required for family planning services, sterilization, or pregnancy termination. Prior authorization must be obtained before the services are rendered or the services will not be eligible for reimbursement.

To obtain authorization for family planning services, please complete the Aetna Medicaid Administrators LLC **Prior Authorization: Aetna Family Planning Service Request Form**, available on the MC website under **Forms**. Requests should be faxed to:

Aetna Medicaid Administrators LLC
800-573-4165

To obtain authorization for sterilization or pregnancy - termination:

- Complete applicable form(s)
    - ***For sterilization:*** Aetna Medicaid Administrators LLC's **Prior Authorization: Aetna Family Planning Service Request Form**, available under **Forms** on the MC website, listed above and the **AHCCCS Attachment A - Consent for Sterilization Form** contained in the **AHCCCS AMPM 420-Family Planning.** Permanent sterilization is only covered for MC members 21 years of age or older.
    - ***For pregnancy termination:*** Aetna Medicaid Administrators LLC's **Prior Authorization: Aetna Family Planning Service Request Form**, listed above.
- Fax completed prior authorization form and signed consent form prior to the procedure to:

    Aetna Medicaid Administrators LLC
    800-573-4165

For members enrolled in the Department of Economic Security, Division of Developmental Disabilities (DES/DDD) health professionals must obtain prior authorization from MC by faxing

your request to 602-431-7155. Final determination will be made by the DES/DDD medical director prior to providing sterilization procedures for members enrolled with DES/DDD, in addition to Aetna Medicaid Administrators LLC. Notification of approved requests will be faxed or mailed to the provider.

MC Chapter 8 - Maternity

8.00 - Maternity Overview

MC assigns newly identified pregnant members to an OB provider to manage their pregnancy and postpartum care. MC allows the member freedom of choice when choosing an OB provider, but they should do so in a timely manner as to not compromise the continuity of care. Members who transition to a new Contractor or become enrolled during their third trimester are allowed to complete their maternity care with their current AHCCCS registered provider, regardless of contractual status, to ensure continuity of care.

While pregnant, the member will have a PCP to manage their routine non-OB care. If a member chooses to have an OB as their PCP during their pregnancy, MC will assign the member to an OB PCP. Once an OB PCP has been assigned, the member will remain with their OB PCP until the end of the postpartum period, then they will be reassigned to their previously assigned PCP. The OB provider is reimbursed in accordance with their contract.

Maternity services shall be provided for members of childbearing age in compliance with the most current American College of Obstetricians and Gynecologists (ACOG) standards. Prenatal care, labor/delivery, and postpartum care services may be provided by a Licensed Midwife (LM) within their scope of practice, while adhering to AHCCCS risk-status consultation/referral requirements.

Per AMPM 410, Maternity Care Services, Maternity Care Services include, but are not limited to:

- Medically necessary preconception counseling
- Identification of pregnancy
- Medically necessary education and prenatal services for the care of pregnancy
- The treatment of pregnancy-related conditions
- Labor and delivery services
- Postpartum care
- Family Planning Services and Supplies

8.01 – High-Risk Maternity Care

- In partnership with OB providers, MC care managers identify pregnant women who are "at risk" for adverse pregnancy outcomes. MC offers a multi-disciplinary program to assist providers in managing the care of pregnant members who are at risk because of medical conditions, substance use, serious mental illness (SMI), social circumstances, or

non-compliant behaviors. MC also considers factors such as noncompliance with prenatal care appointments and medical treatment plans in determining risk status.

- Referrals to the High-Risk Perinatal Care Management Department can be made by faxing the completed ICM Perinatal Referral Form, available under **Forms** on the MC website, electronically to **OBfaxes@aetna.com** or to the fax number 602-431-7552. Please include the provider group and Tax ID Number.
- Members identified as "at risk" are reviewed and evaluated for ongoing follow up - during their pregnancy by an obstetrical care manager.
- When submitting the ICM Perinatal Referral Form, please clearly document all high-risk issues. The form is reviewed by our perinatal triage RN. All high-risk pregnant members are care managed by a skilled social worker or registered nurses throughout the perinatal and post-partum period.

Maternity Care for Members with Developmental Disabilities

Women with developmental disabilities may have higher rates of adverse pregnancy outcomes. MC recognizes the needs of DDD enrolled pregnant women and our intent is to keep our providers updated.

ALL pregnant MC members with a Developmental Disability (DD) designation are considered high-risk and require engagement by the high-risk perinatal care management team.

Identified DDD enrolled pregnant members enrolled in the care management process receive comprehensive interventions during the perinatal and post-partum periods by skilled professional care managers.

Providers caring for DDD enrolled pregnant women should:

- REFER ALL DDD enrolled pregnant MC members to the High-Risk Perinatal Care Management program. The perinatal care management team will assist with coordination of care by providing member specific education and support, along with referrals to community resources as needed.
- Referrals can be made by faxing the ICM Perinatal Referral Form, available under **Forms** on the MC website, electronically to **OBfaxes@aetna.com** or to the fax number 602-431-7552. Please include the provider group and Tax ID Number.
- When submitting the ICM Perinatal Referral Form, please clearly document all high-risk issues. The form is reviewed by our perinatal triage RN. All High-Risk pregnant members are care managed by a skilled social worker or registered nurses throughout the perinatal and post-partum period.

8.02 - OB Care Management

MC's perinatal care management provides comprehensive care management services to high-risk pregnant members, for improving maternal and fetal birth outcomes. The perinatal care management team consists of a social worker, care management associates, and professional registered nurses skilled in working with the unique needs of high-risk pregnant women. Perinatal care managers take a collaborative approach to engage high risk pregnant members telephonically throughout their pregnancy and post-partum period.

Members who present with high-risk perinatal conditions should be referred to perinatal care management. These conditions include:

- Under 16 or over 36 years of age;
- A history of preterm labor before 37 weeks of gestation;
- A history of twins/multiples;
- Has an infant under 18 months old;
- Obesity;
- Asthma;
- Dental issues;
- Diabetes;
- High Blood Pressure/Hypertension;
- Bleeding and blood clotting disorders;
- Chronic medical conditions;
- Polyhydramnios or oligohydramnios;
- Placenta previa, abruption or accreta;
- Cervical changes;
- Multiple gestation;
- Hyperemesis;
- Poor weight gain;
- Alcohol use, Substance use, or Smoking/Vaping/Tobacco use;
- Mental illness;
- Domestic violence;
- Homelessness;
- Poor Nutrition; and
- Non-compliance with OB appointments.

Referrals can be made by faxing the member information on the **Perinatal Referral Form**, available under Forms on the MC website, electronically to **OBfaxes@aetna.com** or to the fax number 602-431-7552. Please include the provider group and Tax ID Number.

8.03 - OB Incentive Program

MC's perinatal care management offers an OB incentive program for providers who identify and refer members with high-risk pregnancies. The OB incentive program rewards providers with $25.00 for each member ACOG submitted within the first trimester. Identification of high-risk conditions within the first trimester promotes early intervention of care coordination services and serves to improve birth outcomes.

8.04 - Obstetrical Care Appointment Standards

MC has specific standards for the timing of initial and return prenatal appointments. These standards are as follows:

Initial Visit

All OB providers must make it possible for members to obtain initial prenatal care appointments within the timeframes identified:

Pre-Natal Care Appointment Availability Table

Category	Appointment Availability
First Trimester	Within 14 calendar days of the request for an appointment
Second Trimester	Within 7 calendar days of the request for an appointment
Third Trimester	Within 3 business days of the request for an appointment
Return Visits	Return visits should be scheduled routinely after the initial visit. Members must be able to obtain return prenatal visits: First 28 weeks - every four weeks From 28 to 36 weeks - every two to three weeks From 37 weeks until delivery – weekly
High Risk Pregnancy Care	Visits should be scheduled within 3 business days of identification of high risk by the Contractor or maternity care provider, or immediately if an emergency exists. Return visits scheduled as appropriate to their individual needs; however, no less frequently than listed above.

Postpartum Visits	Postpartum visits should be scheduled routinely after delivery. Routine postpartum visits should be scheduled within 1 – 12 weeks after delivery.

8.05 - General Obstetrical Care Requirements

All providers must adhere to the standards of care established by the American College of Obstetrics and Gynecology (ACOG), which include, but are not limited to the following:

- Use of a standardized prenatal medical record and risk assessment tool, to document all aspects of maternity care.
- Completion of history including medical and personal health (including infections and exposures), menstrual cycles, past pregnancies and outcomes, family, and genetic history.
- Clinical expected date of confinement.
- Performance of physical exam (including determination and documentation of pelvic adequacy).
- Performance of laboratory tests at recommended time intervals.
- Comprehensive risk assessment incorporating psychosocial, nutritional, medical, and educational factors.
- Routine prenatal visits with blood pressure, weight, fundal height (tape measurement), fetal heart tones, urine dipstick for protein and glucose, ongoing risk assessment with any change in pregnancy risk recorded and an appropriate management plan.
- A perinatal mood and anxiety disorder (PMAD) screening must be documented on the claims form for all pregnant members. For additional information regarding Maternity Care and Delivery billing, please refer to the **MC Claims Processing Manual**, **Chapter 2 – Professional Claim Types by Specialty, Section 2.5 – Obstetrical Billing** available on the MC website.
- Refer members with a perinatal mood and anxiety disorder to a Behavioral Health provider. Please call 800-564-5465 with requests for assignment to a behavioral health provider:
    - Member medical records are maintained and document all aspects of maternity care provided.
    - All cesarean sections shall include medical necessity documentation. All inductions and cesarean sections done prior to 39 weeks shall follow the ACOG guidelines. Any inductions performed prior to 39 week, or cesarean sections performed at any time that are found not to be medically necessary based on the nationally established criteria are not eligible for payment.

8.06 - Additional Obstetrical Physician and Practitioner Requirements

- Screen all pregnant members for HIV and STIs, including testing for syphilis at the first prenatal visit, during the third trimester, and at time of delivery. Offer counseling and treatment if the results are positive
- Educate members about healthy behaviors during pregnancy including the importance of proper nutrition, dangers of lead exposure, tobacco cessation, avoidance of alcohol and illegal drugs, screening for STIs, the labor and delivery process, breastfeeding, infant care, prescription opioid use, inter-conception health and birth spacing, family planning options, including LARC and IPLARC, and postpartum follow up.
- Perform a brief verbal screening and intervention for substance use utilizing an evidence-based screening tool and an appropriate referral shall be made as needed.
- Screen pregnant members through the Controlled Substances Prescription Monitoring Program (CSPMP) once a trimester, for those members receiving opioids, appropriate intervention and counseling shall be provided, including referral for behavioral health services as indicated for Substance Use Disorder (SUD) assessment and treatment.
- Encourage initiation and duration of breastfeeding per evidence-based practices including skin-to-skin contact, no food or drink other than breastmilk (unless medically necessary), provider recommendation of breastfeeding, early initiation of breastfeeding, rooming in, etc.
- Conduct perinatal mood and anxiety disorder (PMAD) using a norm-referenced validated screening tool at least once during pregnancy and then repeat at the postpartum visit with appropriate counseling and referrals made if a positive screening is obtained.
- Ensure delivery of newborn meets MC criteria.
- Remind delivery hospital of requirement to notify MC on the date of delivery.
- Ensure high-risk members are referred to the perinatal care management team and to a qualified provider. Provide follow-up to ensure they are receiving appropriate care.
- Refer members for support services and community-based resources such as WIC and home visitation programs for pregnant women and their children.
- Encourage members to participate in childbirth classes at no cost to them. The member may call the facility where she will deliver and register for childbirth classes.
- Ensure prenatal services are provided within the established timeframes.
- Ensure postpartum visits are completed within the required timeframe Per the ACOG, depending on the member's health, this can be between 1-12 weeks post-delivery.
- The first and last prenatal care dates of service, as well as the number of obstetrical visits that the member had with the provider are recorded on all claim forms submitted regardless of the payment methodology used.

Providers may also consult with an MC medical director for members with other conditions that are deemed appropriate for perinatology referral. Please call 602-263-3000 or 800-624-3879 with requests for assignment to a perinatologist.

In non-emergent situations, all obstetrical care physicians and practitioners must refer members to MC providers. Referrals outside the contracted network must be prior authorized. Failure to obtain prior authorization for non-emergent OB or newborn services out of the network will result in claim denials. Members may not be billed for covered services if the provider neglects to obtain the appropriate approvals.

8.07 - Provider Requirements for Medically Necessary Termination of Pregnancy

Medically necessary pregnancy termination services are provided through Aetna Medicaid Administrators LLC. An Aetna Medicaid Administrators LLC Medical Director will review all requests for medically necessary pregnancy terminations. Documentation must include:

- A copy of the member's medical record;
- A completed and signed copy of ***Attachment C - Certificate of Necessity for Pregnancy Termination*** in the **AHCCCS Medical Policy Manual, Chapter 410 – Maternity Care Services**.
- Written explanation of the reason that the procedure is medically necessary. For example, it is:
    - Creating a serious physical or mental health problem for the pregnant member.
    - Seriously impairing the 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.

If the pregnancy termination is requested because of incest or rape, the following information must be included:

- Identification of the proper authority to which the incident was reported, including the name of the agency;
- The report number; and
- The date that the report was filed.

When termination of pregnancy is considered due to rape or incest, or because the health of the mother is in jeopardy secondary to medical complications, please contact Aetna Medicaid

Administrators LLC at 602-798-2745 or 888-836-8147. All terminations requested for minors must include a signature of a parent or legal guardian or a certified copy of a court order.

For members enrolled in the Department of Economic Security, Division of Developmental Disabilities (DES/DDD) health professionals must obtain prior authorization from MC by faxing your request to 602-431-7155. Final determination will be made by the DES/DDD medical director prior to providing sterilization procedures for members enrolled with DES/DDD, in addition to Aetna Medicaid Administrators LLC. Notification of approved requests will be faxed or mailed to the provider.

8.08 - Reporting High-Risk and Non-Compliant Behaviors

Obstetrical physicians and practitioners must refer all "at risk" members to MC's High-Risk Perinatal Care Management department by calling 602-263-3000 or 800-624-3879 and selecting the option for maternity care. Providers may also fax their information to 602-351-2313. The following types of situations must be reported to MC for members that:

- Are diabetic and display consistent complacency regarding dietary control and/or use of insulin.
- Fail to follow prescribed bed rest.
- Fail to take tocolytics as prescribed or do not follow home uterine monitoring schedules.
- Admit to or demonstrate continued alcohol and/or other substance abuse or opioid prescription history on CSPMP. Please refer to **Section 4.13 – Controlled Substances Prescription Monitoring Program (CSPMP)** for information on signing up for this regulatory required program.
- Show a lack of resources that could influence well-being (e.g., food, shelter, and clothing).
- Frequently visit the emergency department/urgent care setting with complaints of acute pain and request prescriptions for controlled analgesics and/or mood-altering drugs.
- Fail to appear for two or more prenatal visits without rescheduling and fail to keep rescheduled appointment. Providers are expected to make two attempts to bring the member in for care prior to contacting the MC Care Management Department.

8.09 - Outreach, Education and Community Resources

MC is committed to maternity care outreach. Maternity care outreach is an effort to identify currently enrolled pregnant women and to enter them into prenatal care as soon as possible. PCPs are expected to ask about pregnancy status when members call for appointments, report positive pregnancy tests to MC and to provide general education and information about

prenatal care, when appropriate, during member office visits. Pregnant members will continue to receive primary care services from their assigned PCP during their pregnancy.

MC is involved in many community efforts to increase the awareness of the need for prenatal care. PCPs are strongly encouraged to actively participate in these outreach and education activities, including:

- The **WIC Nutritional Program** - Please encourage members to enroll in this program.

Various other services are available in the community to help pregnant women and their families. Please call MC's Care Management department for information about how to help your patients use these services.

Questions regarding the availability of community resources may also be directed to the Arizona Department of Health Services (ADHS) Hot Line at 800-833-4642.

8.10 - Providing EPSDT Services to Pregnant Members under Age 21

Federal and state mandates govern the provision of EPSDT services for members under the age of 21 years. The EPSDT provider is responsible for providing EPSDT services to pregnant members under the age of 21 unless the member has selected an OB provider to serve as both the OB and PCP. In that instance, the OB provider must provide EPSDT services to the pregnant member.

Additional Claims Information

While these services are already performed in the initial prenatal visit, additional information is necessary for claims submission. The provider (PCP or OB) providing EPSDT services for members 12-20 years of age must submit the medical claims for these members. When submitting claims, please include one of the following codes that reflect the appropriate well visit:

Ages 12 through 17 years

- New patient - 99384
- Established patient - 99394

Ages 18 through 20 years

- New patient - 99385
- Established patient - 99395

8.11 - Loss of AHCCCS Coverage during Pregnancy

Members may lose AHCCCS eligibility during pregnancy. Although members are responsible for maintaining their own eligibility, providers are encouraged to notify MC if they are aware that a pregnant member is about to lose or has lost eligibility. MC can assist in coordinating or resolving eligibility and enrollment issues so that pregnancy care may continue without a lapse in coverage. Please call Member Services at 602-263-3000 or 800-624-3879 to report eligibility changes for pregnant members. Providers can also help by notifying members that in the event of loss of eligibility for services, they may contact ADHS for referrals to a low-cost or no-cost services. They can also go to the ADHS website to search for a **provider/clinic**.

8.12 - Pre-Selection of Newborn's PCP

Prior to the birth of the baby, the mother selects a PCP for the newborn. The newborn is assigned to the pre-selected PCP after delivery. If the mother does not choose a PCP for the newborn, then a PCP will be auto assigned. The mother may elect to change the assigned PCP at any time.

8.13 – Newborn Notification Process

Providers must fax a newborn notification to MC's dedicated Profax number – 844-525-2221. MC will report newborn information to AHCCCS and in turn will fax back the newborn AHCCCS ID number to the provider.

Authorization Information

Well Newborn:

- No authorization is required for vaginal delivery (2 days).
- No authorization is required for cesarean section delivery (4 days).

Sick Newborn:

- Authorization will be created and faxed back to provider with newborn AHCCCS ID and authorization number.

MC Chapter 9 – Emergency and Non-Emergency Transportation

9.00 – Mercy Care Covered Transportation Services

MC covers transportation within certain limitations for all members based on member age and eligibility, as specified in A.A.C. R9-22-211. Covered transportation services include:

- Emergency transportation.
- Medically necessary non-emergency transportation.
- Medically necessary maternal and newborn transportation through the Maternal Transport Program and the Newborn Intensive Care Program.
- Medically necessary transportation under the Emergency Triage, Treat, and Transport (ET3) program.

9.01 – Emergency Transportation

Emergency transportation is covered in emergent situations in which specially staffed and equipped ambulance transportation is required to safely manage the member's medical condition. Basic life support, advanced life support, and air ambulance services are covered, depending upon the member's medical needs. Prior authorization shall not be required for reimbursement of emergency transportation.

Notification to MC of emergency transportation provided to a member is not required, but the provider shall submit documentation with the claim that justifies the service.

- Emergency transportation may be initiated by an emergency response system call "9-1-1", fire, police, or other locally established system for medical emergency calls. Initiation of a designated emergency response system call by an AHCCCS member automatically dispatches emergency ambulance and Emergency Medical Technician (EMT) or paramedic team services from the Fire Department. At the time of the call, emergency teams are required to respond, however, upon arrival on the scene, the services required at that time (based on field evaluation by the emergency team) may be determined to be:
    - Emergent,
    - Non-emergent, but medically necessary, or
    - Not medically necessary.
- Emergency transportation coverage also includes the transportation of a member to a higher level of care for immediate medically necessary treatment, including when occurring after stabilization at an emergency facility.
- Emergency transportation is covered to the nearest appropriate facility capable of meeting the member's physical or behavioral health needs.

- MC may establish preferred hospital arrangements, which shall be communicated with emergency services providers. If the provider transports the member to MC's preferred hospital, the provider's claim shall be honored even though that hospital may not be the nearest appropriate facility. However, the provider shall not be penalized for taking the member to the nearest appropriate facility whether or not it is MC's preferred facility.
- The nearest appropriate facility for a member enrolled with MC is the nearest facility equipped to provide the necessary physical and/or behavioral health care services.
- Examples of conditions requiring emergency transportation to obtain immediate treatment include, but are not limited to the following:
    - Untreated fracture or suspected fracture of spine or long bones;
    - Severe head injury or coma;
    - Serious abdominal or chest injury;
    - Severe hemorrhage;
    - Serious complications of pregnancy;
    - Shock, heart attack or suspected heart attack, stroke, or unconsciousness,
    - Uncontrolled seizures; and
    - Condition warranting use of restraints to safely transport the member to services.

  For utilization review, the test for appropriateness of the request for emergency services is whether a prudent layperson, if in a similar situation, would have requested such services. Determination of whether a transport is an emergency is based on the member's medical condition at the time of transport.
- Air ambulance services are covered under the following conditions:
    - The air ambulance transport is initiated at the request of:
        - An emergency response unit,
        - A law enforcement official,
        - A clinic or hospital medical staff member, or
        - A physician or practitioner.
    - The point of pickup is:
        - Inaccessible by ground ambulance,
        - A great distance from the nearest hospital or other provider with appropriate facilities to treat the member's condition and ground ambulance will not suffice, or
        - The medical condition of the member requires immediate intervention from emergency ambulance personnel or providers with the appropriate facilities to treat the member's condition.

Air ambulance vehicles shall meet Arizona Department of Health Services (ADHS) licensing requirements and requirements set forth by the Federal Aviation Administration. Air ambulance companies shall be licensed by the ADHS and be registered as a provider with AHCCCS.

9.02 – Emergency Triage, Treat, and Transport Program

Services associated with the ET3 program are covered when an Emergency Transportation provider responds to a "9-1-1", fire, police, or other locally established system for emergency calls. AHCCCS registered Emergency Transportation Providers in possession of a Certificate of Necessity (CON) from ADHS, or tribal providers who have signed the AHCCCS attestation of CON equivalency, are allowed to transport a member to an Alternative Destination Partner or provide treatment to the member on scene, as specified in this policy.

Transportation to an Alternative Destination Partner

Upon the emergency response team's arrival on the scene and their field evaluation of the member, if the services required at that time are determined to be medically necessary, but not emergent, the Emergency Transportation provider may transport the member to an Alternative Destination Partner. These transports are allowed when:

- The transport to an Alternative Destination Partner will meet the member's level of care more appropriately than transport to an emergency department
    - The Alternative Destination Partner is within or near the responding emergency transportation provider's service area;
    - The Emergency Transportation provider has a pre-established arrangement with the Alternative Destination Partners located within their region; and
    - The Emergency Transportation provider has knowledge of the Alternative Destination Partner's:
        - Hours of operation;
        - Clinical staff available;
        - Services provided; and
        - Ability to arrange transportation for the member to return home when needed.

Treatment on Scene

Upon the emergency response team's arrival on the scene and their field evaluation of the member, if the services required at that time are determined to be medically necessary, but not

emergency, the Emergency Transportation provider may provide treatment to the member in accordance with the provider's scope of practice and their emergency transport service's medical direction. Treatment on scene may also be performed, when medically indicated, via a telehealth visit performed in accordance with AHCCCS AMPM Policy 320-I.

Definitions

The definitions related to covered transportation services are as follows:

- **Ambulatory Vehicle** – Ambulatory transportation means a vehicle other than a taxi but includes vans, cars, minibus, or mountain area transport. The MC member must be able to transfer with or without assistance into the vehicle and not require specialized transportation modes.
- **Taxi** – A vehicle that has been issued and displays a special taxi license plate pursuant to A.R.S. § 28-2515.
- **Wheelchair Van** – The vehicle must be specifically equipped for the transportation of an individual seated in a wheelchair. Doors of the vehicle must be wide enough to accommodate loading and unloading of a wheelchair. Wheelchair vans must include electronic lifts for loading and unloading wheelchair bound transports. The vehicle must contain restraints for securing wheelchairs during transit. Safety features of wheelchair vans must be maintained, as necessary. Any additional items being transported must also be secured for safety. The member must require transportation by wheelchair and must be physically unable to use other modes of ambulatory transportation.
- **Stretcher Van** – The vehicle must be specifically designed for transportation of a member on a medically approved stretcher device. The stretcher must be secured to avoid injury to the member or other passengers. Safety features of stretcher vans must be maintained, as necessary. Any additional items being transported must also be secured for safety. The MC member must need to be transported by stretcher and must be physically unable to sit or stand, and any other means of transportation is medically contraindicated.

9.03 – Emergency Transportation Provider Requirements for Emergency Transportation Services Provided to Members Residing on Tribal Lands

In addition to other requirements specified in this manual, emergency transportation providers rendering services on a Native American Reservation shall meet the following requirements:

- Tribal emergency transportation providers shall be certified by the Tribe and Center for Medicare and Medicaid Services (CMS) as a qualified provider and shall be registered as an AHCCCS provider.

- If a non-tribal emergency transportation provider renders services under a contract with a Tribe, either on reservation or to and from an off-reservation location, the provider shall be State licensed and certified and shall be registered as an AHCCCS provider.
- Non-tribal emergency transportation providers not under contract with a Tribe shall meet requirements specified in this manual for emergency transportation providers.

Emergency transportation services are covered to manage an emergency physical or behavioral health condition and to the nearest appropriate facility capable of meeting the member's health needs as outlined in this manual.

9.04 – Medically Necessary Non-Emergency Transportation for Physical and Behavioral Health Services

Medically necessary non-emergency transportation is covered consistent with A.A.C. R9-22-211 when furnished by non-emergency transportation providers to transport the member to and from a covered physical or behavioral health service. Medically Necessary Non-Emergency Transportation is also referred to as Non-Emergency Medical Transportation.
Such transportation services may also be provided by emergency transportation providers after an assessment by the emergency transportation team or paramedic team determines that the member's condition requires medically necessary transportation.

- Medically necessary non-emergency transportation services are covered under the following conditions:
    - The physical or behavioral health service for which the transportation is needed is a covered AHCCCS service. Refer to **AHCCCS AMPM Policy 310-BB**;
    - If the member is not able to provide, secure, or pay for their own transportation, and free transportation is not available;
    - The transportation is provided to and from the nearest appropriate AHCCCS registered provider.
- If a member is not able to provide, secure, or pay for their own transportation, and free transportation is not available, non-emergency transportation services are also covered to transport a member to obtain Medicare Part D covered prescriptions.
- Medically necessary non-emergency transportation services furnished by all providers who offer transportation:
    - For members residing in Maricopa and Pima Counties and enrolled with MC, NEMT services are only covered for trips within 15 miles of the pick-up location when traveling to a pharmacy within Pima and Maricopa Counties. Mileage is calculated from the pick-up location to the drop off location, one direction. Trips to compounding/specialty pharmacies over 15 miles require authorization

from MC to be considered a covered service. NEMT trips for members traveling to an MSIC or IHS/638 facility are exempt from this limitation.

- Medically necessary non-emergency transportation is furnished by non-ambulance providers. Non-ambulance transportation providers shall comply with all of the following:
    - The member shall not require medical care in route;
    - Passenger occupancy shall not exceed the manufacturer's specific seating capacity;
    - Members, companions, and other passengers shall follow state laws regarding passenger restraints for adults and children;
    - Vehicle shall be driven by a licensed driver following applicable State laws;
    - Vehicles shall be insured. Refer to the AHCCCS Minimum Subcontract Provisions Insurance Requirements on the AHCCCS website;
    - Vehicles shall be in good working order;
    - All passengers shall be transported inside the vehicle; and
    - School-based providers shall follow the school-based policies in effect (Refer to AMPM Chapter 700)
- AHCCCS covers the cost of medically necessary non-emergency transportation furnished by a non-ambulance air or equine NEMT provider only when of the following conditions are met:
    - The service is exclusively used to transport the member to ground accessible transportation;
    - The AHCCCS member's point of pick up or return is inaccessible by ground transportation; and
    - The ground transportation is not accessible because of the nature and extent of the surrounding Grand Canyon terrain.
- Medically necessary non-emergency transportation furnished by ambulance providers. Medically necessary non-emergency transportation furnished by ambulance providers is appropriate if:
    - Documentation that other methods of transportation are contraindicated;
    - The member's medical condition, regardless of bed confinement, requires the medical treatment provided by the qualified staff in an ambulance;
    - For hospital patients only:
        - Round-trip air or ground transportation services may be covered if an inpatient hospitalized member travels to another facility to obtain necessary specialized diagnostic and/or therapeutic services (such as a CT scan or cobalt therapy). Such transportation may be covered if services are not available in the hospital in which the member is

inpatient.

- Transportation services to the nearest medical facility that can render appropriate services are also covered, when the transport was initiated through an emergency response system call and, upon examination by emergency medical personnel, the member's condition is determined to be non-emergent but one which requires medically necessary transportation.

AHCCCS and MC may elect to waive prior authorization requirements for medically necessary non-emergency ambulance transportation as well as any notification requirements. However, such claims are subject to review for medical necessity. Medical necessity criteria are based upon the medical condition of the member at the time of the transport.

9.05 – Documentation Requirements

MC will conduct retrospective audits of non-emergency ground transportation providers to verify that the mileage, wait time, diagnosis, and medical necessity are correct and that all charges are supported and justifiable. The transportation provider will submit a trip report and justification of the transport upon request by MC any time after the date of service. Each service must be supported with the following documentation:

- Complete transport service provider's name and address
- Printed name and signature of the driver who provided the service
- Vehicle identification (license # and state)
- Vehicle type (car, van, wheelchair van, stretcher, etc.)
- Recipient's full name
- Recipient's AHCCCS ID#
- Recipient's date of birth
- Complete date of service, including month, day, and year
- Complete address of pick-up destination
- Time of pick up
- Odometer reading at pick up
- Complete address of drop off destination
- Time of drop off
- Odometer reading at drop off
- Type of trip – one way or round trip
- Escort name and relationship to recipient being transported
- Signature (or fingerprint) of recipient* verifying services were rendered

- Signature Clarification- If the member is unable to sign or utilize a fingerprint, the parent/guardian, caretaker/escort, or family member can sign for the member. The relationship to the member must be noted. If the member that is unable to sign is traveling alone, the trip report may be signed by the provider at the medical or behavioral health service appointment. The driver can never sign for the member.

All NEMT services for provider types NT and 28 will require submission of a trip ticket or EDI information noting the completed pick-up and drop-of locations for review prior to payment. All NEMT services without the required documentation will result in a claim denial.

9.06 – Transportation Network Company

A Transportation Network Company (TNC) providing medically necessary nonemergency transportation services to members shall comply with the following:

- Only provide services to members, and bill, through an NEMT Broker pursuant to the Broker's contract with a Contractor.
- Only receive scheduled member rides from an NEMT Broker. The TNC is not allowed to take member calls or schedule member rides directly.
- Utilize a digital network or software application capable of:
  - Providing the TNC, from the NEMT Broker, only the following information:
    - The first and last name of the member;
    - The member's phone number;
    - The address where the member will be picked up;
    - The address where the member will be dropped off; and
    - The date and time of the service.
  - Limiting the information provided by the TNC to the driver to the following information:
    - The first name of the member;
    - The member's phone number;
      a. The digital network software application must provide the driver a "masked" phone number for the driver to contact the member,
      b. The number provided to the driver will not be the member's actual phone number but using the masked number the digital network or software application will connect the driver to the member.
    - The address where the member will be picked up;
    - The address where the member will be dropped off; and

        - The date and time of the service.
    - Maintaining a record of the actual service provided by the driver including:
        - The address where the member was picked up;
        - The address where the member was dropped off; and
        - The date and time the service was rendered.
- Maintain all records regarding driver information {including criminal background and federal health care program exclusion checks), vehicle inspections and reports, services, trips, and enforcement actions for a minimum of six complete calendar years.

9.07 – Public Transportation

If public transportation is available in the service area, MC shall ensure public transportation is offered as an option to a member when NEMT services are requested. Providing the member with an option of public transportation shall not prohibit the member's access to other transportation services, as specified in this Policy.

FFS providers may offer Public Transportation options to FFS members traveling to and from AHCCCS approved services. For billing information, please reference **MC Claims Processing Manual, Chapter 2 – Professional Claim Types by Specialty, Section 2.10 – Transportation Claims** available on the MC website.

The following shall be considered when offering public transportation to a member:

- Location of the member to a transportation stop.
- Location of the provider of services to a transportation stop.
- The public transportation schedule in coordination with the member's appointment.
- The ability of the member to travel alone on public transportation.
- Member preference.

9.08 – Maternal and Newborn Transportation

The Maternal Transport Program (MTP) and the Newborn Intensive Care Program (NICP) administered by ADHS provides special training and education to designated staff responsible for the care of maternity and newborn emergencies during transport to a perinatal center. The high-risk transport team is dispatched after consultation with the MTP or NICP perinatologist or neonatologist. Only contracted MTP or NICP providers may provider air transport.

9.09 – Other General Information

For additional information regarding emergency and non-emergency transportation, please refer to:

- AMPM Chapter 1200 for additional information regarding Arizona Long Term Care System (ALTCS) authorization requirements.
- AMPM Chapter 800 for complete information regarding prior authorization for non-ALTCS FFS members.
- Fee-For-Service Provider Manual or the AHCCCS IHS/Tribal Provider Billing manual for billing information. These manuals are available on the AHCCCS Website at **www.azahcccs.gov**.
- ACOM Policy 205 for information regarding reimbursement of non-contracted ground Ambulance providers.
- **MC Claims Processing Manual, Chapter 2 – Professional Claim Types by Specialty, Section 2.10 – Transportation Claims**.

9.10 – Data and Reporting

The Provider must submit all reports outlined in the MC Provider Manual and requested by MC staff.

MC reserves the right to include additional provider reporting requirements at any time it is deemed necessary.

9.11 – Professional Standards and Responsibilities

Professional Standards and Responsibilities include:

- The Provider will ensure all employees and drivers shall have a valid State driver's license free of moving violations and will verify the driver's records through AZ-DMV.
- The Provider shall meet all requirements for provider eligibility including:
    - Licensed by the appropriate State authority.
    - Registered with the Arizona Health Care Cost Containment System (AHCCCS).
    - Credentialed with MC. MC is not responsible for payment to non-registered providers. The Provider shall ensure that independent drivers meet these same requirements.
- The Provider must deliver services when and where the individual needs them within the context of safety for the individual and staff providing the service.
- The Provider must maintain complete, accurate, and timely documentation of all delivered services.
- The Provider shall have enough qualified staff to deliver, manage and coordinate service delivery.
- The provider will provide additional support for individuals under 12 as clinically appropriate.

- The provider will attempt to utilize all appropriate ways to locate or contact the member prior to determining that the member is a "no-show."
- The Provider will train all staff and subcontractors in accordance with the MC Provider Manual.
- Each driver should be trained on CPR and first aid every two years and HIPAA training annually.
- The Provider and its workforce will adhere to all cultural competency requirements as outlined in the MC Provider Manual, Cultural Competency Plan, AHCCCS ACOM 405 Policy, including cultural competency/sensitivity training, to all drivers and employees. All services provided must consider the member's and their family's language and cultural preferences.
- The Provider agrees to meet with MC on a quarterly basis or as needed to review and resolve grievance trends or service issues.
- The Provider must ensure that all subcontractors adhere to the requirements outlined in their scope of work.

9.12 – Vehicle Requirements

Vehicle Requirements include the following:

- Passenger occupancy must not exceed the manufacturer's specified seating occupancy.
- Members, escorts, and other passengers must follow State laws regarding restraints for adults and children.
- Members must be transported inside the vehicle.
- Vehicles must be insured and be driven by a licensed driver, following applicable State laws.
- Vehicles must be clean and maintained and be in good working order.
- All vehicles must have a sign or logo with the company name displayed when transporting a member

9.13 – Performance Improvement

The Provider must maintain a Quality Assessment and Performance Improvement program designed to evaluate the quality and accessibility of the services they deliver, and customer satisfaction with those services. This information must be collected on a routine and frequent basis, formally communicated to all levels of staff within the organization and used to improve service delivery to all individuals accessing the services outlined in this contract. The Provider's performance improvement program must be described in detail in an Annual Quality Management Plan and Work plan. Each year, the Provider must evaluate its Quality Assessment and Performance Improvement program, incorporating successful programs and interventions

into subsequent Plans, and discontinuing programs and interventions that did not meet established goals or yield performance improvements.

The Provider shall develop and maintain a process to collect and analyze member satisfaction information for all programs and report the results to MC.

9.14 – Performance Outcome Measures

The Provider must meet or exceed standards for the performance measures described below.

Performance Measure	Standard
Transport Timeliness	
Average drop off time prior to member appointment.	< 60 minutes
Average wait time for transportation after appointment completion	< 60 minutes
Member Satisfaction	
Member satisfaction with services	85%
Telephone Performance Standards	
Average Service Level	≥ 75%
Average Speed of Answer	≤ 30 seconds
Average Abandonment Rate	≤ 5%
Complaint Rate	
Average Monthly Complaint Rate Per 1000 Trips	< 3.5

MC Chapter 10 – Care Management and Disease Management

10.00 - Care Management and Disease Management Overview

MC has a comprehensive care management program. The Medical Care Management team considers the medical, social, and cultural needs of members by targeting, assessing, monitoring, and implementing services for members identified as "at risk." Care Management services are available for all eligible members, including MC members who are identified as "at risk," such as transplant and hemophilia, or those who are high-service utilizers, and are assigned a care manager.

A wide spectrum of services is available for members, providers and families who need assistance in finding and using appropriate health care and community resources. The MC Care Management staff:

- Considers a member's HRSN when assessing, monitoring, and implementing services for members. For more information regarding HRSN, please review the **MC Claims Processing Manual**, **Chapter 2 – Professional Claim Types by Specialty, Section 2.17 – Social Determinants of Health** available on the MC website.
- Assists members and families with navigating through the complex medical and behavioral health systems.

Please refer to our **Clinical Guidelines** on the MC website for treatment protocols under evidence-based guidelines related to:

- Asthma
- Alcohol Abuse
- ADHD
- CAD
- Chronic Obstructive Lung Disease (COPD)
- Congestive Heart Failure (CHF)
- Diabetes
- HIV/AIDS
- Hypertension
- Major Depressive Disorder
- Opioids for Chronic Pain
- Immunizations
- Preventive Screenings
- Prenatal Services

In addition, the following information is available:

- **Arizona Opioid Prescribing Guidelines**
- Clinical Guidelines for the Treatment of Children
- Treating behavioral health disorders in children
- Treating behavioral health disorders in adults

10.01 - Referrals

To make a referral**,** leave a message for the central intake coordinator at 602-453-8391. You may also email your referral to **AcuteCMReferral@mercycareaz.org**. The referral is reviewed and assigned to the appropriate ICM team within 3-5 business days. Once assigned, care managers will contact the member either by telephone or by letter. The Care Management staff communicates with members, family/caregiver, PCP, and any other providers on an ongoing basis while the member's care is open.

10.02 - Care Management

Care management is an activity that helps to ensure a member's bio-psychosocial needs are appropriately coordinated through early identification of health risk factors and special healthcare needs.

Care Managers are licensed clinical health professionals or care management coordinators trained in motivational interviewing. They are experienced with using a comprehensive, biopsychosocial approach when working with our members to create care plans that help members meet their identified goals.

A Care Manager is usually assigned for a short period to help members learn how to manage their illnesses and meet their healthcare needs. Since all members do not need Care Management, MC has developed criteria to determine who may benefit the most. If you feel a member may be appropriate for Care Management, the following criteria may help guide you. Please refer a member if he or she:

- Frequently uses the ER instead of seeing their providers for ongoing issues.
- Recently had multiple hospitalizations (physical health and/or behavioral health).
- Is having difficulty obtaining medical benefits or referrals ordered by providers.
- Is diagnosed with CHF, diabetes, asthma, COPD, or depression and requires assistance with management of their condition.
- Is in the process of receiving a transplant, up to 1-year post-transplant.
- Has been diagnosed with autism spectrum disorder or a developmental disability.
- Is diagnosed with HIV.

- Is pregnant with high-risk conditions, including the following:
    - Teen pregnancy
    - Over 35 years of age
    - Exposure to opioids or other substances during pregnancy
    - History of pre-term delivery
    - Hypertension
    - Diabetes
    - Asthma
    - Pregnant with more than one fetus
    - Cardiac disease
    - Hepatitis C
    - Incompetent Cervix
    - Enrolled in DDD LTC program
    - Is a child with any of the following:
        - Newborn with Neonatal Abstinence Syndrome or maternal drug exposure
        - CALOCUS score of 4 or above
        - Serious Emotional Disturbance
        - Possible CRS condition
        - Transitioning from foster care to MC
        - Enrolled with AzEIP (Arizona Early Intervention Program)
- Has recently been incarcerated
- May need exclusive provider restriction for overutilization of drugs with abuse potential
- Needs/or is currently receiving Medication Assisted Treatment for opioid use
- Has recently experienced a care transition, such as inpatient or skilled facility admission
- Needs help applying for the Arizona Long Term Care Program
- Poor adherence to the treatment plan, medical regimen, and/or appointments

If in doubt, just refer!

A Care Manager will contact the member to schedule a time to complete an assessment. They will ask the member questions about his or her health and the resources currently being used. Answers to these questions provide the Care Manager with a better understanding of what assistance is needed most. Next, the member and the Care Manager will work together to develop a care plan. The Care Manager will also educate the member on how to obtain the care he or she needs. The Care Manager may also talk with the member's health care providers to coordinate care needs. Condition management interventions may also be part of the plan of care. Once care plan goals are met, MC releases the member from the Care Management

program. High Risk Care Management is not required for members who are not on ALTCS, so a member has the right to decline assistance from our care management staff.

10.03 - Condition Management

Disease Management or Condition Management is incorporated into the plan of care developed by the member, the care manager, and other members of the care team, as indicated.

Members with specific conditions also receive mailings with information which helps them effectively manage their care related to that condition.

MC Chapter 11 – Concurrent Review

11.00 - Concurrent Review Overview

MC conducts concurrent utilization review on each member admitted to an inpatient facility, including skilled nursing facilities and freestanding 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 Milliman Care Guidelines® and the AHCCCS NICU/Nursery/Step-Down Utilization Guidelines. Admission certification is conducted within one business day of receiving notification. It is the responsibility of the facility to notify MC of all member admissions and emergency department visits to ensure that a service medical necessity review is conducted so that claims are not delayed. Services rendered without notification will result in the claim being held for retrospective review. Failure to notify MC of an admission or emergency department visit within ten (10) days of the encounter may result in denial of the claim.

Continued stay reviews are conducted by MC concurrent review staff before the expiration of the assigned length of stay for Behavioral Health and Skilled Nursing stays. Since Medical stays are calculated by APR-DRG, this does not apply to those stays. Providers will be notified of approval or denial of length of stay. The concurrent review staff works with the medical directors in reviewing medical record documentation for hospitalized members. MC medical directors may make rounds on site, as necessary. MC concurrent review staff will notify the facility care management department and business office at the end of the member's hospitalization stay, by fax, of the days approved and at what level of care.

11.01 - MILLIMAN Care Guidelines®

MC uses the Milliman Care Guidelines® to ensure consistency in hospital–based utilization practices. The guidelines span the continuum of patient care and describe best practices for treating common conditions. The Milliman Care Guidelines® are updated regularly as each new version is published. A copy of individual guidelines pertaining to a specific care is available for review upon request.

11.02 - Discharge Planning Coordination

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

The MC Concurrent Review Staff (CRS) works 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 is not 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 physician with names of contracted MC providers (i.e., home health agencies, DME/medical supply companies, other outpatient providers). The CRS plays a key role in assisting with discharge planning and may authorize services required for a safe discharge such as pharmacy, home health, and DME. MC CRS staff works to make sure there is a safe discharge even when the primary payer is not MC, so it is important that the facilities notify MC of all members.
- Informing hospital staff and attending physician of covered benefits as indicated.

11.03 - Physician Medical Review

MC conducts medical review when an admission or service request does not meet level of care or medical necessity criteria. Clinical reviewers apply established criteria and refer unmet cases to an appropriately qualified reviewer, such as a medical director, dental director, pharmacist for pharmacy requests, physician reviewer, or BCBA-D for ABA services.

The reviewer may request more information or consult with the provider before deciding to approve, deny, modify, reduce, suspend, or terminate an existing or pending service. Decisions are based only on appropriateness of care and service, and MC does not reward staff or reviewers for denials.

A peer-to-peer discussion is a consultation with an appropriately qualified MC reviewer. It may occur before a decision to clarify needed information or after a Notice of Adverse Benefit Determination (NABD) to explain the denial rationale, medical necessity criteria, and relevant guidelines. Peer-to-peer discussions are information only and are not appeals, reconsiderations or additional levels of review.

When an NABD is issued, MC notified the requesting practitioner that a qualified reviewer is available to discuss the denial, documents the denial notice date and time, and coordinates one discussion with the provider. The discussion is conducted by the original reviewer when available or by another available medical director or appropriately qualified reviewer.

A post-NABD discussion shall not reverse, modify, or overturn the denial. Any challenge or request for reconsideration after an NABD must follow the applicable member appeal process.

For inpatient denials, MC verbally notifies hospital staff of denied continued stay and sends written notice with the effective date of payment termination or level-of-care reduction. Providers may dispute the finding by phone or in writing; formal disputes follow the MC claim dispute process.

Delegated entities, including Liberty Dental and eviCore, manage their applicable peer-to-peer processes. MC remains responsible for appeals. Peer-to-peer is not offered for post-service denials; providers must use the applicable appeals process.

11.04 Medical Necessity Criteria for MC DD

To support prior and continued authorization decisions, MC DD uses nationally recognized evidence-based criteria, which are applied based on the needs of individual members and characteristics of the local delivery system. Criteria is reviewed annually and approved by the Medical Management/Utilization Management Committee. If MCG Guidelines indicate "current role remains uncertain" for the requested service, the next criteria in the hierarchy or other nationally accepted guidelines, should be consulted and applied. For prior or continued authorization of outpatient or inpatient behavioral and physical health services, MC DDD applies:

- Criteria require by AHCCCS and by the applicable state or federal regulatory agency.
- Applicable AHCCCS Medical Policy Manual (AMPM) or MCG Guidelines as the primary decision support for most medical diagnoses and conditions.
- American Society of Addiction Medicine (ASAM)
- Other nationally accepted guidelines

In addition, if a denial is issued for admission to a Behavioral Health Inpatient Facility, MC DDD will provide a clearly outlined alternative plan at the time of the denial. This may require development of a Child and Family Team (CFT), if one has not already been established, or consultation with the CFT. It is expected that the alternative treatment plan will adequately address the behavioral health treatment needs of the child and will provide specific information detailing what services will be provided, where these services will be provided, when these services will be available, and what specific behaviors will be addressed by these services. It is also expected that the alternative treatment plan will include what crisis situations can be anticipated and how the crisis will be addressed. Please refer to:

- Admission to Behavioral Health Hospital Facility or Behavioral Health Inpatient Facility Authorization Criteria; and
- Continued Behavioral Health Hospital Facility or Behavioral Health Inpatient Facility Authorization Criteria.

To obtain additional information on how to access or obtain practice guidelines and coverage criteria for authorization decisions, please contact MC DDD Member Services at 800-564-5465.

Alternative Placement not Available upon Discharge

If a member receiving inpatient services no longer requires services on an inpatient basis under the direction of a physician, but services suitable to meet the member's behavioral health needs are not available or the member cannot return to the member's residence because of a risk of harm to self or others, services may continue to be authorized as long as there is an ongoing, active attempt to secure a suitable discharge placement or residence in collaboration with the community or other state agencies as applicable. All such instances shall be logged and provided to MC DDD upon request.

MC Chapter 12 – Quality Management

12.00 - Quality Management Overview

The MC CMO provides leadership and direct oversight for the Quality Management (QM) program. MC works in partnership with providers to continuously improve the care given to our members. The MC QM Department is comprised of the following areas:

- The Quality of Care (QOC) unit monitors the quality of care provided by the network providers, as well as the review and resolution of issues related to the quality of health care services provided to members.
- The Prevention and Wellness unit is responsible for quality improvement activities and clinical studies using data collected from providers and encounters. Findings are reported to AHCCCS and to providers about their performance on specific quality indicators.
- The Credentialing unit is responsible for provider credentialing/re-credentialing activities.
- The Performance Improvement unit monitors and improves HEDIS and other clinical performance measure rates, maternity, family planning, and EPSDT quality indicators.
- Provider Monitoring is responsible for monitoring provider services and service sites per AHCCCS AMPM 910-Attachment A requirements.

For more information about the MC QM program, or to obtain a written summary of the program, please contact your Network Management Representative or call the Network Management Department at 800-624-3879.

12.01 – Quality of Care Concerns/Incident, Accident, Death Reporting Processes

MC QM adheres to all Quality of Care (QOC) policies published in the AHCCCS AMPM, including but not limited to, Chapter 900 (**960** & **961**). Members with DDD enrollment are additionally subject to the policies as published in **AdSS 960** & **AdSS 961**. MC QM additionally employs the **AHCCCS Contract and Policy Dictionary** for the definition of policy specific terms.

Providers are required to register for the AHCCCS Quality Management System (QMS) Portal to submit IAD reports to MC QM.

IADs cannot be emailed and providers must use the **AHCCCS QM Portal** to report IAD issues for members enrolled in all MC lines of business.

Applicable to all AHCCCS Plans: Per AHCCCS Policy 961, IADs shall be submitted into the QM Portal within two business days of the occurrence or notification to the provider of the occurrence. Sentinel IADs (listed below) shall be submitted by the provider into the AHCCCS QM Portal within one business day of the occurrence or becoming aware of the occurrence.

1. **An IAD is reportable if it includes any of the following:**
    a. Allegations of abuse, neglect, or exploitation of a member,
    b. Death of a member,
    c. Delays or difficulties in accessing care (e.g., outside of the timeline specified in ACOM Policy 417),
    d. Healthcare acquired conditions and other provider preventable conditions (refer to AMPM Policy 960 and AMPM Policy 1020),
    e. Serious injury,
    f. Injury resulting from the use of a personal, physical, chemical, or mechanical restraint or seclusion (refer to AMPM Policy 962),
    g. Medication error occurring at a licensed residential Provider site including:
        i. Behavioral Health Residential Facility (BHRF),
        ii. DDD Group Home,
        iii. DDD Adult Developmental Home,
        iv. DDD Child Developmental,
        v. Assisted Living Facility (ALF),
        vi. Skilled Nursing Facility (SNF),
        vii. Adult Behavioral Health Therapeutic Home (ABHTH), or
        viii. Therapeutic Foster Care Home (TFC), and any other alternative Home and Community Based Service (HCBS) setting as specified in AMPM Policy 1230-A,
    h. Missing person from a licensed Behavioral Health Inpatient Facility (BHIF), BHRF, DDD Group Home, ALF, SNF, ABHTH, or TFC,
    i. Member suicide attempt,
    j. Suspected or alleged criminal activity, and
    k. Any other incident that causes harm or has the potential to cause harm to a member.
2. **Sentinel IADs include:**
    a. Member death or serious injury associated with missing person,
    b. Member suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting,
    c. Member death or serious injury associated with a medication error,

d. Member death or serious injury associated with a fall while being cared for in a healthcare setting,
e. Any stage 3, stage 4, and any unstageable pressure ulcers acquired after admission or presentation to a healthcare setting,
f. Member death or serious injury associated with the use of seclusion and/or restraints while being cared for in a healthcare setting,
g. Sexual abuse/assault on a member during the provision of services.
h. Death or serious injury of a member resulting from a physical assault that occurs during the provision of services, and
i. Homicide committed by or allegedly committed by a member.

If an IAD is returned to a provider for additional information or corrections, the provider must provide the additional information and/or make the request corrections and re-submit the IAD to MC within 24 hours.

The provider is required to ensure that all suspected cases of abuse, neglect, and exploitation of a member are reported to all appropriate authorities, including but not limited to: Adult Protective Services (APS), Department of Child Safety (DCS), local police, and the Arizona Department of Health Services (ADHS). MC will submit the report to the regulatory agency as soon as possible but no later than 24 hours of becoming aware of a concern. The report shall be submitted verbally and/or electronically (e.g., email or online), as appropriate. Required documentation is recorded in the QM Portal including, at a minimum:

- Name and title of the person submitting the report,
- Name of the regulatory agency (e.g., APS, DCS, etc.) the report was submitted to,
- Name and title of the person at the regulatory agency receiving the report,
- Date and time reported,
- Summary of the report, and
- Tracking number, as applicable, received from the regulatory agency (e.g., APS, DCS) as part of the reporting process.

Documentation Related to Quality of Care Concerns

Quality of Care (QOC) concerns may be referred by state agencies, internal AHCCCS sources or internal MC ACC-RBHA departments (e.g., Grievance and Appeals, Utilization Management, Children's System of Care, Adult System of Care, Medical Management, etc.), and external sources (e.g., behavioral health members; providers; other stakeholders;

Incident, Accident, and Death reports). A QOC can be referred for any participating or non-participating provider and out of state placements. Upon receipt of a QOC concern, AHCCCS follows the procedures below. As participants in the QOC process, MC ACC-RBHA follows these same procedures:

- Document each issue raised, when and from whom it was received and the projected timeframe for resolution.
- Determine promptly whether the issue is to be resolved through one or more of the following MC areas:
    - Quality of Care,
    - Customer Service/Complaint Resolution,
    - Grievance and appeals process, and/or
    - Fraud, waste, and program abuse.
- Acknowledge receipt of the issue and explain, as requested, to the member or provider the process that will be followed to resolve his or her issue through written correspondence. If the issue is being addressed as other than a QOC investigation, explain to the member or provider the process that will be followed to resolve their issue using written correspondence. QOC related concerns will remain in the quality management department due to peer protection state and federal regulations: 42 U.S.C. 1320c-9, 42 U.S.C. 11101 et seq., A.R.S. §36-2401, A.R.S. §36-2402, A.R.S. §36-2403, A.R.S. §36-2404, A.R.S. §36-2917.
- Assist the member or provider as needed to complete forms or take other necessary actions to obtain resolution of the issue.
- Ensure confidentiality of all member information.
- Inform the member or provider of all applicable mechanisms for resolving the issue as requested.
- Document all processes (include detailed steps used during the investigation and resolution stages) implemented to ensure complete resolution of each issue, including but not limited to:
    - Corrective action plan(s) or action(s) taken to resolve the concern,
    - Documentation that education/training was completed. This may include, but is not limited to, in-service attendance sheets and training objectives,
    - New policies and/or procedures, and
    - Follow-up with the member that includes, but is not limited to:
        - Assistance as needed to ensure that the immediate health care needs are met; and

- Closure/resolution letter that provides sufficient detail to ensure all covered, medically necessary care needs are met and a contact name/telephone number to call for assistance or to express any unresolved concerns.

Process of Evaluation and Resolution of Quality of Care Concerns

The quality of care concern process at MC includes documentation of identification, research, evaluation, intervention, resolution, and trending of member and provider issues. Resolution must include both member and system interventions when appropriate. The quality of care process is a stand-alone process and not combined with other agency meetings or processes. This process is outlined as– Quality of Care and Peer Review.

- MC completes the following actions in the QOC process:
  - Identification of the quality of care issues,
  - Initial assessment of the severity of the quality of care issue,
  - Prioritization of action(s) needed to resolve immediate care needs when appropriate,
  - Review of trend reports to determine possible trends related to the provider(s) involved in the allegation(s) including type(s) of allegation(s), severity, and substantiation, etc.,
  - Research, including, but not limited to a review of the log of events, documentation of conversations, and medical records review, mortality review, etc., and
  - Quantitative and qualitative analysis of the research, which may include root cause analysis.
- All QOC investigations are documented in the AHCCCS QM Portal, ensuring that the case is updated within the QM Portal to reflect changes during the investigation as additional details and allegations are discovered and added to the QOC. MC ensures that a final severity level is assigned to the case at the conclusion of the investigation.
- For substantiated QOC allegations it is expected that some form of action is taken, for example:
  - Developing an action plan to reduce/eliminate the likelihood of the issue reoccurring,
  - Determining, implementing, and documenting appropriate interventions,
  - Monitoring and documenting the success of the interventions,
  - Incorporating interventions into the organization's Quality

Management (QM) program if appropriate, or
- Implementing new interventions/approaches, when necessary.

Each issue/allegation must be resolved; member and system resolutions may occur independently from one another. The following process and determination are used for each allegation in a QOC concern

Tracking/Trending of Quality of Care Issues

MC uses data pulled from QOC database and AHCCCS CQM Portal to monitor the effectiveness of QOC related activities to include complaints and allegations received from members and providers, as well as from outside referral sources. MC ACC-RBHA also tracks and trends QOC data and reports trends and potential systemic problems to AHCCCS.

The data from the QOC database is analyzed and evaluated to determine any trends related to the quality of care or service in MC's service delivery system or provider network and aggregated for the state. When problematic trends are identified through this process, MC QM will incorporate the findings in determining systemic interventions for quality improvement. MC QM incorporates trended data into systemic interventions.

- As evaluated trended data is available, MC will prepare and present analysis of the QOC tracking and trending information for review and consideration of action by the Quality Management Committee and Chief Medical Officer, as Chair- member of the Quality Management Committee.
- Quality tracking and trending information from all closed quality of care issues within the reporting quarter will be presented quarterly to the Quality Improvement Meeting (QIM) committee and Community Based Integrated Health and Clinical Services Committee (CBIHCS).

If a significant trend is found, MC may choose to consider it for a performance improvement activity to improve the issue resolution process itself, and/or to make improvements that address other system issues raised during the resolution process.

A significant trend is defined as: An accumulation of allegations in any one subcategory that may not warrant review by the CBIHCS/Peer Review Committee if considered individually, but may, because of their frequency or the repetition of similar issues, be treated like those of a higher severity level if considered together (e.g., recurring rudeness or discriminatory behavior). Trends are monitored and identified by QOC investigative nurses ongoing as part of the QOC investigative process and monitored on an ongoing basis by the QM-QOC

Manager who will review and present significant trends to the CMO/ACMO. If these instances occur, they may be considered significant and are considered for Peer Review

MC will submit, if not completed and by the provider, to AHCCCS CQM all pertinent information regarding an incident of abuse, neglect, exploitation, and unexpected death as soon as aware of the incident. Pertinent information must not be limited to autopsy results only but must include a broad review of all issues and possible areas of concern. Delays in the receipt of autopsy results shall not result in a delay in the investigation of a quality of care concern by MC. Delayed autopsy results will be used to confirm the resolution of the QOC concern.MC will also include an addendum in the QM Portal if the cause and manner of death changes the findings of a QOC investigation.

MC ensures that member health records are available and accessible to authorized staff of their organization and to appropriate State and Federal authorities, or their delegates, involved in assessing quality of care or investigating member or provider quality of care concerns, complaints, allegations of abuse, neglect, exploitation grievances and Health Care Acquired Conditions (HCAC). Member record availability and accessibility must follow Federal and State confidentiality laws, including, but not limited to, Health Insurance Portability and Accountability Act (HIPAA) and **42 C.F.R. 431.300 et seq**.

Provider-Preventable Conditions

If a Health Care Acquired Condition (HCAC) or Other Provider Preventable Condition (OPPC) is identified, MC will conduct a quality of care investigation and report the occurrence and results of the investigation to the AHCCCS Clinical Quality Management Unit through QM Portal documentation.

12.02 – Quality of Care (QOC), Peer Review and Fair Hearing Process

The QM Department reviews potential QOC issues referred by all internal and external sources, including IAD's submitted through the AHCCCS QMS Portal. For issues that are submitted to QM but are determined to not be a QOC concern, MC QM will inform the submitter of the process to be used to resolve the issue as needed/requested.

The QOC process is a stand-alone process that is completed through the QM Department. The QOC process includes identification, research, evaluation, intervention, resolution, and trending of member and provider issues. The quality of care process is a stand-alone process not combined with other agency meetings or processes.

- MC completes the following actions in the QOC process:

    - Identification of the quality of care issues,
    - Initial assessment of the severity of the quality of care issue,
- Prioritization of action(s) needed to resolve immediate care needs when appropriate,
- Review of trend reports to determine possible trends related to the provider(s) involved in the allegation(s) including type(s) of allegation(s), severity, and substantiation, etc.,
    - Research, including, but not limited to a review of the log of events, documentation of conversations, and medical records review, mortality review, etc., and
    - Quantitative and qualitative analysis of the research, which may include root cause analysis.
    - All QOC investigations are documented in the AHCCCS QM Portal, ensuring that the case is updated within the QM Portal to reflect changes during the investigation as additional details and allegations are discovered and added to the QOC. MC ensures that a final severity level is assigned to the case at the conclusion of the investigation.
    - All IAD/IRF's are redacted (PHI/PII), via the QM Portal, within 3-days of completion for submission to the Independent Oversite Committee (IOC) as specified in contract and AMPM Policy 960.

Providers must comply with all QOC review activities including:

- Providing requested medical records in a timely manner
- Responding to questions and/or
- Developing corrective action plans

Each QOC concern is fully investigated and assigned a severity level based on potential adverse effect(s) for the member. QOC severity level is defined by AHCCCS as follows:

- **Level 0** – (Track and Trend Only) No quality issue finding.
- **Level 1** – Quality issue exists with minimal potential for significant adverse effects to the patient/recipient.
- **Level 2** – Quality issue exists with significant potential for adverse effect to the patient/recipient.
- **Level 3** – Quality issue exists with significant adverse effects on the patient/recipient, is dangerous and/or life-threatening.
- **Level 4** – Quality issue exists with the most severe adverse effects on the patient/recipient; no longer impacts the patient/recipient with the potential to cause harm to others.

MC has established and maintains a Peer Review Committee. The Peer Review Committee serves as the primary entity responsible for ensuring MC and subcontracted providers adhere to a clinically appropriate peer review process. Cases are referred to the MC Peer Review Committee when appropriate. The scope of peer review includes cases where there is evidence of deficient quality, or the omission of the care or service provided by a participating, or non-participating, physical, or behavioral health care professional or provider whether delivered in or out of state. The peer review process ensures that providers of the same or similar specialty participate in the review and recommendation of individual peer review cases.

Matters appropriate for peer review may include, but are not limited to:

- Questionable clinical decisions,
- Lack of care and/or substandard care,
- Inappropriate interpersonal interactions or unethical behavior,
- Physical or sexual abuse by provider staff,
- Allegations of criminal or felonious actions related to practice,
- Issues that immediately impact the member and that are life threatening or dangerous,
- Unanticipated death of a member,
- Issues that have the potential for adverse outcome, or
- Allegations from any source that bring into question the standard of practice.

Peer Review Committee membership will include:

- The Chief Medical Officer (Chair),
- The Associate Chief Medical Officer,
- The QM Administrators,
- Quality of Care Reviewers,
- Medical Directors,
- At least one provider of the same or similar specialty under review and representation of healthcare professionals from local communities in which MC has enrolled members, and
- MC's CMO may invite provider with a special scope of practice when necessary.

Non-voting Members:

- Licensed Practitioners, internal and external, when necessary

The Peer Review Committee will convene at least quarterly but, in emergent cases, the Chair or designee will call an ad hoc meeting.

The Peer Review Committee is responsible for making recommendations to the CMO. Appropriate actions may include, but are not limited to peer contact, education, reduced or revoked credentials, and limit on new member enrollment, sanctions, or other corrective actions. The Medical Director is responsible for implementing the actions, which may include, but is not limited to the following:

- Peer contact: The Committee may recommend that the MC medical director or CMO personally contact the healthcare professional or provider to discuss the committee's action.
- Education: The Committee may recommend that information or educational material be sent to the healthcare professional or provider or that the healthcare professional or provider seek additional training. Confirmation of the completed training will be required to be sent to MC.
- Committee appearance: The Committee may recommend that the healthcare professional or provider attend a committee meeting to discuss the issue with committee members
- Credentials action: The Committee may recommend that MC reduce, restrict, suspend, terminate, or not renew the healthcare professional's MC credentials necessary to treat members as a participating provider.
- The Peer Review Committee may require new interventions/approaches when necessary.

The QM department monitors the success of the CAP/interventions.

Per AHCCCS Policy 960, if an adverse action is taken with a provider for any reason, including those related to quality of care concern, MC must report the adverse action to the AHCCCS within 24 hours as well as to the National Practitioner Data Bank.

Upon receiving notification that a health care professional's organizational provider or other provider's affiliation with their network is suspended or terminated because of a quality of care issue, MC will provide written notification to the appropriate regulatory/licensing board and AHCCCS. MC, as active participants in the process, are required to notify MC ACC-RBHA of the same.

Some Peer Review decisions may be appealable. To exercise this option, the appeal process for a fair hearing must be followed. A copy of the peer review and fair hearing policy is available to all providers upon request.

The QOC, peer review, and fair hearing processes are protected by Federal and State law. All information used in the peer review process is kept confidential and is not discussed outside of the peer review process.

12.03 – Provider Monitoring

MC monitors the services provided to members through various methods, including but not limited to medical record reviews, service site visits, personnel record reviews, and member interviews. The Provider Monitoring Team performs a series of key provider review and audit activities to improve the quality and safety of medical and behavioral healthcare services by ensuring compliance with federal and state regulations. Member medical records are evaluated for accuracy and completeness of documentation regarding the member's health status, health needs, health services provided for the member, and any resulting changes over time. Provider education and assistance are critical components of the Provider Monitoring program. Providers must comply with all Provider Monitoring audit process and tool standards that are applicable to their respective clinical programs. If providers fail to meet established minimum performance thresholds, non-compliance with personnel record requirements and other areas of concern, Corrective Action Plans (CAP) may be required, up to and including monetary sanctions.

Provider Monitoring Team Behavioral Health Audits

Behavioral Health Clinical Chart Audit (BHCCA):

BHCCAs are completed annually for outpatient clinics, provider types 77, and IC, and include up to 30 members, adults, and children, across all lines of business.

1. Assessment
    a. A comprehensive assessment must be completed at minimum annually.
    b. A BHP must cosign the assessment within 72 hours if assessment is completed by a BHPP/BHT.
    c. Assessments must contain presenting concerns, and diagnostic information.
    d. A Mental Status Exam must be completed at minimum annually.
    e. Assessments must include Communication Accommodations being assessed including any required accommodation for hearing, vision, cognitive limitations, or language interpretation.
    f. Assessment must assess member's physical and behavioral health history, medication history, family and developmental background, trauma history, and risk factors including exploitation, substance use, and safety concerns.
    g. If members have a substance use diagnosis, a standardized tool (e.g., CRAFFT, ASAM) must be utilized.
    h. Assessments must include risk assessments.

i. Assessment must include current and/or past social and environmental needs, including living situation, socialization, education, vocational training, employment, and access to public and private resources.
j. Assessments must indicate evidence of the presence or absence of a Health Care Decision Maker (HCDM), guardian, or conservator.
k. Assessments must indicate evidence of current or past criminal justice involvement.
l. Assessments must contain evidence of court-ordered evaluation/treatment (COE/COT), if applicable for members over 18.

2. Service Planning
    a. Service Plans must be completed annually at minimum, and must be signed and dated by the member, or HCDM if applicable. A BHP must cosign the Service Plan if the Service Plan was completed by a BHPP/BHT. (Note: Verbal agreement by member or HCDM is sufficient for all lines of business except ALTCS).
    b. There must be evidence that the member and/or HCDM actively participate in the development or review of the Service Plan.
    c. Service Plans must address needs identified in the assessment related to living environment (including but not limited to safety/security, housing, neighborhood, food availability, transportation, safety/access to weapons or firearms, etc.).
    d. Service Plans must address needs identified in the assessment related to socialization (including but not limited to social supports, isolation, loneliness, recreational and/or familial activities).
    e. Service Plans must address needs identified in the assessment related to education and/or vocational training.
    f. Service Plans must address needs identified in the assessment related to employment for members 16 or older (including but not limited to work preference, need for employment supports, volunteer activities, etc.).
    g. Service Plans must include the member/family vision and that the goals on the plans are based on the member/family vision.
    h. Service Plans must include goals that utilize the strengths and resources identified in the assessment and the service planning process.
3. General Clinical Chart
    a. Peer Support Services and Family Support Services must be offered annually at minimum, as appropriate based on age of the member.
    b. All new services recommended on the Service Plan must be implemented within 45 days, 21 days for DCS CHP members.

c. Services on the Service Plan must be implemented as planned.
d. Members 6 through 17 must have a CALOCUS completed as part of the initial assessment and every 6 months thereafter, or more frequently if there is a significant change in the members' status.
e. If a child has a CALOCUS level of care 4, 5, or 6 there must be a high needs case manager (HNCM) assigned or documentation identifying why an HNCM is not assigned.
f. The member must be made aware of how to contact the provider responsible for coordinating, planning, and/or delivering services and supports. Note: For members enrolled in ALTCS-EPD, the assigned ALTCS-EPD case manager must be clearly identified in the chart with documentation showing the member was informed of how to contact them.
g. There must be evidence that collaboration occurs across the delivery of care as other services or supports are identified to address the members' needs. Examples may include communication with behavioral health providers involved in additional treatment or supports, coordination with physical health providers, engagement with other systems such as DCS, DES/DD, ADJC, ADCRR or others as appropriate.
h. The provider must complete PCP Coordination at least annually.
i. HRSN must be identified and when necessary, coordinated across providers and community social service agencies.
j. Engagement or re-engagement must be completed after identification of a behavioral health crisis, safety concern, or significant event (e.g., 72 hours for crisis, 7 days post-discharge, or 1-3 business days for missed appointments). Significant events may include discharge from an inpatient facility, ER utilization, behavioral health crisis involvement, changes in level of care or missed clinical appointments.
k. Transition Age Youth (TAY): transition activities must begin no later than 16 years of age or upon initiation of services for anyone entering services over the age of 16 and not yet 18 years of age.
l. Child members who meet qualifying criteria for SED must be offered an SED Eligibility Identification, or there must be evidence the member/HCDM has declined the option for SED Eligibility Identification.
m. Adult members who meet qualifying criteria for SMI must be referred for and/or offered an initial SMI Eligibility Determination and referred to the Determining Entity, or that the member/HCDM declined the option for SMI Eligibility Determination.

n. For members with an SMI designation, there must be evidence of members being assessed for Special Assistance at minimum annually.
o. Services must be continually evaluated with the member/family to ensure there is progress with the member in meeting service plan goals.

4. Person Centered
    a. Member's or family's cultural preferences must be assessed, considered, and incorporated into the member's treatment recommendations at minimum annually.
    b. Member's or family's preferred spoken language must be assessed, and if applicable, qualified interpretation or qualified translation services must be offered or provided as needed in that language when indicated.
    c. Members must be made aware of providers and the option to choose from an array of service providers for services included in the service plan (voice and choice). Note: Providers must do more than distribute a member handbook. They are expected to engage in direct documented conversations with the member about available provider options.
    d. Progress notes must demonstrate ongoing collaboration with the member/family and the provider is responsive to their input and preferences.
    e. Members must be informed of their right to file a grievance or appeal annually.
    f. Members must be informed of their privacy rights under HIPAA including receipt and acknowledgement of the Notice of Privacy Practices at time of enrollment and at minimum once every three years.
    g. Crisis/safety plans must be completed annually at minimum.
    h. Advance Directive (for Adults only): members must be provided written information about their right to create an Advance Directive, and documentation must indicate whether an Advance Directive has been completed, declined or is not on file.
5. DCS CHP
    a. Must include evidence:
        i. That the services provided to the member were effective in addressing crisis.
        ii. That services provided to the member reduce placement disruption and placement in more restrictive levels of care.
        iii. That services provided to the member reduced symptoms.
        iv. That the services provided to the member improved the member's educational progress.

v. That services provided to the member promote natural childhood development.
vi. That the BHP participated in and provided oversight of the CFT practice.
vii. That the CFT meetings are conducted at a frequency consistent with the needs of the child.
viii. That the provider invited DCS Specialist or DCS Specialist's Supervisor to attend the CFT meetings.
ix. That DCS Specialist or DCS Specialist Supervisor attends the CFT meetings in person, by telephone or electronically.
x. That available relevant information about the child, including the child's behavioral health and medical history, is reviewed during CFT meetings.
xi. That there is an initial evaluation within seven days of an Integrated Rapid Response referral.
xii. That services have been provided at least once per month, following an Integrated Rapid Response referral for behavioral health services subsequent to a rapid response.
xiii. That members who received Integrated Rapid Response referral for behavioral health services had an individual service plan completed in less than 90 days from their intake appointment.

Behavioral Health Inpatient Facility (BHIF):

BHIF audits are completed annually and include child members across all lines of business.

1. Admission
    a. BHIF must complete a behavioral health assessment prior to initiation of services.
    b. BHIF must complete a medical history and physical exam within 30 days prior to admission with an interval note within 7 days OR a completed medical history and physical exam within 24 hours after admission.
    c. BHIF must complete a treatment plan at the time of admission and document this in the record within 24 hours following admission.
    d. BHIF must obtain general consent from the member, or legal guardian if applicable, prior to or at the time of admission.
2. Coordination
    a. There must be documentation of ongoing participation by the provider in CFT meetings and communicated regularly with the member's other CFT

members including family, outpatient provider, child welfare, law enforcement, and any other providers the member is receiving services from.

b. There must be documentation that the provider is collaborating with the member's PCP per their policy and procedures.

3. Treatment Planning
    a. The treatment plan must include:
        i. The member's presenting issues, including the acuity of the presenting issue.
        ii. The behavioral health services and physical health services to be provided to the member.
        iii. The signature of the member or the member's representative and date signed, or documentation of the refusal to sign.
        iv. The date of when the member's treatment plan will be reviewed.
        v. The discharge date if determined and the treatment needed after discharge.
        vi. The signature of the personnel member who developed the treatment plan and the date signed.
    b. There must be evidence of efforts by the BHIF provider to engage the member and member's representative/family to participate in the development and review of the treatment plan.
    c. The BHIF treatment plan must align with the strengths, needs and goals identified in the CFT's service plan.
4. Service Provision
    a. The BHIF record must include documentation demonstrating that individual and/or group counseling services are made available/provided to the member at the frequency and number of hours identified in the member's treatment plan.
    b. The BHIF record must include sufficient documentation for each individual and/or group counseling session, consistent with the requirements of AAC R9-10-315(C)(1-5).
5. Discharge Planning
    a. There must be documentation that discharge planning began upon admission to the BHIF.
    b. The BHIF must complete a written discharge plan and document it in the record prior to discharge.
    c. The discharge plan must include:
        i. Identification of any specific needs of the member after discharge.
        ii. The discharge date if it has been determined.

iii. A description of the level of care that may meet the member's assessed and anticipated needs after discharge.

d. There must be evidence of efforts by the BHIF provider to engage and involve the member and member's representative/family to participate in the development and ongoing review of the discharge plan.
e. There must be documented evidence that the discharge plan was provided to the member/member's representative before the discharge occurs.
f. The BHIF must complete a discharge summary and document it in the record within 10 working days after the member's discharge.
g. The discharge summary must include:
    i. The member's presenting issue and other physical health and behavioral health issues identified in the member's nursing assessment, behavioral health assessment, or treatment plan.
    ii. A summary of the treatment plan provided to the member.
    iii. The member's progress in meeting treatment goals, including treatment goals that were and were not achieved.
    iv. The name, dosage, and frequency of each medication ordered for the member by a medical practitioner at the BHIF at the time of the member's discharge.
    v. A description of the disposition of the member's possessions, funds or medications brought to the BHIF by the member.

Behavioral Health Inpatient:

Inpatient audits occur annually and include both adult and child members across all lines of business.

1. Admission
    a. The inpatient medical record must contain a medical history and physical examination completed on the member within 30 calendar days before admission with an interval note or within 48 hours after admission.
    b. The inpatient provider must complete a treatment plan at the time of admission and document it in the record within 48 hours following admission.
    c. The inpatient provider must obtain informed consent from the member (or HCDM if applicable) before or at the time of admission.
    d. The inpatient provider must notify the member's behavioral health outpatient provider of admit within 24 business hours after admission.
2. Coordination
    a. There must be documentation noting:
        i. Coordination with the member's known PCP during the inpatient stay.

ii. That the inpatient provider verified the member's medication list and dosages prescribed by the outpatient behavioral health provider and/or PCP.
iii. Ongoing communication with the member's behavioral health outpatient clinical team throughout the duration of the inpatient stay.

3. Medical Record
    a. The inpatient treatment plan must include:
        i. The member's presenting issue.
        ii. The behavioral health services and physical health services to be provided to the member while inpatient.
        iii. Member/HCDM signature and date signed.
        iv. Signature of the personnel member who developed the treatment plan and the date signed.
        v. The date the plan will be reviewed.
        vi. The treatment needed after discharge.
    b. There must be documentation of:
        i. Efforts by the inpatient provider to engage the member to actively participate in the development of the treatment plan.
        ii. Efforts by the inpatient provider to involve the parent/guardian in treatment and discharge planning.
4. Discharge
    a. There must be documentation of:
        i. Discharge planning in the record prior to discharge.
        ii. Discharge planning that identifies the specific needs of the member after discharge.
        iii. Discharge instructions and evidence that a copy of discharge instructions were provided to the member/HCDM.
        iv. Discharge planning process included the member's aftercare provider and/or behavioral health outpatient team if applicable.
    b. The inpatient provider must coordinate with the behavioral health outpatient provider to ensure the member was scheduled for an appointment with their outpatient behavioral health provider within 7 days of discharge.
    c. There must be evidence that a copy of the member's discharge instructions was provided to the member's aftercare provider.

Behavioral Health Residential Facility (BHRF):

BHRF audits are completed annually and include child and adult members across all lines of business. BHRF audits include a Medical Record Review, Personnel File Review, and a Site Observation.

CAP Follow Up Audits will be completed 6 months after annual BHRF audits are completed.

Medical Record Review:

1. Admission
    a. Records must include:
        i. Members' current legal status (e.g., ward of the court, Power of Attorney, Guardianship, Conservator, Health Care Decision Maker (HCDM), and record includes any associated paperwork.
        ii. Active special status situations such as court ordered treatment (COT) (evidenced in the records if applicable).
        iii. A medical history and physical exam or nursing assessment for the member's admission.
        iv. A medical history and physical exam completed by a medical professional, or, the RN assessment completed by an RN, which must be completed within 30 calendar days prior to admission or within 72 hours after admission.
    b. If the medical history and physical examination or nursing assessment was completed prior to admission and the medical practitioner or RN documented an interval note within 7 days following admission to indicate accuracy or any required changes to the document.
    c. IF the assessment located was completed by the member's behavioral health home, it must be completed within the past 12 months prior to admission.
    d. IF the assessment located was completed by the member's BHH, the BHRF BHP must review the assessment within 48 hours of admission.
    e. IF the assessment located was completed by the BHRF staff, it must be completed prior to initiation of services.
    f. IF the assessment located was completed by the BHRF staff, and by a BHT or RN, the assessment must be signed by a BHP within 24 hours following completion.
    g. Active Treatment
    h. The member's BHH ISP must be completed within the past 12 months prior to BHRF admission.
    i. The BHRF treatment plan must be completed prior to initiation of services.

j. The BHRF treatment plan must be signed by a BHP within 24 hours following completion if completed by a BHT.
k. The BHRF treatment plan must be comprehensive and include the following:
    i. Individualized needs specific to member's physical and behavioral health conditions and reason for admission.
    ii. Measurable and achievable goals that address individualized needs.
    iii. Specific treatment interventions that address the goals/objectives.
    iv. Discharge planning that prepares the member and/or family for the member's return to home or community, as quickly as possible.
l. BHRF staff, including the BHRF BHP, the outpatient clinical team, and member and HCDM as applicable must meet once a month to review and modify the treatment plan.
m. Documentation must include the member's progress in achieving his or her treatment goals.
n. Documentation must indicate the member is present in the facility 24 hours per day.
o. Start and stop times must be present on all documents, including notes for therapeutic services occurring in the facility.
p. Each service documented must indicate the date, time, and valid signature of the professional conducting the treatment activity, and the professional's printed full name.

2. Therapeutic Service Provision
    a. Individual and/or group counseling services are provided or made available to the member at a frequency consistent with identified needs. If the member is not receiving individual and/or group counseling services as a part of BHRF service provision, there must be clear documentation in the record explaining why counseling services are not clinically indicated.
    b. Skills training and development is provided or made available to the member of a type and frequency consistent with identified needs. The following skill areas are included under the umbrella of therapeutic services that BHRFs must make available to members:
        i. Independent Living Skills (e.g., self-care, household management, budgeting, avoidance or exploitation/safety education and awareness);
        ii. Community Reintegration Skill building (e.g., use of public transportation system, understanding community resources and how to use them); and

iii. Social Communication Skills (e.g., conflict and anger management, same/opposite six friendships, development of social support networks, recreation.

If member is not receiving skills training and development as part of BHRF service provision, there must be clear documentation in the record explaining why skills training and development services are not clinically indicated.

c. Behavioral health prevention/promotion education and medication training and support services are provided or made available to the member of a type and frequency consistent with identified needs. The following skill/support areas are included in, but not limited to, the umbrella of therapeutic services that BHRFs must make available to members:
   i. Symptom management (e.g., including identification of early warning signs and crisis planning/use of crisis plan);
   ii. Health and wellness education (e.g., benefits of routine medical check-ups, preventive care, communication with the PCP and other health practitioners);
   iii. Medication education and self-administrations skills;
   iv. Relapse prevention;
   v. Psychoeducation Services and Ongoing Support to Maintain Employment Work/Vocational skills, educational needs assessment and skill building;
   vi. Treatment for Substance Use Disorder (e.g., substance use counseling, groups).

   If the member is not receiving behavioral health prevention/promotion education and medication training and support services as part of BHRF service provision, there must be clear documentation in the record explaining why none of these skill/support areas are clinically indicated.
      i. If the member is not receiving any of the therapeutic services/support described above, through an agency other than the BHRF, the record must include a description of the need/goals applicable to the service(s), frequency and duration of services to be provided, identification of the provider meeting the need, why BHRF and current BHP are unable to provide these services for the member and why the outpatient team must provide them separately.
      ii. If the BHRF is licensed to provide personal care services in accordance with 9 A.A.C. 10 Article 7, and member need for personal care services has been identified, the record must include documentation

of applicable personal care services provided to the member at a frequency consistent with identified needs.

3. Member and Family Involvement
    a. BHRF providers must arrange for the member and family/natural supports to have regular communication with each other.
4. Cultural Competence
    a. Assessment and treatment plans must reflect the values, priorities and cultural preferences of the member and family.
    b. Services must be culturally responsive to the needs of the member and family.
5. Discharge Planning
    a. The discharge plan must include:
        i. Specific skills and supports, aligned with the member's strengths, that the member needs to be successful upon return to the community.
        ii. Types and frequency of professional support services needed upon discharge.
        iii. Realistic/quantifiable/measurable goals and objectives to inform when the member is discharge ready.
        iv. Information, including clear instructions, for the member/guardian and family (if applicable) on how to access services after discharge including contact information.

Personnel File Review:

1. The provider's service site personnel file must contain evidence of a current certificate to provide Cardiopulmonary Resuscitation (CPR).
2. The provider's service site personnel file must contain evidence of a current certificate to provide First Aid.
3. There must be evidence of employee's verification of skills or competencies to provide care.
4. There must be evidence that the agency contacted at least three references, one of which shall be a former employer. Results of the contacts shall be documented in the employee's personnel record.
5. There must be evidence that the provider conducted the pre-hire and annually thereafter search of the APS/CPS Registry as required in AHCCCS Minimum Subcontract Provisions.
6. If the setting provides services to members diagnosed with or at risk for autism, there must be evidence that staff have completed specific certification, training program or demonstrate competency in the ability to provide services to that population.

7. If the setting provides services to members diagnosed with dementia or related disorders, there must be evidence that staff have completed specific certification, training program or demonstrate competency in the ability to provide services to that population.
8. If the setting provides services to members with traumatic brain injury, there must be evidence that staff have completed specific certification, training program or demonstrate competency in the ability to provide services to that population.
9. If the setting provides services to members with persistent aggressive behavior, there must be evidence that staff have completed specific certification, training program or demonstrate competency in the ability to provide services to that population.
10. If the setting provides services to any identified specialized populations not previously stated, there must be evidence that staff have completed specific certification, training program or demonstrate competency in the ability to provide services to that population.

Crisis Stabilization & Observation: Please contact Provider Monitoring for specific requirements and audit guidelines.

Mercy Care Child Direct Support Provider (DSP): Please refer to Mercy Care Specialty provider requirements located in Availity.

Peer Recovery Support Specialist (PRSS) Policy and Personnel File Review:
PRSS audits occur every three years and include up to ten Certified PRSSs in the role of PSS for the review.

1. Policy Review:
    a. Providers must have policies/procedures:
        i. Requiring the PRSS to qualify as a Behavioral Health Paraprofessional (BHPP), Behavioral Health Technician (BHT), or Behavioral Health Professional (BHP).
        ii. Describing requirements for individuals employed as a PRSS to obtain a minimum of eight hours of continuing education and ongoing learning relevant to peer support per year. At least one hour shall cover ethics and boundaries related to the practice of peer support.
        iii. Documenting both clinical and administrative supervision of PRSS in accordance with their provider type requirements.
        iv. Providers must have policies/procedures ensuring supervisors of PRSSs have access to training and ongoing learning relevant to the provision of peer support services and the supervision of PRSSs.

2. Personnel File Review:
    a. PRSS employees must meet the qualifications to be either a Behavioral Health Paraprofessional (BHPP), Behavioral Health Technician (BHT), or a Behavioral Health Professional (BHP).
    b. PRSS employees must self-identify as an individual who has lived experience of mental health conditions, and/or substance use, for which they have sought support, and have an experience of sustained recovery to share.
    c. PRSS Staff must meet the qualifications to be certified as a PRSS and have a copy of their Peer Support Employment Training Program certification in their personnel file.
    d. The personnel file must include evidence of AHCCCS receipt and approval of PRSS credentialed in another state; inter-state reciprocity, if applicable.
    e. There must be evidence documenting that the PRSS has had a minimum of eight hours of continuing education and ongoing learning, relevant to peer support, per year. One hour must cover ethics and boundaries related to the practice of peer support.
    f. There must be evidence that the PRSS has received clinical and administrative supervision conducted by a BHT or BHP at a minimum of 1 hour in a two-week period or as outlined in the agency policies and procedures.

Sub-Acute Audit: Please contact Provider Monitoring for specific requirements and audit guidelines.

Therapeutic Foster Care (TFC) Audit:
TFC Audits are completed annually and consist of a Medical Record Review of up to 10 child members and a Policy Review.

Medical Record Review:

1. Assessment
    a. The medical record must contain a current assessment completed by the primary behavioral health provider.
2. TFC Agency Intake
    a. The TFC agency must notify the members:
        i. PCP of the TFC admit.
        ii. Behavioral health provider of the TFC admit.
3. TFC Agency Active Treatment
    a. There must be evidence of an intake/referring agency's ISP located within the member's TFC record.

b. There must be evidence of a current TFC agency treatment plan, completed annually at minimum.
c. The TFC agency treatment plan must include:
    i. Individualized physical needs (goals).
    ii. Individualized behavioral needs (goals).
    iii. Individualized developmental needs (goals).
d. The record must contain a current TFC agency safety plan in alignment with TFC setting.
e. The TFC agency's documentation is in alignment with the child and family team's (CFT) documentation.
f. There must be evidence of a BHP meeting with the TFC Agency worker and the TFC Family Provider at least once per month.

4. TFC Agency Home Visits
    a. There must be evidence of an assigned TFC Agency worker that conducts home visits.
    b. During the initial six weeks of a child receiving services in a TFC, there must be evidence of the TFC agency conducting one home visit per week with the child and TFC Family Provider.
    c. For continued stay beyond the initial six weeks, there must be evidence of the TFC Agency conducting a minimum of two home visits per month (or more frequently as needed).
    d. Is there evidence of the TFC Agency completing supporting documentation of each home visit, including review of the TFC Treatment Plan with TFC Family Provider.
    e. There must be evidence of the TFC Agency completing supporting documentation of each home visit, including review of therapeutic interventions provided.
    f. There must be evidence of the TFC Agency completing supporting documentation of each home visit, including checking medical record documentation and medication logs.
5. TFC Agency Discharge Planning
    a. The TFC agency must complete a discharge plan within 7 days of admission.
    b. The TFC discharge plan must identify a caregiver for post-discharge.
    c. The TFC discharge plan must engage the identified caregiver that will support the member post-discharge in planning for transition and transition visits.
    d. The TFC discharge plan must be reviewed monthly at the CFT meeting.
    e. The TFC discharge plan must outline criteria for member's discharge.
    f. The TFC agency's discharge plan must recommend post-discharge services.

g. If the member has not been successful in TFC and a higher level of care is required, the TFC discharge plan must outline the steps necessary to make this transition.

6. TFC Agency Provider Requirements
    a. Progress notes must be signed by the "Licensed Parents" facilitating the TFC interventions.
    b. The TFC family provider must send monthly summaries to the TFC licensing agency.
    c. Progress notes must be dated and written no less than one per day by the TFC family provider.
    d. The TFC Family provider must participate in the CFT.
    e. There must be evidence:
        i. That the TFC family provider participates in the IEPs.
        ii. That the TFC family provider provides basic parenting functions. (e.g., food, clothing, shelter)
        iii. That the TFC family provider provides personal care services, including medical needs.
        iv. That the TFC family provider provides daily living skills, including social skills.
        v. That the TFC family provider provides transportation.
        vi. That the TFC family provider provides educational support.
        vii. That the TFC family provider provides development of community activities.
        viii. That the TFC family provider supports cultural, spiritual/religious beliefs.
7. Policy Review
    a. Have programmatic support available to TFC Family Providers 24 hours per day seven days a week, which are outlined in a TFC Agency crisis response policy that includes:
        i. Supervisor's availability and the use of crisis response provider to augment hours of availability,
        ii. The TFC Agency fulfilling the role of first line support for TFC Family Provider and member during times of crisis,
        iii. Access to a TFC Agency and/or appropriate agency staff on a 24/7 basis, and
        iv. Ensuring that escalation to appropriate TFC Agency clinical leadership is available at all times.

PM Team Medical Audits:

Home and Community Based (HCBS) for EPD Residential Audit

HCBS EPD Residential audits are completed annually for Assisted Living Facilities including Assisted Living Centers, Assisted Living Homes, and Adult Foster Homes for LTC and DDD lines of business. The facility must be in compliance with the items below.

Medical Record Review

1. Resident Rights
    a. Documented evidence that members were given their Resident Rights upon admission to the facility.
    b. A copy of Resident Rights and current community phone numbers must be posted in a location that is clearly visible to residents and their visitors.
2. Service Plans/Timelines
    a. Service Plans must be completed within 14 days of a resident being admitted into the facility.
    b. The Service Plan must be reviewed within appropriate timeframes according to the Arizona Administrative Code (A.A.C.) based on the level of care (directed, personal, supervisory) for each resident, it must be current and at the appropriate level of care.
    c. Members at risk for falls have observable interventions in place.
    d. The Service Plan must document if the member is on a special diet.
    e. The Service Plan must be updated and include any changes of the member's condition.
3. Medication Administration
    a. Members that take their medications independently are to:
        i. Have a physician order stating they can be responsible for their own medications
        ii. Have a current assessment that documents their ability to take their own medications and
        iii. Keep all controlled substances locked and secure
    b. Facilities assisting members with medication administration need to:
        i. Ensure that the Medication Administration Record (MAR), accurately reflects the practitioner's orders
        ii. Document that medications are administered as ordered by the practitioner
        iii. Missed or refused doses are appropriately documented to reflect why the medication was not given

iv. Keep each member's medication separate from other members' medication and stored and locked in an appropriate location
v. Member's receiving insulin must have it administered by an insulin trained caregiver
vi. Stored insulin must be labeled with member's name, date opened and cannot be older than the manufacturer's guidelines

4. Skin Assessment
    a. The PCP must be notified by the facility if there is documentation of skin breakdown
    b. If skin breakdown is present, the facility must provide ongoing monitoring and treatment per the practitioner's orders
    c. Members confined to a bed or wheelchair must be examined by a medical practitioner at least every six months
5. Vital Signs/Weight Assessment Monitoring
    a. Vitals and Weight need to be recorded per the facilities policy, Service Plan, and/or practitioner order
    b. Unexpected changes in vital signs need to be reported to the medical practitioner
    c. Unexpected changes in weight need to be reported to the medical practitioner
6. Member Medical Record
    a. Each member has to have their own individual record
    b. If a member is receiving services from an outside agency, the services provided at the facility need to be documented in the member's record
7. Incident Reporting or Change in Condition
    a. When a member has an accident, injury, incident (including abuse, neglect, and exploitation), abnormal findings or a change in condition, the facility must notify the member's family/HCDM and ALTCS Case Manager within 24 hours. Notification must include the date/time of incident, summary of the incident, immediate actions taken and the outcome.
    b. When a member has a change in their physical, cognitive, or functional condition, there must be documentation in the record of actions taken, that the PCP was notified, follow up was completed and the service plan was updated.
8. Additional Requirements
    a. Flu immunization or refusal must be documented annually
    b. Pneumococcal immunization or refusal must be documented in the record if ordered by a physician

c. DNR on record needs to be signed by a medical practitioner and a witness
d. DNR cards must be on orange paper and stored in a confidential but accessible location

9. Licensed Behavioral Health Facilities
    a. Behavioral health services must be provided under the direction of a BHP. All orders must be signed by a BHP with credentials documented.
    b. Members that were administered a psychotropic medication must have documentation in their record of the member's behaviors and attempts to redirect behavior prior to the administration of the medication.
    c. Documentation of the effectiveness of prescribed psychotropic medications
    d. The member's Service Plan must include:
        i. The reason the member is needing services
        ii. Prescribed psychotropic medications
        iii. Services to assist the member with adjusting their psychosocial interactions and/or behaviors
        iv. The date and signature of the BHP

Personnel File Review

1. Policy/Screenings/Certifications
    a. The facility must have a book of policies and procedures that outlines contingency plans.
    b. All staff must have documentation in their file that at least three references, one of which was a former employer, were contacted at the time of hire.
    c. All staff must have electronically dated documentation in their file, that they have been checked in the Central Registry for APS and DCS Incidents. This must be checked at the date of hire and annually thereafter.
    d. All staff must have documentation in their file of a current fingerprint clearance card. This can also be checked in the Central Registry.
    e. Direct care staff must have a copy of a current CPR card in their file.
    f. Non-licensed direct care staff or staff as mentioned in the facilities policy, must have a copy of current First Aid present in their file.
    g. Documentation of completed in-service education/training required by the facility's policy and procedures, including evidence that staff's ability to complete required skills and competencies to provide care has been verified.
    h. All staff must complete annual training on abuse, neglect and exploitation prevention, recognition, and reporting.

Setting Requirements

1. Employment/Volunteerism
    a. The facility must engage individuals of work and/or school age to see if they are interested in working or going to school.
    b. The facility must support and promote community employment opportunities for members and complete a referral for employment services if the member expresses an interest in employment.
    c. The facility must support and promote community volunteer opportunities for members.
    d. The facility must support members with career exploration opportunities.
    e. The facility must provide members with opportunities to learn new skills to assist with volunteer or employment opportunities.
    f. The facility must assist the member with securing transportation to attend work and/or volunteer activities.
2. Community Life
    a. The facility needs to provide access to information and opportunities for community activities for members to attend.
    b. The facility must assist members with securing transportation so they can attend community events and have staff and informal supports to assist if needed.
    c. Members must have regular opportunities to engage in activities in integrated settings and with people not living in the home.
3. Personal Resources
    a. Members choose who assists them with managing their personal funds and how to spend their funds.
    b. Members need access to the community to purchase goods and services of their choosing.
    c. The facility needs to utilize an interest/preference inventory for each member to ensure their basic necessities are met with items they prefer.
4. Payor Source
    a. All members residing in the facility shall have the same access to activities, services, and amenities regardless of who funds the service.
5. Home Selection
    a. The facility shall allow members to visit the setting prior to choosing to live there.
    b. The facility needs to utilize completed interest/preference inventory to document the member's goals and risk assessment to ensure the member is accommodated in the least restrictive manner.

c. Members have the option of residing in a private room if they are able to afford the rental difference.

6. Person-Centered Service Plan
    a. Facilities must support members in participating in their Person-Centered Service Plan.
    b. The facility must participate in Person-Centered Service Plan meetings and maintain a current copy in the member's medical record or electronically. Documentation needs to be present that the setting helped identify health and safety risks that necessitate restrictions, a risk management plan and input into the member's goals that support community involvement.
    c. The facility shall support a discussion with the member regarding the member's opportunities to interact with the greater community, ability to make their own decisions and having privacy.
    d. The facility shall have a process in place to routinely gather customer satisfaction to ensure the needed support is available to members to assist them with achieving their goals.
7. Service Plan
    a. Facility Service Plans must be completed within 14 days of an individual being admitted.
    b. Service Plans must be current and updated according to A.A.C R9-10-808 according to the members' level of care.
        i. Supervisory Care Services shall be reviewed and updated at least every 12 months
        ii. Personal Care Services shall be reviewed and updated at least every six months
        iii. Directed Care Services shall be reviewed and updated at least every three months
    c. Documentation must show that the member was provided with supports to ensure the individual understands their Service Plan. This would include the participation of HCDM if applicable.
    d. The facility shall utilize detailed interest and preference surveys to gather information from the members and involved supports in regard to the member's life history, past work history, hobbies, and community activity preferences to assist with developing goals both in the facility and out in the community.
8. Individual Rights
    a. Personal Care assistance must be completed in private.

b. Member rights must be provided to each member in plain language and also posted in the facility common area. There needs to be evidence that the member understands their rights, including involving the member's HCDM if applicable.
c. There must be information present to notify members who to contact if they have concerns or complaints.
d. The facility must provide access to a telephone and/or computer for member's personal use in a location that ensures privacy.
e. The facility must have documentation of the protection of members from restrictive measures including isolation, physical restraint, and chemical/pharmacological restraint.

9. Independence
    a. Members shall have a key/code to enter the front door of the facility, freely exit the facility and free from a curfew or other requirement with a scheduled return. If safety affects the member's ability to come and go from the home freely, this needs to be documented in the Person-Centered Service Plan and facility Service Plan. There shall be no blanket restrictions for all members in the home.
    b. The members are able to make informed decisions about what they want to do daily, including making alterations to their schedule. If needed, the facility shall support the member to make informed decisions about what they want to do daily, including schedule changes.
    c. Members that are unable to use public transportation need to have access to transportation training.
    d. Members shall have full access to the kitchen/kitchenette at any time. If safety affects the member's ability to access the kitchen, this needs to be documented in the Person-Centered Service Plan and facility Service Plan. There shall be no blanket restrictions for all members in the home.
    e. Members shall have full access to the laundry at any time. If safety affects the member's ability to access the laundry room, this needs to be documented in the Person-Centered Service Plan and facility Service Plan. There shall be no blanket restrictions for all members in the home.
    f. Members shall have full access to shared living spaces at any time. If safety affects the member's ability to access shared living spaces, this needs to be documented in the Person-Centered Service Plan and facility Service Plan. There shall be no blanket restrictions for all members in the home.
10. Choice

a. Members shall have the option to request for an alternate staff member to assist them, and the facility shall honor the request when they can accommodate.
b. Members shall have the ability to freely make requests for changes in the way their services and support are delivered.
c. Members shall choose their roommate and have the chance to consider other roommate options if they would like to change their roommate. The facility needs to have a process in place to assess roommate satisfaction and a process to help members make roommate choices.

11. Setting/Residency Agreement
    a. The facility shall utilize the standard AHCCCS residency agreement that is in plain language, and the facility must ensure that members understand their residency agreement. This includes involving the HCDM if applicable.
    b. The written agreement needs to contain protections to address termination of the residency agreement, due process, and appeals.
12. Privacy
    a. Members must have lockable bedroom/unit doors with access to the key and only appropriate staff having keys for an emergency.
    b. The facility needs to have lockable bathroom doors for privacy.
    c. Staff are required to knock and receive permission before entering a member's room.
    d. Members are free to decorate their own room including moving furniture and hanging up items on the walls.
    e. Members need to be consulted on décor for common areas.
13. Dining
    a. Members have a choice of alternate menu options if they don't like what is being served.
    b. Members need to have a choice at what time they want to eat, whom to eat with and the option to eat alone.
    c. Members need to have access to food/snacks/drinks at all times and the opportunity to purchase their own.
14. Visitors
    a. The facility shall not have visiting hours or any restrictions when family and friends can visit.
    b. The facility shall have areas or furniture that support members to meet with family and friends in private.
15. Accessibility

a. The facility shall be accessible for people to safely and freely move around, including entering and exiting. The facility needs to be free from barriers that may prevent entering and exiting common areas or member rooms.
b. The members need to have physical accessibility to appliances and furniture.
c. The facility needs to have resources for assessing and providing individualized modifications based on individual needs. This includes grab bars, shower chairs, etc.

16. Training
    a. All staff must be trained on the prevention of abuse, neglect, and exploitation. Training must address retaliation and penalization.
17. Memory Care
    a. The facility must utilize an environmental design to accommodate members risks for wandering or exit seeking behaviors while maximizing the members' initiative, autonomy, and independence.
    b. All staff must be trained on:
        i. Underlying conditions, diseases, and disorders that may lead to wandering or exit seeking behavior
        ii. Observing individuals for the purposes of identifying through observation (patterns, frequency, and triggers) the root cause(s) for the wandering or exit seeking behavior
        iii. Employing less restrictive interventions to maximize an individual's initiative, autonomy, and independence
        iv. Assessment of the individual's communication style (verbal, non-verbal) and needs in order to support staff to interpret non-verbal cues, body language, and behavioral changes and learn to anticipate member needs and ensure staff support optimizes each member's life experience by affording them the opportunities to make decisions to the greatest extent possible.

Home and Community-Based (HCBS) for Adult Day Health (ADH) Audits

HCBS Adult Day Health audits are completed annually for Adult Day Health Facilities for LTC and DDD lines of business. The facility must be compliant with the items below.

Medical Record Review

1. Resident Rights
    a. Documented evidence that members were given their Resident Rights upon admission to the program.

   b. A copy of Resident Rights and current community phone numbers must be posted in a location that is clearly visible to residents and their visitors.
2. Assessment/Services Plans/Timelines
   a. The medical record must contain a signed medical assessment completed by the member's medical practitioner within 60 days prior to enrollment. The assessment needs to include physical health, cognitive status, cognitive deficits, physical, mental, and emotional concerns, medication schedule, treatments, special dietary needs, and known allergies.
   b. Service plans must be completed within 14 days of a resident being admitted into the program.
   c. The Service Plan must be reviewed within appropriate timeframes, according to the Arizona Administrative Code (A.A.C.) based on the level of care (directed, personal, supervisory) for each resident and must be current and at the appropriate level of care.
   d. Members at risk for falls have observable interventions in place.
   e. The Service Plan must document if the member is on a special diet.
   f. The Service Plan must be updated and include any changes in the member's condition.
3. Medication Administration
   a. Facilities assisting members with medication administration need to:
      i. Ensure that the Medication Administration Record (MAR) accurately reflects the practitioners orders
      ii. Document that medications are administrated as ordered by the practitioner
      iii. Missed or refused doses are appropriately documented to reflect why the medication was not given
      iv. Keep each member's medication separate from other members' medication and stored and locked in an appropriate location
4. Member Medical Record
   a. Each member has to have their own individual record
5. Incident Reporting or Change in Condition
   a. When a member has an accident, injury, incident (including abuse, neglect, and exploitation), abnormal findings or a change in condition, the facility must notify the member's family/HCDM and ALTCS Case Manager within 24 hours. Notification must include the date/time of the incident, summary of the incident, immediate actions taken and the outcome.

b. When a member has a change in their physical, cognitive, or functional condition, there must be documentation in the record of actions taken, that the PCP was notified, follow-up was completed, and the service plan was updated.

Personnel File Review

1. Policy/Screenings/Certifications
    a. The facility must have a boof of policies and procedures that outlines contingency plans.
    b. All staff must have documentation in their file that at least three references, one of which was a former employee, were contacted at the time of hire.
    c. All staff must have electronically dated documentation in their file that they have been checked in the Central Registry for APS and DCS incident. This must be checked at the date of hire and annually thereafter.
    d. All staff must have documentation in their file of a current fingerprint clearance card. This can also be checked in the Central Registry.
    e. Direct care staff must have a copy of a current CPR card in their file.
    f. Non-licensed direct care staff or staff as mentioned in the facilities' policy must have a copy of current First Aid present in their file.
    g. Documentation of completed in-service education/training required by the facility's policy and procedures, including evidence that staff's ability to complete required skills and competencies to provide care has been verified.
    h. All staff must complete annual training on abuse, neglect, and exploitation prevention, recognition, and reporting.

Setting Requirements

1. Employment/Volunteerism
    a. The facility must engage individuals of work and/or school age to see if they are interested in working or going to school.
    b. The facility must support and promote community employment opportunities for members and complete a referral for employment services if the member expresses an interest in employment.
    c. The facility must support and promote community volunteer opportunities for members.
    d. The facility must support and promote employment opportunities in the community.
    e. The facility must support members with career exploration opportunities.

f. The facility must provide members with opportunities to learn new skills to assist with volunteer or paid employment opportunities.
g. The facility must have access to day activities and outings, including in non-disability settings.
h. The facility must assist the member with securing transportation to attend work and/or volunteer activities.

2. Community Life
    a. Members need the ability to interact with the general public through visitation to the program and/or activities in the general community.
    b. The facility needs to provide opportunities for members to learn and engage in activities in the community, comparable to peers.
    c. The facility needs to provide access to information and opportunities for community activities for members to attend.
    d. The facility must assist members with securing transportation so they can attend community events and have staff and informal supports to assist if needed.
3. Personal Resources
    a. Members choose who assists them with managing their personal funds and how to spend their funds.
    b. Members need access to the community to purchase goods and services of their choosing.
    c. The facility needs to provide the members with access to money management habilitation or rehabilitation skill building training.
4. Payor Source
    a. All members residing in the facility shall have the same access to activities, services, and amenities regardless of who funds the service.
5. Program Selection
    a. The facility shall allow members to visit the setting prior to choosing to receive services there.
6. Person-Centered Service Plan
    a. Facilities must support members in participating in their Person-Centered Service Plan.
    b. The facility must participate in Person-Centered Service plan meetings and maintain a current copy in the member's medical record or electronically. Documentation needs to be present that the setting helped identify health and safety risks that necessitate restrictions, a risk management plan, and input into the member's goals that support community involvement.

c. The facility shall support a discussion with the member regarding the member's opportunities to interact with the greater community, ability to make their own decisions and having privacy.
d. The facility shall have a process in place to routinely father customer satisfaction to ensure the needed support is available to members to assist them with achieving their goals.

7. Service Plan
    a. Services Plans must be current and updated according to the *Arizona State Statues* according to the members' level of care.
    b. Documentation must show that the member was provided with supports to ensure the individual understands their Service Plan. This would include the participation of HCDM if applicable.
8. Individual Rights
    a. Member rights must be provided to each member in plain language and also posted in the facility common area. There needs to be evidence that the member understands their rights, including involving the member's HCDM if applicable.
    b. There must be information present to notify members who to contact if they have concerns or complaints.
    c. The facility must provide access to a telephone and/or computer for member's personal use in a location that ensures privacy.
    d. The facility must have documentation of the protection of members from restrictive measures including isolation, physician restraint, and chemical/pharmacological restraint.
9. Independence
    a. Members shall have the choice and opportunity to freely come and go at the
    b. facility. If safety affects the member's ability to come and go from the program freely, this needs to be documented in the Person-Centered Service Plan and facility's Service Plan. There shall be no blanket restrictions for all members in the program.
    c. The members are able to make informed decisions about what they want to do daily, including making alterations to their schedule. If needed, the facility shall support the member to make informed decisions about what they want to do daily, including schedule changes.
    d. Members that are unable to use public transportation need to have access to transportation training.

e. Members in the same setting shall have alternate schedules for services and activities.
f. Members need to have the ability to schedule activities at their own convenience.
g. Members shall engage in activities specific to their skills, abilities, desires, needs, and preferences, including engaging in activities with people of their own choosing and in areas of their own choosing.

10. Choice
    a. Members shall have the option to request for an alternate staff member to assist them, and the facility shall honor the request when they can accommodate.
    b. Members shall have the ability to freely make requests for changes in the way their services and support are delivered.
11. Privacy
    a. The facility needs to have lockable bathroom doors for privacy.
    b. Staff are required to provide personal care assistance for a member in private.
12. Dining
    a. Members have a choice of alternate menu options if they don't like what is being served.
    b. Members need to have a choice on what time they want to eat, whom to eat with and the option to eat alone.
    c. Members need to have access to food/snacks/drinks at all times and the opportunity to purchase their own.
13. Visitors
    a. The facility shall not have visiting hours or any restrictions when family and friends can visit.
    b. The facility shall have areas or furniture that support members to meet with family and friends in private.
14. Accessibility
    a. The facility shall be accessible for people to safely and freely move around, including entering and exiting. The facility needs to be free from barriers that may prevent entering and exiting common areas.
    b. The members need to have physical accessibility to appliances and furniture.
    c. The facility needs to have resources for assessing and providing individualized modifications based on individual needs. This includes grab bars, shower chairs, etc.
15. Training

a. All staff must be trained annually on the prevention of abuse, neglect, and exploitation. Training must address retaliation and penalization.

Electronic Visit Verification (EVV) Audit

EVV audits are completed annually for providers that provide services in a member's home. EVV audits are applicable to LTC, DCS CHP, ACC-RBHA and DDD lines of business. The provider must be compliant with the items below.

Policy Review

1. EVV Policy and Procedures
    a. Provider's EVV policy must include provider responsiveness to missed or late visits. The provider must answer the phone 24/7 or return a phone call within 15 minutes to the member(s) who are reporting the missed or late appointment.
    b. Documentation must be present that the phone was answered 24/7 or the member was provided with a return call within 15 minutes when reporting a missed or late appointment.
    c. Provider's EVV policy must include the process for documenting visit exceptions and manual edits.

Record Review

1. Contingency Plan
    a. The plan needs to be completed utilizing the AMPM 540, Attachment D template. All areas must be completed, and it must be signed by the member/HCDM.
    b. The plan must be reviewed with the member/HCDM annually and there must be documented evidence of the review.
    c. The plan must be documented in the EVV system.
2. Designee Attestation
    a. If the member or HCDM is unable to verify services, a designee can be appointed. A designee attestation needs to be completed utilizing the AMPM 540, Attachment A template. It must be signed by the member/HCDM and the designee.
    b. The appointed designee must be documented in the EVV system.
3. Paper Timesheets
    a. If a member/HCDM is unable to verify visits electronically, a paper timesheet may be used. If a paper timesheet is used, the member/HCDM must utilize the standardized AHCCCS attestation in the AMPM 540, Attachment B. The

attestation must be reviewed with the member/HCDM annually to ensure the member's circumstances and use of paper timesheets has not changed.

b. The member must meet one of the following circumstances for the use of a paper timesheet.
    i. Provider staff and the member live in a geographic area that has limited or no access to a telephone or the internet.
    ii. Electronic devices will cause adverse physical or behavioral health symptoms/side effects.
    iii. Moral or religious grounds and prohibit them from using other verification methods.
    iv. Live with their caregiver or have on-site access to provider staff 24 hours and if the use of other verification methods would be a burden.
    v. Members that have safety concerns and require their address and location information be protected.
c. Provider agencies can utilize the paper timesheet in the AMPM 540, Attachment C or their own paper timesheets if they contain all data elements present in the AHCCCS template.
d. Timesheets must be completed correctly and contain the independent verification of date and time.
e. Paper timesheet data entered into the EVV system must be consistent with the documented timesheet.
f. There must be a hard copy of the paper timesheet on file with a wet signature.

4. Visits
    a. The provider must document visit exceptions and manual edits using reason/resolution codes and documenting memos when needed.
    b. Within 30 days, the provider must document live-in caregivers and their specific relationship to the member in the EVV system. If changes occur, this needs to be updated in the EVV system within 30 days.

Home Health Audit

Home Health audits are completed at a minimum every three years for ALTCS, ACC-RBHA, DDD and DCS CHP lines of business. Please contact Provider Monitoring for specific requirements and audit guidelines.

12.04 – Ambulatory Medical Record Review (AMRR)

MC participates with the AzAHP and AMRR Collaborative to monitor Obstetrical/Gynecological providers, primary care EPSDT providers (PCPs), and primary care providers who treat adult

members. MC monitors Oral Health providers who treat adults and children. AMRRs and Oral Health Audits are performed under the direction of the MC CMO in collaboration with the Vice President of Quality Management. The AMRR and Oral Health review tools incorporate the AHCCCS and CMS required medical records standards, professional and community standards, and accepted and recognized practice guidelines.

12.05 – Quality Management Studies

MC uses a variety of information sources to conduct quality management studies, including member medical records, claims, prior authorization logs, statistical reports, and utilization review reports. As part of the quality improvement process, MC asks its provider network to assist in the collection of medical record information or other information as needed for special studies or reviews. The QM Department manages several annual clinical studies.

12.06 – Data Collection and Reporting

The QM Department collects data and analyzes MC performance for the following indicators:

- Well-child visits in the first 15 months of life
- Well-child visits for members aged 3-6
- EPSDT participation rates
- Childhood immunization (for members 24 months old)
- Adolescent immunization
- Annual dental visits for members aged 1-20
- Preventive Dental Care
- Dental Sealant Application
- Children's access to primary care providers
- Adolescent well-care visits
- Cervical cancer screening
- Adult access to preventive/ambulatory health services
- Mammograms
- Diabetes management
- Appropriate Asthma medication
- Chlamydia screening
- Prenatal care
- Postpartum services
- Hospital Readmissions
- PCP follow-up after discharge
- 7 and 30 days follow up after a BH Inpatient discharge
- ED Utilization

- Inpatient Utilization
- Diabetes, COPD and CHF Admissions
- Flu Shots

Clinical indicators are reviewed regularly to monitor progress. Findings and results of studies and surveys are shared with health professionals via newsletters.

12.07 - Reports

The QM department has developed reports for health professionals on the following topics:

- **Well woman:** A quarterly report of members who need a mammogram, cervical cancer screening, or chlamydia screening.
- **Diabetes:** A quarterly report of members diagnosed with diabetes and diabetes-related services rendered during the past 12 months.
- **Immunizations:** A monthly report listing members due for one or more immunizations.
- **Well Child:** A monthly report listing members due for a Well Child visit.
- **HEDIS Star:** A quarterly report listing MCA members in need of one or more of the following services:
    - Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis
    - Breast Cancer Screening
    - Controlling High Blood Pressure
    - Comprehensive Diabetes Care
    - Colorectal Cancer Screening
    - Osteoporosis Management in Women Who Had a Fracture

12.08 – Credentialing/Re-Credentialing

The Credentialing Committee (comprised of both network peer physicians and MC Medical Directors) reviews all credentialing information and forwards their recommendations to the CMO who presents the information to the Quality Management Oversight Committee and the MC's Board of Directors for a final decision. Providers have the following rights:

- To review their application and information obtained from outside sources, (e.g., state licensing agencies and malpractice carriers) except for references, recommendations, or other peer-review protected information.
- To correct erroneous information submitted by another source. MC would notify credentialing applicants if information obtained from other sources (e.g., licensure boards, National Practitioner Data Bank, etc.) varies substantially from that provided by the applicant.

12.09 – Streamlining Processes

MC is dedicated to improving and streamlining credentialing processes and timelines for those providers credentialed and re-credentialed directly through MC. In addition, contractual relationships have been developed to delegate credentialing and re-credentialing activities to approved, qualified outside entities throughout the state. This practice has been put into place to decrease the time spent completing multiple credentialing applications for providers belonging to one of these entities and to ensure a complete and comprehensive network for MC members.

Providers credentialed/re-credentialed through a delegated entity must still be approved through the MC Board of Directors prior to providing care or services to members. Providers are re-credentialed every three years and must complete the required reappointment application. Updates of malpractice coverage, state licenses, and Drug Enforcement Agency (DEA) certificates, if applicable, are also required. The MC Special Needs Unit (SNU) coordinates care and services with the carve-out programs for MC members enrolled in AZ Department of Economic Security, Division of Developmental Disabilities (DES/DDD).
MC performs the following activities:

- Assists in resolving coordination of benefit issues.
- Monitors timeliness of services delivered by MC providers.
- Provides information or clarification to parents/guardians and providers.

Ensures services are provided by the appropriate resource – either MC or carve out program.

- Serve as the MC liaison for the state agencies listed above, and their contractors and DD services.

12.10 – Reporting and Monitoring of Seclusion and Restraint

The use of S&R shall only be used to the extent permitted by and in compliance with A.A.C. R9-10-225, A.A.C. R9- 21-204, and A.A.C. R9-10-316. Licensed behavioral health facilities and programs, including out-of-state facilities, authorized to use seclusion and restraint must report each occurrence of seclusion and restraint and information on the debriefing subsequent to the occurrence of seclusion or restraint to MC QM within five (5) business days of the occurrence. The individual reports must be submitted on the Policy 962, Attachment A, Seclusion and Restraint Individual Reporting Form. This form is available on MC's website. The facility may alternatively submit their electronic medical record that includes all elements listed on the Policy 962 Attachment A.

Each reported occurrence of seclusion and restraint is required to include a complete copy of the written order that include the requirements as per A.A.C. R9-21-204**.**

In the event that a use of seclusion or restraint requires face-to-face monitoring, a report detailing face-to-face monitoring is submitted to MC QM along with the Policy 962, Attachment A, Seclusion and Restraint Individual Reporting Form. The face-to-face monitoring form must include the requirements as per A.A.C. R9-21-204**.**

All documentation related to a single seclusion or restraint submission, including all required supporting records and the 962 Attachment, **must be consolidated into one complete PDF document prior to submission**. Submissions containing multiple separate attachments will be considered non-compliant and will not be accepted for review.

In order to maintain consistency, all seclusion and restraint reported events for MC members are to be submitted via email directly to **MercyCareSandR@MercyCareAZ.org** or via fax to 1- 855-224-4908.

Providers are also responsible for reviewing and becoming familiar with **AdSS 962** for DES-DDD plan specific polices related to QOC related occurrence and notification requirements.

Definitions

Behavioral Health Inpatient Facilities (BHIF): A health care institution, as specified in A.A.C. R9-10-101, that provides continuous treatment to an individual experiencing a behavioral health issue that causes that individual to:

1. Have a limited or reduced ability to meet the basic physical needs.
2. Suffer harm that significantly impairs the judgment, reason, behavior, or capacity to recognize reality.
3. Be a danger to self.
4. Be a danger to others.
5. Be persistently or acutely disabled as specified in A.R.S. § 36-501, or 6. Be gravely disabled.

Chemical Restraint: A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition. Refer to 42 CFR 482.13 (e)(1)(i)(B). Chemical Restraints shall be interpreted and applied in compliance with the Center for Medicaid Services (CMS) State Operations Manual, Appendix A at A-0160 for Regulations and

Interpretive Guidelines for Hospitals at: https://www.cms.gov/Regulations-and-Guidance/Guidance/ Manuals/Downloads/som107ap_a_hospitals.pdf

Mechanical Restraint: Any device, article, or garment attached or adjacent to a member's body that the member cannot easily remove and that restricts the member's freedom of movement or normal access to the member's body, but does not include a device, article, or garment:

1. Used for orthopedic or surgical reasons, or
2. Necessary to allow a member to heal from a medical condition or to participate in a treatment program for a medical condition.

Personal Restraint: The application of physical force without the use of any device, for the purpose of restricting the free movement of a member's body. For Behavioral Health Inpatient Facility (BHIF) or outpatient treatment centers licensed to provide behavioral health observation/stabilization services (Crisis Facility), personal restraint does not include:

1. Holding a member for no longer than five minutes, without undue force, in order to calm or comfort the member.
2. Holding a member's hand to escort the member from one area to another.

Seclusion: The involuntary solitary confinement of a patient in a room or an area where the patient is prevented from leaving as specified in A.A.C. R9-10-101.

Seclusion of Individuals Determined to have a Serious Mental Illness (SMI): The restriction of a member to a room or area through the use of locked doors or any other device or method which precludes a member from freely exiting the room or area or which a member reasonably believes precludes his/her unrestricted exit [A.A.C. R921-101(B)].

In the case of an inpatient facility, confining a client to the facility, the grounds of the facility, or a ward of the facility does not constitute Seclusion. In the case of a community, residence, restricting a client to the residential site, according to specific provisions of a service plan or court order does not constitute Seclusion, as specified in A.A.C. R9-21-101(B).

MC Chapter 13 – Referrals and Authorizations

13.00 - Referral Overview

It may be necessary for an MC member to be referred to another provider for medically necessary services that are beyond the scope of the member's PCP. For those services, providers only need to complete their own Referral Form and refer the member to the appropriate MC PHP. MC's website includes a provider search function for your convenience. More information is available **Section 4.48 – Availity** of this manual regarding prior authorizations.

There are two types of referrals:

- Participating providers (particularly the member's PCP) may refer members for specific covered services to other practitioners or medical specialists, allied healthcare professionals, medical facilities, or ancillary service providers.
- Member may self-refer to certain medical specialists for specific services, such as an OB/GYN.

Referrals must meet the following conditions:

- The referral must be requested by a participating provider and be in accordance with the requirements of the member's benefit plan (covered benefit).
- The member must be enrolled in MC on the date of service(s) and eligible to receive the service.

If MC's network does not have a PHP to perform the requested services, members may be referred to out of network providers if:

- The services required are not available within the MC network.
- MC prior authorizes the services.

If out of network services are not prior authorized, the referring and servicing providers may be responsible for the cost of the service. The member may not be billed if the provider fails to follow MC's policies. Both referring and receiving providers must comply with MC policies, documents, and requirements that govern referrals (paper or electronic) including prior authorization. Failure to comply may result in delay in care for the member, a delay or denial of reimbursement or costs associated with the referral being changed to the referring provider. Referrals are a means of communication between two providers servicing the same member. Although MC encourages the use of a Referral Form, it is recognized that some providers use telephone calls and other types of communication to coordinate the member's medical care.

This is acceptable to MC if the communication between providers is documented and maintained in the members' medical records.

13.01 - Referring Provider's Responsibilities

- Confirm that the required service is covered under the member's benefit plan prior to referring the member.
- Confirm that the receiving provider is contracted with MC.
- Obtain prior authorization for services that require prior authorization or are performed by a non-PHP.
- Complete a Referral Form and mail or fax the referral to the receiving provider.

13.02 - Receiving Provider's Responsibilities

PHPs may render services to members for services that do not require prior authorization, and that the provider has received a completed MC referral form (or has documented the referral in the member's medical record). The provider rendering services based on the referral is responsible to:

- Schedule and deliver the medically necessary services in compliance with MC's requirements and standards related to appointment availability.
- Verify the member's enrollment and eligibility for the date of service. If the member is not enrolled with MC on the date of service, MC will not render payment regardless of referral or prior authorization status.
- Verify that the service is covered under the member's benefit plan.
- Verify that the prior authorization has been obtained, if applicable, and includes the prior authorization number on the claim when submitted for payment.
- Inform the referring provider of the consultation or service by sending a report and applicable medical records to allow the referring provider to continue the member's care.

13.03 - Period of Referral

Unless otherwise stated in a PHP's contract or MC documents, a referral is valid for the full extent of the member's care starting from the date it is signed and dated by the referring provider, if the member is enrolled and eligible with MC on the date of service.

13.04 - Maternity Referrals

Referrals to Maternity Care Health Practitioners may occur in two ways:

- A pregnant MC member may self-refer to any MC contracted Maternity Care Practitioner.

- The PCP may refer pregnant members to a MC contracted Maternity Care Practitioner.

At a minimum, Maternity Care Practitioners must adhere to the following guidelines:

- Coordinate the members maternity care needs until completion of the postpartum visits.
- Schedule a minimum of one postpartum visit at approximately six weeks postpartum.
- When necessary, refer members to other practitioners in accordance with the MC referral policies and procedures.
- Schedule return visits for members with uncomplicated pregnancies consistent with the American College of Obstetrics and Gynecology standards:
    - Through twenty-eight weeks of gestation – every four weeks
    - Between twenty-nine- and thirty-six-weeks' gestation every two weeks
    - After the thirty sixth week – once a week
    - Schedule first-time appointments within the required timeframes
    - Members in first trimester – within seven calendar days
    - Members in third trimester – within three calendar days
    - High-risk Members – within three calendar days of identification or immediately when an emergency condition exists.

13.05 - Ancillary Referrals

All practitioners and providers must use and/or refer to MC contracted ancillary providers.

13.06 - Member Self-Referrals

MC members can self-refer to participating providers for the following covered services:

- Family Planning Services
- OB Services
- GYN Services
- Dental Services for Members Under Age 21
- Vision services for Members Under Age 21
- Behavioral Health Services

When a member self refers for any of the above services, providers rendering services must adhere to the same referral requirements as described above.

13.07 - Prior Authorization

MC requires prior authorization for select acute outpatient services and planned hospital admissions. Prior authorization is not required for the following:

- Emergency services
- Observation services

Prior authorization guidelines are reviewed and updated regularly. To request an authorization or check on the status of an authorization, please visit **Availity**. More information is available in this Provider Manual under **Section 4.48 – Availity** of this manual regarding authorizations. You may also call our Prior Authorization department at 602-263-3000 or 800-624-3879 (toll-free).

Our **On-Line Prior Authorization Search Tool (ProPat)** is now available on our website with no log-in. It is currently available on our Prior Authorization tab/webpage for each line of business. Locations are as follows:

- **Mercy Care Complete Care**
- **Mercy Care ACC-RBHA**
- **Mercy Care Long Term Care**
- **Mercy Care DD**
- **Mercy Care Advantage**

ProPat gives you the ability to look up codes to determine if they require Prior Authorization.

The tool is the same for all lines of business; however, it is important to note that you must indicate the line of business you are searching for in the tool to make sure accurate information is pulled up for that line of business.

To request a prior authorization, be sure to:

- Always verify member eligibility prior to providing services.
- Complete the appropriate authorization form (medical or pharmacy).
- Attach supporting documentation when submitting. This could include:
    - Recent progress notes documenting the need for the service
    - Lab results
    - Imaging results (x-rays, etc.)
    - Procedure/Surgery reports
    - Notes showing previous treatment tried and failed
    - Specialty notes

To check on the status of an authorization, please visit **Availity**.

You can fax your authorization request to 1-800-217-9345.

Important to Note: When checking whether a service requires an authorization under MC's **Online Prior Authorization Search Tool** , please keep in mind that a listed service does not guarantee that the service is covered under the plan's benefits. Always check plan benefits first to determine whether the service is covered or not.

13.08 - Types of Requests

- **Expedited Service Authorization Requests That Do Not Pertain to Medications:** A request for services in which either the requesting provider indicates, or the MC determines that following the standard timeframes for issuing an authorization decision could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. In these circumstances, the authorization decision must be expedited and must be made within 72 hours from the date of receipt of the service request regardless of whether the due date falls on a weekend (Saturday and Sunday) or legal holiday as defined by the State of Arizona.
- **Expedited Authorization Request Downgraded to a Standard Request:** When MC receives an expedited request for a service authorization and the requested service is not of an expedited medical nature, the MC will downgrade the expedited authorization request to a standard request.
- **Standard Service Authorization Request That Do Not Pertain to Medications:** A request from the member, the representative, or a provider for a service for the member. The authorization decision must be made within 7 calendar days from the date of receipt of the service request.
- **Service Authorization Requests for Medications:** Service authorization requests for medications must be decisioned no later than 24 hours from receipt of the submitted request. If the service authorization request lacks sufficient information to render an approval or denial decision for the medication, MC will send a request for additional information to the prescriber no later than 24 hours from receipt of the service authorization request. For service authorization requests lacking information, MC will make sufficient attempts to obtain the missing information and issue a final decision no later than seven business days from the initial date of the request.

13.09 – Medical Prior Authorization

The Prior Authorization team is responsible for processing prior authorization requests for non-emergency, elective procedures and services that are in our prior authorization code list, referenced above.

13.10 – Complex Radiology Service Authorizations

eviCore healthcare administers prior authorization services for complex radiology and pain management services for MC. Services requiring authorization but performed without authorization may be denied for payment, and you may not seek reimbursement from members.

Prior authorization is required for the following complex radiology services:

- CT/CTA
- MRI/MRA
- PET

Services performed in conjunction with an inpatient stay, observation, or emergency room visit are not subject to authorization requirements.

To request an authorization from eviCore healthcare, please submit your request online, by phone or by fax to:

- Log onto the **eviCore healthcare Online Web Portal.**
- Call eviCore healthcare at 888-693-3211.
- Fax an **eviCore healthcare Request Form** (available online at the eviCore healthcare Online Web Portal) to 888-693-3210.

In order to avoid unnecessary denials, it is important to submit medical necessity documentation along with your request to support the need for these services.

For urgent requests: If services are required in less than 48 hours due to medically urgent conditions, please call eviCore healthcare's toll-free number for expedited authorization reviews. Be sure to tell the representative the authorization is for medically urgent care. eviCore healthcare recommends that ordering physicians secure authorizations and pass the authorization numbers to the rendering facilities at the time of scheduling. eviCore healthcare will communicate authorization decisions by fax to both the ordering physicians and requested facilities. Authorizations contain authorization numbers and one or more CPT codes specific to the services authorized. If the service requested is different than what is authorized, the rendering facility must contact eviCore healthcare for review and authorization prior to claim submission.

13.11 – Bariatric Surgery Criteria

MC covers bariatric surgery if there are clinical indications to support the need for the surgery and member fails to achieve and maintain significant weight loss with nonsurgical treatment. MC maintains a list of approved Bariatric Surgeons to conduct the surgery, as well as other specialists for the perioperative medical clearance and clinicians whose multidisciplinary services are necessary in the preoperative weight-loss program, such as nutritional and psychological counseling. Please contact our member services department to get a list. Servicing provider is responsible for ensuring that member meets clinical indications for the procedure. For the specific guidelines that MC utilizes to review bariatric surgery records for the medical necessity, please contact our Member Services or Prior Authorization department. To look up the CPT codes for Bariatric Surgery prior authorization requirements, please use the **Online Prior Authorization Search Tool**.

13.12 - Pharmacy Prior Authorization

The Pharmacy Prior Authorization team is responsible for processing prior authorization requests for the following:

- Medications not included in the MC's PDL, also referred to as a formulary.
- Medications that require prior authorization.
- Step Therapy medications.
- Medications with Quantity Limits.

A team of Arizona licensed pharmacists and certified pharmacy technicians authorize based on a set of pre-established clinical guidelines. Refer to Pharmacy Management under each line of business.

Electronic Prior Authorization (ePA)

MC is committed to making sure our providers receive the best possible information, and the latest technology and tools available.

We have partnered with CoverMyMeds® and SureScripts to provide you a new way to request a pharmacy prior authorization through the implementation of Electronic Prior Authorization (ePA) program.

With Electronic Prior Authorization (ePA), you can look forward to:

- Time saving
- Decreased paperwork, phone calls, and faxes for prior authorization requests
- Quicker determinations
- Reduced average wait times, resolution often within minutes

- Accommodating and Secure
- HIPAA compliant via electronically submitted requests

Getting started is easy. Choose ways to enroll:

- **No cost required! Let us help get you started!**
- Visit the CoverMyMeds® website
- Call CoverMyMeds® toll-free at **866-452-5017**
- Visit the SureScripts website
- Call SureScripts toll-free at **866-797-3239**

Billing Information:

BIN: 610591
PCN: ADV
Group: RX8805 (MCCC, MC DD, MCLTC)
Group: RX8822 (MC ACC-RBHA)

13.13 – Applied Behavioral Analysis

Behavior Analysis Services are a MC covered benefit for individuals with Autism Spectrum Disorder (ASD) and/or other diagnoses as justified by medical necessity.

Members must receive ABA services from a provider in MC's provider network. Medically necessary services, including ABA, are determined by the member's Child and Family Team (CFT) or Adult Recovery Team (ART).

Behavior Analysis Services are designed to accomplish one or more of the following:

- increase functional skills,
- increase adaptive skills (including social skills),
- teach new behaviors,
- increase independence and/or reduce or eliminate behaviors that interfere with behavioral or physical health.

Behavior Analysis Services are prescribed or recommended in specific dosages, frequency, intensity, and duration by a qualified Behavioral Health Professional (BHP) as the result of an assessment of the member, the intensity of the behavioral targets, and complexity and range of treatment goals.

Please refer to the Behavioral Health Services Billing Matrix on the Medical Coding Resources AHCCCS website for more information regarding required coding information, including covered settings or other billing/coding information.

Behavioral Analysis providers are required to submit prior authorization for Adaptive Behavior Treatments (CPT Codes 97153-97158). Adaptive Behavior Assessments (CPT Codes 97151 and 97152) will not require authorization. Service(s) rendered without authorization may be denied for payment. For Behavioral Analysis services a specific prior authorization form has been developed for initial and re-authorization of services. To access the form and a list of required clinical documentation, visit our website under Forms website named Prior Authorization for ABA Services. Prior authorization, if determined medically necessary, is approved for a maximum for 6 months, re-authorization will be required for continued service delivery.
The ABA service codes must be billed with the appropriate modifier to identify the experience level of the staff rendering the service.

Modifier tiers:

- BHT/RBT - Less Than bachelor's degree - Modifier HM
- Trainee, Master, BCaBA - bachelor's degree Level - Modifier HN
- BCBA - Master's Degree Level - Modifier HO
- BCBA-D - Doctoral Level - Modifier HP

13.14 - Nutritional Assessment and Nutritional Therapy

MC covers nutritional assessment and nutritional therapy for members over 21 on an enteral, parenteral, or oral basis when determined medically necessary to provide either complete daily dietary requirements, or to supplement a member's daily nutritional and caloric intake.
The following requirements apply:

- Must be assessed at each visit.
- Members in need of nutritional assessment or nutritional therapy should be identified and referred to a registered dietician in MC's network.
- Members in need of nutritional supplements may be referred to Epic Medical Solutions, MC's contracted DME provider for these services.
- Nutritional therapy requires prior authorization and approval by MC. To determine prior authorization, MC requires the AHCCCS **Attachment A – Certificate of Medical Necessity for Commercial Oral Nutritional Supplements for Members 21 Years of Age or Greater – Initial or Ongoing Request** form found on the AHCCCS website, along clinical notes, supporting documentation and evidence of required criteria as indicated in the Certificate of Medical Necessity be sent to Epic Medical Solutions. Their fax number is 480-883-1193. Epic will contact MC to request prior authorization.

For detailed information regarding Nutritional Assessment and Nutritional Therapy, please refer to the **AHCCCS Medical Policy Manual (AMPM), Chapter 300 - 310-GG Nutritional Therapy, Metabolic Foods, and Total Parenteral Nutrition** found on the AHCCCS website.

13.15 – Metabolic Medical Foods

Members who have been diagnosed with the following genetic metabolic conditions and who need metabolic medical foods may receive services through their genetics provider. MC covers medical foods, within the limitations specified in the **AHCCCS Medical Policy Manual, (AMPM), Chapter 300 – 310-GG Nutritional Therapy, Metabolic Foods, and Total Parenteral Nutrition** found on the AHCCCS website, for any member diagnosed with one of the following inherited metabolic conditions:

- Phenylketonuria
- Homocystinuria
- Maple Syrup Urine Disease
- Galactosemia (requires soy formula)
- Beta Keto-Thiolase Deficiency
- Citrullinemia
- Glutaric Acidemia Type I
- Isovaleric Acidemia
- Methylmalonic Acidemia
- Methylcrotonyl CoA Carboxylase Deficiency
- Pionic Acidemia
- Argininosuccinic Acidemia
- Tryosinemia Type I
- HMG CoA Lyase Deficiency
- Very long chain acyl-CoA Dehydrogenase deficiency (VLCAD)
- Long Chain acyl-CoA Dehydrogenase deficiency (LCHAD)

13.16 - Extensions and Denials

If MC requires additional clinical documentation to decide on the prior authorization request, MC will extend the turnaround time for an additional fourteen (14) calendar days. MC will notify the provider and member of this extension and detail the request for additional documentation. If the requested supporting documentation is not received within the requested timeframe, MC may deny the request for prior authorization on the date that the timeframe expires.

13.17 - Prior Authorization and Referrals for Services

- **Laboratory Services and Referrals:** Sonora Quest Laboratories, a subsidiary of Laboratory Sciences of Arizona, ("SQ") is MC's in-network provider of laboratory services for all lines of business. Providers shall only refer members to SQ for laboratory services unless prior authorization is obtained for an out-of-network laboratory provider. Services rendered by an out-of-network laboratory provider will be denied if prior authorization is not obtained.

  Only specific lab testing is covered when performed in the office. Please refer to **the MC Claims Processing Manual, Chapter 2 – Professional Claims Type by Specialty, Section 2.0 – Laboratory Services** available on the MC website for a listing of the office tabs code list. Prior authorization is NOT required for approved in office lab procedures that are on the office labs code list.
- **Radiology Services Referrals:** Prior authorization IS required before referring members for certain radiology services. To request an authorization, find out what requires authorization or check on the status of an authorization, please visit **Availity**.
- **Infusion or Enteral Therapy Referrals:** Prior authorization is NOT required to refer members to a contracted infusion or enteral provider. However, any medically necessary services rendered by an infusion, enteral provider or through a home health agency must be prior authorized. All infusion medications must be processed through the MC PBM (Pharmacy Benefit Manager) pharmacy benefit. Referrals may be processed through the PBM. All enteral needs are processed through the nutritional therapy contracted provider for MC and comply with medical necessity criteria.
- **Durable Medical Equipment (DME) Referrals:** Prior authorization is NOT required to refer members to a contracted DME provider. However, certain services may require prior authorization, as indicated in the provider's contract.
- **DES/DDD Prior Authorization:** Prior authorization may be required for some services. For members enrolled in the Department of Economic Security, Division of Developmental Disabilities (DES/DDD) health professionals must obtain prior authorization for required services from MC DD by faxing your request to 800-217-9345. Requests for sterilization, pregnancy termination, transplants, and enclosed beds require a Final determination by the DES/DDD medical director prior to providing the service. Notification of approved requests will be faxed or mailed to the provider.

13.18 - Prior Authorization and Coordination of Benefits

MC renders a determination regarding coverage within the timeframes specified in ACOM Policy 414 in absence or presence of an individual's third-party liability coverage. In instances where the third party has approved a service request through medical necessity review, MC will

not apply a secondary prior authorization and will coordinate benefit coverage with the third party.

MC Chapter 14 – Billing Encounters and Claims

14.00 - Billing Encounters and Claims Overview

The MC Claims department is responsible for claims, resubmissions, claims inquiry/research and provider encounter submissions to AHCCCS.

All providers who participate with MC must first register with AHCCCS to obtain an AHCCCS Provider Identification Number. Please contact AHCCCS directly for this number. Once you have obtained your 6-digit AHCCCS provider ID, notify Network Management.

Billing

14.01 - When to Bill a Member

A member may be billed when the member knowingly receives non-covered services.

- Provider **MUST** notify the member in advance of the charges.
- Provider should have the member sign a statement agreeing to pay for the services and place the document in the member's medical record.

MC members may **NOT** be billed for covered services or for services not reimbursed due to the failure of the provider to comply with MC's prior authorization or billing requirements. Please refer to *Arizona Revised Statute A.R.S. §36-2903.01 (L) and Administrative Codes R9-22-702, R9-27-702, R9-28-702, R9-30-702 I and R9-31-702* for additional information. Arizona *Administrative Code R9-22-702* states in part, *"an AHCCCS registered provider shall not do either of the following, unless services are not covered or without first receiving verification from the Administration [AHCCCS] that the person was not an eligible person on the date of service:*

1. *Charge, submit a claim to, or demand or collect payment from a person claiming to be AHCCCS eligible; or*
2. *Refer or report a person claiming to be an eligible person to a collection agency or credit reporting agency"*

MC members should not be billed or reported to a collection agency for any covered services your office provides.

Provider may **NOT** collect copayments, coinsurance, or deductibles from members with other insurance, whether it is Medicare, a Medicare HMO, or a commercial carrier. Providers must bill MC for these amounts and MC will coordinate benefits. Unless otherwise stated in contract, MC adjudicates payment using the lesser of methodology and members may not be billed for any remaining balances due to the lesser of methodology calculation.

14.02 - Prior Period Coverage

On occasion, AHCCCS eligible members are enrolled retrospectively into MC. The retrospective enrollment is referred to as Prior Period of Coverage (PPC). Members may have received services during PPC, and MC is responsible for payment of covered services that were received.

For services rendered to the member during PPC, the provider must submit PPC claims to MC for payment of covered benefits. The provider must promptly refund, in full, any payments made by the member for covered services during the PPC period.

While prior authorization is not required for PPC services, MC may, at its discretion, retroactively review medical records to determine medical necessity. If such services are deemed not medically necessary, MC reserves the right to recoup payment, in full, from the provider. The provider may not bill the member.

Encounters

14.03 - Encounter Overview

An encounter is a record of an episode of care indicating medically necessary services provided to an enrolled member. To comply with federal reporting requirements, AHCCCS requires the submission of claims and encounters for all services provided to enrolled members. Fines and penalties are levied against MC for failure to correctly report encounters in a timely manner. MC may pass along these financial sanctions to a provider that fails to comply with encounter submissions.

14.04 - When to File an Encounter

Encounters should be filed for **all** services provided, even those that are capitated. MC uses the encounter information to determine if care requirements have been met and establish rate adjustments.

14.05 - How to File an Encounter

To comply with federal reporting requirements, the AHCCCS Administration conducts program integrity studies on a random sample of members' medical records to compare recorded utilization information with submitted encounter data. The study evaluates the correctness or omission of encounter data. It is imperative that claims and encounters are submitted with correct procedure and diagnosis coding, and that the codes entered on the claim correspond to the actual services provided as evidenced in the member's medical record.

Services rendered must also coincide with the category of service listed on the provider record with AHCCCS. If services do not coincide, claims will be reversed, and monies recouped. If

providers do not properly report all encounters, MC may be assessed monetary penalties for noncompliance with encounter submission standards. We may then pass these financial sanctions on to providers or terminate contracts with providers who are not complying with these standards.

Claims

14.06 - When to File a Claim

All claims and encounters must be reported to MC, including prepaid services.

14.07 - Timely Filing of Claim Submissions

Unless a contract specifies otherwise, MC ensures that for each form type Dental/Professional/Institutional) 95% of all clean claims are adjudicated within 30 days of receipt of the clean claim and 99% are adjudicated within 60 days of receipt of the clean claim.

MC shall not pay:

- Claims initially submitted more than five months after date of service for which payment is claimed or after the date that eligibility is posted, whichever date is later; or
- Claims that are submitted as clean claims more than 12 months after date of service for which payment is claimed or after the date that eligibility is posted, whichever date is later (A.R.S.§36-2904.G).

Regardless of any subcontract with MC, when one AHCCCS Contractor recoups a claim because the claim is the payment responsibility of another AHCCCS Contractor (responsible Contractor); the provider may file a claim for payment with the responsible Contractor. The provider must submit a clean claim to the responsible Contractor no later than:

- 60 days from the date of the recoupment,
- 12 months from the date of service, or
- 12 months from date that eligibility is posted, whichever date is later.

The responsible Contractor shall not deny a claim based on lack of timely filing if the provider submits the claim within the timeframes above.

Claim payment requirements pertain to both contracted and non-contracted providers.

14.08 - MC as Secondary Insurer

MC is the payer of last resort. It is critical that you identify any other available insurance coverage for the patient and bill the other insurance as primary. For example, if Medicare is primary and MC is secondary.

- File an initial claim with MC if you have not received payment or denial from the other insurer before the expiration of your required filing limit. Make sure you are submitting timely to preserve your claim dispute rights.
- Upon the receipt of payment or denial by the other insurer, you should then submit your claim to MC, showing the other insurer payment amount or denial reason, if applicable, and enclosing a complete legible copy of the remittance advice or Explanation of Benefits (EOB) from the other insurer.
- When a member has other health insurance, such as Medicare, a Medicare HMO or a commercial carrier, MC will coordinate payment of benefits.
- In accordance with requirements of the Balanced Budget Act of 1997, MC will pay co-payments, deductibles, and/or coinsurance for AHCCCS Covered Services up to the lower of either MC's fee schedule or the Medicare/other insurance allowed amount.

Effective July 1, 2018, Claims should be initially submitted within 150 days from the date of service for a first submission to retain appeal rights, whether the other insurance explanation of benefits has been received or not.

Claims should be resubmitted within one year from the last date of service or 60 days from the date of the other insurance explanation of benefits, whichever is later once the other insurance explanation of benefits is received.

14.09 - Dual Eligibility MCA Cost Sharing and Coordination of Benefits

Coordinating MCA Benefits with MC (except for MC ACC-RBHA) – For MCA members enrolled in both MC (either MC Complete Care, MC Long Term Care and Division of Developmental Disabilities lines of business) and MCA, any cost sharing responsibilities will be coordinated between the two payers. For the most part, providers only need to submit one claim to MC. Once the claim has been paid by MCA, the claims payment information will cross over to MC and benefits will be automatically coordinated. There may be exceptions to this, which are covered in this chapter under the section titled **Instruction for Specific Claim Types.**

Coordinating MCA Benefits with MC ACC-RBHA – For MCA members enrolled in both MC ACC-RBHA and MCA, any cost sharing responsibilities will be coordinated between the two payers. Once the claim has been paid by MCA, a remit will be sent to the provider. MC ACC-RBHA follows the CMS COBA process. Unfortunately, this may involve delays in getting the claims to cross-over to MC ACC-RBHA to coordinate benefits. To expedite claims payment, we recommend that the provider submit the MCA Explanation of Benefits, along with the claim, to MC ACC-RBHA. This will allow benefits to be coordinated quicker.

As a reminder, Medicaid is the payer of last resort. It is very important to verify eligibility on all plans the member may be covered under to determine who the claim should be sent to and how the claim should coordinate.

14.10 - Injuries due to an Accident

In the event the member is being treated for injuries suffered in an accident, the date of the accident should be included on the claim for MC to investigate the possibility of recovery from any third-party liability source. This is particularly important in cases involving work-related injuries or injuries sustained as the result of a motor vehicle accident.

14.11 - How to File a Claim

1) Select the appropriate claim form (refer to table below).

Claim Form Type	
Service	**Claim Form**
Medical and Professional Services	Form 1500 (02-12)
Family Planning Services – Medical	Form 1500 (02-12)
Family Planning Services – Hospital Inpatient	CMS UB-04 Form
Family Planning Services – Outpatient or Emergency Obstetrical Care	Form 1500 (02-12)
Obstetrical Care	Form 1500 (02-12)
Hospital Inpatient, Outpatient, Skilled Nursing Facility and Emergency Room Services	CMS UB-04 Form
General Dental Services for MC ACC-RBHA Only	ADA 2012 Claim Form
Dental Services that are Considered Medical Services (Oral Surgery, Anesthesia)	Form 1500 (02-12)

Instructions on how to fill out claim forms can be found in the **MC Claims Processing Manual**, available on the MC website or in the AHCCCS Fee For Service Manual, as follows:

- **Form 1500 (02-12) Completion Instructions**
- **UB-04 (CMS 1450) Form Completion Instructions**
- **ADA Dental Claim Form Completion Instructions**

2) Complete the claim form.
   a) Claims must be legible and suitable for imaging and/or microfilming for permanent record retention. Complete ALL required fields and include additional documentation when necessary.
   b) The claim form may be returned unprocessed (unaccepted) if illegible or poor-quality copies are submitted or required documentation is missing. This could result in the claim being denied for untimely filing.

3) Submit **original** copies of claims electronically or through the mail (do NOT fax or hand-deliver). To include supporting documentation, such as members' medical records, clearly label and send to the Claims department at the correct address.
   a) Electronic Clearing House - Providers who are contracted with MC can use electronic billing software. Electronic billing ensures faster processing and payment of claims, eliminates the cost of sending paper claims, allows tracking of each claim sent and minimizes clerical data entry errors. Additionally, a Level Two report is provided to your vendor, which is the only accepted proof of timely filing for electronic claims.
      - Please refer to the **MC Claims Processing Manual** available on the MC website for more information on the EDI vendors that MC uses.
      - Contact your software vendor directly for further questions about your electronic billing.
      - Contact your Network Relations Specialist/Consultant for more information about electronic billing.

      Additional information can be attained by reviewing the **MC Claims Processing Manual, Chapter 1 – General Claims Processing Information, Section 1.3 – Electronic Tools and Availity** on the MC website.

      All electronic submission shall be submitted in compliance with applicable law including HIPAA regulations and MC policies and procedures.
   b) Through the Mail

Claim Address Table		
Claims	**Mail To/Email To**	**Electronic Submission**
Medical		
MC Complete Care and MC Long Term Care	Mercy Care Claims Department P.O. Box 982975 El Paso, TX 79998-2975	Through Electronic Clearinghouse Payer ID: 86052
MC ACC-RBHA	Mercy Care ACC-RBHA Claims Department P.O. Box 982976 El Paso, TX 79998-2976	Through Electronic Clearinghouse Payer ID: 33628
Dental		
MC Complete Care		

MC Long Term Care **MC ACC-RBHA**	Liberty Dental Plan Attention: Claims P.O. Box 401086 Las Vegas, NV 89140	Through Liberty Dental Plan Electronic Clearinghouse
Refunds		
For All Plans	Mercy Care Attention: Finance Department P.O. Box 90640 Phoenix, AZ 85066	N/A
Transplant		
Claims-Transplant Component Packets	MercyCareTransplant@AETNA.com	N/A

14.12 - Correct Coding Initiative

MC and AHCCCS follow the same standards as Medicare's Correct Coding Initiative (CCI) policy and perform CCI edits and audits on claims for the same provider, same recipient, and same date of service. For more information on this initiative, please review the CMS website under **National Correct Coding Initiative Edits.**

MC utilizes ClaimsXten as our comprehensive code auditing solution that will assist payers with proper reimbursement. Correct Coding Initiative guidelines will be followed in accordance with both AHCCCS and CMS, in addition to pertinent coding information received from other medical organizations or societies.

ClearClaim is a web-based stand-alone code auditing reference tool designed to mirror MC's comprehensive code auditing solution through ClaimsXten. It enables MC to share with our providers the claim auditing rules and clinical rationale inherent in ClaimsXten.

Providers will have access to ClearClaim through Availity. ClearClaim coding combinations can be used to review claim outcomes after a claim has been processed. Coding combinations may also be reviewed prior to submission of a claim so that the provider can view claim auditing rules and clinical rationale prior to submission of claims.

Further detail on how to use ClearClaim can be found on the application itself by using the help link. ClearClaim can be found after logging in Availity by using the search button and typing in

ClearClaim. For further instruction on Availity, please refer to **Section 4.48 – Availity** in this manual.

14.13 - Correct Coding

Correct coding means billing for a group of procedures with the appropriate comprehensive code. All services that are integral to a procedure are considered bundled into that procedure as components of the comprehensive code when those services:

- Represent the standard of care for the overall procedure, or
- Are necessary to accomplish the comprehensive procedure, or
- Do not represent a separately identifiable procedure unrelated to the comprehensive procedure.

14.14 - Incorrect Coding

Examples of **incorrect coding** include:

- "Unbundling" - 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 to use an additional code when one higher level, more comprehensive code is appropriate.

14.15 - Modifiers

Appropriate modifiers must be billed to reflect services provided and for claims to pay appropriately. MC can request copies of operative reports or office notes to verify services provided. Common modifier issue clarification is below:

- **Modifier 59 – Distinct Procedural Services** - 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).
- **Modifier 25 – Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other 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 25 is used with evaluation and management codes and cannot be billed with surgical codes.

- **Modifier 50 – Bilateral Procedure** - If no code exists that identifies a bilateral service as bilateral, you may bill the component code with modifier 50. MC follows the same billing process as CMS and AHCCCS when billing for bilateral procedures. Services should be billed on one-line reporting one unit with a 50 modifier.
- **Modifier 57 – Decision for Surgery** – must be attached to an Evaluation and Management code when a decision for surgery has been made. MC follows CMS guidelines regarding whether the Evaluation and Management will be payable based on the global surgical period. CMS guidelines found in the Medicare Claims Processing Manual, Chapter 12 – Physicians/Non-physician Practitioners indicate: "*Carriers pay for an evaluation and management service on the day of or on the day before a procedure with a 90-day global surgical period if the physician uses CPT modifier "-57" to indicate that the service resulted in the decision to perform the procedure. Carriers may not pay for an evaluation and management service billed with the CPT modifier "-57" if it was provided on the day of or the day before a procedure with a 0 or 10-day global surgical period.*"
- **EP Modifier – Service provided as part of a Medicaid early periodic screening diagnosis and treatment [EPSDT] program –** must be appended to CPT code 96110 to receive additional developmental screening tool payment. For additional information please refer to the **MC Claims Processing Manual**, **Chapter 3 – Early Periodic Screening and Developmental Testing (EPSDT),** which is available on the MC website.
- **SL Modifier – State Supplied Vaccine** – If a vaccine is provided through the VFC program, the SL modifier must be added to both the vaccine code and the vaccine administration code. For additional information please refer to the **MC Claims Processing Manual**, **Chapter 3 – Early Periodic Screening and Developmental Testing (EPSDT), Section 3.4 – Vaccines for Children Program,** which is available on the MC website.
- **Outpatient Rehabilitation Modifiers**
    - **GN** – Services delivered under an outpatient speech-language pathology plan of care
    - **GO** – Services delivered under an outpatient occupational therapy plan of care
    - **GP** – Services delivered under an outpatient physical therapy plan of care

  To appropriately distinguish between habilitative and rehabilitative services and ensure accurate claims processing, providers must append the appropriate modifiers. These modifiers are required in addition to the CMS/AHCCCS therapy modifiers GN, GO, and GP.

- **96 – Habilitative Services** - When a service or procedure that may be either habilitative or rehabilitative in nature is provided for habilitative purposes, the physician or other qualified health care professional may add modifier 96 to the service or procedure code to indicate the service or procedure provided was a habilitative service. Habilitative services help an individual learn skills and functioning for daily living that the individual has not yet developed and then keep and/or improve those learned skills. Habilitative services also help an individual keep, learn, or improve skills and functioning for daily living
- **97 – Rehabilitative Services** - When a service or procedure that may be either habilitative or rehabilitative in nature is provided for rehabilitative purposes, the physician or other qualified health care professional may add modifier 97 to the service or procedure code to indicate that the service or procedure provided was a rehabilitative service. Rehabilitative services help an individual keep, get back, or improve skills and functioning for daily living that have been lost or impaired because the individual was sick, hurt, or disabled.
- The **CMS Therapy Code List and Disposition Table** for the current year provides more specifics on the usage of these modifiers.

Please refer to your Current Procedural Terminology (CPT) manual for further detail on all modifier usage.

14.16 - Medical Claims Review

To ensure medical appropriateness and billing accuracy, any inpatient and outpatient outlier claims are sent for Medical Claims Review.

14.17 - Checking Status of Claims

Providers may check the status of a claim by accessing MC's secure website or by calling the Claims Inquiry Claims Research (CICR) department.

Online Status through MC's Secure Website

MC encourages providers to take advantage of using online status through Availity, as it is quick, convenient, can be used off-hours, and used to determine status for multiple claims. More information is available in this manual under **Section 4.48 – Availity**. Availity is available 24-hours-a-day/7-days-a-week to providers. Using Availity will make better use of your time and allow us to focus on more complex claim questions for both you and other providers calling in.

Calling the Claims Inquiry Claims Research Department

Claim status calls are limited to 3-member status requests during our peak business hours (between 10:00 a.m. to 3:00 p.m.). Unlimited status requests will be answered during non-peak hours.

The Claims Inquiry department is also available to:

- Answer questions about claims.
- Assist in resolving problems or issues with a claim.
- Provide an explanation of the claim adjudication process.
- Help track the disposition of a claim.
- Correct errors in claims processing:
    - Excludes corrections to prior authorization numbers (providers must call the Prior Authorization department directly).
    - Excludes rebilling a claim (the entire claim must be resubmitted with corrections, see **Section 14.19 - Claim Resubmission or Reconsideration** in this manual.

Please be prepared to give the service representative the following information:

- Provider name and AHCCCS provider number with applicable suffix if appropriate.
- Member name and AHCCCS member identification number.
- Date of service.
- Claim number from the remittance advice on which you have received payment or denial of the claim.

14.18 - Payment of Claims

MC processes and records the payment of claims through a Remittance Advice. Providers may choose to receive checks through the mail or electronically. MC encourages providers to take advantage of receiving Electronic Remittance Advices (ERA), as you will receive much sooner than receiving through the mail, enabling you to post payments sooner. Please contact your Network Relations Specialist/Consultant for further information on how to receive ERA.

Through **Electronic Funds Transfer (EFT)**, providers can direct funds to a designated bank account. MC encourages you to take advantage of EFT. Since EFT allows funds to be deposited directly into your bank account, you will receive payment much sooner than waiting for the mailed check. Enrollment is through Change Health.

Additional information can be attained by accessing the **MC Claim Processing Manual, Chapter 1 – General Claims Processing Information, Section 1.3 – Electronic Tools and Availity** on the MC website.

14.19 - Claim Resubmission or Reconsideration

Providers have 12 months from the date of service to request a resubmission or reconsideration of a claim. A request for review or reconsideration of a claim does not constitute a claim dispute.

Providers may resubmit a claim that:

- Was originally denied because of missing documentation, incorrect coding, etc.
- Was incorrectly paid or denied because of processing errors.

Claim Resolution Pathway and Definitions

Providers must follow a structured pathway when seeking resolution for payment discrepancies or claim denials. While the overall process is designed to align with federal and state regulatory expectations, it includes both **informal** and **formal** steps. Understanding the distinction between these two steps is essential for compliance and efficient resolution.

- **Claim Reconsideration**
  An information request initiated by a provider to review a claim that was denied or paid incorrectly. Reconsiderations are typically resolved through claims adjustment or reprocessing and do not constitute a formal dispute or appeal.
  Purpose: To correct clerical errors, submit missing documentation, or address processing issues.
  Timeframe: Must be submitted within 12 months from the date of service contingent upon the original claim being submitted timely.
- **Provider Dispute/Appeal**
  A formal written challenge submitted by a provider regarding the denial or payment of a claim. For regulatory purposes, the terms *dispute* and *appeal* are synonymous and refer to the same formal process.
  Purpose: To contest a claim decision after informal resolution attempts (i.e., reconsideration) have failed.
  Timeframe: Must be filed within the later of:
  - 12 months from the date of service,
  - 12 months from the date eligibility was posted, or
  - 60 days from the date of denial of a timely claim submission.

Claim Resolution Process

1. **Step 1: Claim Reconsideration (Informal Strongly Encouraged)**
   Providers are expected to initiate a reconsideration request before pursuing formal dispute or appeal channels. This step allows for information resolution and often avoids the need for legal or administrative escalation. Most payment discrepancies and denials can be resolved through claims adjustment or reprocessing.
2. **Step 2: Formal Dispute/Appeal**
   If the reconsideration does not result in a satisfactory outcome, providers may file a formal dispute or appeal. This process is governed by applicable federal and state regulations and must include all relevant documentation, and a clear statement of the relief requested.

When filing resubmissions or reconsiderations, please include the following information:

- Use the **Resubmission Form** located under the **Forms** section of MC's website.
  - While available for use, this form is no longer necessary. If your preference is to include the form with your claim submission, please attach the claim form first and the letter after to avoid scanning issues and your claim being misrouted as a non-claim submission.
- An updated copy of the claim. All lines **must** be rebilled or a copy of the original claim (reprint or copy is acceptable).
- A copy of the remittance advice documenting which the claim was denied or paid incorrectly.
- Any additional documentation required.
- A brief note describing requested correction.
- Clearly label as "Resubmission" or "Reconsideration" at the top of the claim in black ink and mail to appropriate claims address as indicated in ***Claim Address Table***.

MC can receive submissions and reconsiderations electronically; this is the preferred method.

If billing a resubmission electronically, you must submit with:

- **Professional Claims** - A status indicator of 7 in the submission form location and the Original Claim ID field need to be filled out.
- **Facilities** In the Bill Type field, the last number of the 3-digit code should be a '7' and the original claim ID should be noted in box 64.
  - The submitted change must impact the processing of the original bill or additional bills for the adjustment to occur.

    - Using box 80 to report the Original Claim ID is acceptable; however, this field has character limitations and can cause exclusion of the Original Claim ID. Box 64 is the preferred location.
- You may submit attachments for your resubmission claims via **Availity**. Please click on the link to access this and review information regarding Availability on our website.

When submitting paper resubmissions, failure to mail and accurately label the resubmission or reconsideration to the correct address will cause the claim to deny as a duplicate. The resubmission mailing address is:

MC Complete Care, MC Long Term Care, MC DD, and MC DCS-CHP:
Claims Department
Attention: Resubmissions
P.O. Box 982975
El Paso, TX 79998-2975

MC ACC-RBHA:
Claims Department
Attention: Resubmissions
P.O. Box 982976
El Paso, TX 79998-2976

14.20 - Overpayments

Under Section 6402 of the Patient Protection and Affordable Care Act it states:

"Section 6402 of the Patient Protection and Affordable Care Act (PPACA) amends the Social Security Act (SSA) to include a variety of Medicare and Medicaid program integrity provisions that enhance the federal government's ability to discover and prosecute provider fraud, waste, and abuse. Among the provisions that may have a significant impact on States are newly imposed requirements for health care providers to report any overpayments from Medicaid and Medicare.

Under a new Section 1128J(d) of the SSA, any provider of services or supplies under Medicaid or Medicare must report and return "overpayments," which the statute defines as "any funds that a person receives or retains under either program "to which the person, after applicable reconciliation, was not entitled[.]" A "person" is defined as "a provider of services, supplier, Medicaid managed care organization…, Medicare Advantage organization…, or [Medicare Part D Prescription Drug Plan] sponsor[.]" PPACA § 6402(a). It does not include a beneficiary.

The overpayment must be returned within 60 days from the date the overpayment was "identified," or by the date any corresponding cost report was due, whichever is later. This provision of the law became effective May 22, 2010.

To properly return an overpayment, the individual who has received an overpayment must:

return the payment to the Secretary of the Department of Health and Human Services (Secretary), the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address; and notify the Secretary, State, intermediary, carrier, or contractor to whom the overpayment was returned the reason for the overpayment in writing.

Failure to return an overpayment has severe consequences. *If an overpayment is retained beyond the 60-day deadline, PPACA Section 6402 makes clear that it will be considered an "obligation" under the FCA. As amended by the Fraud Enforcement Recovery Act of 2009 (FERA), the FCA subjects a person to a fine and treble damages if he or she knowingly conceals or knowingly and improperly avoids or decreases an "obligation" to pay money to the federal government. PPACA treats Medicaid and Medicare overpayments alike in stating that failing to refund an overpayment will be considered an "obligation" under the FCA."*

Whether an overpayment is identified directly by the provider, or an overpayment request letter is sent to the provider by MC, the refund along with any supporting documentation should be sent to:

Mercy Care
Attention: Finance Department
P.O. Box 90640
Phoenix, AZ 85066

Supporting documentation must include:

- The overpayment claims number(s); and/or
- The remittance advice specific to the overpayment.

Instruction for Specific Claim Types

14.21 - MC General Claims Payment Information

MC claims are always paid in accordance with the terms outlined in the PHP's contract. Prior authorized services from Non-PHPs will be paid in accordance with AHCCCS processing rules.

Covered Services for each of MC's lines of business are outlined in the Provider Manual under Claims on the MC website under the following sections:

- **Chapter 200 – MCCC, MC DD, and DCS CHP Plan Specific Terms, Chapter 2 – Covered and Non-Covered Services**
- **Chapter 300 – MCLTC – Plan Specific Terms, Chapter 3 – Covered Services**
- **Chapter 400 – MC ACC-RBHA – Plan Specific Terms, Chapter 4 – Covered and Non-Covered Services**

Disclosure Statement: The presence of a rate in the fee schedule does not guarantee payment; the service must be covered by AHCCCS to be considered payable.

14.22 – Inpatient Claims

MC processes inpatient claims at APR-DRG in accordance with AHCCCS requirements. Please refer to the **MC Claims Processing Manual, Chapter 4 – Inpatient Claims** available on the MC website for additional detail.

14.23 – Federally Qualified Health Centers (FQHCs)

Special billing rules apply to FQHCs. Please refer to the **MC Claims Processing Manual, Chapter 5 – Federally Qualified Health Centers (FQHC) Prospective Payment System (PPS) Processing** available on the MC website for additional detail on how these claims should be billed.

14.24 - Skilled Nursing Facilities (SNFs)

Acute Care Skilled Nursing Facility Stay

Providers submitting claims for SNFs should use the **CMS UB-04 Form**. Please refer to the **MC Claims Processing Manual, Chapter 6 – Skilled Nursing Facility Claims** on the MC website for additional detail on how these claims should be billed.

Long Term Care Skilled Nursing Facility Stay

SNF Subacute Care Levels II and III per diem codes 193 and 194 include therapy services (occupational, physical, or speech). The SNF may be reimbursed for therapy services for the Custodial Level of stay. The therapy services must be billed on the UB-04 along with the Custodial Level.

Care Level	Codes	Therapy Service Coverage
Subacute Care Levels II and III	0193, 0194	Included in the SNF per diem

Custodial Level	0191, 0192, 0193	SNF may be reimbursed if billed separately and authorized

Share of Cost (SOC) is the dollar amount a member must contribute toward the cost of their care and most typically applies to MCLTC members residing in Skilled Nursing Facilities (SNF); however, it may also apply to DD members. The amount of the SOC is determined by AHCCCS.

- For MCLTC - Members are required to contribute toward the cost of their care through Share of Cost (SOC). When a recipient's eligibility for MCLTC is approved, a notice is generated to the member which identifies the amount of SOC the recipient owes, regardless of payment received from other payers or insurance. SOC change notices are sent to nursing facilities for any change that might occur to the SOC amount due. The identified SOC provided by AHCCCS is deducted from the payment owed for the claim. If a patient transfers from one facility to another in a month's time and the total SOC could not be applied to the first facility, the remainder will be carried over to the second facility's claim.
- For DD - Members are required to contribute toward the cost of their care based on their income and type of placement. Some members, either because of their limited income or the methodology used to determine the SOC, have a SOC in the amount of $0.00. Generally, only institutionalized members have a SOC. For members receiving Nursing Facility (NF) services, collection of the member SOC shall remain the responsibility of the Division.

Customized Durable Medical Equipment (DME), including customized wheelchairs and specialty beds such as Clinitron bed, may be covered by Medicaid in a SNF when prior authorized. Alternating pressure mattresses and pumps are included in the per diem.

Bariatric products and/or services are covered by Medicaid if they are authorized, and it is not a Bariatric Level of stay. All other ancillary services are included in the SNF per diem. Some services can be paid under Medicare Part B.

Ancillary Service	**Coverage**
Customized DME (including customized Wheelchairs and specialty beds)	May be covered when prior authorized
Alternating pressure mattresses and pumps	Included in the SNF per diem

Bariatric products and/or services	Covered if authorized and it is not a Bariatric level of care
All other Ancillary Services	Included in the SNF per diem

If a member has MCA as primary coverage, providers must bill in accordance with standard Medicare RUG billing requirement rules for MCA. The coordinating claim on the Medicaid side will require separate billing in accordance with the provider contract. This is one of the few situations where billing requirements differ on the MCA side versus the MCLTC side.
Please refer to the **MC Claims Processing Manual, Chapter 6 – Skilled Nursing Facility Claims** on the MC website.

14.25 - Dental Claims

Services provided by an anesthesiologist or medically related oral surgery procedure should be submitted on **Form 1500 (02/12)**. Please refer to the **MC Claims Processing Manual, Chapter 2 – Professional Claims by Specialty, Section 2.11 – Dental Claims**, as well as **Section 2.12 – Oral Surgery Claims** on the MC website for additional claims information.

14.26 – Durable Medical Equipment (DME)

MC covers reasonable and medically necessary durable medical equipment (DME) when ordered by a primary care provider or a practitioner within certain limits based on member age and eligibility. Durable Medical Equipment (DME) may be purchased or rented. Total expense of the rental must not exceed the purchase price of the item.

- Emergent/Post hospitalization discharge DME and supplies must be provided within 24 hours from when MC receives the initial request for authorization to the delivery of the equipment from the provider.
- Routine or non-customized DME and supplies (prior authorization required), must be provided within 10 days from the date of the prior authorization request to the delivery of the equipment from the provider.
- Routine or non-customized DME and supplies (prior authorization not required) must be provided within 10 days from when the provider receives the initial request for the delivery of the equipment from the provider.
- Augmentative Communication Devices must be provided within 90 days from when MC receives the initial request for authorization to the delivery of the equipment from the provider.
- Customized DME must be provided within 90 days from when MC receives the initial request for authorization to the delivery of the equipment from the provider.

Contracted providers are expected to submit quarterly reporting to MC by no later than the 15th of the month (or next business day) following quarterly reporting period, which is required by AHCCCS. This reporting measures both MC's and vendors' performance on insuring that the member receives the services timely.

MC requires contracted DME providers to provide order date and delivery date for each DME order quarterly via the Provider Delivery portal in Availity. Providers must use the standardized DME template to upload the DME order and delivery date. Providers are expected to adhere to the DME delivery timeliness standards listed below:

- Emergent/Post-hospitalization discharge DME and supplies <24 hours
- Routine or non-customized DME and supplies (PA required or no PA required) <10 days
- Augmentative Communication Devices <90 days
- Customized DME <90 days

Contracted DME providers must comply with all DME reporting requirements including:

- Providing requested reports/data in a timely manner
- Responding to questions and/or requests for additional information in a timely manner
- Developing corrective action plans

14.27 - Augmentative and Alternative Communication Device Systems

For DD members, DME and supplies will include augmentative and alternative communication device systems as of 10/1/2020.

For your convenience, we have developed an **Augmentative and Alternative Communication Device Systems (AAC) Provider Guideline**. Please click on the link to view in further detail.

This provider guide is intended for health care professionals such as physicians, speech language pathologists (SLP), occupational therapists (OT), and physical therapists (PT) who assist members considering augmentative and alternative communication (AAC) as a system of techniques and tools to address the needs of members with significant and complex communication disorders characterized by impairments in speech-language production and/or comprehension, including spoken and written modes of communication.

14.28 - Family Planning Claims

- Claims for medical services will only be accepted on **Form 1500 (02/12).**
- Inpatient hospitalizations, outpatient surgery, and emergency department facility claims should be filed on **CMS UB-04 Form**.

- Please refer to the **MC Claims Processing Manual, Chapter 2 – Professional Claim Types by Specialty, Section 2.14 – Family Planning Claims** for additional billing information.
- Family Planning services may be billed with other services on the same claim. When billed on the same claim though, a provider will receive two remits, one for family planning services and one for non-family planning services, as these services are paid out of separate funds.
- Family Planning claims may be submitted electronically.

Providers must submit the following information:

- AHCCCS Provider ID number.
- Family planning service diagnosis (all claims **must** have).
- Explanation of Benefits from other insurance (including Medicare).
- Correctly signed and dated sterilization consent forms.
- The 30-day waiting period can be waived for emergent or medically indicated reasons.
- Operative reports for surgical procedures.
- Use HCPCS "J" codes, and provide the drug administered, NDC code and the dosage for injected substances.
- Payment for IUDs requires a copy of the invoice to establish cost to the provider.
- Anesthesia claims require an ASA code for surgery with the appropriate time reflected in minutes.
- For Family Planning Services Extension Program members, X-ray and lab charges will be paid only if they are related to family planning. There must be a Family Planning Service diagnosis.
- A separate claim must be submitted for each date of service.

Members may request services, such as infertility evaluations and abortions from providers, whether they are registered with AHCCCS, but must sign a release form stating that they understand the service is not covered and that the member is responsible for payment of these services.

If you have authorization or claims questions related to family planning, please call:

Aetna Medicaid Administrators LLC
602-798-2745: Phoenix
888-836-8147: Outside Phoenix

14.29 - Complete Obstetrical Care Package

Reimbursement for obstetrical care is dependent upon the provider's contract with MC. Please refer to your contract for further detail. Providers are expected to bill for obstetrical care according to the terms of their contract and should file claims using **Form 1500 (02/12)**.

Fee for Service

For additional information regarding fee for service billing, please refer to the **MC Claims Processing Manual, Chapter 2 – Professional Claim Types by Specialty, Section 2.5 – Obstetrical Billing** available on the MC website. It is important to note that providers must bill all pre-natal and post-partum visits when submitting a finalized claim. This information is required per AHCCCS guidelines to increase the data available for calculating Performance Measures as well as to provide an opportunity to improve care, services, and outcomes for members. Most providers are currently contracted on a fee for service basis and are paid in accordance with CPT Guidelines.

Global Case Rate

Providers contracted at a global case rate are reimbursed as follows:

Services Included in the Package

- Initial and subsequent prenatal visits, including early, periodic, screening, diagnosis, and treatment services (EPSDT - see below) for patients less than 21 years of age
- Treatment of pregnancy related conditions, including hypertension and gestational diabetes
- Treatment of urinary tract infections and pelvic infections
- Routine labs and blood draws
- In-hospital management of threatened premature labor
- In-hospital management of hyperemesis gravidarum
- External cephalic version performed in hospital
- Induction of labor by prostaglandins and/or oxytocin and/or combined
- Amnioinfusion
- Trial of vaginal birth after a cesarean (VBAC)
- Delivery by any method, including cesarean section
- Episiotomy and repair, including 4th degree lacerations
- All routine post-partum care, including follow-up visit
- Any management that would ordinarily be considered part of OB care.

Services will not be separately reimbursed if billed separately.

If a provider does not complete all the services in the Global Obstetrical Care Package, this may result in a lesser payment or potential recoupment of payments made.

Services Not Included in the Package

- Amniocentesis
- Obstetrical Ultrasonography
- Non-stress and contraction stress tests
- Coloscopy and/or biopsy for accepted indication
- Return to operating or delivery room for postpartum hemorrhage/curettage
- Non-obstetrical related medical care
- Cerclage.

Separate reimbursement will be provided, if medically necessary.

14.30 - Trimester of Entry into Prenatal Care

Claims for obstetrical services are submitted on **Form 1500 (02-12)**. Health providers must bill in accordance with the **MC Claims Processing Manual, Chapter 2 – Professional Claim Types by Specialty, Section 2.5 – Obstetrical Billing** available on the MC website.

While the goals of early entry into prenatal care and regular care during pregnancy have not changed, HEDIS guidelines will be followed to determine trimester of entry into prenatal care. Entry into prenatal care and the number of prenatal visits is measured and monitored by MC and AHCCCS as part of the Quality Management Program.

14.31 - Provider Remittance Advice

MC generates checks weekly. Claims processed during a payment cycle will appear on a remittance advice ("remit") as paid, denied, or reversed. Adjustments to incorrectly paid claims may reduce the check amount or cause a check not to be issued. Please review each remit carefully and compare to prior remits to ensure proper tracking and posting of adjustments. We recommend that you keep all remittance advices and use the information to post payments and reversals and make corrections for any claims requiring resubmission. Call your Network Relations Specialist/Consultant if you are interested in receiving electronic remittance advices.

The Provider Remittance Advice (remit) is the notification to the provider of the claims processed during the payment cycle. A separate remit is provided for each line of business in which the provider participates.

Information provided on the remit includes:

- The Summary Box found at the top right of the first page of the remit summarizes the amounts processed for this payment cycle.
- The Remit Date represents the end of the payment cycle.
- The Beginning Balance represents any funds still owed to MC for previous overpayments not yet recouped or funds advanced.
- The Processed Amount is the total of the amount processed for each claim represented on the remit.
- The Discount Penalty is the amount deducted from, or added to, the processed amount due to late or early payment depending on the terms of the provider contract.
- The Net Amount is the sum of the Processed Amount and the Discount/Penalty.
- The Refund Amount represents funds that the provider has returned to MC due to overpayment. These are listed to identify claims that have been reversed. The reversed amounts are included in the Processed Amount above. Claims that have refunds applied are noted with a Claim Status of REVERSED in the claim detail header with a non-zero Refund Amount listed.
- The Amount Paid is the total of the Net Amount, plus the Refund Amount, minus the Amount Recouped.
- The Ending Balance represents any funds still owed to MC after this payment cycle. This will result in a negative Amount Paid.
- The Check # and Check Amount are listed if there is a check associated with the remit. If payment is made electronically then the EFT Reference # and EFT Amount are listed along with the last four digits of the bank account, the funds were transferred. There are separate checks and remits for each line of business in which the provider participates.
- The Benefit Plan refers to the line of business applicable for this remit. TIN refers to the tax identification number.
- The Claim Header area of the remit lists information pertinent to the entire claim. This includes:
    - Member/Patient Name
    - ID
    - Birth Date
    - Account Number,
    - Authorization ID, if Obtained
    - Provider Name,
    - Claim Status,
    - Claim Number
    - Refund Amount, if Applicable

- The Claim Totals are totals of the amounts listed for each line item of that claim.
- The Code/Description area lists the processing messages for the claim.
- The Remit Totals are the total amounts of all claims processed during this payment cycle.
- The Message at the end of the remit contains claims inquiry and resubmission information as well as grievance rights information.

More information is available in this manual under **Section 4.48 – Availity** regarding Remittance Advice Search.

An electronic version of the Remittance Advice can be attained. You can also receive an ERA through an 835 file. We encourage our providers to take advantage of EDI, EFT, and ERA, as it shortens the turnaround time for you to receive payment and reconcile your outstanding accounts. Please contact your Network Relations Specialist/Consultant to assist you with this process.

14.32 – Program Integrity

Criteria Used in Program Integrity Reviews

The criteria include timeliness, correctness, and omission of encounters, in addition to billing for services not documented in the medical record, incorrectly documented in the medical record, or insufficiently documented in the medical record. These criteria are defined as follows:

- Timeliness - The time elapsed between the date of service and the date that the encounter is received;
- Correctness - A correct encounter contains a complete and accurate description of a covered physical or behavioral health service provided to a member. Correctness errors frequently identified include, but are not limited to, invalid procedure or revenue codes and ICD-10 diagnoses not reported to the correct level of specificity;
- Omission - Provider documentation shows a service was provided; however, an encounter was not submitted;
- Documentation Issues - A description of adequate documentation is referenced in **Section 4.19 – Member's Medical Records** of this manual.

MC conducts program integrity audits with providers that submit claims to MC whether the provider is contracted with MC or not. The program integrity audits help ensure that covered healthcare services are appropriately documented and billed and that they support the identification of opportunities for improvement in billing practices.

MC will establish a review schedule with providers and provide advance notice of the program integrity audit. Reviews will typically be conducted remotely, but may be conducted on-site at a provider's office, if necessary. The purpose of the program integrity audit is to confirm that covered services are billed correctly and completely and in a timely manner. Providers should take special care to ensure that valid procedure and revenue codes are utilized and that the coding of diagnoses reflects the correct level of specificity.

Provider Responsibilities

Providers must deliver covered services in accordance with all AHCCCS and MC guidelines and policies. Healthcare providers must document adequate information in the clinical record and submit encounters in accordance with **Chapter 14 – Billing Encounters and Claims** in this manual. Any program integrity findings that indicate suspected fraud, waste and/or program abuse must be reported to the AHCCCS Office of Inspector General as required. A determination of simple or straightforward billing errors as the result of a program integrity audit may result in a recoupment of the related funds/voiding of related claims. Lack of documentation that is not pervasive may also result in recoupment.

Program Integrity Findings

At the conclusion of the audit, if MC requires further action from the provider (i.e., rebilling) findings will be shared with the provider at that time via exit interview/formal audit reports. If no action is required by the provider, MC will close the audit without the need for formal audit findings/reports. The purpose of the program integrity audit is to ensure appropriate billing and is not meant to be a scoring mechanism so formal findings/reports may not always be necessary.

Prepayment Review Process

MC may determine that prepayment review might be a useful tool based on findings resulting from Program Integrity Reviews, other audit processes, or data mining activities. This is not an audit process, but simply a mechanism to ensure clean claiming is occurring. Providers are chosen at random and may be chosen more than once within a particular year.

During the prepayment review process, samples of claims will be selected for review which will require the submission of medical records to determine final claim action. Any claims selected for prepayment review will be pended and medical records will need to be submitted before the claim can be finalized. Once records have been received for prepayment review and MC has reviewed the records against services billed the pended claim may either be adjusted for payment or denied.

- Claims will be selected on a bi-weekly basis.

- MC requires that records be submitted within 10 days of the receipt of the email noting the claims selected for review to ensure integrity of the documentation to be reviewed. **As noted above, this is not an audit, but rather a claiming action.**
- Records are to be submitted in one block through the process noted in your prepayment review letter and not submitted one claim at a time. If any records are missing from the block of claims selected for review, the review will be placed on hold and the review will not start until all records have been received from that block of claims.
- MC shall complete the reviews in a timely manner but will not exceed 30 days from the date the records are received.
- The prepayment review process will be valid for a 90-day period. At the end of the 90 days, MC shall assess progress and determine if a new prepayment review cycle will be needed or if the prepayment review process will be closed.

Claim Resubmissions and Recoupments

Any claims recouped as part of the Program Integrity process or claims denied as part of the Prepayment Review process (after records are received and reviewed) are not eligible to be resubmitted. New claims may not be submitted to replace these services**.**

Noncompliance with the prepayment review will result in claims being denied without the ability to rebill. Any records not received by the end of the prepayment review cycle will not be eligible for reconsideration to overturn the denials.

As this is not a formal audit process, there may not be formal findings communicated to the provider. If MC determines any follow up action is needed, we will reach out at that time.

AHCCCS Encounter Validation

AHCCCS performs periodic encounter validation studies. All AHCCCS contractors and subcontractors are contractually required to participate in this process. In addition, the encounter validation studies enable AHCCCS to monitor and improve the quality of encounter data.

MC Chapter 15 – Fraud, Waste and Abuse

15.00 – Fraud, Waste and Abuse Overview

MC takes fraud, waste and abuse issues seriously and actively works to detect, prevent, and report fraud, waste, and abuse within the Medicaid system. These efforts are consistent with our mission to provide care to those in the Medicaid system while exercising sound fiscal responsibility.

Fraudulent activity hurts the Medicaid system overall and not just MC. Our goal is to ensure that tax dollars spent on health care are spent responsibly and used to provide necessary care for as many members as possible.

Some examples of actions that are reportable to the state's investigative agencies include:

- Physical or sexual abuse of members (should be reported via QM Quality of Care processes).
- Improper billing and coding of claims.
- Pass through billing.
- Billing for services not rendered.
- Raising fees for Medicaid patients to allowable amounts if these fees are not billed to other patients.
- Unbundling and up coding may be construed as fraud if a pattern is found to exist.

In addition, member fraud is also reportable, and some examples include:

- Use of another member's identification to obtain services.
- Fraudulent application for eligibility.
- Sale of durable medical equipment while on loan to members.
- Prescription fraud.

MC is required to report cases of suspected fraud, waste, or abuse to the AHCCCS Office of Inspector General within 10 calendar days. Other agencies may be involved in cases of criminal activity or abuse. The AHCCCS Office of Inspector General is responsible for determining if suspected fraud or abuse cases warrant referral to the State Attorney General's office. The AHCCCS Office of Inspector General has the authority to levy civil monetary penalties, issue recoupment letters, and utilize other types of sanctions if fraud, waste, or abuse is substantiated.

Anyone who suspects member or provider fraud, or abuse may report it either to the MC hotline number at 800-810-6544 or directly to the State hotline at:

Provider Fraud

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

Member Fraud

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

Member or provider fraud can also be reported through MC's website through the Fraud, Waste and Abuse tab on either the member or provider sections of the website. This will generate an email to our fraud, waste, and abuse staff.

Per the AHCCCS website, the chief goal of the AHCCCS Office of Inspector General is to ensure that AHCCCS (Medicaid) funds are used effectively, efficiently, and in compliance with applicable state and federal laws and policies. Every dollar lost to the misuse of AHCCCS benefits is one less dollar available to fund programs which provide essential medical services for Arizona residents. The Office of Inspector General audits and investigates providers and members who are suspected of defrauding the AHCCCS program, recovers overpayments, issues administrative sanctions, and refers cases of suspected fraud for criminal prosecution. You are encouraged to immediately report matters involving fraud, waste, and abuse.

MC has developed a Provider FWA 101 training, available on our **website** and **YouTube channel**, to support provider education. The training is included in initial onboarding and can also be used by providers to educate new staff and reinforce FWA awareness through ongoing refresher training.

Prepayment Review Process

MC may determine that prepayment review might be a useful tool based on findings resulting from Program Integrity Reviews, other audit processes, or data mining activities. This is not an audit process, but simply a mechanism to ensure clean claiming is occurring. Providers are chosen at random and may be chosen more than once within a particular year.

During the prepayment review process, samples of claims will be selected for review which will require the submission of medical records to determine final claim action. Any claims selected

for prepayment review will be pended and medical records will need to be submitted before the claim can be finalized. Once records have been received for prepayment review and MC has reviewed the records against services billed the pended claim may either be adjustment for payment or denied.

- Claims will be selected on a bi-weekly basis.
- MC requires that records be submitted within 10 days of the receipt of the email noting the claims selected for review to ensure integrity of the documentation to be reviewed. **As noted above, this is not an audit, but rather a claiming action**.
- Records are to be submitted in one block through the process noted in your prepayment review letter and not submitted one claim at a time. If any records are missing from the block of claims selected for review, the review will be placed on hold and the review will not start until all records have been received from that block of claims.
- MC shall complete the reviews in a timely manner but will not exceed 30 days from the date of the resubmitted claim with records.
- The prepayment review process will be valid for a 90-day period. At the end of the 90 days, MC shall assess progress and determine if a new prepayment review cycle will be needed or if the prepayment review process will be closed.

Claim Resubmissions and Recoupments

Any claims/encounters recouped as part of the Program Integrity process or claims denied as part of the Prepayment Review process (after records are received and reviewed) are not eligible to be resubmitted. New claims may not be submitted to replace these services.

Noncompliance with the prepayment review will result in claims remaining denied without the ability to rebill. Any records not received by the end of the prepayment review cycle, will result in claims remaining denied without the ability to rebill.

As this is not a formal audit process, there may not be formal findings communicated to the provider. If MC determines any follow up action is needed, we will reach out at that time.

15.01 - Deficit Reduction Act and False Claims Act Compliance Requirements

Each Provider Agreement requires all providers to adhere to Deficit Reduction Act (DRA) requirements. The DRA requires that any entity (which receives or makes payments, under a state plan approved under Title XIX or under any waiver of such plan, totaling at least $5 million annually) must establish written policies for its employees, management, contractors, and agents regarding the False Claims Act (FCA). The FCA applies to claims presented for payment by federal health care programs. The FCA allows private persons to bring a civil action against those who knowingly submit false claims upon the government.

Activities for which one may be liable under the FCA:

- Knowingly presenting to an officer or employee of the United States government a false or fraudulent claim for payment or approval.
- Knowingly making, using, or causing a false record or statement to get a false or fraudulent claim paid or approved by the government.
- Conspiring to defraud the government by getting false or fraudulent claims allowed or paid.
- Having possession, custody, or control of property or money used, or to be used by the government and intending to defraud the government by willfully concealing property, delivering, or causing to be delivered less property than the amount for which the person receives.
- Authorizing to make or deliver a document, certifying receipt of property used by the government and intending to defraud the government and making or delivering a receipt without completely knowing that the information on the receipt is true;
- Knowingly buying, or receiving as a pledge of an obligation or debt, public property from an officer or employee of the government, or a member of the Armed Forces, who lawfully may not sell or pledge the property; or
    - Knowingly making, using, or causing to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the government.
    - The definition of “knowing” and “knowingly” as it relates to the FCA includes actual knowledge of the information, acting in deliberate ignorance of the truth or falsity of the information, and/or acting in reckless disregard of the truth or falsity of the information. Proof of specific intent to “defraud” is not required for reporting potential violations of the law.

15.02 - False Claims Training Requirements

As required by MC’s contract with AHCCCS Administration, providers must train their staff on the following:

- The administrative remedies for false claims and statements.
- Any state laws relating to civil or criminal penalties for false claims and statements.
- The whistleblower (or relater) protections under such laws.

15.03 - Administrative Remedies for False Claims and Statements

The United States Government (Government) has administrative remedies available to it in cases that have resulted in FCA violations. The administrative remedy for violating the FCA is three times the dollar amount that the government is defrauded and civil penalties of $14,308

to $28,619 for each false claim by the party responsible for the claim. If there is a recovery in the case brought under the FCA, the person suing (relater) may receive a percentage of the recovery against the party that had responsibility for the false claim. For the party that had responsibility for the false claim, the government may seek to exclude it from future participation in federally funded health care programs or impose integrity obligations against it.

15.04 - State Laws Relating to Civil or Criminal Penalties or False Claims and Statements

To prevent and detect fraud, waste, and abuse, many states have enacted laws like the FCA but with state-specific requirements, including administrative remedies and relater rights. Those laws generally prohibit the same types of false or fraudulent claims for payments for health care related goods or services as are addressed by the federal FCA. For further information on specific state law requirements, contact MC's Compliance Office.

Additional information on the Deficit Reduction Act and False Claims Act is available on the following websites:

- Deficit Reduction Act – Public Law 109-171
- Arizona Revised Statutes (ARS):
    - ARS 13-1802: Theft
    - ARS 13-2002: Forgery
    - ARS 13-2310: Fraudulent schemes and artifices
    - ARS 13-2311: Fraudulent schemes and practices; willful concealment
    - ARS 36-2918: Duty to report fraud
    - AAC R9-22-1101, et seq.: Civil Monetary Penalties

MC CHAPTER 16 – WORKFORCE DEVELOPMENT

16.00 – General Information

This chapter applies to AHCCCS Complete Care (ACC), AHCCC Complete Care – Regional Behavioral Health Authority (ACC-RBHA), Arizona Long Term Care System/Elderly and Physically Disabled (ALTCS/EPD), Department of Child Safety/Comprehensive Health Plan (DCS CHP), and Department of Economic Security/Division of Developmental Disabilities (DES/DDD) contracted Providers. The purpose of this chapter is to describe provider requirements, expectations, and recommendations in developing the workforce. Initiatives in this chapter align with AHCCCS Workforce Development Policy **ACOM 407** & ACOM 407 Attachment A.

Workforce Development Groups:

Arizona Association of Health Plans (AzAHP) unites the companies that provide health care services to the almost two million people that are members of AHCCCS. AzAHP offers valuable training programs through our Arizona Healthcare Workforce Development Alliance – ACC, ACC-RBHA; and supplies assistance and resources to enhance the long-term care workforce through the ALTCS AZ Healthcare Workforce Development Alliance.

Arizona Healthcare Workforce Action Network (AZHWAN). MC is a member of and supports the efforts of the AZHWAN. The Workforce Action Network was established by the AHCCCS Office of Healthcare Workforce Development due to the desire to continue and expand successful collaborations that were developed during the ARP initiatives of 2021-2024. The purpose of the Healthcare Workforce Action Network is to align industry, education, policy and more, as well as streamline efforts while simultaneously removing duplication. This workgroup is currently operated through the Center of the Future of Arizona (CFA), and includes representatives from: Community organizations, advocacy groups, higher education, government and state agencies, managed care organizations, lobbyists, and provider organizations.

AZ Healthcare Workforce Development Coalition (AHWFDC) includes members from AHCCCS, Arizona Complete Health, Banner University Family Care, Department of Child Safety Comprehensive Health Plan (DCS CHP), Department of Economic Security/Division of Developmental Disabilities (DES/DDD), Health Choice Arizona, MC, Molina Complete Care and UnitedHealthcare Community Plan. This group represents ACC, ACC-RBHA, ALTCS, DCS CHP, DES/DDD and H2O programs. Together we ensure that initiatives across the state of Arizona align with all lines of business.

AZ Healthcare Workforce Development Alliance – ACC, ACC-RBHA (AHWFDA-ACC, ACC-RBHA) is comprised of all the AHCCCS Complete Care (ACC) & Regional Behavioral Health Authority (RBHA) Plans in the state of Arizona. This includes Arizona Complete Health, Banner University Health Plans, Department of Child Safety Comprehensive Health Plan, Health Choice Arizona, MC, Molina Complete Care, and United Healthcare Community Plan. Together they act as a single point of contact for reference and direction for the shared provider network. This Alliance is dedicated to working with Relias, the Arizona Health Care Cost Containment System (AHCCCS), health care Providers, members, and communities as a whole; to drive long lasting and effective changes in workforce development and Member outcomes. To achieve this vision, they are working collaboratively as eight separately established Health Plans to assist the Provider network in the transition from a prescriptive and compliance-based system, to a more autonomous, integrated, and competency-based system. Their mission is to evaluate, monitor, and support the development of the capability, capacity, connectivity, culture, and commitment of the provider workforce.

AZ Healthcare Workforce Development Advisory Committee – ACC, ACC-RBHA (AHWFDAC-ACC, ACC-RBHA) is comprised of leaders, stakeholders, and experts who provide guidance and direction on strategic items important to the ongoing partnership and success around the use of Relias solutions and services, as well as Workforce Development initiatives. This Committee is responsible for maintaining a working relationship and alignment with statewide goals and objectives, as well as providing input to AHCCCS on policies and initiatives related to Workforce Development.

AZ Healthcare Workforce Development Alliance – ALTCS (AHWFDA-ALTCS) Banner University Family Care, Division of Developmental Disabilities (DDD), MC, and UnitedHealthcare Community Plan in collaboration with AHCCCS and AzAHP. Together we analyze the current state, forecast future trends, and develop action plans to provide resources and support to our Arizona Long-Term Care network.

AZ Workforce Development Advisory Council – ALTCS (AWFDAC – ALTCS) is organized by AHCCCS and includes members from: Banner University Family Care, Department of Economic Security, MC, UnitedHealthcare Community Plan, Community Stakeholders and LTC Advocacy Groups. The purpose of this group is to share resources, develop strategies and support state-wide initiatives in Long-Term Care that are aligned with Arizona's Plan for an Aging Population: Aging 2020 and AHCCCS Policies:

ACOM 429 and **ACOM 407**: Direct Care Worker Training and Testing Program. Additionally, this committee will offer advice and recommendations on initiatives set by the Managed Care Organizations (MCOs).

AZ Healthcare Workforce Development Alliance – DCS CHP (AHWFDA-DCS CHP) – MC and Department of Child Safety Comprehensive Health Plan in collaboration with AHCCCS. Together we analyze the current state, forecast future trends, and develop action plans to provide resources and support to our network. Initiatives outlined under this alliance align with the ACC/RBHA AWFDA initiatives and also take into consideration needs for contracted Providers who are serving DCS CHP Members.

AZ Healthcare Workforce Development Alliance – DD (AHWFDA-DD) – MC and UnitedHealthcare Community Plan in collaboration with the Division of Developmental Disabilities and AHCCCS. Together we analyze the current state, forecast future trends, and develop action plans to provide resources and support to our network. Initiatives outlined under this alliance align with the AWFDA-ACC, ACC-RBHA initiatives and also take into consideration needs for contracted Providers who are serving DD Members.

MC Workforce Development Advisory Board & Taskforce is an internal, multidisciplinary collaborative that provides insights for the purpose of strategic planning and readiness preparation to the MC Workforce Development Operation (WFDO). These insights enable integrated network monitoring and assessing of current workforce capacity and capability, forecasting and planning for future workforce capacities and capabilities, and the ability to develop culturally mindful strategies that support provider organizations to build sustainable WFD approaches that enable recruitment of premier professionals, staff development programs, retention through career pathways, enhance competitiveness and are responsive to the needs of the network, workers and the member populations that we serve. Members include leadership staff from the following departments: Adult/Children's Systems of Care, Clinical Health Services, Crisis-Cultural Prevention-Court Programs, Cultural Competency, Grant Funding, Long-Term Care, Marketing, Medical Management, Network Management, Office of Individual and Family Affairs, Operations, Provider Education, Quality Management, Technology, Workforce Development.

Definitions:

Provider Workforce Development (WFD) is a strategic approach to improving healthcare access, service quality, and member outcomes by strengthening workforce capacity and

capability through workforce planning competency development, recruitment, retention, career advancement, and organizational workforce practices.

Workforce Capability is the interpersonal, cultural, clinical/medical, and technical competence of the collective workforce or individual worker.

Workforce Capacity is the number of qualified, capable, and culturally representative personnel required to sufficiently deliver services to members.

Workforce Connectivity is the workplace's linkage to sources of potential workers, information required by workers to perform their jobs, and technologies for connecting to workers and/or connecting workers to information.

Workforce Competency refers to the extent that employees have the knowledge, skills, abilities, and attributes needed to be successful in the workplace. The success of an organization depends on how capable and skilled their workforce is. To create this dynamic an organization must develop and measure competencies that are specific to the job tasks and functions expected for each employee.

Workforce Development Mission, Vision & Values:

Our Mission

Inspire. Connect Develop.

Our Vision

Our vision is to offer premier learning and professional growth opportunities that innovate and transform the lives of the individuals servicing or serviced by our integrated health care system.

Building a Workforce Culture

MC aims to create a culture of high-performing organizations and recognizes that this level of success depends on the capability of the employees at those organizations. MC also recognizes that although formal education is important, it does not necessarily provide employees with the appropriate skills to succeed in the workplace. The solution lies in creating a work environment where employees are expected to practice and demonstrate the specific skills needed for their individual job role. In a competency-based system, both the employer and the employee benefit. This is a result of establishing a transparent blueprint for recruitment, job expectations, performance evaluation, and advancement paths.

MC in collaboration with the **AZ Healthcare Workforce Development Coalition** (AHWFDC) supports the following statements:

- The AHWFDC, as a collective, is committed to promoting the delivery of high-quality services within Healthcare organizations by fostering collaboration and respect for individual differences, preferences, language needs, and other culturally informed considerations across the communities we serve throughout the lifespan of member service and professional workforce development.
- Together, we believe that practices grounded in cultural awareness, fairness, trauma-informed care, and a sense of belonging – while promoting role-specific competencies – acknowledge and build upon individuals' unique backgrounds strengths, and values. These practices can help reduce or mitigate the effects of traumatic and adverse experiences, support positive lifelong health outcomes for members, strengthen professional competencies, and create welcoming supportive environments for all.

Five Workforce Development Components (5 Cs)

The AHCCCS identified WFD components noted below help Arizona effectuate a comprehensive process of professional skill and knowledge development within our statewide healthcare community to help ensure a sustainable and competent workforce serving our members.

- **Building Workforce Capacity**: Ensuring a sufficient workforce to provide services which meet members' needs. Looking/planning ahead to determine the future need for additional workers.
- **Developing Worker Capability**: Continuously, transforming systems of training for competency, evaluation, and development.
- **Earning Worker Commitment**: Cultivating the workforce to be engaged in Workforce Development initiatives set forth by your agency and by the state of Arizona.
- **Establishing Workplace Connectivity**: Promoting increased communication, collaboration, and innovation with internal and external customers to promote better healthcare outcomes.
- **Aligning Workplace Culture**: Developing a shared vision of the integrated healthcare process from the members' perspective, including philosophy, experience, and delivery.

16.01 – Contract Requirements

MC's Workforce Development Operation (WFDO) implements, monitors, and regulates Provider WFD activities and requirements listed in this chapter. In addition, MC evaluates the impact of the WFD requirements and activities to support Providers in developing a qualified, knowledgeable, and competent workforce.

- The MC Network Management Department works in conjunction with the WFDO to provide initial and on-going development opportunities for contracted Provider agencies. Please contact the Network Management Consultant that has been assigned to your agency, for additional information.

MC ensures the provision of high-quality services by fostering collaboration, respect for differences, preferences, language, and other cultural needs within the communities we serve. We believe that creating culturally and linguistically responsive programs that build on people's strengths and values while reducing the effects of traumatic and other adverse experiences, achieve positive health outcomes and create welcoming environments.

With the above stated, 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 (including but not limited to):

- Abuse & Neglect Prevention Task Force
- Arizona Administrative Code (A.A.C.)
- Arizona Association of Health Plans (AzAHP)
- Arizona Health Care Cost Containment System (AHCCCS)
- Arizona Revised Statutes (A.R.S)
- Arnold v. ADHS and JK v. Humble settlement agreements
- BK v. Faust (DCS) Settlement Agreement
- Centers for Medicare and Medicaid Services (CMS)
- Commission on Accreditation of Rehabilitation Facilities (CARF)
- Culturally and Linguistic Appropriate Services (CLAS) Standards
- Licensure Regulatory Boards
    - Arizona Board of Behavioral Health Examiners
    - Arizona Board of Psychologist Examiners
    - Arizona Medical Board, etc.
    - **Bureau of Medical Facilities Licensing (BMFL)**
    - **Bureau of Residential Facilities Licensing (BRFL)**
    - Office of Licensing and Regulation (OLR)
- Health Plan Provider Manuals
- Maricopa County Superior Court
- The Joint Commission

All Provider Types

Abuse & Neglect Prevention Taskforce

MC will ensure that providers have access to, and are in compliance with, all training programs and practices required by the Report of the Abuse & Neglect Prevention Task Force (enacted by former Governor Douglas A. Ducey November 1, 2019), as follows:

- Resources and training programs to assist professionals and family caregivers prevent and manage stress and burnout;
- Training for all personnel in the prevention and detection of all forms of abuse and neglect; and
- Routine exercises and drills to test the reactions of staff to simulated conditions where abuse and neglect could potentially occur are incorporated into the providers ongoing workforce/staff training and development plan.

AZ Healthcare Workforce Goals and Metrics Assessment (AHWGMA)

NOTE: Effective 10/1/26 this requirement is currently on hold. The AHWGMA is a data collection tool designed to gather workforce-related feedback and data from provider organizations MC requires contracted provider organizations identified within the designated provider-type groupings to complete the Arizona Healthcare Workforce Goals and Metrics Assessment annually in order to meet the requirements outline in ACOM Policy 407 and ACOM 401 Attachment A. To streamline this process and reduce duplication, all health plans and lines of business have collaborated to develop a single, standardized provider survey that is distributed through one centralized source. The approach replaces multiple, overlapping assessment requests with a more consistent and efficient process. Please refer to **this link** for the most current information including the full list of provider types required to participate and access to the assessment.

Competency Development and Verification

Consistent with AHCCCS Workforce Development requirements, provider organizations are expected to maintain policies, procedures, and practices that support the development, evaluation, and verification of employee competency for the services delivered to AHCCCS members. These processes should be appropriate to the employee's role, responsibilities, and scope of practice and include methods for assessing and documenting competency over time.

Through completion of the annual Arizona Healthcare Workforce goals and Metrics Assessment (AHWGMA), providers are required to attest that competency development, and verification practices are established within their organization and are being implemented in accordance with applicable workforce development requirements.

Healthcare Network Employee Questionnaire (HNEQ)
NOTE: Effective 10/1/26 this requirement is currently on hold. The HNEQ is a data collection tool used to capture feedback and data from an **individual employee** perspective. MC requires that all contracted provider types listed on the AzAHP website complete the Healthcare Network Employee Questionnaire (HNEQ) annually to fulfill the requirements from ACOM 407 & ACOM 407 Attachment A. To meet this requirement, all Health Plans and lines of business have collaborated extensively to create a single employee questionnaire that will be disseminated from one source (AWFDC vs. multiple assessments being disseminated and duplicated). Refer to the **website** for the most up-to-date information, including a list of required Provider Types and a link to the assessment.

Failure to complete the AHWGMA or HNEQ annually may result in corrective action and/or sanctions (including suspension, fines, or termination of contract) as determined by the health plan.

Workforce Development Planning
The objective of Workforce Development Planning is to foster collaboration with internal stakeholders to ensure that members receive services from a sustainable workforce that is qualified, competent, and adequately staffed, as outline in AHCCCS ACOM Policy 407.

A sustainable workforce plays a crucial role in establishing and maintaining continuity of care for members. The approach to Workforce Development is rooted in a comprehensive, systematic, and measurable structure that incorporates best practices at all levels of service delivery. It embraces Adult/Children's Guiding Principles, Adult Learning Theories/Methods, Trauma-informed Care, Equitable Services, and Culturally Competent practices.

Providers are encouraged to continually assess their progress and adapt strategies to ensure the ongoing success and effectiveness of Workforce Development initiatives. The ultimate goal is to foster continuous growth and improvement within the organization, ensuring the delivery of high-quality services to members.

> **Provider – Workforce Development Plan (P-WFDP)**
> MC, Arizona Complete Health, Banner University Family Care, Health Choice Arizona, Molina Complete Care and United Healthcare Community Plan, **require that all ACC, ACC-RBHA Behavioral Health contracted agencies** with **designated Provider types**, develop and maintain an **annual P-WFDP**. Although the P-WFDP is not currently required for other lines of business (LOBs), it is considered a crucial business process. Provider organizations across all lines of business are strongly encouraged to establish a

comprehensive plan that emphasizes workforce development initiatives. By prioritizing these initiatives organizations can enhance service delivery and improve the overall quality of care provided to members.

Provider Expectations (ACC, ACC-RBHA designated Provider types): **Click Here**

- Develop a P-WFDP, which clearly outlines organizational workforce development initiatives (see *Components of a Provider Workforce Development Plan*, below), within 90 days of becoming a contracted Provider.
- Annually, review and update the P-WFDP to set new initiatives and objectives. Previous years' iterations must be kept on file for a minimum of five years.
- **Submission & Attestation Requirements:**
    - **Submission Requirements**:
        - Providers are required to submit their P-WFDP upon request by their contracted Health Plan(s).
        - Providers who wish to receive feedback and who have completed their P-WFDP using the Jotform template that is provided by the AZ WFD Alliance, may submit their plan between February 1st – February 28th each year.
        - **Community Service Agencies (CSAs):** As part of the annual credentialing review process CSAs are required to complete and submit an annual P-WFDP. Please provide this document, to the Credentialing team at your renewal time.
            - AMPM 965 Community Service Agencies (Attachment B, Documentation Submission Standards)
              "Develops, documents and implements a workforce development plan that describes how the CSA will develop and maintain its own training system of job relevant and competence based orientation, basic, specialized and advanced training, coaching and mentoring programs and supervisory practices; or how it will link to other workforce development resources to ensure that all employees develop the basic, specialized and advanced competency required to perform the specific duties states in the job description per A.A.C. R9-10-1006."
    - **Attestation**:
        - All ACC, ACC-RBHA BH contracted Provider organizations with designated Provider types will be required to complete an attestation indicating that they have developed a P-WFDP on the

Arizona Healthcare Workforce Goals and Metrics Assessment (AHWGMA).

Failure to meet the annual updates, submission, and attestation requirements outlined above, may result in corrective action (including suspension, sanctions, or termination of contract), from your contracted Health Plan(s).

Components of a Provider Workforce Development Plan:
To enhance workforce planning efforts, organizations should incorporate the following strategic components into their P-WFDP:

- **Needs Assessment**: Conducting a thorough analysis of the organization's current workforce and future needs. This involves identifying skill gaps, assessing employee competencies, and determining the organization's long-term goals and objectives.
- **Organizational Goals and Objectives**: Establishing clear and measurable goals that align with the organization's strategic objectives. These goals should address specific areas of workforce development, such as skill enhancement, leadership development, or diversity and inclusion initiatives.
- **Employee Education, Development & Training Programs**: Designing and implementing education programs to address identified skill gaps and enhance employee competencies. This may include both internal training programs and external partnerships with educational institutions or professional development providers.
- **Succession Planning**: Identifying key positions within the organization and developing strategies to ensure a pipeline of qualified candidates for future leadership roles. This may involve mentoring programs, talent identification, and career development plans.
- **Performance Management**: Implementing performance management systems to monitor and evaluate employee performance. This includes establishing clear performance expectations, regularly assessing employee performance, and taking appropriate actions to support and improve performance.
- Please visit the P-WFDP Resource website for additional support: Click **here**

Arizona Long Term Care System/Elderly and Physically Disabled (ALTCS/EPD)

MC will promote WFD initiatives with ALTCS/EPD Providers that support the growth of business practices, improve member outcomes, and increase the competency of the workforce.

Department of Child Safety/Comprehensive Health Plan (DCS CHP)

MC will promote WFD initiatives with DCS CHP Providers that support the growth of business practices, improve member outcomes, and increase the competency of the workforce.

Department of Economic Security/Division of Developmental Disabilities (DES/DDD)

DES (DDD) providers fall under ALTCS/EPD and/or ACC Contracts.

Physical Health/AHCCCS Complete Care (ACC)

Various trainings are currently available through the MC website to improve member outcomes and improve the competency of the workforce. These trainings are separate from those offered through Relias, mentioned below.

Primary Care Providers and all clinical staff at the office must complete the Primary Care Provider Onboarding and Integrated Care annual training.

- **Attestation:** All contracted Provider organizations with a designated Primary Care Physician will be required to complete this training annually and submit an attestation indicating that they have completed the training and agree to comply with all policies, procedures, and requirements outlined in the training.

Behavioral Health AHCCCS Complete Care (ACC) and Regional Behavioral Health Authority (RBHA) (All Staff)

AHWFDA Provider Forums

The Arizona Healthcare Workforce Development Alliance (AHWFDA-ACC, ACC-RBHA) hosts monthly webinars to provide information, resources, and updates for Behavioral Health ACC/RBHA contracted providers. These virtual meetings occur on the second Thursday of each month and registration information for these events will be sent out via email, to all individuals on the Workforce Development email distribution list. It is the Provider agency's responsibility to attend these sessions or review the recorded webinars when they are made available. These recordings can be found by visiting the AWFDA Website: **Click Here**

Relias Learning

All AHCCCS Complete Care (ACC)/ Regional Behavioral Health Authority (RBHA) Behavioral Health (BH) Providers must have access to Relias Learning. This is the Learning Management System used by the ACC, ACC-RBHA Health Plans and their contracted BH providers through the Arizona Association of Health Plans (AzAHP). Agencies must designate a Relias Administrator (or Supervisor if utilizing the Small Provider Portal) to manage and maintain their Relias Learning portal. This includes activating and deactivating users, enrollment and disenrollment of courses/events, and general reporting and/or oversite of the users in the Relias, to ensure compliance with training requirements.

Per AHCCCS' ACOM 407 and the HP Provider Manuals, it is a contractual requirement that all ACC, ACC-RBHA BH contracted agencies with designated Provider types (listed below) track

their staff's course completions of the mandated statewide training requirements through the Statewide Learning Management System, identified as Relias.

- 29 – Community/Rural Health Center (RHC)
- 39 - Habilitation Provider
- 77 - Behavioral Health Outpatient Clinic
- A3 - Community Service Agency
- A6 - Rural Substance Abuse Transitional Agency
- B1 - Level I Residential Treatment Center-Secure (IMD)
- 78 - Level I Residential Treatment Center Secure (non IMD)
- B2 - Level I Residential Treatment Center-Non-Secure (non-IMD)
- B3 - Level I Residential Treatment Center-Non-Secure (IMD)
- B7 - Crisis Services Provider
- B8 - Behavioral Health Residential Facility
- C2 - Federally Qualified Health Center (FQHC)
- CF – Counseling Facility
- ES – Enhanced Shelter
- HA – Statewide Housing Administrator
- HO – Housing & Health Opportunities (H2O) Programs
- IC – Integrated Clinic

Additional Provider types below are only to be included if the agency is also contracted under of or more of the above Provider Types.

- B5 - Sub Acute Facility (1-16 Beds)
- A5 - Behavioral Health Therapeutic Home
- BC - Board Certified Behavioral Analyst
- 85 - Licensed Clinical Social Worker (LCSW)
- 86 - Licensed Marriage & Family Therapist (LMFT)
- 87 - Licensed Professional Counselor (LPC)
- A4 - Licensed Independent Substance Abuse Counselor (LISAC)

Additionally, all contracted MC BH Providers must be set up to use Relias Learning to report <u>all</u> training activities for their staff to include but not limited to:

- Attendance, course completion, and training content for:
    - Technology based/Online Courses
    - Webinars/Web Conferences
    - Live Training, Seminars, Conferences, and/or Events

Relias Features and Services

Below are some general features/services received in using the Relias training platform:

- **Mandatory Health Training:**
  Relias offers thousands of courses, to provide staff with engaging learning content that's guaranteed to be current with state and federal mandates.
- **Competency Review:**
  Relias allows users to evaluate and track competencies on the LMS, whether looking to track workforce development plan competencies or job-specific competencies. Relias' tool allows users to customize and build out a review that meets the needs of any organization and requirements.
- **Tracking & Reporting:**
  Never wonder whether staff is compliant. Relias tracking and reporting system can help generate essential reports and visual charts on data from surveys or audits quickly and easily. Reports Trackers allow easy and efficient methods for non-training requirements for each individual employee. The Requirements Tracker is commonly used to track things such as CPR certification, driver's license renewals, and professional license renewals.
- **Improve Member Outcome:**
  Expand the knowledge, capabilities, and commitment of the workforce so they can enhance the quality of care they provide. Better performance ultimately leads to better outcomes.
- **Cultivate Lifelong Learning:**
  Expose the workforce to new ideas and strategies to continually review and retool their knowledge in a rapidly changing environment. Offer CE and CME not only for recertification or license maintenance but also to instill in clinicians a mindset to know more and do better.
- **Attract & Retain Top Talent:**
  Be seen as an employer of choice. Boost applicant flow and retention rates by promoting CE and CME in recruiting communications.

Requesting Relias Access for Newly Contracted Providers:

1. MC's Network Management Representative makes a request, for Relias access, through the MC Workforce Development Operation (**WFD@MercyCareAZ.org**). The request should include the following information:
   a. **Provider Organization Name**
   b. **Taxpayer Identification Number(s) (TIN)**
   c. **National Provider Identifier(s) (payor/primary NPI)**

   d. **Contract Start Date**
   e. **Primary Address**
   f. **CEO Key WFD Contact(s):**
      - **Name**
      - **Title**
      - **Email**
   g. **Contract Type (ACC/RBHA)**
   h. **Population Served (GMH/SU, Adults/Children, SMI, etc.)**
   i. **Provider Type Code(s)**
   j. **Number of Employees supporting the ACC-RBHA contract**
   k. **List of Health Plans Provider is contracted with (if known)**
      - Support = Paid by, partially paid by or supporting
      - Example: AzCH, Banner, BCBS Health Choice, Mercy Care, Molina, United
2. The MC Workforce Development Administrator notifies the AzAHP Project Manager that a contracted Provider is requesting a Relias Sub-Portal and provides the information outlined above in items "a-i."
3. The MC Workforce Development Administrator submits a request to the Relias Client Success Manager.
4. The Relias Client Success Manager will notify the Relias Account Owner.
5. Providers must set up an account under the Arizona Association of Health Plans (AzAHP) and complete a one-time implementation fee of $1,500. To begin the process or ask additional questions, reach out to **Mercy Care Workforce Development**.
   a. Provider agencies with 20 or more users will be required to purchase access to Relias Learning for a one-time fee of $1,500 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.
   b. 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.
   c. Provider agencies that expand to 20 or more users will be required to purchase full-site privileges to Relias Learning immediately upon expansion.
   d. Provider agencies with an existing Relias contract will be required to connect their current site to the AzAHP Relias Enterprise at a cost of $1,500. [Special circumstances may apply and each case will be assessed on a case-by-case basis].
6. The Provider signs the agreement and remits the $1,500 payment to Relias when invoiced.
   a. If a Provider opts to contract with Relias for additional user license for staff that fall outside of their Health Plan contract and/or content not currently covered under the

AzAHP Relias Enterprise, that Provider will be responsible to cover those costs. **Fee is subject to change if a Provider requires additional work beyond a standard sub-portal implementation.*

b. Provider agencies with an existing Relias contract will be required to fulfill the terms of their current contract with Relias and move forward with a new sub-portal under the AzAHP Relias Enterprise at a cost of $1,500.

7. Following Relias Legal and Finance Approval - Relias Professional Services sets up a sub-portal in the AzAHP Enterprise and provides "Administrator" training to the appropriate Provider contact(s).

Relias Learning: Requesting Additional User Licenses:

1. Requests for additional licenses should be made, by the Provider organizations, directly through the Arizona Healthcare Workforce Development Alliance (AHWFDA-ACC, ACC_RBHA): There is no cost for additional Relias user licenses who are supporting the provider organization's ACC-RBHA contract. Providers will need to email the AHWFDA (**workforce@azahp.org**) with the following information:
    a. Provider Organization Name
    b. Relias Organization ID (You can find this number under your "Settings Tab," "Site Properties," "Settings" at the very bottom of the page). If you have difficulty locating it, call Relias at 1-800-381-2321 for assistance.
    c. Number of user licenses you wish to add
    d. Reason for the request (e.g., Program expansion, Acquisition of new agency, Agency growth, etc.)
    e. Attestation statement indicating that user accounts will be used for employees who are supporting the provider organization's ACC-RBHA contract, under the required Provider Type(s).

Required Training

MC requires that Behavioral Health Providers under the ACC, ACC-RBHA lines of business, ensure that all staff who work in programs that support, oversee, or are paid by the Health Plan contract have access to Relias and are enrolled in the AWFDA Training Plans listed below. This includes, but is not limited to, full-time/part-time/on-call, direct care, clinical, medical, administrative, leadership, executive and support staff (finance, marketing, maintenance, HR, QM, billing, food services, front desk, paid family caregiver, etc.).

Exceptions:

- Any staff member(s) hired for temporary services working less than 90 days is required to complete applicable training at the discretion of the Provider.

- Any staff member(s) hired as an intern is required to complete applicable training at the discretion of the Provider.
- Any staff member(s) working as a volunteer is required to complete applicable training at the discretion of the Provider.
- Any Independent Contractor (IC) is required to complete applicable training at the discretion of the Provider.
- Behavioral Health Hospitals
- Individually Contracted Practitioners
- Prevention Providers
- Transportation Providers

NOTE: Employees working at the Provider organization who are not paid by, supporting, or overseeing the ACC, ACC-RBHA Health Plan contract, under the **required Provider Type(s)** should not be included in your AzAHP Relias portal.

AHWFDA – All Staff – Required Training Plan (90 Days - Relias)

1. *AHCCCS – NEO – Member Employment Services (0.5hrs)
2. *AHWFDA – AHCCCS 101 (2.0hrs)
3. *AHWFDA - Cultural Competency in Health Care (1.0hr)
4. *AHWFDA – Preventing and Reporting Fraud, Waste & Abuse (FWA) (0.5hrs)
5. *AHWFDA – Quality of Care Concern (1.0hr)
6. Basics of Corporate Compliance (0.5hrs)
7. HIPAA: Basics (0.5hrs)
8. Integrated Approach to Primary and Behavioral Healthcare (1.0hr)
9. Preventing, Identifying, and Responding to Neglect and Abuse (1.0hr)
10. Supporting Client Rights for Paraprofessionals in Behavioral Health (1.0hr)

AHWFDA – All Staff – Required Training Plan (Annual – Relias)

1. RapidReg: HIPAA Proficiency Check (0.15hrs) Due: January 31st
2. RapidReg: Preventing, Recognizing, and Reporting Proficiency Check (0.25hrs) Due: April 30th
3. RapidReg: Corporate Compliance Proficiency Check (0.2hrs) Due: May 31st
4. *AHWFDA – Cultural Competency in Health Care (1.0hrs) Due: July 31st
5. *AHWFDA – Preventing and Reporting Fraud, Waste & Abuse (FWA) (0.5hrs) Due: October 31st
6. *AHWFDA – Quality of Care Concern (1.0hr) Due: December 31

Required Training: ACC and ACC-RBHA (Program Specific)

Additional course requirements and competencies are listed below as relevant to each staff member's job duties, scope of work and responsibilities. Providers may decide to assign additional courses or competencies based upon individual needs and initiatives.

All Behavioral Health Providers

- **Covered Behavioral Health Services Guide**
  - **Course Name:** *Mercy – Covered Behavioral Health Services Guide*
  - **Length:** 0.25hrs
  - **Requirement (90-Day):** This course is required for all Member-facing Behavioral Health Staff providing services as well as Billing and Administrative staff involved in service delivery and/or billing. Staff are required to complete this within 90 days of their hire date.
  - **Objective:** The AHCCCS Covered Behavioral Health Services Guide (CBHSG) provides general information on behavioral health services and commonly used billing codes. This guidance is developed by AHCCCS and delivered by Mercy Care.
  - **Delivery Method:** This training is available online via the Relias Learning Management System, and available for enrollment through the Training Plan titled "*Mercy – Covered Behavioral Health Services Guide (90-Day) Requirement (BH staff, Billing & Admin)".* Agencies without Relias access may complete this course via our **YouTube channel**.

ACT/FACT Teams

All new team members (inclusive of Psychiatrist and RN's) receive standardized training in Evidence-Based Practices for 16 hours (at least a 2-day workshop or equivalent within two months of hiring. Existing team members receive annual refresher training of at least 8 hours (1-day workshop or equivalent). Providers will track this metric and must include training on the topics below in the total hour requirement for EBP, however, training should not be solely limited to the following topics:

- Assertive Community Treatment
- Family Psychoeducation
- Integrated Dual Disorders Treatment
- Illness Management and Recovery
- Trauma Informed Care
- Permanent Supportive Housing
- Supported Employment

- Motivational Interviewing

Behavioral Health Technicians

- **Senate Bill 1162**
    - Pursuant to Arizona Senate Bill 1162, a Behavioral Health Technician (BHT) is an individual employed by a licensed behavioral health facility or hospital who provides behavioral health services under the supervision of a Licensed Behavioral Health Professional or other authorized clinical supervisor and performs delegated functions consistent with their demonstrated training and competency.
    - Provider organizations employing Behavioral Health Technicians are responsible for ensuring compliance with all applicable state laws, AHCCCS requirements, licensing standards, and organizational policies related to qualifications, training, supervision, competency verification, and documentation.
    - Prior to providing supervised direct services, Behavioral Health Technicians must complete the minimum training requirements established under Senate Bill 1162. Provider organizations may establish additional training, competency, supervision, and professional-development requirements that exceed statutory minimums. Ongoing training shall be provided in accordance with applicable laws, regulations, accreditation requirements, and organizational policy.
    - For the most current Behavioral Health Technician requirements, including qualifications, training standards, duties, and supervision requirements, providers should refer to Arizona Senate Bill 1162 and any subsequent guidance issued by the Arizona Health Care Cost Containment System (AHCCCS) or the Arizona Department of Health Services (ADHS).

Children's System of Care

- **Birth to Five Assessment**
    - Employees completing Birth to Five assessments are required to have training in this area prior to using the assessment tool with members. On-going competency assessments are also required to evaluate an employee's knowledge and skills.
- **Child and Adolescent Level of Care Utilization System (CALOCUS)**
    - The CALOCUS is a "standardized assessment tool that provides determination of the appropriate intensity of services needed by a child or adolescent and their

family, and guides provision of ongoing service planning and treatment outcome monitoring in all clinical and community-based settings."
    - CALOCUS meets definitional criteria as a tool under contract and policy
    - Utilize AHCCCS website for general resources, including the Medical Coding Resources, Billing Health Services Matrix, Claims Clues, **AMPM 320-O**, **AMPM 570**, and current contract, and
    - Utilize national resources such as CPT Manual.
  - AHCCCS began requiring the CALOCUS on July 1, 2021, to determine level of care for children 6-18 years of age. **AHCCCS-FAQ - CALOCUS**
    - As of January 2025, the American Academy of Child, and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AACP) have partnered on the CALOCUS-CASII. As a result of this partnership, all training of the CALOCUS will be done by AACAP. AHCCCS has contracted with AACAP for the new online self-paced training and will cover the cost for providers to be trained in CALOCUS.
- Provider Organization Requirements: Employees that have been identified to complete the CALOCUS-CASII assessments are required to participate in AHCCCS designated CALCOUS training, and complete the training prior to the administration of the CALOCUS **AMPM 580**, Section F.
- Relias Instructions:
  1. Enroll employees who are required to complete the CALOCUS-CASII training in the CALOCUS-CASII Training Plan in Relias named ***AWFDA – CALOCUS – CASII Completion Certificate Requirement.**
     - Enrolling employees in the training plan will automatically enroll them in the Requirements Tracker. Instructions to access AACAP training are included in the module.
     - Enrolled learners will complete an attestation statement:
       - "I attest to completing this training prior to the administration of the CALOCUS – in accordance with AMPM Policy 580."
  2. Once the employee has successfully completed the CALOCUS-CASII training through **AACAP,** the certificate is uploaded in the Relias *AHWFDA – CALOCUS – CASII Completion Certificate Requirement Requirements Tracker, and the provider agency's supervisor/administrator will mark the training plan as complete.
- **Training hosted by AACAP can be accessed using the following steps:**
  Entering the Promo Code for the course:
  1. Access AACAP's online store to view available training courses: www.aacap.org/store-onlineEC

2. Select the desired course "CALOCUS-CASII" and click on the "Add to Cart" button.
3. Click on the "Proceed to Checkout" button.
4. **Existing AACAP account holders**: Login using AACAP account username and password credentials.
    - **New AACAP Users:** Create an AACAP account profile including username and password by clicking "Create a new account."
5. When checking out, enter the promotional code **AHCCCSFREE** and click apply which will provide a 100% discount.

Accessing the course:

1. Access AACAP's learning management system, "Pathways": www.aacap.org/pathways
2. Select "Access Your Courses"
3. Log in using your established credentials from your purchase
4. Your course(s) will be listed on the left side of the screen

For any questions or issues relating to login or clinical content please reach out to: clinical@aacap.org
The new CALOCUS training will take approximately 6 hours to complete. The learner will receive a certificate following successful completion of the course. This certificate of completion will be uploaded into RELIAS to receive training credit.

*An additional note for consideration: At this time AHCCCS will not be covering the cost of the LOCUS training.

- **Conducting the CALOCUS-CASII Assessment:**
  There are two options for employees to complete the CALOCUS-CASII Assessment. Agencies must decide which option best aligns with their organizational needs
    1. **Deerfield/AHCCCS Portal**
       The CALOCUS assessment tool completed with the Deerfield/AHCCCS Portal
        - See the CALOCUS FAQ Section AHCCCS/DEERFIELD PORTAL & EHR Q1 for detailed instructions
    2. **EHR Integration of CALOCUS**
        - See the CALOCUS FAQ Section AHCCCS/DEERFI8ELD PORTAL & EHR Q3-4 for detailed instructions

- **Training Monitoring Process:** MC will monitor the CALOCUS-CASII requirements as outlined in AMPM 580-F. This monitoring process is essential to ensure compliance with the AHCCCS requirement and maintain fidelity to the established guidelines.

- **Child and Family Team (CFT)**
  It is the responsibility of the Health Plans to ensure delivery of services within CFT Practice are in alignment with the Arizona Vision, The Twelve Principles for Children's Service Delivery, **JK Settlement** and **AMPM Chapter 500 – Care Coordination Requirements**, specifically AMPM 580 Child and Family Team. To meet these standards and provide consistent best-in-class CFT experiences, the Arizona Health Plans, system partners, University of Connecticut (UCONN) School of Social Work, and AHCCCS have collaborated in the revision of the Statewide CFT.

  Prerequisite Modules, CFT Facilitator Course, CFT Train-the Trainer (TtT) and CFT Applied Supervisor Training
  The CFT Prerequisites and CFT Facilitator Trainings have been revised to include updated Arizona specific content as well as FOCUS model information from the Innovations Institute at University of Connecticut (UCONN) School of Social Work. CFT Champions are expected to start training all newly hired CFT Facilitators in the revised curriculum starting 10/1/2026. For all other requirements regarding CFT Practice please refer to the **AZ Child and Family Team Practice Initiative Announcement** document.

  - **Training and Supervision Expectations**
    - Provider agencies who have employees that are designated to facilitate/lead CFT's shall be trained in the elements of the CFT Practice Guide, complete and in-person, AHCCCS approved CFT facilitator curricula, and demonstrate competency via the Arizona Child and Family Team Supervision Tool.
    - The CFT Supervision Tool must be completed within 90 days, and facilitators must maintain or enhance proficiency within six months as attested to by a supervisor, and annually thereafter (**AMPM 220 (F), Attachment C & D**).
  - **Monitoring Process**
    - **CFT Champion Certification**
      - All agencies who are required to have CFT Champion will be tracked in Relias.
      - Workforce Development will maintain a list of all CFT Champions and their provider agencies.

- **Arizona Child and Family Team Supervisions Tool**
  - The Supervision Tool requirements will be tracked in Relias via the Competency Evaluation Tool for all employees who facilitate/lead CFT's. (**AMPM 580(F), Attachment C & D**)
- **CFT Facilitator Training Hardship Waiver**
  - In the event the 2 Day CFT training becomes a barrier or hardship for an organization, provider organizations may request a CFT Facilitator Training Hardship Waiver. Within the waiver, providers will need to identify why delivering the course as originally designed presents a hardship. They must also supply a detailed plan of what changes they will make to the 2 Day CFT Facilitator training while still meeting all the elements of the training. The plan will be submitted to the Workforce Development Team at **workforce@azahp.com**. Provider organizations must obtain approval before the training occurs.

- **Department of Child Safety Comprehensive Health Plan Advanced Coordination of Care**
  - Effective 12/1/2022 all employees who facilitate Child and Family Teams (CFT) are expected to complete this training within 90-days of their hire date or within 90-days of their transition into a CFT Facilitator role.

- **Early and Periodic Screening, Diagnostic and Treatment (EPSDT)**
  - Please refer to: **Chapter 5 – Early Periodic Screening, Diagnostic and Treatment (EPSDT)** in this manual for requirements.

- **Levels of Care and Discharge Planning**
  - Employees who are facilitating Child and Family Teams (CFT) are expected to complete this training within 90 days of their hire date or within 90 days of their transition into a CFT Facilitator role. The course is designed to review the 4 levels of care, prior authorization, and steps to create a successful discharge plan.

- **Understanding the Unique Behavioral Health Needs of Children and Families Involved with Department of Child Safety (aka Unique Needs)**
  - Providers servicing children and families involved with Department of Child Safety (DCS) are required to complete this course within 90 days of the staff member's hire date.

Community Service Agencies

Community Service Agencies (CSAs) must submit documentation as part of the initial and annual CSA credentialing process indicating that all direct service staff and volunteers have completed training specific to CSAs prior to providing services to members. For a complete description of all required training specific to CSAs, see the **AHCCCS AMPM Policy 965 – Community Service Agencies.**

Crisis Service Providers

Crisis Service Providers shall, ensure that employees providing crisis services are trained and evaluated for competency via a specialized training program.

1. Be based on the core list of topic areas, including but not limited to:
    a. First Aid,
    b. Cardiopulmonary Resuscitation (CPR),
    c. Non-violent crisis intervention,
    d. Cultural awareness and responsiveness,
    e. Trauma informed care,
    f. Evidence-based practices (e.g., SAMHSA National Guidelines for Behavioral Health Crisis Care, Roadmap to the Ideal Crisis System),
    g. Mental health screening and assessment,
    h. Risk assessment and safety planning,
    i. Substance use disorders,
    j. Co-occurring disorders,
    k. Traumatic brain injuries,
    l. Dementia,
    m. Developmentally appropriate interventions for children and adolescents,
    n. Physical, intellectual, and developmental disabilities,
    o. Psychiatric medications and side effects,
    p. De-escalation techniques,
    q. Language assistive devices, and
    r. National Standards for Culturally and Linguistically Appropriate Services (CLAS).
2. Be focused on preparing practitioners for competently using skills not just learning them. The definition of competency being a description of the skills that practitioners use when performing the tasks required to provide the crisis service - not for showing they learned the concepts at the end of a class.
3. Have BHP and BHT/BHPP learning tracks. Learning tracks may overlap in certain content areas; however, the intent is to gear each track to the differences in roles and tasks that BHPs and BHT/BHPPs have when delivering crisis services.

Reference **AHCCCS AMPM 590 – Behavioral Health Crisis Services** for further details.

Department of Child Safety/Comprehensive Health Plan (DCS CHP)
Behavioral Health ACC, ACC-RBHA Providers who are serving youth in DCS CHP programs will have additional training requirements. These will be specified in a future publication of this manual.

Employment and Rehabilitation
Per AHCCCS ACOM Policy 447 – Employment, a Competency Evaluation Tool is required to evaluate, attest to, and monitor staff competencies, which have been divided into the following based on type of position:

- AHCCCS Employment Workforce Competencies – For Dedicated Employment Staff
- AHCCCS Employment Workforce Competencies – For Other Clinical and Direct Service Staff
- Please see the **AHCCCS Frequently Asked Questions (FAQ) – Competency Evaluation Tool** for details regarding requirements and enrollments for these tools. The form and additional resources can be found on the **AzAHP website.** Click AZ Healthcare WFD Coalition at the top of the page and from the menu choose Resources > ACOM 447 or click **here**.

General Mental Health/Substance Use (GMH/SU)

- **American Society of Addition Medicine (ASAM)**
    - Employees completing assessments of substance use disorders and subsequent levels of care, are required to complete ASAM Continuum training. This course is required prior to a staff member using the assessment tool with members and annually thereafter. The assessment used should be consistent with the most recent edition American Society of Addiction Medicine (ASAM) Criteria. Please Note: The initial course must be an ASAM specific class. The annual requirement may be met by completing any approved substance use/abuse course.
    - **ASAM CONTINUUM Implementation in Arizona:** Click **here.**
- **AHWFDA – Mental Health Block Grant (MHBG)**
    - To ensure that the network is informed on how to support underinsured individuals, MC's expectation is that all contracted general mental health/substance use (GMH/SU) providers are knowledgeable about the Mental Health Block Grant (MHBG). This includes requiring all employees who are member-facing to take the online RELIAS training (within 90 days of employment and annually thereafter).
- **AHWFDA - Substance Use Block Grant (SUBG)**

- To ensure that the network is informed on how to support underinsured individuals, MC's expectation is that all contracted general mental health/substance use (GMH/SU) providers are knowledgeable about the Substance Use Block Grant (SUBG). This includes requiring all employees who are member-facing to take the online RELIAS training (within 90 days of employment and annually thereafter).

Peer and Family Support Specialists and Their Supervisors

- Individuals employed as a peer and/or recovery support specialist shall have at a minimum, two hours of continuing education and ongoing learning relevant to peer support per year (**AMPM 963**, Section F)
- Individuals employed as a supervisor of a peer and/or recovery support specialist shall have access to continuing education relevant to the provision of peer support services and supervision of peer and/or recovery support specialists (**AMPM 963**, Section H)
- Individuals employed as a parent and/or family support specialist shall have access to continuing education relevant to parent and/or family support. (**AMPM 964**, Section D)
- Individuals employed as a supervisor of a parent and/or family support specialist shall have access to continuing education relevant to the provision of family support services and supervision of parent and/or family support specialists (**AMPM 964**, Section F)

Continuing education may be accessed through Relias, the **Arizona Peer, and Family Career Academy**, webinars, and/or any additional trainings within your agency or in the community relevant to peer and family support services and the supervision of peer and family support specialists.

Peer and Recovery Support Specialist (PRSS) Training Requirements: AMPM 963

As outlined in AMPM 963 – Peer and Recovery Support Service Provision Requirements, under Section H. Peer and Recovery Support Specialist Credentialing program curriculum standards:

- In addition to the core elements 1. a-d, all PSETPs shall incorporate into their curriculum AHCCCS-provided training materials specific to psychosis, including anosognosia (ARS 36-2903.15).
- All presently employed PRSS credentialed prior to October 1, 2025, complete AHCCCS-provided training materials through the statewide learning management system no later than October 1, 2026.
- **Two identified courses that meet this requirement**:
  - **Relias**: *AHCCCS – Understanding Psychosis and Anosognosia – For Peer and Recovery Support Specialists

- **AZ Peer and Family Career Academy** – Understanding Psychosis and Anosognosia (**https://www.azpfca.org/course-calendar**)

Prevention of Abuse and Neglect

- The Provider workforce shall have access to and be compliant with all workforce training and/or competency requirements specified in federal and state law, AHCCCS policies, guidance documents, manuals, contracts, plans such as network development, quality improvement, corrective action, etc., and/or special initiatives.
- Providers shall have processes for documenting training, verifying the qualifications, skills, and knowledge of personnel; and retaining required training and competency transcripts and records.

Residential Care (24hr care facilities)

- Crisis Prevention/de-escalation training is required for all member facing staff prior to serving members and annually thereafter.
- For facilities where restraints are approved, a nationally approved restraint training is required initially and annually for all member facing staff. This curriculum should include non-verbal, verbal, and physical de-escalation techniques.
- For more information, please reference **AHCCCS AMPM Policy 962: Reporting and Monitoring of Seclusion and Restraint**.

RBHA Health Homes

- **MC – Exclusive Prescriber Program**
  - MC's expectation is that all contracted RBHA Health Homes are knowledgeable about the MC Exclusive Prescriber Program, which is also known as Pharmacy Restriction and a required program by AHCCCS under **AMPM 310-FF** regarding member misuse of the pharmacy benefit around medications with abuse potential. This includes requiring all employees who are member-facing (BHMPs, Provider Case Managers and Care Coordinators) to take the online Relias training titled "*MC – Exclusive Prescriber Program*," (within 90-days of employment and annually thereafter).
- **MC – Individualized Service Planning (ISP)**
  - All RBHA Health Homes must have (at a minimum) one Facilitator in the course titled "*MC – Individualized Service Planning (ISP), Facilitator (RBHA Health Homes)." This facilitator course will certify individuals to train employees at their agency on the course titled, "MC – Individualized Service Planning (ISP)":* This course is required for any staff at the RBHA Health Homes who will be working

with members in the development of their ISP and additionally required for the Behavioral Health Profession who will be signing as the licensed staff on the ISP. This includes, but is not limited to: Regionals, Clinical Directors, BHTs at the RBHA Health Home/staff assisting with ISP development, Rehab Specialist, Peer Support, Family Mentor and BHP who signs off on the assessment ISP). Staff are required to receive an in-person/virtual initial training (within 90-days of hire or new position) and in-person/virtual annual refresher thereafter on ISP development. Course completions for learners at your agency need to be tracked through Relias, under the designated course name: *MC – Individualized Service Planning (ISP)* Course Code*: 782440*

- MC will run monthly Course Completion History reports through Relias and follow-up with Provider agencies who appear to have missed completions.

- We strongly recommend that the staff who clinically oversee the RBHA Health Home regional/CD are the individuals who are providing this training to employees.

- **MC - Special Assistance**
  MC ACC-RBHA is required to comply with the AHCCCS Office of Human Rights **AMPM 320-R: Special Assistance For Members With Serious Mental Illness** by ensuring that all provider organization staff are adequately trained in the area of Special Assistance. Special Assistance Training can be divided into two classes or types. The training required for each staff will depend on their respective roles within the agency.

  Special Assistance Training Type 1: Online "self-paced" training
  - **Course Name**: *MC – Special Assistance (TBT)*
  - **Length:** 1.5hrs
  - **Requirement (90-Day & Annual):** This training is required for all clinical staff who are not actively working within the AHCCCS QM Portal, but who are still required to maintain a general understanding of Special Assistance. Staff are required to complete this within 90 days of their hire date and annually thereafter.
  - **Objective:** This training will be designed as a broad overview to offer a basic understanding to staff so they can perform the following functions:
    - Identify when a member with a Serious Mental Illness meets criteria for Special Assistance
    - Identify when a member with a Serious Mental Illness needs an advocate or guardian, or alternatively already has an existing advocate or guardian in place
    - Understand an advocate or guardian's role in a member's treatment and services
    - Understand compliance measures as outlined by the **AMPM-320-R**

- **Delivery Method**: This training is available online via the Relias Learning Management System

Special Assistance Training Type 2: Live virtual sessions with MC's Special Assistance Liaison

- **Course Name**: *MC – Special Assistance (Event)*
- **Length:** 1.5hrs
- **Requirement (90-Day & Annual)**: This training is required for all staff leadership and clinical staff who actively work within the AHCCCS QM Portal to update members' status with respect to their need for Special Assistance. Staff are required to complete this within 90 days of their hire date and annually thereafter.
- **Objective**: This training is designed to offer a comprehensive overview of Special Assistance in conjunction with a detailed walk through of how to use the AHCCCS QM Portal for Special Assistance members.
- **Delivery Method**: This training is conducted live and delivered by MC in an effort to ensure providers are equipped with the information and tools they need to successfully manage their members on Special Assistance in the portal. Upcoming sessions have been created and are now available via the Relias Learning Management System.
- **Frequency:** The training will be offered monthly and will be open to all clinical staff. Staff are required to attend at minimum annually but may attend more frequently.

RBHA Integrated Health Homes: Integrated Health Homes (IHH)

All RBHA Integrated Health Homes (IHHs) must ensure their staff are trained on integrated care within their organization. IHH leadership, including the lead psychiatrist and primary care physician, must attend the webinar on Integrated Care that National Council for Mental Wellbeing (NCMW) and their Center of Excellence for Integrated Health Solutions (CoE-HIS) is facilitating through the year for MC. Leadership staff must attend a National Council Webinar on Integration, annually at a minimum basis. Additionally, it is encouraged that integrated health homes, behavioral health homes and primary care providers attend any webinars MC holds on integration and programmatic requirements pertaining to their provider type during the year.

Division of Licensing Services (DLS) Required Training

It is the provider's responsibility to be aware of all training requirements that must be completed and documented in accordance with all additional licensing or accrediting licensing

agencies, i.e., **Bureau of Medical Facilities Licensing (BMFL)** / **Bureau of Residential Facilities Licensing (BRFL), Joint Commission,** grant requirements and other entities, as applicable.

Training Expectations for Clinical and Recovery Practice Protocols
Under the direction of the AHCCCS Chief Medical Officer, the Department publishes national practice guidelines and clinical guidance documents to assist MC Providers. These can be found on the AHCCCS website under **Clinical Practice Tools.**

Additional Expectations
Specific situations may necessitate the need for additional trainings. For example, quality improvement initiatives that may require focused training efforts and/or new regulations that impact the public healthcare system (e.g., the Balanced Budget Act (BBA), Medicaid Modernization Act (MMA), the Affordable Care Act (ACA), and Deficit Reduction Act (DRA). Additional trainings may be required, as determined by geographic service area identified needs. The data that can be collected from providers includes, but is not limited to:

- Case file reviews, Utilization management, System of care data, Court system data, Information needed to serve specific populations

Reporting Requirements

AZ Healthcare WFD Alliance (AHWFDA ACC, ACC-RBHA) Quarterly Reports
The ACC, ACC-RBHA Arizona Workforce Development Alliance (AWFDA) will run Quarterly Learner/Course Status Reports on the two AHWFDA Training Plans: *AHWFDA – Core Training Plan (90 Days) & *AWFDA – Core Training Plan (Annual). The requirement for Providers is to hold a 90% (or higher) completion rate for this group of courses, within the specified reporting period. Reporting time frames for this initiative are listed below:

- 01/01-03/31 – AHWFDA will run this report on 4/30
- 04/01-06/30 – AHWFDA will run this report on 7/31
- 07/01- 09/30 – AHWFDA will run this report on 10/31
- 10/01-12/31 – AHWFDA will run this report on 1/31
    i. If the above date falls on a weekend/holiday the report will be run on the next business day.
    ii. Results will be posted, publicly, on the **AZAHP website**.

Provider agencies falling at 89% or below on each the above reports are encouraged to have at least 1 Relias Administrator/Supervisor from their agency complete the course titled: *Relias Administrative Mastery Program (RAMP).* RAMP is a structured training and certification pathway designed to help administrators build deep, practical expertise in managing and

optimizing the Relias Platform. It is intended for both new and experienced Relias administrators and focuses on platform setup, training management, reporting, and compliance workflows.

Provider agencies falling below 90% on the above completion reports may be subject to corrective action and/or sanctions (including suspension, fines, or termination of contract) by their contracting Health Plan(s).

AHCCCS/MC RBHA Ownership of any Intellectual Property

This serves as disclosure of ownership of any intellectual property created or disclosed during the service contract such as educational materials created for classroom training and/or learning programs.

All material published by MC in any medium is protected by copyright. The Licensed Materials shall be used in the form provided to participant without alteration, including MC branding and copyrights. The Licensed Material shall be used solely for educational, non-commercial, not-for-profit purposes, and consistent with the purpose of the training.

Exceptions:

- Cases in which the production of such materials is part of sponsored programs;
- Cases in which the production of such materials is part of a MC paid subscription to online learning content;
- Cases in which substantial University resources were used in creating educational materials; and
- Cases which are specifically commissioned by contracted vendors or done as part of an explicitly designated assignment other than normal contactor educational pursuits.

Supplemental Provider Training and Education

Providers have access to technical assistance and additional training to improve skill development as well as continued education opportunities. The provider may select from additional training courses through a variety of ways, including e-learning, webinars, on-line tools, and instructor lead training. All courses developed by MC are delivered using a trauma informed approach in a culturally competent manner.

Workforce Development Consultation

MC employs WFD Consultants as key personnel and points of contact to implement and oversee compliance and competency initiatives, for all lines business. These individuals are available to assist your agency with:

- Workforce Development strategy and planning;

- Workforce capacity and capability assessment;
- Talent identification, acquisition, and workforce pipeline development;
- Workforce succession planning, career pathway development, career advancement, and retention;
- Organizational workforce development systems, processes, best practices, and sustainability planning;
- Training requirements, workforce development deliverables, and compliance expectations;
- Competency-based training approaches;
- Workforce data analysis, action planning, and continuous improvement strategies;
- Professional development and focused skill enhancement;
- Resource navigation, community partnerships, and collaboration opportunities; and
- Cultivation of respectful, inclusive, culturally responsive, and trauma-informed cultures.

On-Site/Virtual Training Requests

All requests will be reviewed and responded to within 5-7 business days.

- Submit On-site request to **wfd@mercycareaz.org**
  - The form is located on the MC website
- On-site/Virtual training can only be provided if a minimum of 10 individuals are registered for the training. Requests for less than 10 individuals will not be scheduled.
- The procedure for cancelling an on-site training request hosted by MC is as follows:
  - A provider must notify MC WFD (**wfd@mercycareaz.org**) at minimum 48 hours before the scheduled on-site training activity. In the event the Provider has not canceled within this timeframe, the opportunity to gain on-site training in the future could be limited.

For additional WFD requests or general questions please contact MC's WFD department by e-mailing **wfd@mercycareaz.org**.

Complaints

The MC WFD team seeks to offer a high-level of collaboration and partnership with our provider workforce and learning audience. We strive to provide learning experiences that honor cultural diversity and inclusion and reflect an understanding of trauma-informed care. Should there be a need to file a formal complaint regarding course content, administrative processes or team member behavior or comments, please submit your concerns to the email address noted below and mark the email, Complaint. Upon receipt and review, an initial

response will be provided within 48 business hours. Email for all complaints: wfd@mercycareaz.org

Relias Learning Assistance

For technical assistance with the functionality of your Relias Learning portal, please contact Relias directly at: 1800-381-2312, 1833-224-4008 (Relias Connect, Premier for AzAHP network) or online via Relias Connect.

Additional Online Resources

- Arizona Coalition for Military Families: Training Events
- Arizona Health Care Cost Containment System (AHCCCS)
- AZ Healthcare Workforce Development Coalition (AHWFDC)
- Be Connected: Service Members, Veterans, Families, Communities
- FreeCME.com
- Mercy Care Arizona
- Mercy Care Training Resource Website
- PsychArmor

MC Chapter 17 – Centers of Excellence

17.00 – Centers of Excellence General Information

MC promotes the adoption of Evidence Based Practices (EBP) that serve targeted membership and conditions through recognition of Centers of Excellence. The Centers of Excellence programs are developed in collaboration with providers that have implemented specific EBPs and participate in data exchange and program evaluation activities throughout the contract year. The Program Descriptions shown below highlight the goals, preferred practice, and outcome measurements for the current contract year in each of the selected areas.

17.01 – Birth to Five (Early Childhood) Centers of Excellence Description

The following information describes the Goals and Measurements of a Center of Excellence for the current contract year. Programs that do not meet the definitions of practice and/or minimum performance thresholds may not be renewed for the subsequent year. The descriptions are created in collaboration with clinicians and providers and will be reviewed and updated on an annual basis.

Goals for the Program

MC has implemented a birth to five program that uses evidence-based prevention, treatment, and practices to accomplish the following goals:

- Promotion of wellness for young children and their families, maximizing multiple aspects of life functioning:
    - Developmental milestones
    - Social Emotional Skills
    - Parent Confidence
    - Family Satisfaction
    - Living Environment

Preferred Practices or Methodologies

- A panel of comprehensive age-appropriate trauma-informed assessment, incorporating infant/toddler and family/caregiver needs
- Use of evidence-based interventions to best meet the clinical needs of the child and family
- EPSDT standards, measures, and timelines
- Ongoing collaboration with key stakeholders (AzEIP, DDD, DCS, preschool/HeadStart)
- Use of a family-centered approach, focused on bonding and attachment of the child to their caregiver

- Arizona Association of Infant Mental Health (AzAIMH) Endorsed providers participating in the assessment and family-centered care planning process
- Training and education provided to the early childhood development network in Arizona

Measurements

The Health Plan will evaluate the provider using the agreed upon metrics for consideration and continued designation.

17.02 – Transition Aged Youth/FEP Centers of Excellence Description

The following information describes the Goals and Measurements of a Center of Excellence for the current contract year. Programs that do not meet the definitions of practice and/or minimum performance thresholds may not be renewed for the subsequent year. The descriptions are created in collaboration with clinicians and providers and will be reviewed and updated on an annual basis.

Goals for the Program

First Episode Psychosis programs based on the Coordinated Specialty Care Model ensure individuals between the ages of 15 and 35 years old who have experienced their first episode of psychosis within the last year receive immediate access to care to prevent exacerbation of symptoms, promoting early recovery and a return to a natural developmental trajectory. FEP programs designated as Centers of Excellence shall deploy a multidisciplinary team providing comprehensive support including therapy, medication management, family education, and assistance with employment & education to eligible individuals with an intentional focus on promoting recovery and improving quality of life. Goals of the program include:

1. Early intervention
2. Symptom reduction
3. Functional improvement
4. Family involvement
5. Shared decision making

Preferred Practices or Methodologies

- Offer services including:
  - Clinical Assessment
  - Cognitive Behavioral Therapy (CBT)
  - Family Psychoeducation
  - Social Rehabilitation

    - Peer Support and Substance Use/Abuse, and Cognitive Enhancement/Remediation Therapy
- Encourage members to remain in treatment longer, experience greater improvement in quality of life, psychopathology, and involvement in work/school
- First Episode Center will complete an assessment for every member referred to ensure program appropriateness
- Adhere to fidelity standards outlined by the Substance Abuse and Mental Health Services Administration (SAMHSA) Evidenced Based Practice including the Coordinated Specialty Care (CSC) team-based model
    - Team Leadership
    - Case Management
    - Medication Management
    - Psychotherapy
    - Family Education and Support
    - Pharmacotherapy and Primary Care Coordination Measurements

Measurements

- The Health Plan will evaluate the provider using the agreed upon metrics for consideration and continued designation.

17.03 – Adolescents with Substance Use Disorder Centers of Excellence Description

The following information describes the Goals and Measurements of Center of Excellence for the current contract year. Programs that do not meet the definitions of practice and/or minimum performance thresholds may not be renewed for the subsequent year. The descriptions are created in collaboration with clinicians and providers and will be reviewed and updated on an annual basis.

Goals for the Program

MC has implemented an adolescent substance use program that utilizes evidence-based prevention, treatment, and practices to accomplish the following goals:

- Reducing substance misuse, use disorder, overdose, and related health consequences
- Preventing or reducing the frequency and severity of relapse
- Identify and address health equity and social risk issues
- Continued engagement with recovery support service

- Maximizing multiple aspects of life functioning:
    - Family Involvement
    - Substance use
    - Mental health
    - Life satisfaction

Preferred Practices or Methodologies

- Appropriate screening tools for assessment of substance use/ use of ASAM criteria to determine level of care
- Appropriate assessment for comorbid BH and PH
- Use of psychosocial supports for engagement in treatment
- Appropriate use and/or coordination of MAT services as appropriate
- Engagement in harm reduction

Measurements

- The Health Plan will evaluate the provider for continued designation using the following metrics.

17.04 – Transition Aged Youth/Transition to Independence Process Centers of Excellence Description

The following information describes the Goals and Measurements of a Center of Excellence for the current contract year. Programs that do not meet the definitions of practice and/or minimum performance thresholds may not be renewed for the subsequent year. The descriptions are created in collaboration with clinicians and providers and will be reviewed and updated on an annual basis.

Goals for the Program

- Ensuring Transition-Age Youth (ages 16-21) develop the skills and receive the support needed to successfully transition into adulthood
- Make available the specialty services to adolescents achieve goals stated in their individual service plan outlining the need and goal for the Specialty Provider
- Ensure TAY in TIP programs achieve positive Clinical Outcomes in accordance with the Five TIP Domains:
    - **Employment and Career**
        - Increasing exploration, placement, and progress in employment and possible careers

- **Personal Effectiveness & Wellbeing**
  - Improving emotional coping and self-management skills.
  - Increasing competence and confidence in continuing to advance their life and future
  - Decreasing interference from mental health and/or substance use problems with their functioning in their school, work, community, and/or relationships
- **Educational**
  - Increasing engagement and progress in schooling and post-secondary education and technical/vocational training.
- **Living Situation**
  - Improving stability in living situation in safe home-like settings
  - Decreasing crisis placements, restrictive residential facilities, and involvement with the criminal system and incarceration
- **Community – Life Functioning**
  - Learning and utilizing relevant life skills for functioning in home, school, work, and community settings, including problem-solving & decision-making skills.
  - Improving interpersonal skills and expanding relevant social supports and connections

Preferred Practices or Methodologies

The Provider should apply TIP Guidelines to work with Transition aged youth and beyond to young adulthood

- Engage young people through relationship development, person centered planning and a focus on their futures
- Use of Evidence Based Practices for TAY population
- Use of a Nationally Recognized Assessment Tool for TAY (Casey Life Skills Assessment, TAPIS)
- Use of Screening Tool to assess HRSN
  - Use of ACEs screening tool
- Tailor services and supports to be accessible, coordinated, developmentally appropriate, and builds on strengths to enable the young person to pursue their goals
- Implementation of the AHCCCS Transition Age Youth Guidance Tool within program
- Acknowledge and develop personal choice and social responsibility

- Ensure a safety-net of supports by involving family members, and other supporters as defined by the individual
- Enhance the individual's competencies to assist them in achieving greater self-sufficiency and confidence
- Maintain an outcome focus
- Involve selected family or supporters as well as community partners in the TIP system at all levels of service
- Services and/or transition for services across children and adult systems
- Willing to work with young adults ages 16 to 21
- Collaboration with Case Manager to promote services being in place within appointment timelines (access to care workflow process)

Measurements

The Health Plan will evaluate the provider using the agreed upon metrics for consideration and continued designation.

17.05 – Adults with Chronic Pain Centers of Excellence Description

The following information describes the Goals and Measurements of a Center of Excellence for the current contract year. Programs that do not meet the definitions of practice and/or minimum performance thresholds may not be renewed for the subsequent year. The descriptions are created in collaboration with clinicians and providers and will be reviewed and updated on an annual basis. Additionally, COE providers must ensure a clear workflow for integrating behavioral health with medical interventions, including joint care planning.

Goals for the Program

- Ensure that members receive a comprehensive assessment and treatment planning that includes medication management, restorative therapies, interventional procedures, Behavioral Health approaches, & integrative healthcare.
- Ensure patients have access to safer, more effective chronic pain treatment by improving the way opioids are prescribed through an evidence-based clinical practice guideline, while reducing the number of people who misuse, abuse, or overdose from opiates
- Improve a member's quality of life when living with chronic pain
- Offer access to alternative therapies and procedures for members with chronic pain and a diagnosed Opioid Use Disorder
- Enhance behavioral health outcomes for members with chronic pain

Preferred Practices or Methodologies

Due to its complexity, acute and chronic pain management generally consists of five treatment approaches. To be a COE for pain management, providers would need to address each of the five domains below and provide services from a holistic approach based upon the members clinical need and covered benefits.

- **Medications**
  - For Example:
    Suboxone, Vivitrol, Narcan, Gabapentinoids, Neuropathic Rx, NSAIDs, OTCs
  - Pharmacy Review of Polypharmacy: Proactive involvement in reviewing medication regimens for high-risk members
- **Restorative Therapies**
  - Traction, physical therapy, massage therapy, cold/hot, bracing, therapeutic exercise, occupational therapy, biofeedback
- **Interventional Therapies**
  - Epidural steroid injections, nerve block, dry needling, trigger points, spacer devices, stem cell therapy, cryoneuroablation, joint injections; TENS units, Chiropractic Care, neuromodulation, spinal decompression
- **Behavioral Health Therapies**
  - Behavioral, CBT, Acceptance & Commitment therapy, mindfulness-based stress reduction, expression therapy, MI, psycho-physiological approaches; motivational interviewing, psychoeducation, family psychoeducation, Case Management, counseling types (individual, group)
- **Integrative Health**
  - Acupuncture, massage, manipulative therapies, mindfulness-based stress reduction (MBSR), detox
  - Family/Caregiver Engagement: Defined strategy for involving family or caregivers in assessment, education, and care planning
  - Address Health Related Social Needs
    - Warm handoffs to Community Resources and documented process for connecting members
  - Equity Review: Periodic analysis of access and outcomes by demographic group to ensure parity and target gaps

Measurements

The Health Plan will evaluate the provider using the agreed upon metrics for consideration and continued designation.

17.06 – Autism Spectrum Disorder Centers of Excellence Description

The following information describes the Goals and Measurements Center of Excellence for the current contract year. Programs that do not meet the definitions of practice and/or minimum performance thresholds may not be renewed for the subsequent year. The descriptions are created in collaboration with clinicians and providers and will be reviewed and updated on an annual basis.

Goals for the Program

- Ensure screening and assessment of individuals that are at-risk for or may have a diagnosis of ASD. Assessments should also consider differential diagnoses such as trauma, communication disorder, or anxiety
- Ensure diagnosis within the first 2 years of age based on AHCCCS recommendation or requirement
- Provide access to multi-disciplinary team meetings which will bring together the expertise of Primary Care, mental health, and specialty providers to create and maintain comprehensive treatment planning
- Ensure timely availability of specialty ASD-focused services
- Member, families, and/or caregivers are satisfied with the timelines and level of service provided
- Improve health and daily functioning
- Members are engaged socially and in the community
- Reduction with undesired behavior or challenging behavior
- Members are involved and stable in the community
- Prepare members for independent living
- Increase age-appropriate social skills

Preferred Practices or Methodologies

- Use of a National Recognized Age-Appropriate Assessment Tool for ASD (i.e., FBA, VB-MAPP, Vineland)
- Use of Screening Tool to assess HRSN (comprehensive assessment that includes HRSN). e.g., PRAPARE
- Utilization of a multi-systemic approach and collaboration with key stakeholders to assist with long-term services and supports.
- Annual Interdisciplinary Team Meeting comprised of the member/family, behavioral and physical health providers that have experience in serving members with complex health conditions, to develop an integrated treatment plan geared specifically to the members needs and goals

- Participate and adopt identified training and evidence-based practices and demonstrate expertise in one of the following areas:
    - Applied Behavior Analysis (ABA) techniques of data collection, contingency management and positive reinforcement
    - Antecedent management strategies that include use of visual supports for communication and environmental structure, such as the Treatment and Education of Autistic and Related Communication Handicapped Children (TEACCH)
    - DIR and DIR Floortime®
    - Speech therapy intervention procedures to teach and reinforce communication skills
    - Occupational therapy intervention procedures to facilitate fine and gross motor skills
    - Picture Exchange Communication System (PECS)
    - Other nationally recognized best practices.
    - Provides support and system navigation for members to receive age-appropriate services across the life span (children, youth, adults)

Measurements

The Health Plan will evaluate the provider using the agreed upon metrics for consideration and continued designation.

17.07 – Supportive Care for Dementia Center of Excellence Description

The program will focus on dementia care management with the goal of improving quality of life for people living with dementia, reducing strain on unpaid caregiver, and enabling individuals to remain safely in their homes and communities for as long as possible. By preventing or delaying nursing home placement, the program seeks to enhance outcomes for both people living with dementia and their caregivers. These goals will be achieved through a comprehensive package of services, including care coordination and care management, caregiver education and support, and access to respite services.

Goals for the Program

Goals and thresholds have been developed collaboratively with clinicians and providers to ensure alignment with best practices and member outcomes. Please note the following:

- Programs must meet the defined standards of practice and minimum performance thresholds to remain eligible for renewal in the subsequent year.
- These definitions and expectations are reviewed and updated annually to reflect evolving clinical standards and organizational priorities.

Preferred Practices or Methodologies

The program will address the key drivers of poor-quality dementia care:

1. Defining a standardized approach to dementia care delivery for MC members.
2. Aiming to address the burden experienced by unpaid caregivers by providing caregiver training and support services, including 24/7 access to a support line, as well as connections to community-based providers.
3. How to provide respite services for the unpaid caregiver to temporarily have breaks from caregiving responsibilities.
4. Screening for Health-Related Social Needs (HRSNs) to help navigate beneficiaries to local, community-based organizations to address the needs.
5. Maintain an interdisciplinary care team that must include:
    a. Care Navigator who has received training in dementia, assessment, and care planning
    b. Clinician with dementia proficiency as recognized by experience caring for adults with cognitive impairment; experience caring for patients 65 years or older; or specialty designation in neurology, psychiatry, geriatrics, geriatric psychiatry, behavioral neurology, or geriatric neurology.

Measurements

The Health Plan will evaluate the provider using the agreed upon metrics for consideration and continued designation.

MC Chapter 18 – Grievance System, Member Rights and Claim Disputes

MC's Grievance System includes a process for member grievances, member appeals, provider claim disputes, and access to the State Fair Hearing system.

A Grievance is any written or verbal expression of dissatisfaction over anything that does not involve appealing a decision, such as a denial or discontinuance of services or benefits. Grievances may be filed by a member or provider authorized in writing to act on the member's behalf. A grievance may be submitted orally or in writing to any MC Grievance and Appeal staff. Grievances include, but are not limited to, issues regarding:

- Quality of care or services
- Accessibility or availability of services
- Interpersonal relationships (e.g., rudeness of a provider or employee, cultural barriers, or insensitivity)
- Claims or billing
- Failure to respect a member's rights

An appeal is a request for review of an action by a member or their authorized representative, such as a provider. An appeal can be filed for various reasons including the denial or limited authorization of a requested service, the type or level of service, or for the reduction, suspension, or termination of a previously authorized service. An authorized representative acting on behalf of the member, with the member's written consent, may file an appeal or request a State Fair Hearing on behalf of a member.

18.00 – Title 19 Member Appeals Process

Definitions

"Day" is defined as any calendar day unless otherwise specified.

Computation of Time

Computation of time for appeals begins the day after the act, event or decision and includes the final day of the period. For purposes of computing all timeframes, except for the standard service authorization timeframes and extensions thereof, if the final day of the period is a weekend day (Saturday or Sunday) or legal holiday, the period is extended until the end of the next day that is not a weekend day or a legal holiday.

For a standard service authorization with or without an extension, if the final day of the period is a weekend day or legal holiday the period is shortened to the last working day immediately preceding the weekend day or legal holiday.

Computation of time in calendar days includes all calendar days. Computation of time in workdays includes all working days, i.e., non-weekend.

Language and Format Requirements

MC is responsible for sending notice to Title XIX/XXI eligible members must ensure that:

- Notice and written documents related to the appeals process must be available in each prevalent, non-English language spoken within MC's Geographic Service Area;
- As applicable, MC must provide free oral interpretation services to explain information contained in the notice or as part of the appeal process for all non-English languages;
- Notice and written documents related to the appeals process must be available in alternative formats, such as Braille, large font or enhanced audio and take into consideration the special communication needs of the member; and
- Notice and written documents must be written using an easily understood language and format.

Delivery of Notices

All notices identified herein, including those provided during the appeal process, shall be mailed to the required party at their last known residence or place of business. If it may be unsafe to contact the member at his or her home address, or the member has indicated that he or she does not want to receive mail at home, the alternate methods identified by the individual for communicating notices shall be used.

Prohibition of Punitive Action

MC or Providers must not take punitive action against a Title XIX/XXI eligible member who decides to exercise their right to appeal. MC does not take punitive action against member or member's legal guardian who requests an expedited resolution to an appeal or who supports a Title XIX/XXI eligible member's appeal.

Notice of Adverse Benefit Determination (NOA)

For Title XIX/XXI covered services, notice must be provided following:

- The denial or limited authorization of a requested service, including the type or level of service;
- The reduction, suspension, or termination of a previously authorized service;

- The denial, in whole or in part, of payment for a service that is not TXIX/XXI covered; and
- The denial of the Title XIX/XXI member's request to obtain services outside the network.

Complex Case Request

MC is responsible for sending all Notices of Adverse Benefit Determination (NOA) to Title XIX/XXI eligible members. Providers who determine an action are required to complete a **Complex Case Review Form**, available under **Forms** on the MC website, and forward their request to MC Medical Management at **ComplexCase@MercyCareAZ.org** for review. Providers must include the following information in their email request:

- Member name, date of birth, AHCCCS ID number, services request, type of request, whether the request is immediate or routine
- Brief description of the reason for the notice with any applicable dates
- The name of the requestor, their title, email address, fax, and phone number

ACT services

ACT teams are required to submit Complex Case Review forms for all Title XIX/XXI eligible members who have been screened for ACT services (per ACT referral screening protocols) and member has been preliminarily determined to not meet ACT criteria by the ACT screening team. ACT teams shall complete a Complex Case Review form within 7 calendar days from the day the ACT screening team rendered a preliminary decision that the member who was referred does not meet criteria for ACT services.

Non-Prior Authorized Level of Care

Providers are expected to work with the member regarding clinical and service needs. Providers will review needs of the member and determine if the member/guardian agrees regarding services. If a member/guardian is not in agreement, the provider will complete the following actions:

- Utilize staffing to address member needs
- Include the right support system
- Update the ISP to support member outcomes
- If unable to come to agreement, the provider will complete the **Complex Case Review Form**, available under **Forms** on the MC website, and submit it to MC at email: **ComplexCase@MercyCareAZ.org**.
- MC will respond and coordinate next steps on complex cases that can't be resolved at the provider level. If the provider is unable to support the member in the current setting and needs subject matter expert support from the plan level.

- MC will respond and coordinate next steps in accordance with timeframes below:
    - Within one business day on immediate resolution requests
    - Within 5 business days on routine resolution requests

The provider does not complete an NOA for member closures. The provider needs to follow the guidelines in **MC Provider Manual Chapter 400 - ACC-RBHA, Chapter 2 – Network Provider Service Delivery Requirements, Section 2.04, Outreach, Engagement, Re-engagement, and Closure** for the following areas:

- Engagement
- Reengagement
- No Show Policy
- Follow-Up After Significant and/or Critical Events
- Ending an Episode of Care for Person in Behavioral Health System
- Further Treatment Declined
- Lack of Contact

Authorized Level of Care

When a provider has determined they are not clinically able to support the member in current setting, they will:

- Outreach the assigned MC Utilization Review staff, and
- MC UM staff reviews the case with the medical director (MDR) to determine if the member still meets medical necessity.
    - If the member still meets medical necessity, the UM team will coordinate a transfer to another provider at the same level of care.
    - If the member no longer meets medical necessity, the MDR completes a denial, and MC issues the NOA in accordance with applicable policies.

AHCCCS sends notices to Title XIX/XXI eligible members enrolled with a Tribal ACC-RBHA (TRBHA) following:

- The denial or limited authorization of a requested service, including the type or level of service (see **MC Provider Manual Chapter 400 - ACC-RBHA, Chapter 13 – Service Authorizations, Section 13.00 - Securing Services and Prior Authorization**); and
- The reduction, suspension, or termination of a previously authorized service. AHCCCS sends notices to Title XIX/XXI eligible members who have been adversely affected by a PASRR determination in the context of either a preadmission screening or a resident review.

Communication of Notice to Title XIX/XXI Eligible Members

The use of **Notice of Adverse Benefit Determination** is required when providing notice regarding an action concerning a Title XIX/XXI member which will include the following:

- The requested service;
- The reason/purpose of that request in layperson terms;
- The action taken or intended to be taken (denial, limited authorization, reduction, suspension, or termination) with respect to the service request;
- The effective date of the action;
- The reason for the action, including member specific facts;
- The legal basis for the action;
- Where members can find copies of the legal basis;
- The right to and process for appealing the decision; and
- Legal resources for members for help with appeals, as prescribed by AHCCCS

Delivery of Notices

The **Notice of Adverse Benefit Determination** must be mailed to the Title XIX/XXI eligible member and, when applicable, their legal representative or designated representative (e.g., Department of Economic Security/Division of Children, Youth and Families/Department of Child Safety (DCS) Specialist and/or advocate for SMI members requiring special assistance). For Title XIX/XXI eligible members under the age of 18, the **Notice of Adverse Benefit Determination** must be mailed to their legal or custodial parent or a government agency with legal custody of the Title XIX/XXI eligible member.

All notices must be mailed to all parties at their last known residence or place of business. If it may be unsafe to contact a member at his or her home address, or the member does not want to receive mail at home, alternate methods identified by the member for communicating notice must be used.

Notice of Adverse Benefit Determination Timeframes

Notice of Adverse Benefit Determination for Service Authorization Requests

For service authorization requests, the following timeframes for sending **Notice of Adverse Benefit Determination** are in effect (See **MC Provider Manual Chapter 400 - ACC-RBHA, Chapter 13 – Service Authorizations, Section 13.00 – Securing Services and Prior Authorization** for required timeframes for decisions regarding prior authorization requests):

- For an authorization decision related to a service requested by or on behalf of a Title XIX/XXI eligible member, MC must send a **Notice of Adverse Benefit Determination** within 14 days following the receipt of the member's request;

- For an authorization request in which MC indicates or determines, that the 14-calendar day timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function, the responsible entity must make an expedited authorization decision and send the **Notice of Adverse Benefit Determination** as expeditiously as the member's health condition requires;
- If the Title XIX/XXI eligible member requests an extension of either timeframe above, the MC must extend the timeframe up to an additional 14 days;
- If MC needs additional information and the extension is in the best interest of the member, MC shall extend the 14-calendar day or the three working day timeframe up to an additional 14 days. If MC extends the timeframe, MC must:
    - Give the Title XIX/XXI eligible member written notice of the reason for the decision to extend the timeframe using **Notice of Extension of Timeframe for Service Authorization Decision Regarding Title XIX/XXI Services**, and inform the member of the right to file a complaint if the member disagrees with the decision; and
    - Issue and carry out the determination as expeditiously as the member's condition requires and no later than the date the extension expires.
    - For service authorization decisions not reached within the maximum timeframes outlined above, the authorization shall be considered denied on the date that the timeframe expires.
    - MC shall provide the requesting provider with written notification of a decision to deny a service authorization.

Notice of Adverse Benefit Determination for Service Termination, Suspension or Reduction

For service terminations, suspensions or reductions, the following timeframes are in effect:

- MC must send the **Notice of Adverse Benefit Determination** at least 10 days before the date of the action with the following exceptions. MC may send the **Notice of Adverse Benefit Determination** no later than the date of the action if:
    - MC has information confirming the death of a Title XIX/XXI member;
    - MC receives a clear written statement signed by the Title XIX/XXI member or their legal representative that the member no longer wants services or gives information to MC that requires termination or reduction of services and indicates that the member understands that this will be the result of supplying that information;
    - The Title XIX/XXI member is an inmate of a public institution that does not receive federal financial participation, and the member becomes ineligible for TXIX/XXI;
    - The Title XIX/XXI member's whereabouts are unknown, and the post office

returns mail to MC indicating no forwarding address;
- The Title XIX/XXI eligible member's whereabouts are unknown, and the post office returns mail, directed to the Title XIX/XXI eligible member, to MC or the provider, indicating no forwarding address;
- MC establishes the fact that the Title XIX/XXI member has been accepted for Medicaid by another state. MC may shorten the period of advance notice to five days before the date of action if MC has verified facts indicating probable fraud; or
- MC may shorten the period of advance notice to five (5) working days before the date of action if there are verified facts indicating probable fraud by the Title XIX/XXI eligible member.

Notice of Adverse Benefit Determination for Denial of Claim for Payment

MC is designated to authorize services and shall send a **Notice of Adverse Benefit Determination** to the Title XIX/XXI eligible member if they deny a claim for payment to the provider for a service that is not Title XIX/XXI covered.

Title XIX/XXI Appeal and State Fair Hearing Process

A Title XIX/XXI eligible member may appeal the following actions with respect to Title XIX/XXI covered services:

- The denial or limited authorization of a requested service, including the type or level of service;
- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service that is not TXIX/XXI covered;
- The failure to provide TXIX/XXI services in a timely manner;
- The failure to act within the timeframes required for standard and expedited resolution of appeals and standard disposition of grievances; and
- The denial of a TXIX/XXI member's request to obtain services outside the MC's provider network.

A Title XIX/XXI eligible member adversely affected by PASRR determination in the context of either a preadmission screening or a resident review may file an appeal under this policy.

Responsibility

MC is responsible for processing appeals and does not delegate this function to a provider. AHCCCS processes appeals related to actions initiated by a Tribal ACC-RBHA or one of their subcontracted providers. Any responsibilities attributed to MC are the responsibility of AHCCCS

if the action relates to a Tribal ACC-RBHA or one of their subcontracted providers or relates to an appeal concerning a PASRR determination. Information gathered during the appeal process is considered confidential and the member's rights to privacy are protected throughout the process.

The following information is provided to familiarize providers with the Title XIX/XXI appeal process.

Filing an Appeal or Request a State Fair Hearing

The following members or authorized representative(s) may file an appeal or request a State Fair Hearing regarding an action:

- A Title XIX/XXI eligible member;
- A legal or authorized representative, (e.g., Department of Child Safety (DCS) Specialist and/or advocate for SMI members requiring special assistance), including a provider, acting on behalf of the member, with the member's or legal representative's written consent.
- A Title XIX/XXI eligible member adversely affected by a PASRR determination in the context of either a preadmission screening or a resident review.

Standard and Burden of Proof

The standard of proof on all issues on appeal shall be the preponderance, or the greater weight, of the evidence. The burden of proof for all issues on appeal is on the complainant (individual or agency) appealing.

Denial of Request for Appeal

In the event MC refuses to accept a late appeal or determines that the decision being appealed does not constitute an action subject to these appeal requirements, MC must inform the appellant in writing by sending a Notice of Appeal Resolution.

Timeframe for Filing Standard Appeal

A Title XIX/XXI eligible member has up to 60 days after the date of the **Notice of Adverse Benefit Determination** to file a standard appeal. The appeal may be filed orally or in writing.

Timeframes for MC to Resolve a Standard Appeal

MC resolves standard appeals and mails written Notice of Appeal Resolution no later than 30 days from the date of receipt of the appeal unless an extension is in effect.

Extension of Timeframe for Standard Appeal Resolution

If a Title XIX/XXI eligible member requests an extension of the 30-day timeframe, MC will extend the timeframe up to an additional 14 days. If MC needs additional information and the extension is in the best interest of the member, MC may extend the 30-day timeframe up to an additional 14 days.

Expedited Appeal

MC conducts an expedited appeal if:

- MC receives a request for an appeal from a Title XIX/XXI eligible member and determines that taking the time for a standard appeal resolution could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function;
- MC receives a request for an expedited appeal from a Title XIX/XXI eligible member supported with documentation from the provider that taking the time for a standard resolution could seriously jeopardize the member's life or health, or ability to attain, maintain or regain maximum function; or
- MC receives a request for an expedited appeal directly from a provider, with the Title XIX/XXI eligible member's written consent, and the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life or health, or ability to attain, maintain or regain maximum function.

Denial of Expedited Appeal

If MC denies a request for expedited resolution of an appeal from a Title XIX/XXI eligible member, MC will resolve the appeal within the standard resolution timeframe and make reasonable efforts to give the member prompt oral notice of the denial. Within two calendar days, MC follows up with written notice of the denial.

Timeframes for MC to Resolve an Expedited Appeal

MC must resolve expedited appeals and mail a written Notice of Appeal Resolution within 72 hours after the day MC receives the appeal unless an extension is in effect.

Extension of Expedited Appeal Resolution Timeframe

If a Title XIX/XXI eligible member requests an extension of the 72-hour timeframe, MC will extend the timeframe up to an additional 14 days. If MC needs additional information and the extension is in the best interest of the member, MC extends the three working day timeframe up to an additional 14 days.

Filing Appeals

All appeals must be submitted in writing, along with substantiating documentation to:

Mercy Care
Attn: Grievance and Appeals
4750 S. 44th Place, Ste 150
Phoenix, AZ 85040
Fax: 602-351-2300

A member can also file an appeal orally by contacting:

Mercy Care
Grievance and Appeals
Phone: 800-564-5465

Requesting a State Fair Hearing

A Title XIX/XXI member or legal guardian may request a State Fair Hearing following MC's resolution of an appeal. A provider or authorized representative acting on behalf of a member, with the member's written consent, may file a state fair hearing request. The request must be in writing and submitted to:

Mercy Care
Attn: Hearing Coordinator
4750 S. 44th Place, Ste 150
Phoenix, AZ 85040
Fax: 866-821-6628

The request must be received by MC no later than 90 days after the date that the member received the Notice of the Appeal Resolution.

Once the State Fair Hearing request is received, MC will forward the state fair hearing request and appeal file to AHCCCS within five (5) business days.

Assistance to Title XIX/XXI Eligible Members in Filing an Appeal and/or Requesting a State Fair Hearing

MC provides reasonable assistance to Title XIX/XXI eligible members in completing forms and other procedural steps. Reasonable assistance includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD (teletypewriter/telecommunications device for the deaf and text telephone) and interpreter capability. Reasonable assistance may be offered by a provider or referred to MC by contacting the Grievance and Appeals department at 800-564-5465.

AHCCCS Timeframe for Resolution of a State Fair Hearing

After receiving the state fair hearing request and appeal file from MC, AHCCCS will send a Notice of Hearing if a timely request for a State Fair Hearing is received. See 9 A.A.C. 34, *AHCCCS Grievance System.*

For appeals resolved pursuant to the standard resolution timeframes, AHCCCS will send an AHCCCS Director's Decision to the Title XIX/XXI member no later than 30 days after the date of the Administrative Law Judge's recommended decision.

For appeals resolved pursuant to the expedited resolution timeframes, within three working days after the date AHCCCS receives the case file and information from MC concerning an expedited appeal resolution, AHCCCS will send the Title XIX/XXI eligible member the AHCCCS Director's Decision which results from the State Fair Hearing and the Administrative Law Judge's Recommended Decision. AHCCCS will make reasonable efforts to provide oral notice of the AHCCCS Director's Decision.

Continuation of Services during Appeal or State Fair Hearing Process

If a member wishes services to continue during the appeal and state fair hearing process, the member must timely request, as described below, the continuation of services when the appeal is initially filed and at the time of request a State Fair Hearing. Services shall be continued based on the authorization that was in place prior to the denial, termination, reduction, or suspension of services that has been appealed if the requirements of this section are met. A Title XIX/XXI eligible member's services can continue during the appeal and State Fair Hearing process, unless continuation of services would jeopardize the health or safety of the member or another member, if:

- The member files the appeal or hearing request timely*, and if;
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment, or the appeal involves a denial if the provider asserts the denial represents a necessary continuation of a previously authorized service;
- The services were ordered by an authorized provider; and
- The member requests continuation of services.

*Timely Filing Requirements:

- Appeals: Timely filing for continuation of services during an appeal means filing the appeal:
    - Within 10 days from the date that the **Notice of Adverse Benefit Determination** was sent; or
    - The intended effective date of the proposed action as indicated in the **Notice of Adverse Benefit Determination**.

- State Fair Hearing: Timely filing for continuation of services during a hearing means filing a hearing request within 10 days from the date the **Notice of Appeal Resolution** was sent for an appeal with continuation of benefits.

Discontinuation of Services during Appeal or State Fair Hearing Process

If services are continued as stated above, MC is required to continue services until one of the following occurs:

- The Title XIX/XXI eligible member withdraws the appeal or request for State Fair Hearing;
- The Title XIX/XXI eligible member does not request a State Fair Hearing and continuation of benefits within 10 calendar days from the date Notice of Appeal Resolution is sent; or
- AHCCCS issues a Director's Decision following a State Fair Hearing that is adverse to the Title XIX/XXI eligible member.

Upheld Appeal

If MC or the AHCCCS Director's Decision upholds MC's action, MC may recover the cost of the services furnished to a Title XIX/XXI eligible member while the appeal or State Fair Hearing decision was pending if the services were furnished solely because of the requirements above.

Overturned Appeal

If MC or AHCCCS Director's Decision reverses a decision to deny, limit, or delay authorization of services, and the member received the disputed services while an appeal or the State Fair Hearing was pending, MC will process a claim for payment from the provider in a manner consistent with the MC or Director's Decision and applicable statutes, rules, and policies. The provider will have 90 days from the date of the reversed decision to submit a clean claim to MC for payment.

If the MC or State Fair Hearing decision reverses a decision to deny, limit, or deny authorization of services, and the disputed services were not furnished during the appeal or the State Fair Hearing process, MC is required to provide the disputed services no later than 72 hours from the date MC received notice reversing the decision.

18.01 – Member Grievance Resolution Process

General Requirements

MC develops and provides training to staff responsible for taking complaints. The training plan is submitted to AHCCCS and updated annually on an ad hoc basis as modified. The training must

include information regarding the complaint (member grievance) process; appeals, SMI grievances, and requests for investigations; and customer service requirements.

Individuals responsible for taking complaints must aid as indicated by the following:

- An action that is subject to appeal through the Title XIX/XXI Member Appeal process shall be treated as an appeal pursuant to **Section 18.00 - Title XIX/XXI Notice and Appeal Requirements** to establish the earliest possible filing date for the appeal.
- For members determined to have SMI who are appealing a decision regarding SMI eligibility, or Non-TXIX/XXI members appealing the need for a covered service, see **Section 18.03 - Notice and Appeal Requirements (SMI and Non-Title XIX/XXI)**.
- For allegations of rights violations concerning members determined to have SMI see **Section 18.02 - Conduct of Investigations Concerning Members with Serious Mental Illness**.

In the event a complainant is dissatisfied with the resolution to a complaint, the issue(s) in dispute may still be referred to applicable appeal and grievance processes.

MC shall not route or otherwise encourage the direct filing of complaints with AHCCCS unless the member is AHCCCS or Arizona Long Term Care Services (ALTCS) eligible and enrolled and the complaint is specific or directly relates to the acute care health plan/provider.

There are no time limits placed on filing a complaint.

MC Requirements for Handling Complaints

Responsibilities for resolving complaints pursuant to requirements of this policy shall not be delegated by MC to provider agencies.

Regardless of whom within the organization receives a complaint or whether it is filed orally or in writing, MC shall have a centralized complaint resolution process and designated individuals to whom all complaints shall be referred.

Complaints may be made to MC orally or in writing by members or those seeking covered services, their families or legal guardian(s), authorized representatives, other agencies, or the public.

- For oral complaints: Call MC at 800-564-5465
- To submit a written complaint: Mail the complaint to:

  Mercy Care
  Attn: Complaints

4750 S. 44th Place, Ste 150
Phoenix, AZ 85040

All complaints will be acknowledged. Complaints filed orally shall be considered acknowledged at the time of filing. Written complaints must be acknowledged to the complainant within 5 working days of receipt by MC but acted upon in accordance with the urgency of the concern. If verbal acknowledgment is not achieved, a written acknowledgement letter must be sent within the 5-day timeframe. The letter will include a contact name and a phone number.

When information is received, either orally or in writing, that the individual has Limited English Proficiency (LEP) or any other communication need; MC must follow requirements outlined in **Section 4.28 Cultural Competency, Health Literacy and Linguistic Services** in this manual, regarding oral interpretation services, translation of written materials, and services for the deaf and hard of hearing:

- For all individuals with LEP, the provider must make available oral interpretation services.
- For individuals needing translation in the prevalent non-English language within the region, MC shall provide a written translation in accordance with the requirements of **Section 4.28 – Cultural Competency, Health Literacy and Linguistic Services** in this manual.
- For individuals who need translation in a language that is not considered a prevalent non-English language within the region or who require alternative formats (such as TTY/TTD), MC shall provide oral interpretation of written materials or make alternative communication formats available as indicated.
- MC must follow up on each complaint as expeditiously as the member's condition requires.

MC must address the identified issues as expeditiously as the member's condition requires. Complaints involving or asserting an immediate need such as a crisis service or assessment, access to medication, or health and safety concerns require immediate follow-up.

MC is required to dispose of each complaint and provide oral or written notice to affected parties as quickly as possible and in conformance with confidentiality requirements. If a member requests a written explanation of the complaint resolution, the complaint resolution response must be mailed within 10 days.

Most complaints should be resolved within 10 business days of receipt, but in no case longer than 90 days.

MC is responsible for investigating the complaint and issuing a resolution decision and shall ensure that:

- Individuals who make decisions regarding complaints are not involved in any previous level of review or decision-making; and
- Individuals making decisions about complaints that involve the denial of an expedited resolution of an appeal, or that involve clinical issues must be health care professionals with the appropriate clinical expertise in treating the member's condition.

If the complainant is dissatisfied with MC's resolution of their complaint, MC will advise the complainant that they may contact AHCCCS for additional review. AHCCCS will review the complaint and MC's efforts to resolve the complaint and intervene as indicated by the review.

In the event MC receives a complaint referred from AHCCCS, MC will provide AHCCCS with a written summary that describes the steps taken to resolve the complaint, including the findings, plan for resolution, if applicable, within the timeframe specified by AHCCCS. MC will acknowledge receipt of AHCCCS referred complaints expeditiously and according to the urgency and response timeframe identified by AHCCCS.

MC shall ensure that any specific corrective action or other action directed by AHCCCS is implemented.

MC shall:

- Maintain individual complaint records that include adequate, dated documentation, including but not limited to:
    - Copies of communication generated during the resolution process;
    - Documentation of actions taken to ensure that immediate health care needs are met;
    - Documentation of all steps taken to resolve the concern, including the date the complaint was acknowledged and the date the complainant was notified of the resolution;
    - Documentation of the plans for resolution;
    - Documentation of plans for correction;
    - Evidence that the resolution and any plans for correction have been implemented; and
    - Evidence that identified issues are referred for additional follow up as indicated, including referrals to Quality Management, Network Management, Grievance and Appeals, Fraud and Abuse, and/or regulatory agencies.

    - For complaints taking greater than 10 business days to resolve from the date of filing, the reason for the delay.
- Maintain a log of all complaints received utilizing a set of fields which documents the following information:
    - The member's first and last name;
    - The date the complaint was made;
    - Title XIX/XXI eligibility status;
    - The source of the complaint;
    - A description of the complaint;
    - Any identified communication need (e.g., need for translator);
    - The outcome reached;
    - The length of time for outcome as indicated in Section G.1.h. of this policy;
    - Covered service category;
    - Treatment setting; and
    - Behavioral health category.
- Routinely review the data collected through the complaint process as part of the MC's quality improvement strategy and network sufficiency review.

18.02 – Serious Mental Illness (SMI) Member Grievance Resolution Process

General Requirements

Members requesting or receiving services shall be notified of their right to file grievances or request investigations according to the requirements set forth in **Section 18.03 - Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI)**. MC and the AzSH, shall respond to grievances and requests for investigations in accordance with this policy and the requirements and timelines contained in **9 A.A.C. 21, Article 4**.

Computation of Time – In computing any period prescribed or allowed by this policy, the period begins the day after the act; event or decision occurs and includes all calendar days and the final day of the period. If the final day of the period is a weekend or legal holiday, the period is extended until the end of the next day that is not a weekend or a legal holiday. If the period is not designated as calendar days and is less than 11 days, then intermediate Saturdays, Sundays, and legal holidays must not be included in the computation.

MC or the AzSH shall use the unique Docket Number each appeal filed. The file and all correspondence generated shall reference the Docket Number.

Agency Responsible for Resolving Grievances and Requests for Investigation

Grievances involving an alleged rights violation, or a request for investigation involving an allegation that a condition requiring investigation exists, which occurred in an agency operated by MC, one of its subcontracted providers or the AzSH, and which does not involve a client death or an allegation of physical or sexual abuse, shall be filed with and investigated by MC or the AzSH.

Grievances or requests for investigation involving physical or sexual abuse or death that occurred in the AzSH, an agency which is operated by MC or one of its subcontracted providers or because of an action of a member employed by MC or one of its subcontracted providers shall be addressed and investigated by AHCCCS.

Grievances involving a rights violation, or a request for investigation involving an allegation that a condition requiring investigation exists and which occurred in an agency that is not AzSH, MC or one of their subcontracted providers, shall be addressed to the appropriate regulatory division or agency.

The AHCCCS Deputy Director, or designee, the MC Chief Executive Officer (CEO), or the Chief Executive Officer of the AzSH, before whom a grievance or request for investigation is pending, shall immediately take whatever action may be reasonable to protect the health, safety and security of any client, complainant, or witness.

Grievance/Request for Investigation Process

Timeliness and Method for Filing Grievances

Grievances or a request for investigation must be submitted to AzSH or MC, orally or in writing, no later than 12 months from the date the alleged violation or condition requiring investigation occurred. This timeframe may be extended for good cause as determined by the AHCCCS Deputy Director, or designee, MC Director, or CEO of AzSH, before whom the grievance or request for investigation is pending.

All grievances or requests for investigation must be submitted orally or in writing to:

Mercy Care
Attn: Grievances and Appeals
4750 S. 44th Place, Ste 150
Phoenix, AZ 85040
Fax Number: 602-351-2300
Phone: 800-564-5465

Within five days of receipt of a grievance or request for investigation, AzSH or MC must inform the member filing the grievance or request for investigation, in writing, that the grievance or request has been received.

Any employee or contracted staff of AzSH, MC or its subcontracted provider, shall, upon request, assist a member receiving services, or their legal guardian, in making an oral or written grievance or request for investigation or direct the member to an available supervisory or managerial staff who shall assist the member to file a grievance or request for investigation.

All oral grievances and requests for investigation must be accurately reduced to writing by AzSH, MC or its subcontracted provider that receives the grievance or request, on the **Appeal or SMI Grievance Form,** available under **Forms** available on the MC website.

Preliminary Disposition

Summary Disposition – AzSH, MC Director or designee, may summarily dispose of a grievance or request for investigation, which shall not include any notice or right for further review or hearing, when:

- The alleged violation occurred more than one year prior to the date of request; or
- The grievance request is primarily directed to the level or type of mental health treatment provided and can be fairly and efficiently addressed through the service planning or appeal process as described in **9 A.A.C. 21, Articles 3 and 4**.

Disposition without Investigation

Within seven days of receiving a grievance or request for investigation, AzSH, MC Director or designee, may resolve the matter without conducting a full investigation when:

- The matter involves no material dispute as to the facts alleged in the grievance or request for investigation;
- The allegation is frivolous, meaning that it:
    - Involves conduct that is not within the scope of Title 9, Chapter 21;
    - Is impossible on its face; or
    - Is substantially like conduct alleged in two previous grievances or requests for investigation within the past year and which have been determined to be unsubstantiated.
- Is resolved fairly and efficiently within seven days without a formal investigation.

Within seven days of the grievance or request for investigation, AzSH, MC's Director or designee, shall prepare a written dated decision which shall explain the essential facts as to why the matter may be appropriately resolved without investigation, and the resolution. The

written decision shall contain a notice of appeal rights, and information to request assistance from the AHCCCS Office of Human Rights (OHR) and the State Protection and Advocacy System. Copies of the decision shall be sent to the member filing the grievance or request for investigation and to the AHCCCS OHR for members who need special assistance.

Conducting Investigation of Grievances

AzSH, and MC shall conduct the investigation pursuant to **A.A.C. R9-21-406**.

If an extension of any timeframe related to the grievance process in **A.A.C. R9-21, Article 4** is needed; it must be requested and approved in compliance with **A.A.C. R9-21-410(B)**. Specifically:

- MC investigator or any other official responsible for responding to grievances must address their extension request to MC Director or designee.
- The MC investigator or any other MC official responsible for responding to grievances must address their extension request to the AHCCCS Deputy Director or designee; and
- A MC request for an extension to complete an investigation for grievances remanded pursuant to **A.A.C. R9-21-407(B)(2)** or any other period established by AHCCCS decisions relating to a grievance shall be addressed to the AHCCCS Deputy Director or designee.

Grievance Investigations – Allegations of Rights Violations or Physical Abuse

The investigator shall:

- Interview the member who filed the grievance and the member receiving services who is identified as the subject of the violation or abuse (if different) prior to interviewing the member alleged to be the perpetrator of the rights violation, or physical or sexual abuse.
- If the member who is the subject of the investigation needs special assistance, the investigator shall contact the member's advocate; or if no advocate is assigned, the member shall contact AHCCCS OHR, and request that an advocate be present to assist the member during the interview and any other part of the investigation process.
- Request assistance from the AHCCCS OHR if the member identified as the subject needs assistance to participate in the interview and any other part of the investigation process.
- Prepare a written report that contains at a minimum:
    - A summary for each individual interviewed of information provided by the individual during the interview conducted;
    - A summary of relevant information found in documents reviewed;
    - A summary of any other activities conducted as a part of the investigation;

- A description of any issues identified during the investigation that, while not related to the allegation or condition under investigation, constitutes a rights violation or condition requiring investigation;
- A conclusion, based on the facts obtained in the investigation, that the alleged violation or abuse is either substantiated or not substantiated based on a preponderance of the evidence. The conclusion must describe those findings and/or factors that led to this determination; and
- Recommended actions or a recommendation for required corrective action, if indicated.

Decisions

Within 5 days of receipt of the investigator's report, AHCCCS' Deputy Director or designee, MC Director, or the CEO of AzSH shall review the investigation case record, and the report, and issue a written, dated decision which shall either:

- Accept the report and state a summary of findings and conclusions and any action or corrective action required of AzSH, MC Director, and send copies of the decision, subject to confidentiality requirements provided for in **MC Provider Manual Chapter 400 - ACC-RBHA, Chapter 14 – Contract Compliance, Section 14.00 Confidentiality** to the investigator, AzSH, MC Director, the member who filed the grievance, the member receiving services identified as the subject of the violation or abuse (if different), and the AHCCCS Office of Human Rights for members deemed in need of Special Assistance. The decision sent to the grievant and the member who is the subject of the grievance (if different) shall include a notice of the right to request an administrative appeal of the decision within 30 days from the date of receipt of the decision. The decision must be sent to the grievant by certified mail or by hand- delivery.
- Reject the report for insufficiency of facts and return the matter for further investigation. The investigator must complete the further investigation and deliver a revised report to AHCCCS' Deputy Director or designee, MC Director, or the Chief Executive Officer of the AzSH within 10 days.

Actions

AHCCCS' Deputy Director or designee, MC Director, or the CEO of the AzSH may identify actions to be taken, as indicated above, which may include:

- Identifying training or supervision for or disciplinary action against an individual found to be responsible for a rights violation or condition requiring investigation identified during investigation of a grievance or request for investigation;
- Developing or modifying a mental health agency's practices or protocols;

- Notifying the regulatory entity that licensed or certified an individual according to **A.R.S. Title 32, Chapter 33** of the findings from the investigation; or
- Imposing sanctions, which may include monetary penalties, according to the terms of a contract, if applicable.

Disagreement with Decision

A grievant or the client who is the subject of the grievance, who disagrees with the final decision of MC or AzSH, may file a request for an administrative appeal within 30 days from the date of their receipt of the MC or AzSH decision. The request for administrative appeal must specify the basis for the disagreement. Failure to specify the basis for the disagreement may result in a summary determination in favor of the MC or AzSH decision.

Administrative Appeal

In the event an administrative appeal is filed, MC or AzSH, shall forward the full investigation case record, which includes all elements in **A.A.C. R9-21-409(D)(1)**, to AHCCCS' Deputy Director or designee through the AHCCCS OGA. The failure of MC or AzSH to forward a full investigation case record that supports the MC or AzSH decision may result in a summary determination in favor of the member filing the administrative appeal. MC or AzSH shall prepare and send with the investigation case record, a memo in which MC states:

- Any objections AzSH or MC has to the timeliness of the administrative appeal;
- AzSH's or MC's response to any information provided in the administrative appeal that was not addressed in the investigation report; and
- AzSH or MC understands the basis for the administrative appeal.

Within 15 days of the filing of the administrative appeal, AHCCCS' Deputy Director, or designee, will review the appeal and the investigation case record and may discuss the matter with any of the members involved or convene an informal conference, and prepare a written, dated decision which shall either:

- Accept the investigator's report with respect to the facts as found, and affirm, modify, or reject the decision of the agency director with a statement of reasons. The decision, along with a notice of the right to request a State Fair Hearing within 30 days from the date of receipt of the decision, shall be sent to the appealing party, with copies of the decision provided to the AzSH or MC Director, as indicated; the OHR; and the applicable human rights committee; or
- Reject the investigator's report for insufficiency of facts and remand the matter with instructions to MC or AzSH for further investigation and decision. MC or AzSH shall conduct further investigation and complete a revised report and decision to AHCCCS'

Deputy Director or designee within 10 days. Upon receipt of the report and decision, AHCCCS shall render a final decision consistent with the procedures described above; or;

- Reject MC's decision and remand the matter with instructions to MC or AzSH to investigate, or to conduct further investigation, issue an initial or revised, decision, and include a notice of the right of the grievant or client who is the subject of the grievance to request an administrative appeal to AHCCCS of the decision within 30 days from the date of receipt of the decision, consistent with the requirements in **A.A.C. R9-21-406, et. seq**.

A grievant or member who is the subject of the grievance who is dissatisfied with the decision of AHCCCS' Deputy Director, or designee may request a State Fair Hearing before an administrative law judge within 30 days of the date of the decision.

Upon receipt of a request for a hearing, the hearing shall be scheduled and conducted according to the requirements in **A.R.S. §41-1092 et seq**.

After the expiration of the time frames for administrative appeal and State Fair Hearing as described above, or after the exhaustion of all appeals regarding outcome of the investigation, MC or AzSH Director, or the Deputy Director, or designee of AHCCCS, shall take any corrective action required and add to the record a written, dated report of the action taken. A copy of the report shall be sent to the AHCCCS OHR for members in need of Special Assistance.

Unless an investigation request is made pursuant to **A.A.C. R9-21-403(A)** or **R9-21-403(B)**, investigations into the deaths of members receiving services shall be conducted as described in **Section 12.01 – Quality of Care Concerns/Incident, Accident, Death Reporting** in this manual.

Grievance Investigation Records and Tracking System

AHCCCS, AzSH, and MC will maintain records in the following manner:

- All documentation received and mailed related to the grievance and investigation process will be date stamped on the day received;
- AHCCCS, AzSH, and MC will maintain a grievance investigation case record for each case. The record shall include:
    - The docket number assigned;
    - The original grievance/investigation request letter and the **Appeal or SMI Grievance Form**;
    - Copies of all information generated or obtained during the investigation;
    - The investigator's report which will include a description of the grievance issue, documentation of the investigative process, names of all members interviewed,

written documentation of the interviews, summary of all documents reviewed, the investigator's findings, conclusions, and recommendations; and
    - A copy of the acknowledgment letter, final decision letter and any information/documentation generated by an appeal of the grievance decision;
- AHCCCS, AzSH, and MC will maintain all grievance and investigation files in a secure designated area and retain for at least 5 years;

Other Matters Related to Grievance Process

Pursuant to the applicable statutes, AzSH and MC shall maintain confidentiality and privacy of grievance always matters and records.

Notice shall be given to a public official, law enforcement officer, or other member, as required by law, that an incident involving death, abuse, neglect, or threat to a member receiving services has occurred, or that a dangerous condition or event exists.

AzSH or MC shall notify the Deputy Director or designee of AHCCCS when:

- A member receiving services files a complaint with law enforcement alleging criminal conduct against an employee;
- An employee or contracted staff files a complaint with law enforcement alleging criminal conduct against a member receiving services;
- An employee, contracted staff, or member receiving services is charged or convicted of a crime related to a rights violation, physical or sexual abuse, or death of a member receiving services.

18.03 – Serious Mental Illness (SMI) Member Appeal Resolution Process

General Requirements for Notice and Appeals

Behavioral health providers must be aware of general requirements guiding notice and appeal rights for the populations covered in this chapter. Behavioral health providers may have direct responsibility for designated functions (i.e., sending notice) as determined by MC and/or may be asked to aid members who are exercising their right to appeal.

Time Computed

In computing any time prescribed or allowed in this chapter, the period begins the day after the act, event or decision occurs. If the period is 11 days or more, the period must be calculated using calendar days, which means that weekends and legal holidays are counted. If, however, the period is less than 11 days, the period is calculated using working days, in which case, weekends and legal holidays must not be included in the computation. In either case, if the final

day of the period is a weekend or legal holiday, the period is extended until the end of the next day, which is not a weekend or a legal holiday.

Language, Format and Comprehensive Clinical Record Requirements

Notice and related forms must be available in each prevalent, non-English language spoken in MC's geographic service area (GSA). As designated by MC, behavioral health providers must provide free oral interpretation services to all members who speak non-English languages for purposes of explaining the appeal process and/or information contained in the notice. MC is responsible for providing oral interpretation services at no cost to the member receiving such services.

Notice and other written documents pertaining to the appeal process must be available in alternative formats, such as Braille, large font or enhanced audio and must take into consideration any special communication needs of the member applying for or receiving behavioral health services MC is responsible for ensuring the availability of these alternative formats.

The provision of notice must be documented by placing a copy of the notice in the member's comprehensive clinical record.

Delivery of notices and appeal decisions

All notices and appeal decisions are mailed to the required party, at their last known residence or place of business. If it may be unsafe to contact the member at his or her home, or the member has indicated that he or she does not want to receive mail at home, the alternate methods identified by the member for communicating notices must be used.

Notice Requirements for Members with Serious Mental Illness

For actions (see definition) related to Title XIX/XXI covered services, see Section **18.00 - Title XIX/XXI Notice and Appeal Requirements**.

The following provisions apply to notice requirements for members determined to have a SMI and for members for which an SMI eligibility determination is being considered.

Members who are evaluated for an SMI eligibility determination must receive the **AHCCCS Appeal or SMI Grievance Form,** available under **Provider Manual Attachments** on the MC website, at the time of determination.

The Notice of Decision and Right to Appeal (for Individuals with a Serious Mental Illness) must be provided to members determined to have a Serious Mental Illness or to members applying for SMI services when:

- Initial eligibility for SMI services is determined. The notice must be sent within 3 days of the eligibility determination;
- A decision is made regarding fees or waivers;
- The assessment report, service plan or individual treatment and discharge plan is developed, provided, or reviewed;
- A decision is made to modify the service plan, or to reduce, suspend or terminate any service that is a covered service funded through Non-Title XIX funds[1]. In this case, notice must be provided at least 30 days prior to the effective date unless the member consents to the change in writing or a qualified clinician determines that the action is necessary to avoid a serious or immediate threat to the health or safety of the member receiving services or others;
- A decision is made that the member is no longer eligible for SMI services; and
- A Pre-Admission Screening and Resident Review (PASRR) determination in the context of either a preadmission screening or an annual resident review, which adversely affects the member.

Additional Notices

The following additional notices must be provided to members determined to have a Serious Mental Illness or members applying for SMI services:

- The **Notice of Legal Rights for Members with Serious Mental Illness,** available under **Forms** on the MC website, must be given at the time of admission to a behavioral health provider agency for evaluation or treatment. The member receiving this notice must acknowledge in writing the receipt of the notice and the behavioral health provider must retain the acknowledgement in the member's comprehensive clinical record. All behavioral health providers must post **Notice of Legal Rights for Members with Serious Mental Illness,** available under **Forms** on the MC website, in both English and Spanish, so that it is readily visible to behavioral health members and visitors;
- The **Nondiscrimination Notice,** available under **Forms** on the MC website, posted in English and Spanish so that it is readily visible to members visiting the agency, and a copy provided at the time of discharge from the behavioral health provider agency.

[1] Actions or decisions that deny, suspend, reduce, or terminate a member's or member's services or benefits to avoid exceeding the state funding legislatively appropriated for those services or benefits do not require Notice.

Provider Notice Responsibility

Following a decision requiring notice to a behavioral health member, MC will ensure the communication of a notice to the member.

Notice Requirements for Non-Title XIX/XXI/Non-SMI Population

Notice is not required to members who are not eligible for Title XIX/XXI or SMI services under this policy.

Appeal Requirements

Appeals that are related to MC or one of their contracted behavioral health providers' decisions must be filed with MC.

Title XIX/XXI eligible members applying for or who have been determined to have a SMI and who are appealing an action affecting Title XIX/XXI covered services may elect to use either the Title XIX/XXI appeal process (see Section **18.00 - Title XIX/XXI Notice and Appeal Requirements**) or the appeal process for members determined to have a SMI described in **Section 18.03 - Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI)**.

Types of Appeal

There are two appeal processes applicable to this section:

- Appeals of members applying for an eligibility determination or who have been determined to have a SMI; and
- Appeals for other covered service-related issues.

Filing Members and Entities

The following members and entities may file an appeal:

- An adult applying for or receiving behavioral health services, their legal guardian, guardian ad litem, designated representative, or attorney if Special Assistance, or the member meeting Special Assistance needs;
- A legal guardian or parent who is the legal custodian of a member under the age of 18 years;
- A court appointed guardian ad litem or an attorney of a member under the age of 18 years;
- A state or governmental agency that provides behavioral health services through an Interagency Service Agreement/Intergovernmental Agreement (ISA/IGA) with AHCCCS, but does not have legal custody or control of the member, to the extent specified in the ISA/IGA between the agency and AHCCCS; and

- A provider, acting on the behavioral health member's behalf and with the written authorization of the member.

Timeframes for Appeals

Appeals must be filed orally or in writing with MC when required, within 60 days from the date of the decision being appealed. Late appeals must be accepted upon showing good cause.

Where to Appeal

- MC
  - Oral appeal: Call (800) 564-5465
  - Fax appeal: Fax 602-351-2300
  - Written appeal:

    Mercy Care
    Attn: Appeals
    4750 S. 44th Place, Ste 150
    Phoenix, AZ 85040

Appeal Process of Members with Serious Mental Illness

An appeal may be filed concerning one or more of the following:

- Decisions regarding the member's SMI eligibility determination;
- Sufficiency or appropriateness of the assessment;
- Long-term view, service goals, objectives, or timelines stated in the Individual Service Plan (ISP) or Inpatient Treatment and Discharge Plan (ITDP);
- Recommended services identified in the assessment report, SP, or ITDP;
- Actual services to be provided, as described in the ISP, plan for interim services or ITDP;
- Access to or prompt provision of services;
- Findings of the clinical team about the member's competency, capacity to make decisions, need for guardianship or other protective services or need for Special Assistance;
- Denial of a request for a review of, the outcome of, a modification to or failure to modify, or termination of an SP, ITDP or portion of an ISP or ITDP;
- Application of the procedures and timeframes for developing the ISP or ITDP;
- Implementation of the ISP or ITDP;
- Decision to provide service planning, including the provision of assessment or care management services to a member who is refusing such services, or a decision not to provide such services to the member;

- Decisions regarding a member's fee assessment or the denial of a request for a waiver of fees;
- Denial of payment of a claim;
- Failure of MC to act within the timeframes regarding an appeal; or
- A PASRR determination, in the context of either a preadmission screening or an annual resident review, which adversely affects the member.

Standard SMI Appeal Process

Within 5 working days of receipt of an appeal, MC must inform the appellant in writing that the appeal has been received and of the procedures that will be followed during the appeal.

In the event MC refuses to accept a late appeal or determines that the issue may not be appealed, MC must inform the appellant in writing that they may, within 10 days of their receipt of MC's decision, request an Administrative Review of the decision with the AHCCCS OGA.

If a timely request for Administrative Review is filed with AHCCCS regarding MC's decision, AHCCCS shall issue a final decision of within 15 days of the request (for members requiring Special Assistance, see **MC Provider Manual Chapter 400 - ACC-RBHA, Chapter 2 – Network Provider Service Delivery Requirements, Section 2.16 – Special Assistance for Members Determined to have a Serious Mental Illness (SMI)**.

Informal Conference with MC

Within 7 working days of receipt of an appeal, MC shall hold an informal conference with the member, guardian, any designated representative, care manager, or other representative of the service provider, if appropriate.

MC must schedule the conference at a convenient time and place and inform all participants in writing, two days prior to the conference, of the time, date and location, the ability to participate in the conference by telephone or teleconference, and the appellant's right to be represented by a designated representative of the appellant's choice.

The informal conference shall be chaired by a representative of MC with authority to resolve the issues under appeal, who shall seek to mediate and resolve the issues in dispute.

MC representative shall record a statement of the nature of the appeal, the issues involved, any resolution(s) achieved, the date by which the resolution(s) will be implemented and identify any unresolved issues for further appeal.

If the issues in dispute are resolved to the satisfaction of the member or guardian, if applicable, MC shall issue a dated written notice to all parties, which shall include a statement of the nature of the appeal, the issues involved, the resolution achieved and the date by which the resolution will be implemented.

If the issues in dispute are not resolved to the satisfaction of the member or guardian and the issues in dispute do not relate to the member's eligibility for behavioral health services, the member or guardian shall be informed that the matter will be forwarded for further appeal to AHCCCS for informal conference, and of the procedure for requesting a waiver of the AHCCCS informal conference.

If the issues in dispute are not resolved to the satisfaction of the member or guardian and the issues in dispute relate to the member's eligibility for SMI services or the member or guardian has requested a waiver of the AHCCCS informal conference in writing, MC shall:

- Provide written notice to the member or guardian of the process to request an administrative hearing.
- Determine at the informal conference whether the member or guardian is requesting MC to request an administrative hearing on behalf of the member or guardian and, if so, file the request with AHCCCS within 3 days of the informal conference.
- For a member who needs special assistance, send a copy of the appeal, results of information conference and notice of administrative hearing to the Office of Human Rights (OHR).
- In the event the member appealing fails to attend the informal conference and fails to notify MC of their inability to attend prior to the scheduled conference, MC shall reschedule the conference. If the member appealing fails to attend the rescheduled conference and fails to notify MC of their inability to attend prior to the rescheduled conference, MC will close the appeal docket and send written notice of the closure to the member appealing.
    - In the event the appellant requests the appeal be re-opened due to not receiving the informal conference notification and/or due to good cause, MC can re-open the appeal and proceed with the informal conference.
- For all appeals unresolved after an informal conference with MC, MC must forward the appeal case record to the AHCCCS OGA within three days from the conclusion of the informal conference.

AHCCCS Informal Conference

Unless the member or guardian waives an informal conference or the issue on appeal relates to eligibility for SMI services, AHCCCS shall hold a second informal conference within 15 days of the notification from MC that the appeal was unresolved.

- At least 5 days prior to the date of the second informal conference, AHCCCS shall notify the participants in writing of the date, time, and location of the conference.
- The informal conference shall be chaired by a representative of AHCCCS with authority to resolve the issues under appeal who shall seek to mediate and resolve the issues in dispute.
- The AHCCCS representative shall record a statement of the nature of the appeal, the issues involved, any resolution(s) achieved, the date by which the resolution(s) will be implemented and identify any unresolved issues for further appeal.
- If the issues in dispute are resolved to the satisfaction of the member or guardian, AHCCCS shall issue a dated written notice to all parties, which shall include a statement of the nature of the appeal, the issues involved, the resolution achieved and the date by which the resolution will be implemented.
    - For a member in need of Special Assistance, AHCCCS shall send a copy of the informal conference report to the OHR.
- If the issues in dispute are not resolved to the satisfaction of the member or guardian, AHCCCS shall:
    - Provide written notice to the member or guardian of the process to request a State Fair Hearing.
    - Determine at the informal conference whether the member or guardian is requesting AHCCCS to request a State Fair Hearing on behalf of the member or guardian and, if so, file the request within 3 days of the informal conference.
    - For a member who needs Special Assistance, send a copy of the notice to the OHR.
    - In the event the member appealing fails to attend the informal conference and fails to notify AHCCCS of their inability to attend prior to the scheduled conference, AHCCCS may issue a written notice, within 3 working days of the scheduled conference, which contains a description of the decision on the issue under appeal and which advises the appellant of their right to request a State Fair Hearing.
    - In the event the appellant requests the appeal be re-opened due to not receiving the informal conference notification and/or due to good cause, AHCCCS can re-open the appeal and proceed with the informal conference.

Requests for State Fair Hearing

A written request for hearing filed with AHCCCS must contain the following information:

- Case name (name of the applicant or member receiving services, name of the appellant and the docket number);
- The decision being appealed;
- The date of the decision being appealed; and
- The reason for the appeal.

In the event a request for State Fair Hearing is filed with MC, MC shall ensure that the written request for hearing, appeal case record and all supporting documentation is received by the AHCCCS OGA within 3 days from such date.

State Fair Hearings shall be conducted and decided pursuant to **A.R.S. §41-1092 et seq**.

Expedited SMI Appeals Process

A member, or a provider on the member's behalf, may request an expedited appeal for the denial or termination of crisis or emergency services, the denial of admission to or the termination of a continuation of inpatient services, if inpatient services are a covered benefit, or for good cause.

Within 1 day of receipt of a request for an expedited appeal, MC must inform the appellant in writing that the appeal has been received and of the time, date, and location of the informal conference; or

Issue a written decision stating that the appeal does not meet criteria as an expedited appeal and that the appellant may request an Administrative Review from AHCCCS of this decision within 3 days of the decision. The appeal shall then proceed according to the standard process described in this chapter.

Expedited Informal Conference

Within 2 days of receipt of a written request for an expedited appeal, MC shall hold an informal conference to mediate and resolve the issues in dispute.

AHCCCS Expedited Informal Conference

Within two days of notification from MC, AHCCCS shall hold an informal conference to mediate and resolve the issue in dispute, unless the appellant waives the conference at this level, in which case the appeal shall be forwarded within one day to the AHCCCS Director to schedule a State Fair Hearing.

Within one day of the informal conference with AHCCCS, if the conference failed to resolve the appeal, the appeal shall be forwarded to the AHCCCS Director to schedule a State Fair Hearing.

Requests for State Fair Hearing

A written request for hearing filed with AHCCCS must contain the following information:

- Case name (name of the applicant or member receiving services, name of the appellant and the docket number);
- The decision being appealed;
- The date of the decision being appealed; and
- The reason for the appeal.

In the event a request for State Fair Hearing is filed with MC, MC shall ensure that the written request for hearing, appeal case record and all supporting documentation is received by the AHCCCS OGA within 3 days.

State Fair Hearings shall be conducted and decided pursuant to **A.R.S. §41-1092 et seq**.

Continuation of Services during Appeal Process

For members determined to have a SMI, the member's behavioral health services will continue while an appeal for a modification to or termination of a covered behavioral health service is pending unless:

- A qualified clinician determines the modification, or termination is necessary to avoid a serious or immediate threat to the health or safety of the member or another individual; or
- The member or, if applicable, the member's guardian, agrees in writing to the modification or termination.

Appeals for Non-Title XIX/XXI/Non-SMI Population

Based on available funding, a member who is Non-Title XXI/XXI and Non-SMI may file an appeal of a decision that is related to a determination of need for a covered service (e.g., modification to previously authorized services for a non-Title XIX/XXI eligible member). In these circumstances, there is no continuation of services available during the appeal process.

MC in processing the appeal must:

- Inform the appellant in writing within 5 working days of receipt that the appeal has been received and of the procedures that will be followed during the appeal;
- Provide the appellant a reasonable opportunity to present evidence and allegations of

fact or law in member and in writing; and
- Provide a written decision no later than 30 days from the day the appeal is received. The decision shall include a summary of the issues involved, the outcome of the appeal, and the basis of the decision. For appeals not resolved wholly in favor of the appellant, MC shall advise the appellant in writing of their right to request an administrative hearing with AHCCCS no later than 30 days from the date of MC's decision, and how to do so.

Requests for State Fair Hearing

A written request for hearing filed with AHCCCS must contain the following information:
- Case name (name of the applicant or member receiving services, name of the appellant and the docket number);
- The decision being appealed;
- The date of the decision being appealed; and
- The reason for the appeal.

In the event a request for State Fair Hearing is filed with MC, MC shall ensure that the written request for hearing, appeal case record and all supporting documentation is received by AHCCCS OGA within 3 days.

Behavioral Health Provider Responsibilities

While providers are not directly responsible for the resolution of appeals, they are required to actively participate in the process as follows:
- Provide information deemed to be necessary by MC, AHCCCS or the Office of Administrative Hearings (e.g., documents and other evidence); and
- Cooperate and participate as necessary throughout the appeal process.

Behavioral health providers must be available to assist a member in the filing of an appeal. For members determined to have an SMI, the Office of Human Rights may be available to assist the member in filing as well as resolving the appeal.

Behavioral health providers must not retaliate against any member who files an appeal or interfere with a member's right to file an appeal. Additionally, no punitive action may be taken against a behavioral health provider who supports a member's appeal.

18.04 – Provider Claim Dispute Process

The provider claim disputes process affords providers the opportunity to challenge a decision by MC that impacts the provider. Providers may file a claim dispute based on:

- Claim denial
- Recoupment
- Dissatisfaction with claim payment
- Imposition of a sanction.

All claim disputes must be submitted to the MC Appeals Department. Claim disputes can be submitted through the following avenues:

- **Preferred Submissions - Email:** mercycareappeals@mercycareaz.org or **FAX:** 860-907-3511
  Note: we can respond back to our providers via fax for your convenience
- **Mail:** 4750 S 44th Pl, Ste 150, Phoenix, AZ 85040

Claim disputes should include all supporting documentation with the initial claim dispute submission. The claim dispute must specifically state the factual and legal basis for the dispute requested, along with copies of any supporting documentation, such as remittance advice (s), medical records, or claims. Failure to specifically state the factual and legal basis may result in denial of the claim dispute.

The claim dispute process should only be used after other attempts to resolve the matter have failed. It is important to remember that before a provider initiates a claim dispute, the following needs to occur:

- The provider should contact MC's Claims and/or Network Management to seek additional information prior to initiating a claim dispute.
- The provider must follow all applicable laws, policies and contractual requirements when filing.
- Pursuant to A.R.S. §36-2903.01(B)(4), all claim disputes related to a claim for system covered services must be filed:
  - Within 60 days of the date of notice, advising that a sanction will be imposed, or
  - For disputes related to the payment, denial, or recoupment of a claim, the later of the following:
    - 12 months of the date of delivery of the service;
    - 12 months after the date of eligibility posting; or
    - Within 60 days after the payment or denial of a timely claim submission, or the recoupment of payment, whichever is later.

Once MC issues a notice of decision regarding a provider claim dispute and the provider disagrees, the provider may request a state fair hearing for further review of the decision.

Many times, disagreements between a provider and MC can be resolved through an informal process. This process is handled through our Network Management department. Contact information for our Network Management department can be found in section **2.00 – Mercy Care Contact Information** of this manual. You can also reach out to your assigned Network Management representative. Providers are encouraged to try and solve issues at the informal level before initiating the formal provider claim dispute process. However, providers should be aware that the formal process contains very specific timeframes within which to file for a review and/or hearing and resolving issues through an informal process does not suspend or postpone these timeframes.

The intent of this chapter is to describe the options available to providers to resolve issues and other events related to a decision of MC. The chapter is organized to delineate the process for filing a claim dispute:

- For providers disputing a decision of MC; and
- The process for requesting an administrative hearing in the event a provider does not agree with the claim dispute decision of MC.

Prior to Filing an Initial Claim Dispute

All providers are encouraged to seek informal resolution of a concern by first contacting the appropriate entity responsible for the decision. For concerns regarding claims, it is important for providers to understand why the claim was denied before initiating a claim dispute. Denied claims may be the result of filing errors or missing supporting documentation, such as an explanation of benefits (EOB) or an invoice. Resubmitting claims with the requested information or corrections can result in resolution of the issue and full payment of the claim. To get assistance with the informal resolution of a decision, please contact:

Mercy Care
4750 S 44th Place, Ste 150
Phoenix, AZ 85040
Phone: 602-263-3000 or 800-624-3879

General Requirements

Computation of Time - A written claim dispute is considered filed when it is received by MC established by a date stamp or other record of receipt. Providers must use the following methodology in computing any period described in this chapter:

- Computation of time for calendar day begins the day after the act, event or decision and includes all calendar days and the final day of the period.
- If the final day of the period is a weekend or legal holiday, the period is extended until the end of the next day that is not a weekend or a legal holiday.

If an issue is unable to be resolved informally, providers may dispute the decision by filing a written claim dispute. For all provider claim disputes related to decisions of MC, the provider must file the claim dispute with MC at:

Mercy Care
Attn: Appeals Department
4750 S. 44th Place, Ste 150
Phoenix, AZ 85040

You may submit your claim dispute through email at mercycareappeals@mercycareaz.org or fax. Not only do we now have the ability to receive disputes by fax, but we can also respond back to our providers via fax, allowing you to receive faster decisions. If you choose to send via fax, please fax your disputes to 860-907-3511.

All claim disputes must be submitted to the MC Appeals Department. Please include all supporting documentation with the initial claim dispute submission. The claim dispute must specifically state the factual and legal basis for the dispute requested, along with copies of any supporting documentation, such as remittance advice(s), medical records, or claims. Failure to specifically state the factual and legal basis may result in denial of the claim dispute.

All documentation received during the claim dispute resolution process must be date stamped upon receipt.

All claim dispute case records must be filed in secured locations and retained for five years after the most recent decision has been rendered.

All decisions shall be faxed or mailed to the party at their last known place of business.

Claim Dispute Log

MC shall maintain a tracking log for all claim disputes. The tracking log shall contain the following information:

- Name of complainant
- Date of receipt
- Nature of dispute
- Resolution
- Date of resolution

Notification of Right to File Claim Dispute

MC must provide an affected provider a remittance advice that includes provider's right to file a claim dispute and how to do so, upon the payment, denial, or recoupment of payment of a claim. MC must notify an affected provider of the right to file a claim dispute and how to do so when a decision is made to impose a sanction.

Initiate Claim Dispute

It is important for providers to ensure the claim dispute is submitted in writing and contains all required information and is filed within the required timeframes. Failure to do so will result in the denial of the claim dispute.

The notice of claim dispute must specify the statement of the factual and legal basis for the claim dispute and the relief requested. Claim disputes may be denied if the filing party has failed to provide a comprehensive factual or legal basis for the dispute.

Claim Disputes may be submitted in writing or through fax. Please note submission information under ***Computation of Time.***

Claim Disputes of MC Decisions

Within 5 days of receipt of a claim dispute, MC shall send written acknowledgment that the claim dispute has been received, will be reviewed and that a decision will be issued within 30 days of receipt of the claim dispute, absent extension of the timeline.

If MC determines that it was not responsible for the claim dispute, they must immediately forward the claim dispute to the responsible plan or to AHCCCS with an explanation of why the claim dispute is being forwarded.

- A copy of the transmittal shall be sent by MC to the party filing the claim dispute.
- The receiving plan must ensure that a decision is rendered within 30 days of MC's receipt of the notice of claim dispute unless an extension has been granted pursuant to 3.g. of this policy.

MC Notice of Decision

MC shall issue a written, dated decision which must be mailed to all parties no later than 30 days after the provider files a claim dispute with MC, unless the provider and MC have agreed to a longer period. The Decision must include and describe in detail, the following:

- The nature of the claim dispute;
- The issues involved;

- MC's decision and the reasons supporting decision, including references to applicable statute, rule, applicable contractual provisions, policy, and procedures;
- The provider's right to request a hearing by filing a written request for hearing to AHCCCCS no later than 30 days after the date the provider receives MC´s decision;
- The provider's right to request an informal settlement conference prior to hearing; and
- If the claim dispute is overturned, the requirement that MC must reprocess and pay the claim(s), with interest, when applicable, in a manner consistent with the decision within 15 business days of the date of the decision.

Extension of Time

To request an extension of the 30-day timeframe, the provider must submit to MC prior to the expiration of the original time limit, a written request including the reasons for the extension and a proposed new timeframe that does not unreasonably postpone final resolution of the matter. A representative of MC may also request an extension. In either case, the provider and MC must agree to the extension in writing. Documentation of the agreement to the extension of time must be maintained in the claim dispute case record.

Requests for a State Fair Hearing

If the party filing a claim dispute is dissatisfied with the MC Notice of Decision or if a Notice of Decision is not received within 30 days after the claim dispute is filed, absent an extension of time mutually agreed to by MC and the provider, a request for a State Fair Hearing must be filed, in writing to:

Fax: 866-821-6628

Mail: Mercy Care
Attn: Hearing Coordinator
4750 S. 44th Place, Ste 150
Phoenix, AZ 85040

Both the State Fair Hearing request letter and envelope should be clearly addressed to the "Hearing Coordinator" and sent to the fax number or mailing address above to avoid delay. Additionally, the state fair hearing request letter shall clearly state "State Fair Hearing Request" in the subject line.

Timeframes for Requesting a State Fair Hearing

The provider's request for a hearing must be filed in writing and received by the Hearing Coordinator no later than 30 calendar days of the date of receipt of the MC Notice of Decision.

A written request for hearing is considered filed on the date it is received by the Hearing Coordinator. as established by a date stamp or other record of receipt.

Requirements for a Request for a State Fair Hearing

The request for an administrative hearing to AHCCCS must include:

- Provider's Information including:
  - Name, AHCCCS identification Number, address, phone number, and MC appeal number
- A copy of the MC Notice of Decision;
- Member's name and AHCCCS identification number; and
- Legal and factual basis for the claim dispute.

Scheduling of a State Fair Hearing

Within 5 days of receipt of a request for state fair hearing, MC will forward the hearing request and claim dispute file to the AHCCCS Office of General Counsel. AHCCCS will then schedule a hearing with the Arizona Office of Administrative Hearings and will notify provider of the date, time, and location of the hearing. See A.A.C. 34, *AHCCCS Grievance System*.

If an AHCCCS or MC decision regarding a claim dispute is reversed through the claim dispute or hearing process, MC shall reprocess and pay the claim(s) with interest, when applicable, in a manner consistent with the decision within 15 business days of the date of the decision unless a different timeframe is specified.